NHS England

ANNUAL REPORT 2022-2023 CVD-R and Diabetes Clinical Networks

NHS England, East of England

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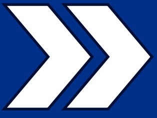

Foreword

Foreword

The Cardiovascular Disease and Respiratory (CVD-R) Networks, together with the Diabetes Network, is delighted to publish its 2022/23 Annual Report. This report highlights some of the key achievements of the Networks over the last year in what continues to be another challenging year for health and care. Specifically, 2022/23 marked a continuing focus on supporting our partners with recovery from Covid-19 and moving forward with pathway transformation to improve the quality of care, access, and outcomes for patients.

The CVD-R and Diabetes Networks aim to seek regional solutions to common issues and provide sound building blocks for the transformation of pathways, as well as looking at better ways to support providers and patients to optimise their treatment and outcomes.

2022/23 marked the second full year of the establishment of CVD-R Networks and at a time when the NHS has undergone considerable challenges and changes due to the COVID-19 pandemic and the formation of our new Integrated Care Systems.

This year, the networks have focused on building these relationships with the new Integrated Care Systems as delivery partners and strengthening the governance to ensure that local and regional priorities are addressed alongside national requirements; as well as building greater partnerships with colleagues from other networks, the Academic Health Science Networks, and voluntary and third sector organisations to align our common objectives to deliver sustainable improvements.

The newly formed Renal Network has also joined the CVD-R Networks to now form the Cardiovascular Disease, Respiratory, Diabetes and Renal Networks.

I am pleased to report that across the Networks we achieved many key objectives during 2022/23, and more details can be found in corresponding sections of this report. I particularly wanted to highlight the following areas of work:

1. The implementation of AI for stroke imaging across the East of England Region
2. The launch of the Diabetes Care Accreditation Process in conjunction with Diabetes UK and the Royal College of Physicians
3. Development of the Out-of-Hospital Cardiac Arrest protocol
4. Commencing the Pulmonary Rehabilitation Accreditation project.

We acknowledge that some areas still need improvement in certain areas, and we continue to work closely with providers and ICBs to address their specific issues including:

- widening the uptake of CVD prevention measures
- improving rates of achievement in the 8 care processes in patients with diabetes; and
- improving outcomes for patients requiring time-critical interventions in stroke services, such as mechanical thrombectomy and thrombolysis, and interventions for patients who have had a heart attack.

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There has been a greater focus on engaging with the patients in the shaping of our pathways via the establishment of the regional PPV Programme. Recent successes include the recruitment of patient representatives to our Respiratory Board; setting up a patient registry; undertaking various patient survey and focus group activities; as well as supporting providers and commissioners by establishing the regional PPV Network with regular well-attended PPV Workshops to share best practice and latest updates.

The Networks are supported by a central team of business support officers - the Deputy Head of CVDR Networks, a Senior Information Analyst and, more recently, a Patient Engagement Lead; all of whom have made a valuable difference to the way in which the networks are able to function and focus on the transformational work required to support the system and partners to improve the outcomes and experiences of patients.

Finally, I would like to also express my gratitude for all the hard work and dedication that the regional Network teams, the clinicians and Integrated Care Board leads have shown over the last year.

I look forward to continuing our work with them over the next year (and beyond) to build on our recent achievements and continue to work towards improving service delivery for all patients in the East of England.

Helena Baxter
Head of CVD-R and Diabetes and Renal Networks and Transformation
NHS England – East of England

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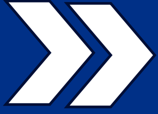

Introduction

Introduction

The Cardiovascular Disease and Respiratory (CVDR) Networks, together with the Diabetes Network, cover a range of long-term conditions across full pathways of care across the East of England region.

The CVDR Networks aim to seek regional solutions to common issues and provide sound building blocks for the transformation of pathways, as well as looking at better ways to support patients at home and optimise their treatment and outcomes.

This family of networks comprises of:

1. Cardiac Clinical Network – which includes prevention, rehabilitation, cardiology, and cardiac surgery.

2. Integrated Stroke Delivery Networks – there are two Integrated Stroke Delivery Networks (ISDNs) in the East of England – North ISDN and South ISDN. The stroke and cardiac networks share the CVD prevention programme.

3. Respiratory Clinical Network – this Network provides leadership across the region to support to quality improvements that can be made in the diagnosis, treatment, rehabilitation, and prevention of respiratory disease in the East of England.

4. Long COVID Clinical Network - a new network sitting within the Respiratory Network umbrella, the Long COVID network was set up in response to the emergence of Post-COVID Syndrome and the need to provide assessment and treatment services for this new condition.

5. Diabetes Clinical Network – this network has been in existence for some years but has recently refocused to assurance of recovery of services post pandemic as well as implementing new technologies and pathways of care.

The detailed aims of the Networks are to:

1. Improve sustainable outcomes in population health and healthcare.
2. Tackle inequalities in outcomes, experience, and access.
3. Enhance quality of care for patients.
4. Increase productivity and value for money.
5. Help the NHS to support broader social and economic development.

In addition, the Networks aim to provide leadership and focus across the East of England in their respective fields, bringing together multi-professional stakeholders from all providers and commissioners.

Regional Team

Helena Baxter
Head of CVDR and Diabetes Clinical Networks and Transformation

Fiona Oliver
Deputy Head of CVD-R, Diabetes and Renal Clinical Networks (until June 2023)

Caron Tozer
Business Manager

Paula Sumray
Business Co-Ordinator/Executive Assistant

Ryan O’Neill
Senior Informatics Data Analyst

Nicola Hawdon
Patient Engagement and PPV Lead

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NHS England
East of England

6 million population

6 Integrated Care Boards

23 trusts

Norfolk and Waveney

Cambridge and Peterborough

Suffolk and North East Essex

Hertfordshire and West Essex

Mid and South Essex

Bedfordshire, Luton and Milton Keynes

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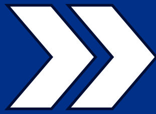

1. Cardiac Clinical Network

Cardiac Clinical Network

The Cardiac Clinical Network was established in the first quarter of 2021/22 to deliver the ambitions of the Long-Term Plan - to support COVID-19 recovery across the East of England region and to deliver the Cardiac Pathways Improvement Programme (CPIP).

The vision and aims of the cardiac network are to "deliver better heart health and healthcare outcomes for all". This is achieved by setting the strategic direction for local cardiac services, driving operational improvement, and implementing high quality, standardised pathways of care across prevention, diagnosis, acute/specialist treatment, rehabilitation, and end of life care.

Network Team

Dr Robert Sherwin
Senior Responsible Officer, Medical Director Specialised Commissioning & Health and Justice

Dr Tom Keeble
Clinical Lead, Acute Coronary Syndrome & Out-of-hospital Cardiac Arrest

Dr Rebecca Schofield
Clinical Lead, Heart Failure and Diagnostics

Dr Chirag Bakhai
Clinical Lead, Primary Care and CVD Prevention

Mr David Jenkins
Clinical Lead, Cardiac Surgery

Mr Narain Moorjani
Clinical Lead, Cardiac Surgery

Miss Alessia Rossi
Clinical Lead, Cardiac Surgery

Kate Foxwell (from Aug 2022)
Quality Improvement Manager

Fantacy Twagira
Project Support Officer

James Fishlock (from Oct 2022)
Project Manager -Cardiac Rehab and Surgery

Rebecca Hall (from Oct 2022)
Project Manager – 7 Day Working

Amanda Harrington
Business Support Officer

"I've been very lucky to have the opportunity to be seconded into the East of England Cardiac Network for one day per week from my role at AstraZeneca. The Network team have been super supportive and welcoming, as have the Cardiology and ICB staff around the region that I've been working with.

It's very rewarding to see how the Network impacts the way patient care and equity of access is steadily improved across the East of England and a real privilege to be able to contribute in some small way to this development by helping to bring key stakeholders together and keep the workstream that I'm attached to moving forwards across the region."

Peter Smith, Project Manager (seconded from Astra Zeneca)

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Network Priorities for 2022/23

Long Term Plan Ambitions:	**Cardiac Pathways Improvement Programme Priorities:**
1. Increase detection of familial hypercholesterolemia to 25% 2. Greater access to echocardiography in primary care 3. Better personalised care for heart failure patients leading to reduced LOS in acute hospitals 4. Improve defibrillator networks to improve survival from out of hospital cardiac arrest 5. Up to 85% of patients eligible for cardiac rehabilitation accessing care	1. Improved CVD prevention, with a focus on Hypertension detection and management 2. Increase access to diagnostics, i.e., NT pro-BNP and echocardiography and reduction of backlog post COVID 19 3. Reduction of P2/P3 waits in cardiac surgery and appointment of clinical leads for cardiac surgery. 4. NSTEMI & STEMI treatment times 5. Reduced time-to-treatment for heart attacks and improved survival from cardiac arrest 6. Clinical/process changes to improve patient flow (e.g., 7/7 working) 7. Improved access and increased uptake in cardiac rehab 8. Heart failure pathways

Additional priorities for the East of England network include:

1. Establishment of effective partnership working with the Integrated Care Systems
2. Wide ranging patient and public engagement in the workstreams
3. Out of Hospital Cardiac Arrest Centre pilot evaluation.

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Network performance and achievements

The network has a series of workstreams designed to ensure we meet the outlined priorities across:

1. CVD prevention
2. Diagnostics
3. Acute Coronary Syndrome
4. Surgery
5. Heart Failure and Breathlessness
6. Cardiac Rehabilitation
7. 7 Day Working

1. CVD Prevention

The Cardiac Network has a CVD Prevention Clinical Advisory Group (CAG) which meets bimonthly and comprises stakeholders from all 6 Integrated Care Systems (ICS) in the region, working in partnership with Eastern Academic Health Science Network (EAHSN) and Health Care Public Health. The CAG covers the prevention agenda for both cardiac, stroke and elements of diabetes. The CAG arranged 1:1 meetings with all ICBs in the region to discuss issues and challenges to achieving prevention targets.

Hypertension – improving treatment to target in all age groups.

- A key area of focus has been in sustaining and enhancing the BP@Home initiative and sharing best practice across the region.
- The network funded some additional BP machines for use in ICSs where uptake was lower.
- The network, together with EAHSN launched a Pilot using digital platforms to support patients to monitor and facilitate self-management of hypertension and this will be evaluated throughout 23/24.
- Bedfordshire, Luton and Milton Keynes ICB have developed their own protocol for optimising BP management and have shared this with other systems.
- The network has continued to work with community pharmacy colleagues to encourage uptake of community pharmacy case finding and management.

Lipid Pathways

- *Familial hypercholesterolemia*: working in partnership with East Genomics Medicine Service Alliance (GMSA) and EAHSN to achieve the ambitions of FH detection in 25% of the population by 2023. The working group has developed a familial hypercholesterolemia pathway, with GP access to genetic testing and a website with information for referrers. This is now live across the region and uptake will be monitored through 23/24.
- *High intensity statins*: the network is working collaboratively with system partners and EAHSN to promote the use of high intensity statins in patients at increased risk of cardiovascular disease.

Atrial Fibrillation (AF)

- In 21/22, the network funded two pilots in the use of AliveCor to aid detection of atrial fibrillation. These pilots have been successful, and we continue to work with systems to identify areas of good practice for screening AF.
- Mid and South Essex used Fibricheck devices to monitor and manage arrhythmias in their cardiology department, leading to reduction in waiting times for patients, reduction in out-patient attendances and reducing overall costs of the service.

