

Project Review Report

The Innovation for Healthcare Inequalities Programme Wave 2 Project

FeNO for the improvement of asthma diagnosis and
management in Suffolk and North East Essex.

LUCY AINSLEY, PROJECT MANAGER SNEE ICB



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Executive summary

Respiratory diseases are a key strategic priority for Suffolk and North East Essex Integrated Care System (SNEE) due to the high prevalence of asthma across the region and existing variations in diagnostic pathways. The aim of the project was to increase access to [FeNO](#) in primary care to enhance the diagnosis and management of asthma in key populations across the region, specifically in coastal and rural communities where diagnostic access has been historically limited, and deprivation is higher than average. FeNO testing provides an objective biomarker for airway inflammation, supporting earlier and more accurate diagnosis of asthma and personalised prescribing of inhaled corticosteroids to help drive transformation and alignment with best practice care for patients with asthma.

Background to InHIP Wave 1 and Wave 2 programmes

The Innovation for Healthcare Inequalities programme (InHIP) was a national collaboration between the [Accelerated Access Collaborative \(AAC\)](#), the [National Healthcare Inequalities Improvement Programme](#) and the [Health Innovation Network](#) delivered in partnership with Integrated Care Systems (ICS). The aim was to enable systems to generate evidence and pilot new approaches to accelerate access to NICE approved innovations.

The focus for the programme was the five clinical areas of maternity, mental health, respiratory, early cancer diagnosis, and cardiovascular disease contained within the [Core20PLUS5](#) approach to reducing healthcare inequalities. Health inequalities are differences in health across the population that are systematic, unfair, and avoidable. They are caused by the conditions in which we are born, live, work, and grow. Reducing health inequalities is key to our strategy and underpins Health Innovation East's purpose – helping the best innovations in health and care reach the people, places, and problems where they bring most benefit.

To deliver InHIP, Health Innovation East (HIE) worked with system partners and key stakeholders across the East of England in two distinct phases: October 2023 to March 2024, Wave 1, and April 2024 to March 2026, Wave 2. Wave 1 projects included three cardiovascular projects with one cancer project. The Wave 2 projects covered three clinical areas including *cancer screening* (breast, bowel and cervical), *cardio-vascular disease* (heart failure with preserved ejection fraction and blood pressure optimisation with atrial fibrillation detection) and *respiratory disease* (interstitial lung disease (ILD) and diagnosis and treatment of asthma).

The specific innovations, technologies, and medicines supported across Wave 2 included:

- [KardiaMobile](#) for detecting atrial fibrillation in Hertfordshire and West Essex and Cambridge and Peterborough.
- [FIT Testing](#) for detecting bowel cancer in Norfolk and Waveney.
- [FeNO](#) for the diagnosis and management of asthma in Mid and South Essex and Suffolk and North Essex.
- [Dapagliflozin](#) to support heart failure with preserved ejection fraction in Milton Keynes.
- [Nintedanib](#) for treating progressive fibrosing ILD across the East of England.

By the 31 December 2025, Wave 2 programmes in the East of England had directly supported 2,707 people in underserved populations to enter health and care pathways with 981 directly starting treatments and or accessing a NICE recommended innovation as a result. We have used the learnings from Wave 1 to further adapt and scale our approach for Wave 2, increasing the number of projects from four to seven across a wider range of clinical and

geographical areas including delivering a regional project alongside local projects and reducing the total investment by 50% yet delivering the same level of impact. This is based on our approach of building on local assets and partnerships, and through scaling activities we understand to be effective. All six projects Wave 2 projects are now complete with one project to be finalised by the summer 2026.

Our approach to evaluation has also developed over the lifespan of the programme. The four initial projects included formal impact evaluations, available from the ICS project teams with the National Health Innovation Network publishing an [Impact Report](#) in December 2024. Wave 2 has taken a proportionate approach to reviewing project learnings, outcomes, and impact, scaled to reflect the budget distributed and partner capacity. Each Project Review Report is drafted with delivery partners to focus on real world examples of how targeted interventions and innovations are improving healthcare access, experience, and outcomes for communities facing the greatest health inequalities.

Background to scope of the project and partners

The SNEE project was delivered as part of the InHIP Wave 2 programme, a national collaboration supporting ICSs to accelerate access to NICE approved innovations. Within SNEE, respiratory disease is a key priority due to high prevalence of asthma, rurality driven access challenges, and variation in diagnostic pathways. FeNO was selected as the innovation because it provides an objective biomarker for airway inflammation, supporting earlier and more accurate asthma diagnosis and enabling personalised inhaled corticosteroid prescribing. Prior to the project, FeNO access across SNEE was inconsistent, with many SystmOne practices performing only a handful of tests per month or none. As noted in the baseline dataset recorded by the ICB as part of this project, “some practices recorded ‘1’ or ‘2’ tests per month, while others had no activity at all.”