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Figure 1: Hypertension - % patients treated to target (Target = 77%)

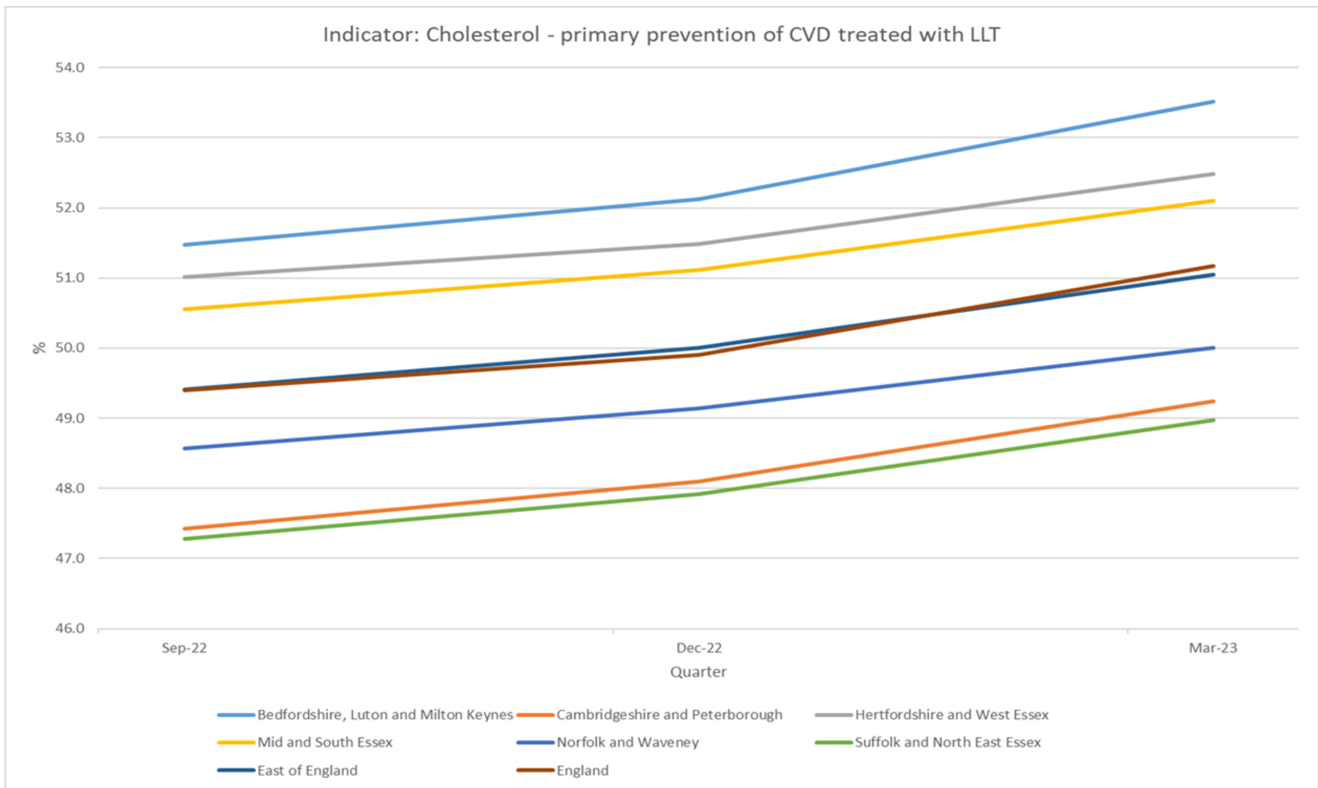
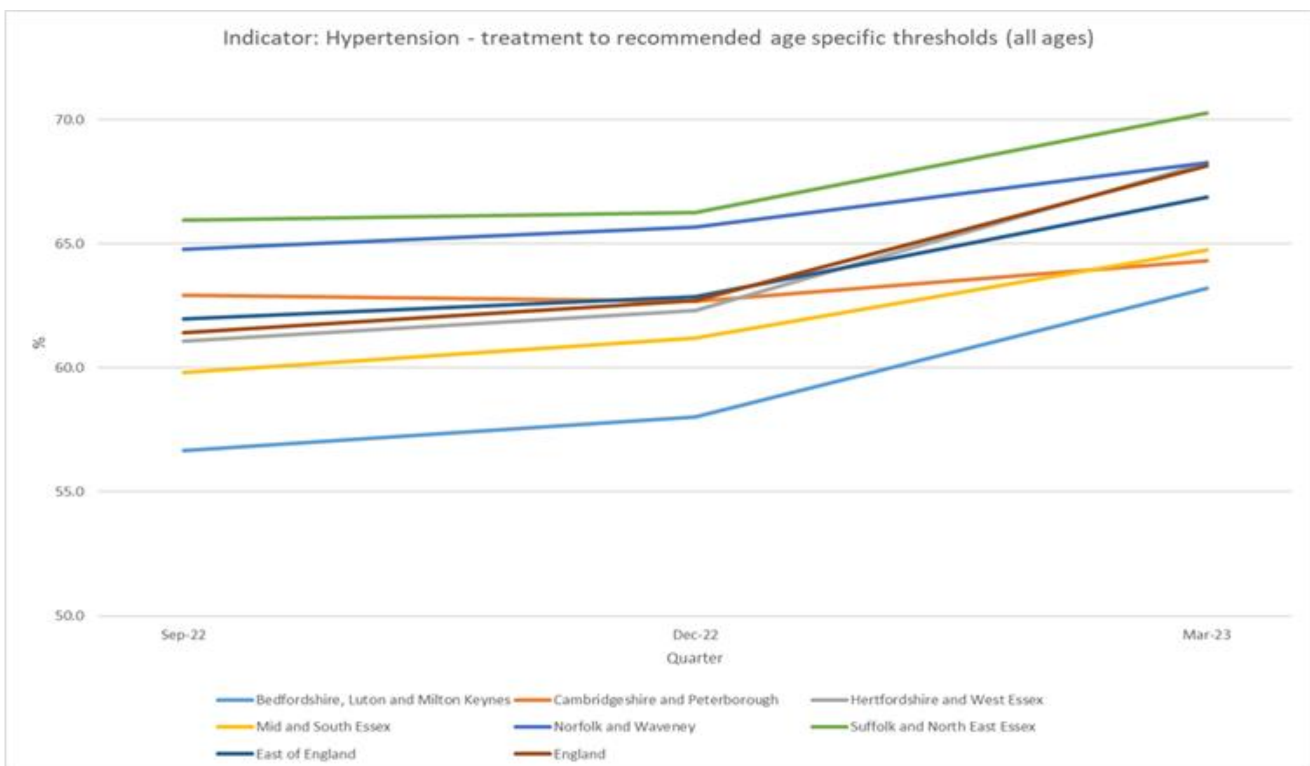


Figure 2| Cholesterol primary prevention (Target 60%)



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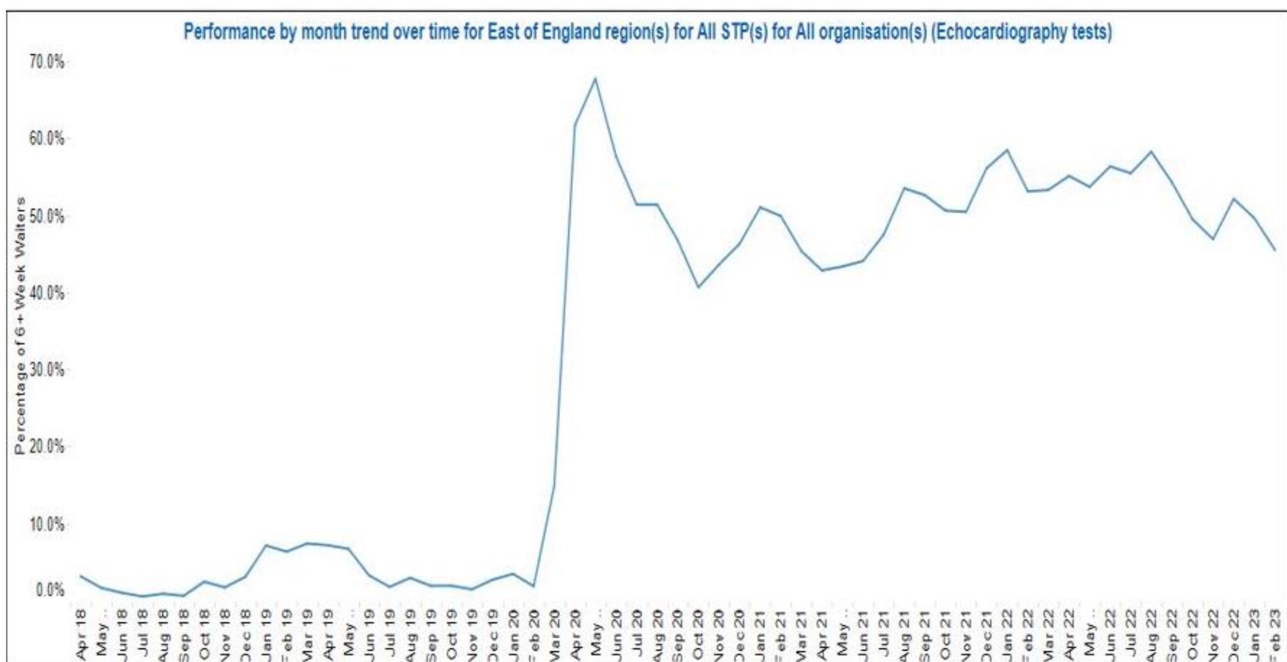
2. Diagnostics

Echo

The main focus of diagnostics work for the network in 22/23 has been in echocardiography and the reduction of waiting times for patients. Engagement with staff in March 2022 highlighted issues with workforce career development and opportunities as well as capacity pressures. The network has been working collaboratively with the NHSE diagnostics team, ICB colleagues, Health Education England and the Leadership Academy to help address these challenges.

Key achievements for 22/23 include:

1. Establishment of a steering group with a wide range of stakeholders.
2. Mapping the variation of workforce across the region.
3. Linking with Health Education England to promote the use of apprenticeships within the region.
4. Working with the Leadership Academy and NHSE Diagnostics Workforce Lead to develop a Leadership Programme for Health Care Scientists.
5. Piloting the Harmony project – standardising referrals and active clinical triage in heart failure.



Harmony

To address part of the echo waiting lists, the network engaged with Astra Zeneca and North West Anglia Foundation Trust (NWAFT) to pilot the Harmony project which was first developed in Glasgow. The aim is to standardise referrals and ensure that patients are triaged by a clinician before being added to the waiting list. The pilot commenced in February 2023 and will be monitored throughout 2023/24 with further roll-out across the region.

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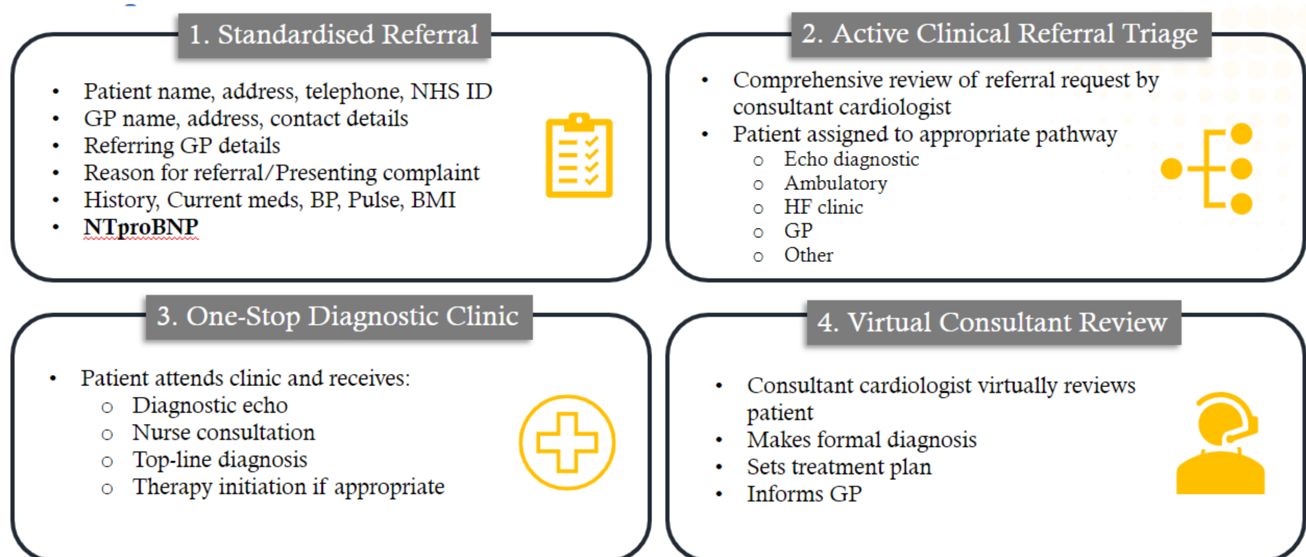

CTCA

Systems identified CTCA as an area of diagnostics needing increased capacity and investment. In response, the network convened a multidisciplinary Steering Group, with Cardiologists, Radiographers, Operations Managers, and the Imaging Networks from across the region. The aims are to eliminate the variation in the region by standardising referral, training, and reporting. A training package for Radiographers has been developed and will be launched alongside a new pilot in the new year. This pilot will trial the separation of scanning and reporting to increase capacity, as well as the sharing of various models of working to determine the most the efficient approach.

3. Acute Coronary Syndrome and Out of Hospital Cardiac Arrest (OHCA)

In Quarter 4 of 2021/22, the network part funded a pilot at Essex Cardiac Tertiary Centre to improve the pathway for patients having an out-of-hospital cardiac arrest (OHCA). During 22/23, this work has progressed with the development of an algorithm in conjunction with British Cardiovascular Intervention Society (BCIS).

The algorithm was aimed at enriching the population of OHCA patients presenting to a Cardiac Arrest Centre in order to try and improve access to immediate cardiology input, assessment and care to increase survivorship. This algorithm is the biggest single change to acute cardiac pre-hospital triage since the advent of STEMI (heart attack) pathways.

The algorithm has been trialed across Essex. The early results look promising with:

- Overall algorithm adherence increased from 45% to 83%
- Overall survival of OHCA patients in our region increased from 17% to 24%
- Overall ICU length of stay decreased from 5.5 to 4 days

The full analysis and subsequent manuscripts are expected later in 2023/24.

To ensure the success of the algorithm, the cardiac network and Essex CTC have forged strong ties with the local ambulance services (EEAST, EHAAT and EAAA), allowing for much more seamless integration of research (BCIS triage algorithm) and education. This powerful collaboration is unique in our region and will make future research and development much easier.

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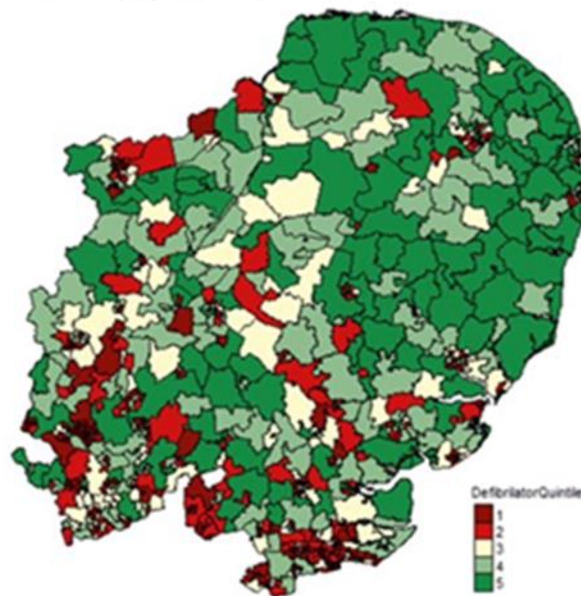
In addition, there has been some joint work between the network, Essex CTC and BCIS to create an OHCA registry and to pilot a nurse led neuro-prognostication service to ensure that guideline mandated neuro-prognostication is offered to all patients at the Essex CTC. This unique model is overseen by a twice weekly MDT with an off-site consultant and has also allowed for stronger local links to be made with Neurologists. This is due to be shared across the region over the next year. As an extension of this work, the network undertook a mapping exercise of defibrillator location across the region to identify any gaps and potential health inequality. This will inform future defibrillator placement.



Non-ST-Elevation Myocardial Infarction (NSTEMI)

The NSTEMI pathway offers the most challenges to the timely treatment of heart attacks in the region. The East of England has 4 main centres for the treatment of heart attacks, with patients being referred from the 18 acute providers. To improve patient pathways, experience and ensure equity in service, the network has three pilots:

1. *Norfolk and Norwich* - Improve Non-ST segment elevation myocardial infarction (NSTEMI) pathway within Norfolk and Waveney by employing a project manager to understand the discrepancy between data for James Paget (15% of NSTEMI treated within 72 hours) and the Norfolk and Norwich (80% in 72 hours). Overall, the target of 60% is being achieved but the discrepancy between sites is stark and shows a marked health inequality.
2. *Royal Papworth* – To enable Royal Papworth Hospital to establish an online learning portal and organise further study days, to increase the referral rate to the Rapid NSTEMI pathway from community services including the East of England ambulance. The rapid NSTEMI pathway is proving a success, and the in-patient transfer is working well although there has been a concern raised that 50% of the referrals onto the pathway are unsuitable. This will; be addressed in on-going evaluation in 2023/4.
3. *Mid-South Essex* - Provision of specialist nursing team to support the Rapid NSTEMI discharge pathway pilot at the Essex Cardiothoracic Centre (CTC).

These pilots will continue throughout 23/24 with learning shared across all the heart attack centres and providers.

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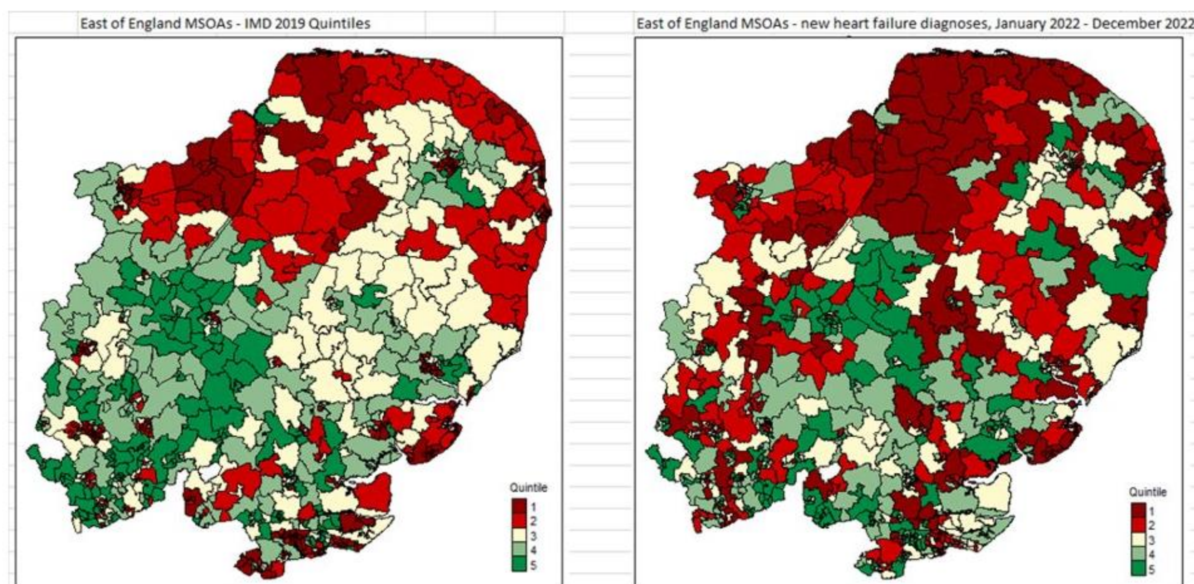
4. Surgery

Three cardiac surgical leads were appointed to the network representing our two cardiac surgical sites – Royal Papworth Hospital and Essex Cardiothoracic Centre.

Priority 2/Priority 3 waits in cardiac surgery:
The aim for 2022/23 was to eliminate all 78 week waits for elective cardiac surgery. This has been achieved across the region. There is mutual aid between MSE and Papworth to ensure medication shortages do not affect surgery.
Mutual aid for P2 / P3 has been considered but not pursued due to capacity issues at both sites and geographical split. Both sites have worked to reduce staff shortages following the Covid-19 pandemic and plans were put in place to return to pre-Covid capacity. Monthly meetings are held with Specialised Commissioning to review progress of recovery plans.

5. Heart Failure and Breathlessness

Heart failure has been highlighted as a priority both nationally and for our integrated care systems in the East of England. Several workstreams were launched in 2022/23 to improve pathways and outcomes for this group of patients.



Discharge Medicines Scheme
The Discharge Medicines Scheme is a commissioned service which has had limited uptake in the East of England. A task and finish group was established to test the Discharge Medicines Scheme specifically for people who are discharged from hospital with a diagnosis of Heart Failure and medication changes. People with Heart Failure are on multiple medications, and they are often altered to try to manage symptoms successfully. These changes can be very confusing and there is a high risk that mistakes may occur until both patient and GP are clear on changes made.

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The results of the pilot are due to be reviewed in quarter one of 2023/24, however early indicators show around a 40% intervention rate when DMS referrals are completed. This means there are 40% of patients receiving the correct medications that otherwise may have experienced errors and delays in their management.

Managing heart failure @ home

There is a lot of work going on across the region to provide heart failure services to patients at home. To date, we have completed the following:

- The network has set up a steering group which meets every 6 – 8 weeks to share good practice, case studies and raise concerns for solutions.
- We have funded a pilot in N&W specifically focused on North Norfolk to ensure equity of service across the whole of N&W and reduce health inequality.
- Pilot H&WE (East and North Herts) was granted national funding.
- Other areas including SNEE and MSE have the infrastructure in place to be able to set up a service with some project management.
- We have been working with Pumping Marvellous to consider a check list of topics for conversation for patients to be prompted to guide consultations on subjects they wish to discuss.

Virtual wards community of practice

Virtual Wards for Heart Failure have been established across the region. The network has set up a Community of Practice in collaboration with the regional Virtual Wards team to allow a space for clinicians to share good practice as well as understand the issues arising and find solutions as a region.

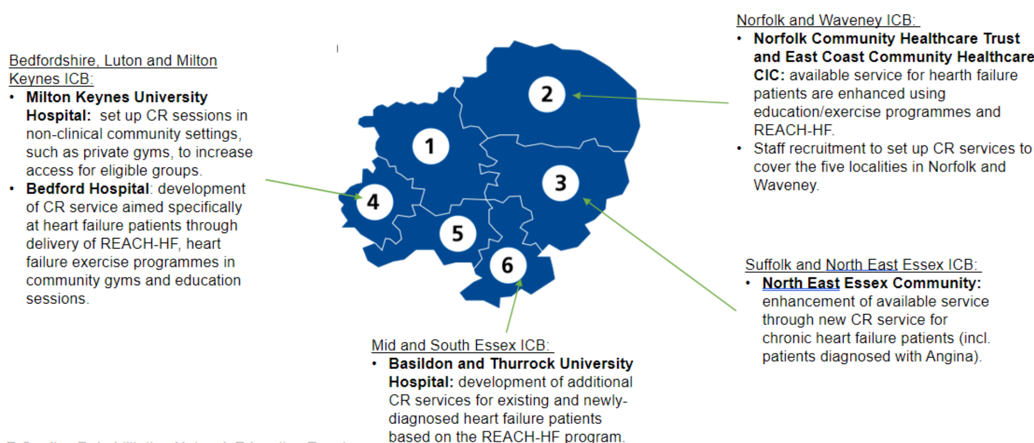
Act on Heart Failure Project

The network has linked Astra Zeneca with BLMK with the sole purpose of redesigning their Heart Failure pathway to optimise service delivery from diagnosis, treatment and end of life care.

An action plan has been produced with an agreed single point of access and newly defined referral process. The project with BLMK will run for one year.

6. Cardiac Rehabilitation

National funding was made available for the region to fund six initiatives across four of our systems. The funding is targeted to increase the availability of cardiac rehabilitation, increase patient choice in how they access services and bring cardiac rehabilitation closer to home to reach more people.



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The network undertook a mapping exercise to understand the provision of services across the region. Highlighted during this work was the amount of people offered rehabilitation who do not access services. This will be a focus for 2023/24.

In addition, the network has joined forces with North East and North Cumbria Cardiac Network and Suffolk and North East Essex ICS to produce a template that meets the National Audit Cardiac Rehabilitation (NACR) data extraction and sits in the SystmOne Library. This will be piloted in the two networks and if successful, will be shared nationally. The aim is to standardise the data inputted into NACR and reduce the time spent on administration, thereby increasing clinical time and the chance of provider accreditation.

7. 7 Day Working

A short-term project manager was employed by the network to undertake a mapping exercise across the region to identify the current position of 7-day services.

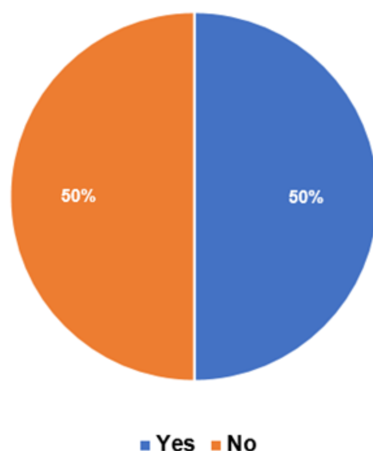
The 3 areas specifically looked at during this mapping exercise were:

1. 7-day access to echo
2. 7-day cardiologist ward rounds
3. 7-day access to heart failure specialist nurses in outpatients and during admission

The results show identify gaps in services and are a basis on which to discuss future service provision with systems. The findings have been shared with systems to support the development of business cases for further investment. The echo results have been added into the echo action plan. Heart Failure specialist nurse numbers have been calculated and will help support decision making for future funding for heart failure.