The project was delivered in partnership between SNEE ICB, Health Innovation East, primary care networks, and participating GP practices. It aligned with ICS priorities around respiratory optimisation, Core20PLUS5 inequalities reduction, and shifting care closer to home. The work particularly supported coastal and rural communities where diagnostic access has historically been limited due to access and travel issues enhanced by long waiting lists for local Spirometry clinics. Support included provision of FeNO devices, training for clinicians and administrative teams, pathway redesign, and embedding consistent coding using SystmOne codes XaRCB and Y1fa5. The project aimed to reduce unwarranted variation, improve diagnostic confidence, and strengthen data quality for population level respiratory planning.

Delivery and key findings

Expanding access to FeNO testing - at baseline, FeNO activity across SNEE was low and inconsistent. Practices such as Combs Ford, Felixstowe Road, and Hawthorn Drive recorded only isolated tests per month, while others had no activity. The dataset shows that in 2024/25, monthly totals were as low as “3”, “1”, or “2” tests in some months. To address this, the project provided FeNO devices to selected practices, prioritising areas with high asthma prevalence, limited diagnostic access, or known inequalities using practice-based data gathered from SystmOne and ICB data sets on deprivation and inequality. Practices were supported to integrate FeNO into routine asthma reviews, diagnostic appointments, and opportunistic testing.

Some practices rapidly embedded FeNO: across the 9 months of the project, The Derby Road Practice recorded 142 tests, and the Framlingham Surgery recorded 97 tests. Others remained at low activity or intermittent, reflecting workforce pressures, winter demand, and differing levels of respiratory expertise.

The project achieved a substantial increase in FeNO activity. Total tests rose from 134 in 2024/25 to 833 as of January 2026.

Key findings

- FeNO can be successfully scaled in primary care with the right support.
- Workforce confidence is a critical enabler.
- Coding standardisation is essential for meaningful data.
- Practices with strong respiratory leadership adopt innovations faster.
- Rural and coastal practices particularly benefited from improved access.

A Reflections from the Programme Manager:

“My experience leading the SNEE FeNO project has reinforced how powerful relatively small diagnostic innovations can be when they are introduced with the right blend of practical support, clinical leadership, and data transparency. It has also highlighted the realities of implementing change in a pressured primary care environment, where even well-designed interventions must compete with workforce gaps, winter demand, and variation in local respiratory expertise.”

This quote highlights how even well planned, evidence-based interventions can encounter challenges due to operational and seasonal pressures within the healthcare environment. It also highlights the importance of balancing priorities, practical hands-on support and maintaining strong leadership in a transparent and clear way.

Impact and benefits

Benefits for patients

- Patients receive earlier clarity about their respiratory condition, reducing anxiety and delays.
- FeNO supports personalised inhaler prescribing, improving symptom control and reducing side effects.
- More conditions can be diagnosed and managed in primary care, reducing the need for hospital appointments.
- Expanded FeNO availability improved equity for rural and coastal communities.

Activity and performance data: The dataset shows:

- 833 total tests recorded across the period.
- Strong month on month growth in performance of tests across 2025/26.
- High performing practices demonstrating what good looks like.
- Clear evidence of increased adoption following training and pathway redesign.

System-wide impact: The project strengthened respiratory pathways, improved diagnostic consistency, and supported ICS priorities around Core20PLUS5 and respiratory optimisation. It also created a replicable model for scaling diagnostics in primary care.

Reflection and learnings

The project was deemed both rewarding and challenging. Rewarding aspects reported included witnessing practices who had used FeNO just once or twice per month prior to the pilot, begin to embed FeNO into routine asthma care. Derby Road and Framlingham are two specific practices that have demonstrated consistent, high-quality activity, showcasing what is possible when clinical leadership, training, and workflow are redesigned and aligned.

The main challenge was the variation in readiness and confidence observed across practices during implementation. Some teams were enthusiastic from the outset, while others needed reassurance, hands-on support, and time to understand how FeNO could fit into their existing diagnostic approach. This could be partly attributed to the operational pressure's practices experienced during the implementation period (Winter 25/26), and the varying levels of expertise and workforce each practice could access internally for support.

Data quality and the initial inconsistency in coding of delivery of tests was also a challenge locally during implementation. Even when practices were performing tests, the activity wasn't always visible because XaRCB and Y1fa5 were not being used reliably. This created early data gaps and made it harder to demonstrate impact until coding guidance and templates were standardised.

What worked well

- Providing devices alongside training accelerated adoption.
- Standardised coding improved data quality and visibility.
- Peer learning between practices helped build confidence.
- Embedding FeNO into existing asthma reviews increased sustainability.

Challenges

- Variation in uptake some practices rapidly embedded FeNO while others remained low activity.
- Workforce confidence required sustained support.
- Winter pressures and staffing gaps affected consistency.

Key learnings

Confidence was the single biggest determinant of uptake. Practices with clinicians who felt comfortable interpreting FeNO results embedded the test rapidly. Where confidence was lower, activity remained sporadic. Confidence improved significantly after training, peer learning, and the introduction of a standardised pathway that clearly set out when and how FeNO should be used.

- Adoption is strongest where confident clinical leadership is present.
- Data transparency motivates improvement.
- Practices need time to embed new diagnostics into routine workflows.
- Coding issues must be addressed early to avoid data gaps.