Of the 14 responses 50% do currently offer echocardiography at the weekend for inpatients

Weekend Access to Echocardiography for Inpatients



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Sharing Best Practice

The Cardiac network has undertaken various activities to share best practice amongst our providers across the region. Three face-to-face events and two webinars were held over the past year:

1. Health Care Science Event
Held in October, it was attended by around 60 delegates and covered topics such as leadership skills, workforce development, management styles and the use of data to inform service planning.

2. Cardiac Rehab Educational event
This event was attended by representatives of all 6 systems and the speakers presented regional innovative practice, offering a set of solutions to improve cardiac rehab services, as well as tackling health inequalities and increasing uptake by offering choice.
The learning has been disseminated across the region and is influencing workstreams moving forward. For example, the network hosted a webinar following feedback from the Cardiac rehab event, covering topics such as accreditation, patient and public voice (PPV), and medications in cardiac rehab services, with the aim to support services to reach the national goal of 85% of eligible population to access Cardiac Rehab services.

3. CVD Prevention Day
Held in February, this event covered the 3 main aspects of cardiovascular disease prevention, with over 100 delegates from a variety of professional backgrounds. This was a showcase of excellent initiatives happening across the region in health checks, AF, hypertension, and lipid management.

Feedback

“I’d like to thank you for the brilliant event you put on for us in Duxford earlier this week. There were some brilliant speakers, covering some really interesting topics and I am looking forward to reporting back to the rest of my team.”
“There was so much useful information!”
“Brilliant opportunity for networking and finding out what other areas are providing in the way of cardiac rehab.”

4. 'Facilitating difficult conversations around end-of-life issues/palliation with Heart Failure patients' - webinar
This webinar was aimed at anyone who has contact with patients with heart failure, both primary, secondary and community care, including GP’s, nurses, pharmacists, doctors, paramedics and physiologists. The focus of the webinar was to support clinicians in developing their skills and insights in facilitating discussion around palliative care and end of life planning with patients.

5. Cardiac Rehab – webinar
This webinar was designed around the feedback from our face-to-face event and covered topics on accreditation, PPV and medications in cardiac rehab services. Feedback was positive with an ask of further face to face or virtual education events in the future.

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Key challenges

Industrial action has proved challenging for many providers, particularly for restoring cardiac surgery and cardiac intervention procedures. The cardiac network event day to showcase innovation across the cardiac pathway planned for March was cancelled and re-booked for the Autumn.

The network has had a few changes in personnel over the year, however the workstreams have maintained their focus on delivery and has increased collaboration with the ICBs.
The formation of the new Integrated Care Boards and Systems led to some changes in key personnel. New ICB governance arrangements have been put in place and a network representative now sits on all CVD board meetings across the region.

Network priorities for 23/24

1. Reduce waits for referral and treatment (P2, P3)
2. Increased access to cardiac diagnostics
3. Timely treatment of MI
4. Cardiac Rehab in Heart Failure
5. National Priorities in Prevention

- 77% of people with hypertension treated to NICE guidance targets
- 60% of people with CVD risk of 20% or above treated to target.

The network is very excited for next year, with all the systems fully formed and key people identified to move workstreams forward. We have a workplan for 23/24 reflecting the above targets as well as considering local CVD plans.

Considering this, the network will have a continued focus on Heart Failure care in addition to national ambitions and plan to do some joint work with the respiratory network and palliative care to focus on advanced care planning and end of life care pathways for people who are breathless.

Network Budget

The cardiac network receives funding from the national team for staffing

1. Staffing budget

Funding Allocation Description	Amount
Network staffing	£223,000

2. Targeted national funds made available to ICBs via the regional team:

Funding Allocation Description	Amount
CVD Leadership	£301,000
Cardiac rehabilitation	£391,000

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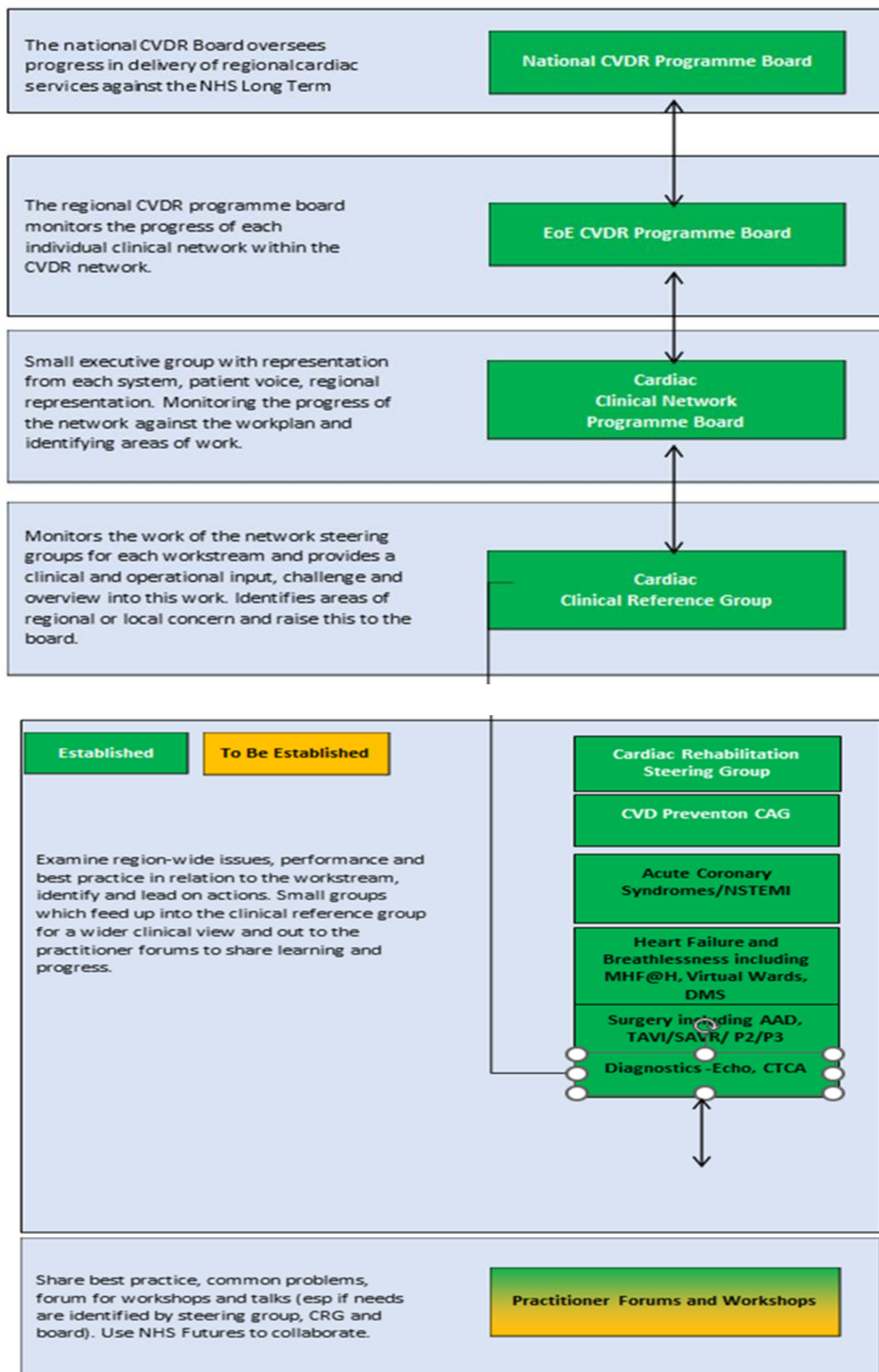
Network governance



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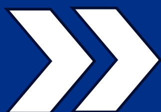

2. Integrated Stroke Delivery Network

Integrated Stroke Delivery Network

In 2019 the NHS Long Term Plan set out ambitious aims for the development and improvement of services for the prevention and management of stroke in England. These aims were further developed in the National Stroke Services Model (NSSM) 2021, Integrated Community Stroke Services Model (ICSSM) 2022 and the stroke Getting It Right First Time (GIRFT) report 2022.

There are two Integrated Stroke Delivery Networks (ISDNs) for the East of England covering three Integrated Care Boards (ICB) in the north and south respectively. The North ISDN includes Cambridgeshire & Peterborough, Norfolk & Waveney, and Suffolk & Northeast Essex systems. The South ISDN includes Mid & South Essex, Hertfordshire & West Essex and Bedfordshire, Luton & Milton Keynes systems. The East of England (EoE) ISDNs were operationalised in April 2021.

Network objectives:

1. Enable improvements in stroke prevention
2. Enable equitable access to acute stroke services across the EoE
3. Work collaboratively to implement the ICSSM across the EoE
4. Work collaboratively to implement the NSSM
5. reduce inequalities and improve outcomes for people who experience a stroke in EoE

The objectives will be met by realisation of the Long-Term Plan goals, implementation of the NSSM, ICSSM and the delivery of the GIRFT recommendations. In addition, the ISDNs support the ongoing regional and ICB level priorities and supervise the operational challenges in relation to mechanical thrombectomy provision.

Network Team

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Network priorities 2022/23

1. Prevention: support systems to improve detection/treatment:

- Primary prevention (AF; High Blood Pressure; Raised Cholesterol), Secondary prevention (stroke TIAs) and tertiary prevention.

2. Pre-hospital care:

- To improve patient outcomes by supporting clinicians in the process of pre-alerting potential stoke patients to Comprehensive Stroke Centres (CSCs) and Acute Stroke Centres (ASC), reducing variation and reducing call to door time.
- To support the national initiative to evaluate the utilisation of pre-hospital video triage in emergency stroke care.

3. Acute Care:

- To increase the proportion of patients who receive thrombectomy after a stroke to 8% by 2024 as per the NHS long term plan.
- Support equitable access to mechanical thrombectomy intervention for all clinically suitable stroke patients in the EoE whilst local services are developed.
- To support the operationalisation of mechanical thrombectomy services at Cambridge University Hospital (Addenbrookes) and support the future development at the Norfolk and Norwich Hospital.
- To procure and implement artificial intelligence (AI) systems across acute stroke services in the EoE, ensuring all services have access to AI by summer 2023.
- To ensure access to highly specialised stroke units for patients with stroke in < 4 hours and for >90% of their stay.
- Nursing- Support RCP stroke guidance compliance in relation to stroke nursing workforce and the availability of stroke specialist nurses
- Support acute stroke service providers to implement quality improvement action plans in relation to the acute care key performance indicators.

4. Post-Hospital Care:

Support systems to implement the new Integrated Community Stroke Specification model and improve access to Life After Stroke services and increase the percentage of patients receiving six-month reviews to 60% by 2024.

5. In-patient rehabilitation:

Support analysis of rehabilitation provision service wide and analyse intensity, frequency and responsiveness of therapy delivery in in-patient rehabilitation settings.

Initiate improvements in the collection and interpretation of SSNAP data pertinent to rehabilitation services.

6. Workforce: support the professional development of staff involved in the stroke pathway through a common framework of competencies and training, working in collaboration with the EoE stroke forum.

7. Data, Evidence & Research: ensure full engagement with the Sentinel Stroke National Audit programme (SSNAP) across all services. Development and implementation of non SSNAP dashboard metrics Enhance recruitment into stroke research studies and evidence base in stroke care.

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Clinical Advisory Groups and progress on key projects and programmes

A series of established Clinical Advisory Groups (CAGs) and working groups continued to progress projects and programmes of work during 22/23. These were:

1. CVD Prevention Clinical Advisory Group
2. Pre-Hospital Clinical Advisory Group
3. Pre-hospital video group
4. Mechanical Thrombectomy
5. Stroke AI and Procurement Working Group
6. Acute Care Stroke Admissions Improvement Clinical Advisory Group
7. Stroke Rehabilitation Clinical Advisory Group
8. Nursing Workforce Clinical Advisory Group
9. Stroke Quality Improvement in Rehabilitation programme (SQuIRe)
10. Patient and Public Voice (PPV)
11. Health Inequalities Working Group

1. CVD Prevention Clinical Advisory Group

The stroke network shares a CVD Prevention Clinical Advisory Group with the Cardiac Clinical Network, which is detailed under the Cardiac Network section.

2. Pre-Hospital Clinical Advisory Group.

Pre-alert proforma – Following the development of the proforma is 2020/21 and a successful pilot with six Trusts, this was embedded as business as usual in late 2022. The benefits of the proforma have shown to be:

- More structured stroke handovers from crews,
- Streamlined booking in processes, leading to faster diagnostics,
- Reduced call to door times.

Wider regional adoption of the pre-alert proforma commenced in early 2023 and has progressed well.

The Clinical Advisory Group developed an East of England *interfacility transfer (IFT)* guide to aid clinicians in referring centres around the use of language with call handlers when requesting emergency transfer to thrombectomy centres. This was implemented in March 2023 and should help improve response times for ambulance transfers.

In collaboration with trusts throughout 2022/23, the CAG will promote joint education and training sessions for frontline crews in relation to the pre-hospital pathway and identifying stroke mimicking symptoms. This will also involve promoting the benefits of populating the standardised regional pre-alert proforma by ambulance crews throughout these learning sessions.

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A priority of the CAG is oversight of the pre-hospital stroke video triage project (see details below) which launched in August 2022.

3. Pre-Hospital Stroke Video Group

Following a successful bid for national funding, a pilot for video triage was implemented at two sites in the East of England - North Cambridgeshire supported by Northwest Anglia Foundation Trust and West Essex supported by University College Hospital operating through the Northeast London and North Central London networks.

The aims of the pre-hospital stroke video triage project are to:

• Develop a strong "one-team" co-operative network within pre-hospital and hospital emergency care services.
• Improve door-to-imaging, door-to-needle, and door-to-Hyper-Acute Stroke Unit times, as well as door-in-door-out times.
• Enhance the assessment for patients presenting with acute neurological symptoms and improve patients getting to the right treatment destination first time.
• Create a TIA pathway for patients following video assessment.

The stroke video triage pathway utilises iPads to connect ambulance clinicians to stroke consultants or registrars using FaceTime. All patient cases that are video triaged are reviewed in clinical case reviews and the final diagnosis of the patient is accessed to ensure the pathways are safe and effective.

Early results for the North Cambridgeshire pathway have demonstrated;

- A significant reduction in door-to-needle times (55 minutes down to 15 minutes)
- 48% of patients being triaged as non-stroke and going directly to the emergency department
- 43% of patients going direct for a CT scan from the ambulance saving vital time.
- A non-conveyance rate of 8% resulting in patients not having to go to the acute centre at all but referred onwards to their GP or another clinic.

There has been positive feedback from patients, ambulance crews, the emergency stroke teams, radiologists and emergency department colleagues. The ISDNs are looking to expand the project wider within the region during 2023.

Early results indicate that pre-hospital stroke video triage pathway is an efficient tool which significantly improves the quality of pre-hospital and hospital emergency stroke care. A full evaluation is planned in August/September 2023.

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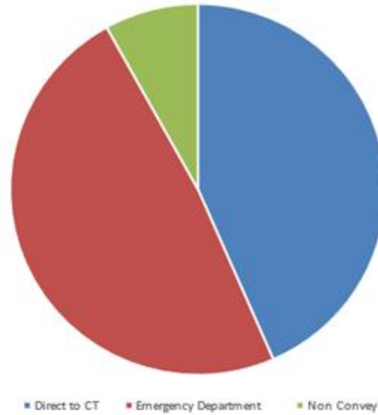
NWAFT Patient Outcomes



Emergency Department – 48%	Direct to CT / ASC – 43%	Non Convey – 8%

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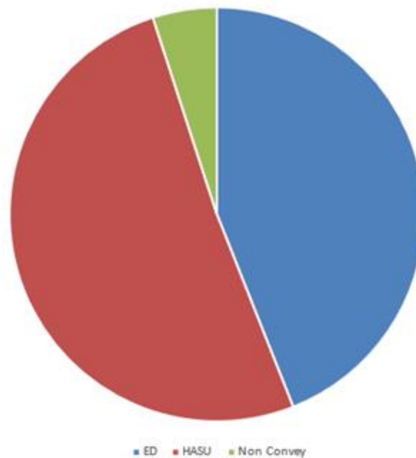
West Essex Data



Emergency Department – 44%	Hyper-Acute Stroke Unit 51%	Non Convey – 5%

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4. Mechanical Thrombectomy (MT).

One of the key deliverables has been to improve rates of mechanical thrombectomy (MT) in the region. Pan-regional steering groups have been established with London colleagues since April 2021. Collaboration has enabled region wide access to MT at the Royal London Hospital in addition to established pathways into Charing Cross and Oxford / Thames Valley while the regional MT services are being developed.

The ISDN continues to support the wide communication of MT availability/alternative providers to all acute providers in the East of England.

Development of regional Mechanical Thrombectomy (MT) services.
Joint steering group established with Cambridge University Hospital (CUH), Norfolk and Norwich University Hospital (NNUH) and Specialised Commissioning to help progress their respective MT services for the region. CUH commenced their first phase MT service (Mon-Fri 8-4). enabling eight of the region's providers to access this service.

Repatriation (MT).
Timely repatriation of patients from MT centres back to the local referring hospitals is essential to maintaining capacity at the comprehensive stroke centres (CSCs) providing MT intervention. The ISDNs developed, and have continued to monitor the efficacy of, the regional repatriation policy which went live in May 2022.

5. Stroke AI Procurement and Implementation

Artificial Intelligence (AI) acute stroke imaging has been a key priority for the ISDNs to implement in 2022/23. The ambition was to introduce AI in all eight remaining sites and fully network all acute stroke centres (Spokes) with comprehensive stroke centres (Hubs) in region and across geographical boundaries that border the EoE ISDNs (i.e., London).

Bringing together key stakeholders, the ISDNs worked with the East of England Collaborative Procurement Hub to develop the technical specification and commercial schedule. The regional contract was awarded on 1 December 2022 to commence from 1 April 2023 with a duration of 2 years with an additional 12 months built in subject to funding from the Clinical Policy Unit (optional).

Nominated AI Trust Champions have been effective in working with the ISDN AI project lead and Brainomix Territory Manager to ensure weekly implementation meetings have been arranged to work through the key requirements for successful deployment at each centre.

Out of the eight centres, one achieved go-live status on 6 March 2023 with two further centres on target for mid-April and the remaining five centres by May/June 23. This will mean by the end of Qtr. 1 in 2023 (Apr-June 23) all acute stroke centres within the East of England will be using an AI system bringing the region to be fully compliant in adopting AI technology in line with the NHS Long Term Plan and the National Stroke Service Model.

Stroke AI has already enabled rapid transfer of image sharing across the regional centres at the same time as supporting timely clinical decision making for thrombolysis and thrombectomy treatment.

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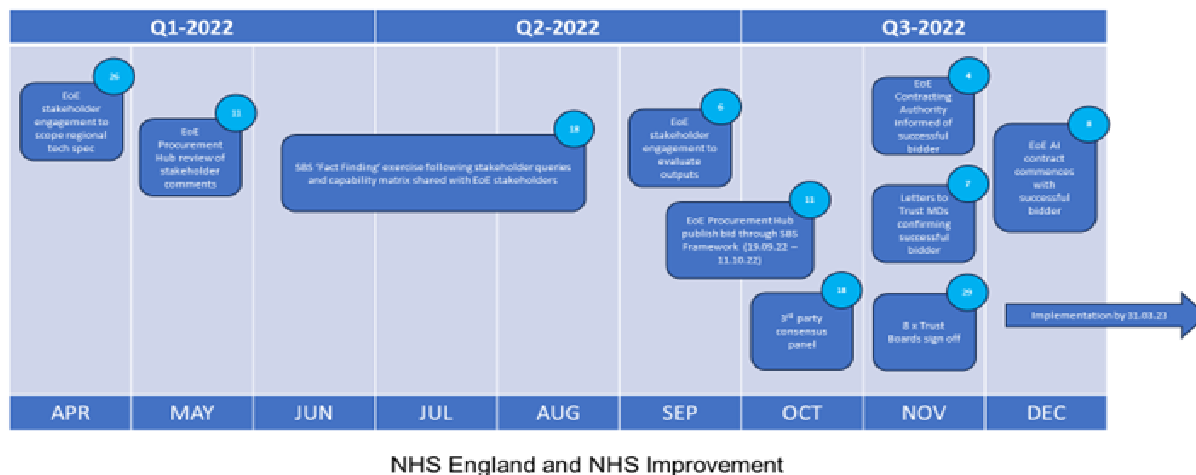

6. Acute Care – Stroke Admissions Pathway Improvement Clinical Advisory Group.

The NHS Long Term Plan aims to improve the quality of care and treatment available for people who have a stroke through ensuring that high quality, specialist care and treatments, such as thrombolysis (clot-busting drugs) and mechanical thrombectomy (clot extraction) are increasingly available to more patients as part of Integrated Stroke Delivery Networks. The Admissions Pathway Improvement CAG aims to ensure access to highly specialised stroke units for patients with stroke within 4 hours and for more than 90% of their stay through:

- Improving awareness of the benefits of organised stroke care to ensure rapid access to stroke units.
- Supporting quality improvement initiatives from the findings of an audit undertaken in the period between February – April 2022. The audit reviewed processes available in acute trusts which support the four-hour access target. The audit also investigated reasons for patients not being admitted to the stroke unit within 4 hours. From this work, innovations and ideas to optimise the admissions pathway were published and shared with trust executive teams, trust stroke leadership teams and the Integrated Care System (IC)S stroke leads. Trust stroke leads were encouraged to meet with their executive teams to evaluate and adapt the innovations and ideas, some of which were cost-neutral, into their local processes. Positive feedback has been reported by stroke leadership teams including a raised awareness of the benefits of organised stroke care to executive and bed management teams. The document has been incorporated into local SSNAP action plans and ICS stroke leads have acknowledged that the document is useful in their quality improvement discussions.
- In response to winter pressures and ambulance off load delays, the Admissions CAG undertook an appraisal of local practice in relation to the off-loading of potential stroke patients that were presenting to acute hospital sites. Baseline data was collated, and comparisons made with national recommendations from both the stroke speciality advisors and ambulance leads. Based on findings and recommendations, local stroke teams were encouraged to develop local pathways supported by policies to support timely access to emergency stroke care. Trusts with local pathways in place kindly shared documents to support this work.

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7. Rehabilitation Clinical Advisory Group

Focus for this CAG has been on a project Increasing Therapy Responsiveness, Intensity and Frequency of therapy intervention in Stroke Inpatient units across the East of England.
Evidence exists to show intensity of rehabilitation for those with motor recovery goals must be delivered at an effective dose to improve outcomes. Our aim was to develop recommendations for in-patient stroke services that enables improvement in the frequency, intensity and responsiveness of stroke therapy and improves SSNAP performance ratings.

This work continues in to 2023 however, the work has encompassed the following to date:

- EoE in-patient services engaged in a regional appraisal to increase the therapy delivered.
- Review of evidence– ReACT study, Productive ward series, Reconditioning Games and work undertaken by local services was performed.
- Teams completed the “Factors influencing Therapy provision within in-patient settings” survey based on recommendations identified in the evidence base.
- SSNAP scores reviewed for April- June, and July – Sept 2022, across therapy domains.
- Time and motion studies completed.
- Local reviews to identify potential changes that would enhance ‘face to face’ capacity.
- Teams reviewed and amended appropriate operational processes (with respect to timing, skill set and environment) to maximise availability of therapists.

The results that have been established have included:

- Local action plans incorporating baseline data, demonstrating percentage change in face-to-face availability created.
- Increase in therapy F2F contact with patients measured by SSNAP Key Indicators 5, 6, 7 and 8.
- 10 key themes and 18 recommendations identified.
- Clinical outcome and length of stay data captured.

Appraisal of factors influencing therapy provision within in-patient settings has identified opportunities for greater clinical intervention by the reduction of administrative tasks and streamlining of daily routines.

Recommendations to be shared across the EoE via the ISDN and next steps will be agreed regionwide and taken to the regional stroke PPV group in relation to communication at discharge, restricted visiting impact and the newly available Stroke record document created by the Stroke Association.