What we would do differently

- Build a buddying model from the start. From the outset, high-performing practices naturally became informal mentors, creating a buddying model that could have been intentionally designed from the start. Formalising this earlier would have helped lower uptake practices adopt FeNO more quickly and feel supported by peers, rather than relying solely on central guidance.
- Secure protected time for respiratory leads, as embedding a new diagnostic into routine workflows takes time. Where practices had a named respiratory lead with protected time, adoption was faster and more consistent.
- Engage PCNs earlier and more consistently, PCN-level leadership helped create shared expectations and reduce variation. Earlier engagement would have strengthened alignment and supported practices that were slower to adopt.
- Introduce hands on training earlier, practices responded best when they could physically use the device, practise interpreting results, and ask questions in real time. Earlier practical sessions would have accelerated confidence and reduced early variation.

Conclusion

The FeNO project has significantly expanded asthma related diagnostic capacity across Suffolk and North East Essex, addressing longstanding variation in asthma diagnosis and improving access for communities that have historically faced barriers to respiratory assessment, particularly those in rural and coastal areas. By increasing availability of FeNO testing within primary care, the project has helped shift diagnostics closer to home, reducing the need for hospital-based investigations and supporting earlier clarity for patients experiencing respiratory symptoms.

Activity increased steadily across the delivery period, reflecting a combination of targeted training, pathway redesign, and the introduction of consistent coding using XaRCB and Y1fa5. These enablers created the conditions for sustained adoption, allowing practices to integrate FeNO into routine asthma reviews, diagnostic appointments, and opportunistic testing. As a result, diagnostic accuracy has strengthened, personalised inhaler prescribing has improved, and avoidable referrals have reduced, supporting both patient experience and system efficiency.

A key achievement has been the improvement in data quality and visibility. Standardised coding and transparent reporting enabled practices and PCNs to understand their activity in context, identify unwarranted variation, and benchmark themselves against peers. This transparency created a healthy sense of accountability and contributed to a culture of continuous improvement. High performing practices demonstrated what good looks like, while others used the data to identify where additional support, training, or workflow adjustments were needed.

Sustainability is strong. FeNO is now embedded in routine asthma pathways across many practices, supported by growing workforce confidence and clearer clinical decision-making frameworks. Practices that were initially low activity have begun to increase their use of FeNO as confidence, familiarity, and peer support has grown. The project has also strengthened relationships between practices, PCNs, and system partners, creating a more cohesive approach to respiratory optimisation.

The learning generated through this work will directly inform future ICS priorities, including inhaler switching programmes, asthma review redesign, and wider diagnostic access for respiratory conditions. The project has demonstrated that with the right support, practical training, clear pathways, strong clinical leadership, and reliable data, primary care can successfully adopt and scale innovative diagnostics that improve outcomes and reduce inequalities.

Overall, the FeNO project provides a strong foundation for ongoing system-wide efforts to improve respiratory health and deliver the Core20PLUS5 priorities. It shows that targeted investment, aligned with local need and supported by robust implementation, can deliver meaningful improvements in access, experience, and outcomes for the communities who need it most.

Case Study – one page summary



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References and Background

Inclusion Criteria

- ✓ Patients aged ≥ 5 years with suspected asthma
- ✓ Patients with ongoing asthma symptoms requiring diagnostic clarification
- ✓ Patients undergoing ICS optimisation
- ✓ Patients with poor symptom control despite treatment

Exclusion Criteria

- ✓ Children under 5
- ✓ Patients unable to perform FeNO testing reliably
- ✓ Patients with acute respiratory infection (test deferred)

Searches / Coding

- ✓ SystemOne codes used:
- ✓ XaRCB – Exhaled nitric oxide test
- ✓ Y1fa5 – Measurement of expired nitric oxide (Quoted from your dataset: “Exact Codes: Exhaled nitric oxide test (XaRCB) & Measurement of expired nitric oxide (Y1fa5)”)

Publicity / Information Assets

- ✓ Patient information leaflets explaining FeNO
- ✓ Practice level posters promoting availability of FeNO testing
- ✓ Standardised FeNO pathway and template
- ✓ Coding guidance and data quality checklist

Acknowledgements

1. Suffolk & North East Essex Integrated Care Board
2. Health Innovation East
3. Participating GP practices across Ipswich & East Suffolk
4. Respiratory clinical leads and PCN teams
5. Administrative and data quality teams
6. InHIP national programme team
7. NICE DG12: FeNO for asthma diagnosis and management

8. NHS Long Term Plan (2019)
9. Core20PLUS5: National Healthcare Inequalities Improvement Programme
10. SNEE Joint Forward Plan (2023–2028)
11. SNEE Population Health Management Strategy
12. Innovation for Healthcare Inequalities Programme (InHIP) Wave 2 documentation
13. FeNO dataset (SystmOne, 2024/25–2025/26): “some practices recorded ‘1’ or ‘2’ tests per month
14. Case study content: “The project aimed to expand access to Fractional Exhaled Nitric Oxide (FeNO) testing
15. NICE NG80: Asthma: diagnosis, monitoring and chronic asthma management