In addition to this project, a rehabilitation CAG subgroup has been examining data collection, data quality and interpretation of SSNAP data regarding rehabilitation in our regional stroke in patient settings. This work is ongoing.

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8. Nursing Workforce Clinical Advisory Group

A regional appraisal of the stroke nursing workforce was completed in 21/22 to understand the impact of correct hyperacute and acute stroke nursing establishments and the utilisation of the specialist nursing workforce. A detailed regional report was compiled and shared system wide. Over 60 key findings were established, and 19 recommendations made.

This work was built on further during 2022/ 23 by way of a dataset created to capture detailed information of the stroke unit nursing work force on a shift-by-shift basis. This was signed off by the regional nursing leads and a trial sample completed at the end of quarter four.

This dataset will provide an unprecedented insight into the nursing provision and a clear understanding of how this specialist work force may be redeployed into non stroke wards and departments. Initial data collection to commence April 23 with initial analysis available in July 23.

9. Integrated Stroke Delivery Networks Stroke Quality Improvement in Rehabilitation programme (SQuIRe)

The SQuIRe programme focusses on delivery of the Integrated Community Stroke Services Model (ICSSM in the region. Between May 2022 and March 2023, the work has focussed both on quality improvement projects and Catalyst Funded Projects. The latter are to impact implementation of components of the ICSSM within the region.

This workstream has included the following:

1. ICS level mapping and data collection for the four initial priority areas for the implementation of the ICSS in the EoE (workforce, enhanced 7-day MDT working, stroke specific training, 6-month review delivery)
    a. Four of the six ICSs in region now have plans for each priority summarised in an ICS level plan. Each plan has focussed on data collection and agreed actions across key stakeholders including the ICB Stroke Lead. The plans are divided into short (within 6 months), mid (between 6-12 months) and longer term (12 months+) goals at the ICS level.
    b. The remaining two ICSs in region now have their SQuIRe QI Leads recruited to and they both start in post in April. They will support the priority planning and data collection as has occurred in the other ICSs in region.
    c. There are monthly meetings in place for each Regional ICSS priority. These meetings are to allow shared learning and to update on progress for the identified plans. All six ICSs are included to ensure that ideas, solutions and challenges can be discussed as each ICS is different in its service configurations and structures. This should allow individual tailoring of solutions. These meetings also include the Stroke Association.
2. Working alongside the EoE PPV Stroke Assurance Group on all ICSS regional priorities to ensure that the SQuIRe workstreams have input from people who have had strokes, their families and informal carers.
3. Supporting the implementation of the Integrated Community Stroke Service using remote working and telerehabilitation in community stroke rehabilitation services – an evaluation of practice by UEA. This project has now progressed through the University Ethics and the ISDN Stroke Governance processes. This work focusses on developing a decision tree to support the where, when and how to best use telerehab to maximise patient outcomes and assist staff. It will also explore how to avoid creating digital inequalities. This evaluation will involve members from the PPV group and clinical staff both from stroke services and the Stroke Association.

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4. Developing the ACP role and infrastructure in stroke rehabilitation within region to transform the stroke pathway and maximise patient outcomes required by new ways of working. This workstream is alongside the Regional Advanced Practice Faculty, UEA, and clinical teams to develop these roles for the stroke pathway at an ICS level. There is now a small but growing CoP for those interested in these roles. This CoP includes those wanting to train, those training and some who are trained. This group will become a self-sustaining peer support group and the future supervisors for others as these roles develop. Work on role description and job description for ACP in stroke rehabilitation is also underway.
5. A NHSE Workforce, Training and Education STAR workshop on 30/03/23 focussed on level 1 Psychological Care as part of the ICCSM. This work is based on understanding what and how of the delivery of level 1 Psychological Care and how it can be implemented as part of the ICSS across services/ providers in the EoE.
6. Catalyst Projects, each focussing on a different component of implementation of the ICSS in region, there were 9 submissions from across all six ICSs in region and, 4 successful bids based on impact to deliver ICSS:
    - **Herts and West Essex:** Delivering an ICS wide Community Stroke Vocational Rehab Service
    - **Mid and South Essex:** Growing our own Stroke MDT workforce using band 4 Rehab Assistants to enhance the Community Stroke pathway delivery across the ICS.
    - **Norfolk and Waveney:** Embedding the Community Stroke Rehabilitation Nurse role into the stroke pathway to enhance the MDT offer and improve patient outcomes.
    - **Suffolk and Northeast Essex:** Delivering six-month reviews with all eligible stroke patients coordinated via an ICS level Hub.

10. Patient and Public Voice (PPV)

The EoE Stroke Patient and Carer Assurance Group launched in June 2022. The ISDNs successfully recruited 22 patient and public voice (PPV) members to the Group including a Chair and two Joint Vice-Chairs. The group signed off their ToRs and meet on a bi-monthly basis. The PPV group has contributed to several of the ISDN projects particularly in relation to SQuIRE and Catalyst pilots regularly attending workshops and focus groups and events. The PPV group is integral to the SQUIRE work, participates in the ISDN Boards and help shape the goals and priorities of the network.

11. Quality Improvement and Sharing Best Practice

- Appraising SSNAP audit attainment and service improvement action plans. Meetings have been conducted per ICS enabling both 1:1 conversation and system wide discussion. Follow up meetings completed followed by phase two follow up calls. Forward plans on assurance agreed with system leads.
- ISDN team integrated into ICS stroke boards and steering groups providing oversight and support in relation to local projects and initiatives.
- Successful face to face stroke conference held on November 1st 22. 200 delegates from the EoE attended, feedback analysed, and report completed.
- Health inequalities project (MSE based commenced Q1) focussing on secondary prevention of stroke in deprived areas. This project progressed well across the year; data collection completed for all initial patient assessments. Funding secured for the evaluation of user experience to be facilitated by the Stroke Association (Spring 23).

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- UK Stroke Forum, National conference- posters showcasing EoE ISDN projects and presentations given by the ISDN team. These presentations included output form the Nursing CAG, Rehabilitation CAG, Admissions CAG and Prehospital stroke video triage.
- The ISDNs successfully launched its @EoEISDNs Twitter account in September 2022 and actively promote the quality improvement work of the workstreams through the platform as well as informing and connecting teams.

Challenges

Alongside the wider challenges facing all networks, the stroke ISDNs have faced some specific challenges.

1. Mechanical thrombectomy.

- Timely access to MT in the region continues to remain a challenge but regional MT service is improving as we start to see an impact of activities set up to address some of the key barriers.

2. Stroke Artificial Intelligence

- Securing sufficient funding to award a two-year contract + optional 1 year from the Clinical Policy Unit - the ISDN have worked with the CPU to agree the funding for two years and will continue to work with them to secure the additional year’s funding to ensure the contract realises a 3-year term.
- Preparedness and responsiveness to implement AI prior to go-live by 31 March 2023 regional deadline.

3. SQuIRe

- Ensuring engagement across all community stroke services as required to understand and define the current stroke pathways and workforces within ICSs.
- Ensuring the expanding SQuIRe workstreams have the meetings in place to focus on moving from planning to implementation with the correct ISDN oversight and governance.
- Maintaining engagement and focus on stroke with each ICSs when there are a number of competing agendas.

4. SSNAP

- Continued challenges relation to the SSNAP audit performance region wide in relation to the stroke unit domain, mainly due to operational pressures and demands on wider services.

5. Admissions Pathway Improvement

- Variable executive sponsor to support optimising the stroke admission pathway.
- Trust capacity issues emanating from winter-related pressures impacting on stroke unit capacity i.e., the protection of stroke specialty beds, thus affecting timely admission and treatment of stroke patients.

6. Health Inequalities

- Patients eligible for the pilot declining the intervention.
- Cost of living crisis impacting on patient ability to make lifestyle changes such as having a healthy diet or accessing the gym.
- Challenges in engaging with onward services- limited knowledge in the availability of onward services, how they are commissioned and their expectations.

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- Competing priorities and workforce pressures impacting on project delivery

Areas of Focus for 2023/24

1. Stroke Artificial Intelligence
-Ongoing support and monitoring of deployment for any Trust's that may have had issues going live by the regional deadline.
-Working with the Contracting Authority to support with quarterly contract reviews for the duration of the regional contract (2 years + 1).

2.Pre-hospital Clinical Advisory Group
- Promote joint education and training sessions for frontline crews across the region in relation to the pre-hospital pathway and identifying stroke mimicking symptoms.
-Continue to monitor Category 2 transfer data in relation to acute stroke presentations and interfacility transfers to comprehensive stroke centres. This data collection will enhance audit and support service improvement opportunities.

3. Pre-hospital Stroke Video Triage (SVT)
-Wider adoption of the pre-hospital SVT across the region with new pilot sites. A full evaluation report to be presented at the end August/September 2023.

4. Admissions Pathway Improvement CAG
-To optimise the delivery of intravenous thrombolysis to all patients that are clinically eligible across the EoE.

5. National optimal stroke imaging pathway (NOSIP).
-Work towards regional compliance in relation to the CT, CTA, CTP component of the NOSIP.
-Establish CT/ CTA/CTP/MRI improvement plan for the EoE via regional workshop. Local implementation plans to be compiled in relation to the full implementation of 24/7 availability and associated reporting.

6. Nursing CAG.
-Data collection pertaining to the stroke unit nursing workforce will continue capturing daily information relating to nursing availability. Reporting will coincide with the publication of SSNAP data. Data analysis will commence in June 2023 with reports available to stakeholders in July.

7. Health Inequalities in Stroke- Tertiary prevention pilot
-To conclude the health inequalities project and support recommendations via a detailed report to be shared with all key stakeholders across the EoE.

8. Mechanical thrombectomy
-Continue to develop regional services at CUH and NNUH as per the presented phased plans. Support and maintain the interim pathways into London MT service. Continue to monitor effective and timely repatriations.
-To monitor and enhance the referral of all patients that are clinically eligible to receive mechanical thrombectomy across the EoE.

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9. SSNAP
-Realise the ambitions of the East of England SSNAP improvement programme, supporting acute service providers to work towards A grade. This work will continue in 23/24 working closely with system leads, in particular ICS stroke leads for assurance.

10. Patient Participation Voice
-Continuous collaboration and partnership working with the East of England PPV assurance group enabling co-production of priorities and associated projects.

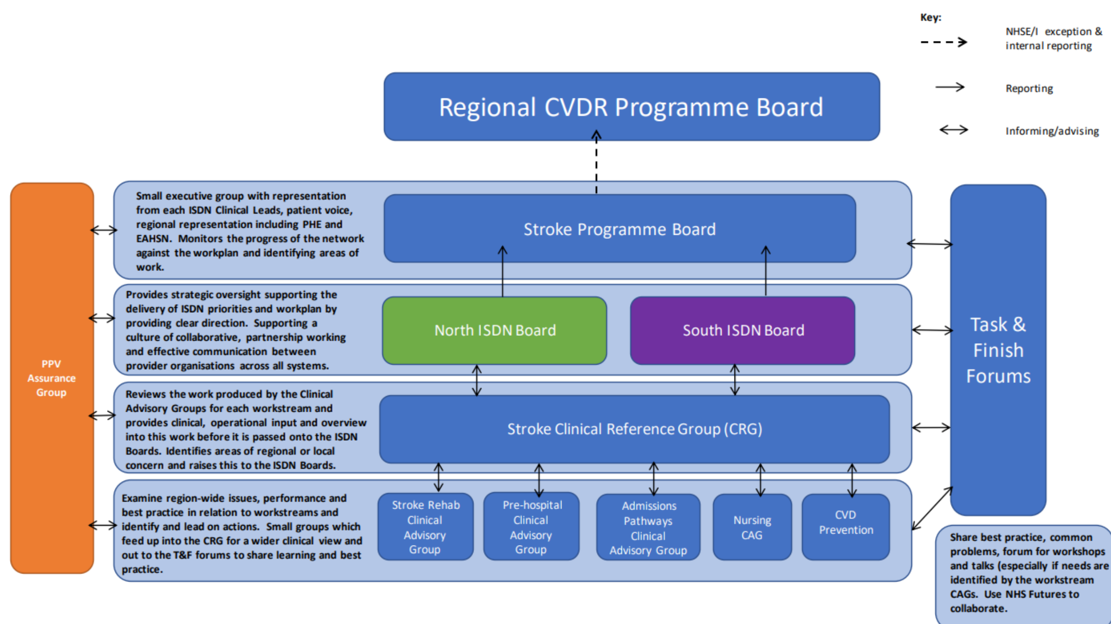
11. Rehabilitation CAG
-To support the delivery of the SQuIRe objectives.
-To progress the TRIF project and support providers to realise recommendations.
Support providers on in-patient rehabilitation to better understand SSNAP data requirements and promote a consistent approach to data collection and interpretation across the EoE.

12. SQuIRe
-The East of England (EoE) ISDNs priorities for the SQuIRe Regional Quality Improvement (QI) projects will continue via regional groups.
In addition, the catalyst projects detailed below will be progressed throughout the year.

- **Herts and West Essex:** Delivering an ICS wide Community Stroke Vocational Rehab Service
- **Mid and South Essex:** Growing our own Stroke MDT workforce using band 4 Rehab Assistants to enhance the Community Stroke pathway delivery across the ICS.
- **Norfolk and Waveney:** Embedding the Community Stroke Rehabilitation Nurse role into the stroke pathway to enhance the MDT offer and improve patient outcomes.
- **Suffolk and Northeast Essex:** Delivering six-month reviews with all eligible stroke patients coordinated via an ICS level Hub.

Network Governance

The governance structure for the ISDNs and SQUIRE role is set out below.



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Network Budget

The stroke ISDNs and the SQUIRE role are funded through the national team, with additional funding available for systems for specific projects:

1. Staffing budget

Funding Allocation Description	Amount
Network staffing (inc SQUIRE)	£585,000

2. Targeted funding for specific projects (to systems)

Funding Allocation Description	Amount
Quality Improvement leads (SQUIRE)	£585,000
Catalyst funding (SQUIRE)	£778,697
AI funding	£110,000
Stroke Video Triage pilot	£100,000

"Since the East of England PPV Assurance group was formed in June 2022, we have heard about, and commented on, plans from many stakeholders to improve the care of stroke patients. Our focus has been on ensuring that the needs of stroke survivors, and their families, are met, that their voices are heard, and they are treated as individuals rather than a series of targets.

"We feel that our views are now being taken seriously by all concerned, and we may be able to make a real difference, especially in the two areas we have identified as key: information and support on discharge from hospital, and psychological care."

Camilla Hermann
Chair of the EoE Stroke Patient and Public Voice

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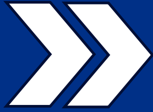

3. Respiratory Clinical Network

Respiratory Clinical Network

The East of England Respiratory Clinical Network is part of the CVDR Clinical Networks team and was established in its current form in August 2020. Its role is to provide leadership to support quality improvements the East of England can make in respiratory care with respect to the Long-Term Plan's goals, recovery from COVID-19, and other local, regional, and national priorities.

Network Priorities

Within the NHS Long Term Plan, respiratory disease is a key area of focus. It affects one in five people in England and is the third biggest cause of death. The priorities for respiratory disease set out in the NHS Long-Term Plan are:

1. Improving outcomes of respiratory disease to equal, or better, than our international counterparts.
2. Early and accurate diagnosis.
3. Increase case finding in COPD patients for pulmonary rehabilitation.
4. New models of care in Pulmonary rehabilitation, including digital tools
5. Increase the number of patients with COPD referred to pulmonary rehabilitation using the COPD discharge care bundle.
6. Reduce use of SABA inhalers for asthma management and pharmacy support to increase uptake of new smart inhalers where clinically indicated.
7. Consistent use, and application, of risk scoring for community acquired pneumonia.
8. Out-of-hospital nurse led supported discharge services for community acquired pneumonia to prevent admission.

Additionally, the national specification for networks has included aims to:
1. Increase access to spirometry in primary/community care.
2. Work towards the accreditation of pulmonary rehabilitation services
3. Implement digitally enabled virtual wards/remote monitoring.

Network Team	
Dr Ellen Makings Senior Responsible Officer, Medical Director for System Improvement **Dr Jonathan Fuld** Clinical Lead, Pulmonary Rehabilitation & Long COVID (April 2022 – Jan 2023) **Dr Abigail Moore** Clinical Lead, Asthma, Diagnostics, ARCU & CAP **Alan Jensen** Quality Improvement Manager	**Roxana Mojoo-Jones** Quality Improvement Project Officer **Sarah Claydon** Quality Improvement Project Officer – PR Accreditation (From Oct 2022) **Claire Doney** Business Support Officer

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Network Performance and Achievements

The network continued its development throughout 2022-23 by building upon the foundations that had been established throughout 2021-22. This included the design of an annual programme plan based upon national, system and provider priorities.

1. **Enhancing patient and carer engagement and participation in service re-design**
2. **Pulmonary Rehabilitation (PR) -** Supporting PR providers with the accreditation programme and development of ICB workplans to achieve the five-year vision for PR.
3. **Respiratory Diagnostics –** primarily spirometry availability in the community to improve early and accurate diagnosis.
4. **Asthma -** Supporting improvements in medicines optimisation and referral pathways.
5. **Community Acquired Pneumonia (CAP) -** Supporting systems to improve the treatment of CAP for patients with learning difficulties, autism, and complex neuro disabilities.
6. **Acute Respiratory Care Units (ARCU)**

"The Respiratory Clinical Network has offered exactly what it says, 'a clinical network for people to come together to share, learn, innovate, question, and make contacts. All of this has been invaluable to me. It has also highlighted the work needed to support staff development and recruitment into respiratory speciality."

Sam Oughton
Respiratory Nurse Specialist

1. Patient and Carer Engagement and Participation in Service Re-design:

The network made significant progress in achievements around Patient and Public Voice (PPV). Three patient representatives were appointed to the network and a virtual registry has been established to identify other patients and carers who have expressed an interest in being involved in the various aspects of the respiratory network.

Using participants from the PPV registry, focus groups were held to provide feedback on an information hub for pulmonary rehabilitation that had been developed by Bedford Luton and Milton Keynes (BLMK) ICB with positive feedback received from all parties.

"BLMK have worked collaboratively with providers and NHS England to develop the Pulmonary Rehab Information Hub. This website gives information and advice to patients that require or may require pulmonary rehabilitation services and gives them information and choice about the services available to them. The East of England team supported with getting input, advice and review from patients ensuring the information is accessible and easy to use."

Mark Morton
Commissioning Manager, Bedford Luton and Milton Keynes (BLMK) ICB

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"Attending the East of England Regional meetings has given me an insight into what can be achieved with a bit of imagination and inspiration and the tools with which I can make change. I have really enjoyed some of the informal debates around Acute Respiratory Infection hubs and Virtual Wards delivery and how integrating them with respiratory services can be achieved.

We have a diverse region with many health care professionals working in a variety of settings and that has enabled me to understand what may (or may not) work in Norfolk & Waveney."

Daryl Freeman FRCGP
Respiratory Clinical Lead Norfolk & Waveney ICB
Associate Clinical Director NCHC

3. Pulmonary Rehabilitation (PR)

PR is an exercise and education programme designed for people with lung conditions who experience symptoms of breathlessness. PR focuses on tailored physical exercise and information that helps people to better understand and manage their condition/s and symptoms, including feeling short of breath. PR was significantly impacted by the COVD-19 pandemic, as many services moved to virtual-only provision to prevent the spread of infection.

At the start of the 2022-23 the network collaborated with systems to set out three key areas in which the region could start to achieve the delivery of the national Five-year vision for PR services.

1) *To perform targeted work at local level to improve PR services equity of access, reduce health inequalities, and work towards the NHS Long Term Plan objectives:*

Priorities for systems in 2022/23 (Q1) was to develop a local five-year plan for PR, based on national direction, that addresses service capacity and reduces health inequalities.

The network supported ICB colleagues to develop a draft vision document for their system and then supported the development of their vision documents into detailed workplans. As well as these workplans stating how an ICS will deliver its vision, they have considered metrics and detail how and when these will be collated to demonstrate the impact the funding is having in supporting the ICS in achieving the above aims.

2) *PRSAS Accreditation Project:*

An important quality improvement standard within the Five-year vision document is that, by 2027 all commissioned ICS PR services are to be provided by accredited providers.

A network organised workshop held on the 24th of March 2022 to discuss accreditation and identified some key themes where the regional team can support systems and providers to work towards achieving accreditation.

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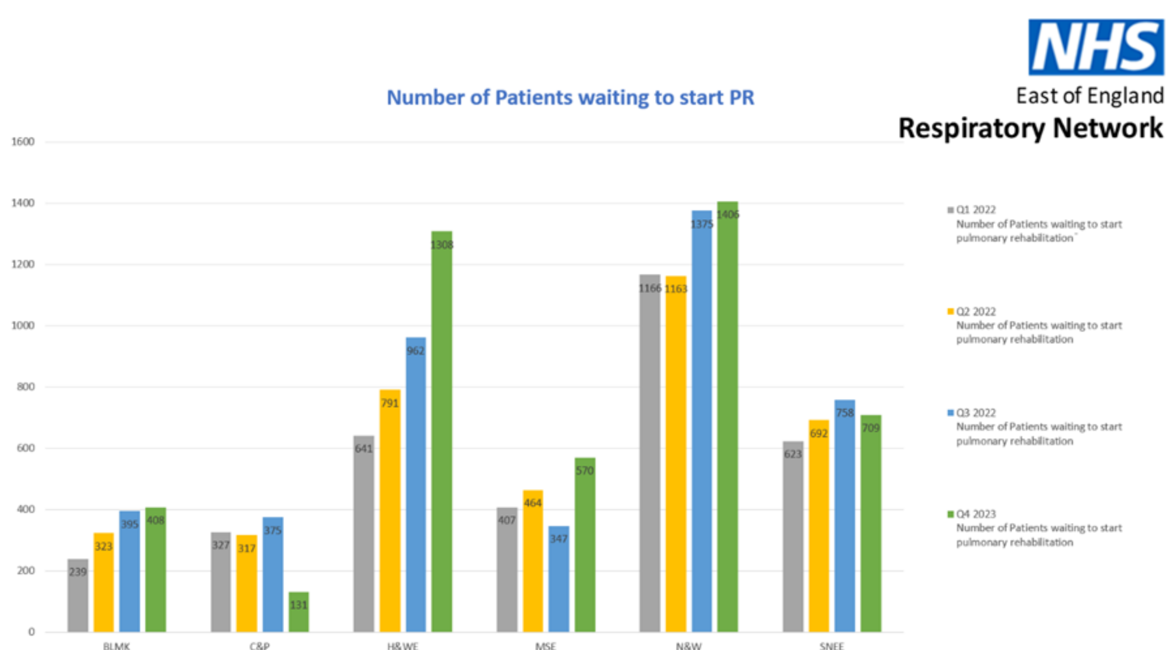
As a result, the network recruited a project manager and invited each ICSs to nominate individual providers working within the East of England Region to be part of an initial cohort of 10 providers to progress through the whole accreditation process.

3) *Innovation projects that support the promote transformation of PR:*

Systems and PR services were given the flexibility to use part of the funding for innovation projects that support the objectives within their workplans and promote transformation of PR.
We allocated funding through expressions of interest for improvement projects and allocated £7k to each ICS to undertake a patient and public voice (PPV) project.

Through the funding and the network support, systems have solid foundation on which to build. However, regional data returns still show significant waiting lists of patients waiting to start PR:

4.



Respiratory Diagnostics

Respiratory diagnostics play a crucial role in the early identification of chronic lung conditions. During the COVID-19 pandemic many non-essential services were stood down including lung diagnostic tests. The restarting of spirometry testing was seen as a high priority and was presenting a challenge for most systems. Issues highlighted included:

- Infection prevention and control concerns
- Staff recruitment & skill mix
- Sufficient estate: i.e., space available & sufficient ventilation in order to complete the tests
- spirometry testing challenges with enough staff trained to an accredited level to be able to conduct spirometry tests.

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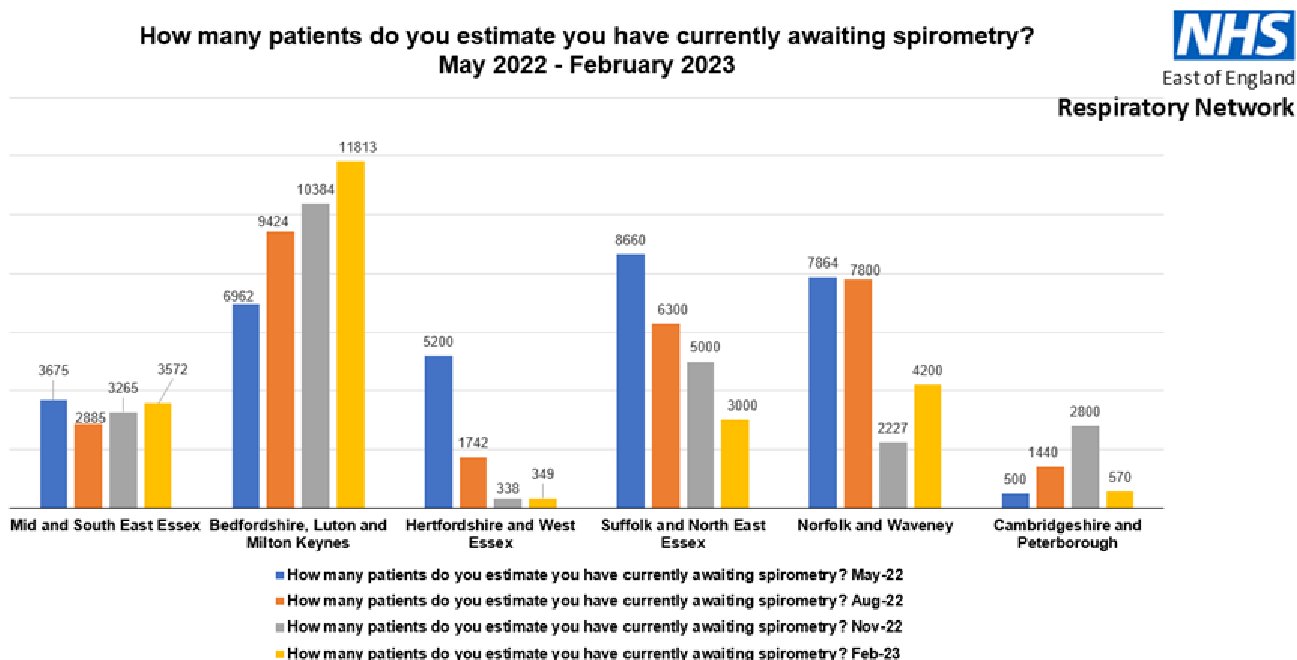
Through the network, national funding for spirometry was made available for each system to support the following:

1) To ensure those performing and interpreting spirometry are appropriately trained and accredited to the standards of the Association of Respiratory Technology and Physiology (ARTP).

2) To support the development of local diagnostic services (such as 'hublets') that support a timely and accurate diagnosis for respiratory conditions.

To monitor the impact and further support systems, the network developed a regional data return to understand current waiting lists and the number of accredited staff each system requires to perform spirometry tests.

The network worked with systems to understand their current delivery models for spirometry testing. There are lots of different models being used by ICSs including PCN based, locally enhanced services and mobile diagnostic hubs.



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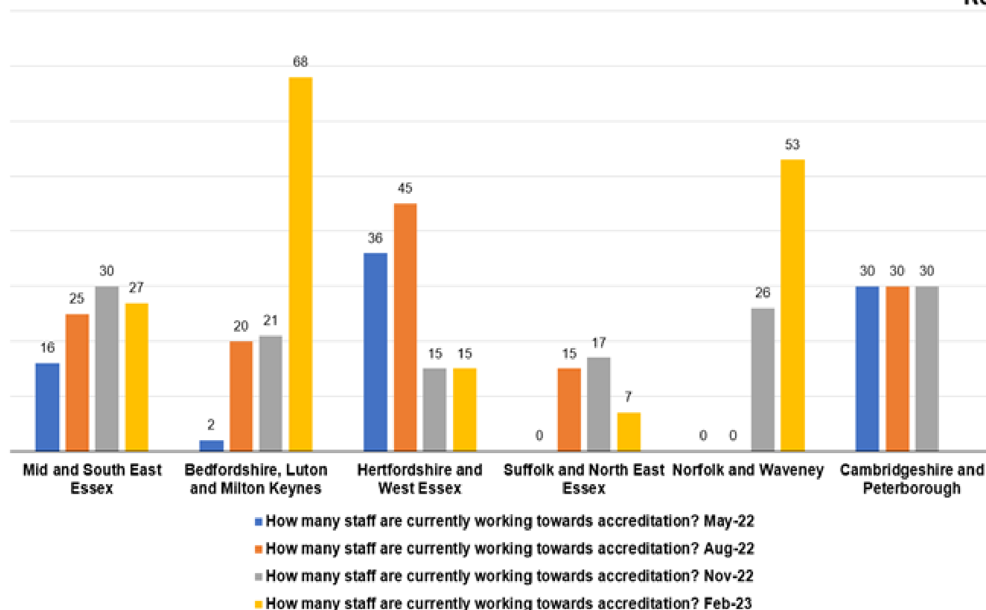
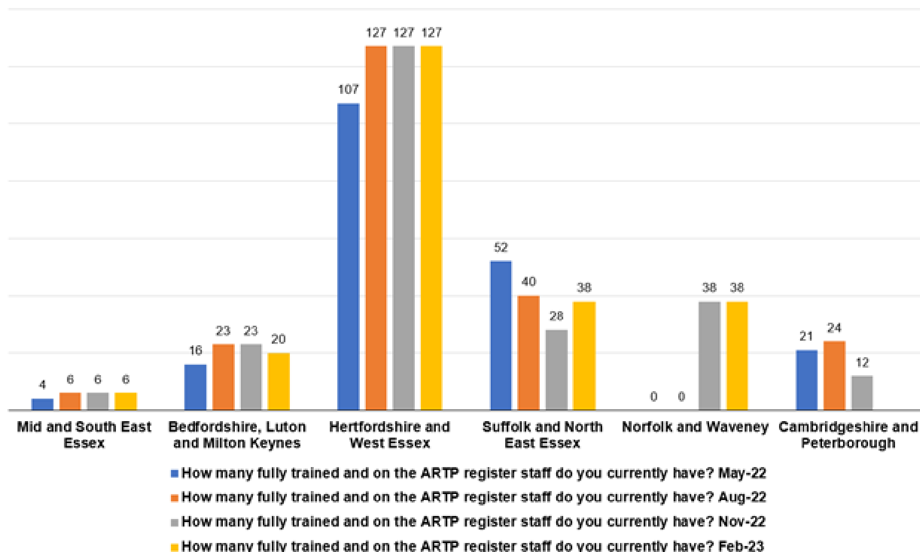
How many staff are currently working towards accreditation?
May 2022 - February 2023



How many fully trained and on the ARTP register staff do you currently have?
May 2022 - February 2023



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5. Asthma

The network focused on two objectives throughout 22-23.

1) *To review, consider and design adjustments to the asthma referral and patient pathways to secondary and tertiary care, supporting their implementation.*

A mapping exercise was conducted at the end of 2021/22 with clear actions to engage with voluntary organisations such as Asthma and Lung UK to understand their strategies and how these linked with those of the network.
The network reviewed the new RightCare toolkit for asthma with the aims of the self-assessment being completed and used by local systems and services to reflect on the strength of their current service provision and to identify opportunities to improve care are across the pathway.

2) *To support systems in ensuring that asthma medicines are optimally used to promote good asthma care, improve asthma control, and prevent asthma attacks.*

In November 2021, the network became aware of the SENTINEL project. This project has developed an intervention to implement the local asthma guideline which has a focus on reducing short-acting beta agonist (SABA) over-reliance and using Maintenance and Reliever Therapy (MART) for appropriate patients. The intervention was designed in collaboration with asthma clinicians and patients using experience-based co-design methodology and includes the five core elements to support sustained improvements in asthma care:

- Healthcare Professional Education.
- Implementation of Sentinel “gold standards” prescribing practice.
- Targeted asthma reviews.
- Patient support and education.
- Real time data monitoring and reporting of asthma care metrics.

The network supported a pilot project to utilise the work undertaken by the SENTINEL project team to help achieve quality improvements to the outcomes of patients with asthma within the East of England.

Both Bedford, Luton and Milton Keynes ICB and Suffolk and North East Essex ICB were successful in their applications to participate in the SENTINEL work supported by the network. The project is still in the pilot stage, due to finish in September 2023.

6. Community Acquired Pneumonia (CAP)

Community Acquired Pneumonia management is a national priority. Following discussions with the regional Learning Disability Mortality Review (LeDeR) network and from providers, the respiratory team agreed to focus on improving care pathways for patients with severe neurological disabilities transitioning from paediatric to adult care. This cohort of patients have complex needs, are susceptible to respiratory infection and represent an area of health inequality. Once established, the CAP Steering Group set its initial objectives as follows:

1) To support the reduction in the number of preventable LeDeR Review pneumonia deaths.
2) To support the improvement in pneumonia, flu & COVID vaccination rates in vulnerable groups

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3) To support systems in the consistent use and application of risk scoring for at risk patients with complex neuro disabilities, learning disabilities and autism.

   a) To support the delivery of this objective, the steering group established a Task and Finish group to deliver a project that is reviewing and identifying how to improve annual review health checks for these patient cohorts.

7. Acute Respiratory Care Units (ARCU)

Acute Respiratory Care Units are an integral part of the hospital care for patients with Acute Respiratory Disease. They developed rapidly during the COVID-19 pandemic to enable a higher level of monitoring and respiratory intervention than expected for a routine ward environment.

Successive national audits had shown wide variation in ARCU service infrastructure and patient outcomes. To promote equity of service and achievement of national standards, the network introduced a peer review process, with the following aims:

- To benchmark against national standards
- For Trusts to learn from each other
- To provide a stimulus for quality improvement
- To be an opportunity to share good practice more widely
- To support units in their work to achieve service improvement

The Network Board agreed the standards and designed the framework for the ARCU peer reviews and recommended a pilot peer review. This was conducted in June 2022 with positive outcomes. The resulting report was considered to have provided an accurate picture of the successes and challenges experienced by the Trust as well as constructive recommendations for improvement.

Following the success of the pilot Peer Review, the network has continued to offer peer reviews to all Acute Hospital Trusts within the region, with two more planned for early 2023-24.

“The positive feedback has been really welcome, knowing that we are getting some things right and knowing what we need to improve on”.

“The whole process has been very helpful gives us a lot to take away and think about”.

ARCU Team’s Feedback

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Challenges

Some specific challenges were identified affecting the progress and speed of delivery of the network aims and objectives.

Data

Obtaining appropriate respiratory data to support network discussions, establish baselines and monitor progress remained a challenge through 2022/23. Part of this was due to information governance issues and part due to required data coming from multiple different sources which is difficult to triangulate. Many of these issues are being addressed by the national team with the development of the respiratory dashboard in 2023/24.

Recruitment and resourcing

Delays to the recruitment of posts integral to the network because of the announced restructure had some impact on the progress of the objectives. Similarly, the formation of the new Integrated Care Boards in July 2022 saw many system roles changing to reflect new ICB structures which affected continuity for some systems.

Pulmonary Rehabilitation.

The requirement for PR Services to return to full Face to Face sessions from April 2022 was delayed due to staffing numbers, patients unable to attend face to face sessions and sufficient estate to be able to deliver sessions. Other challenges included providers having sufficient time to work towards achieving accreditation which was mitigated in part by the appointment of a project manager in the network to work with providers and to support the accreditation process.

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Areas of Focus for 2023/24

1. Overarching Network Objectives:

Key Objective 1: To ensure Patient and Public Voice (PPV) is present within the network so that the patient's voice can help shape the programme's deliverables.
Key Objective 2: To have developed and implement reducing health inequalities plan with clear deliverables.
Key Objective 3: To enhance the support the network can provide to ICBs to help them to achieve the priorities within the East of England.
Key Objective 4: Throughout 2023-24 to have provided support and guidance as required across the East of England

2. Pulmonary Rehabilitation:

Key Objective 1: To work with services taking part in the network's accreditation project to achieve PR accreditation.
Key Objective 2: To Increase referrals, completion rates and reduce the wait time to start a PR programme.
Key Objective 3: To support waiting list management and ensure prioritisation within the waiting list is established to meet the requirements of the patient.
Key Objective 4: To increase access to pulmonary rehabilitation, using a population-management approach in primary care to find eligible patients from existing COPD registers who have not previously been referred to rehabilitation.

3. Respiratory Diagnostics:

Key Objective 1: To ensure that patients have good access to accurate and timely diagnostic services across the region, including considering how health inequalities impact on access to services.
Key Objective 2: To ensure that systems have the optimal numbers of accredited practitioners performing spirometry tests and diagnosis of results and to share best practice across the region.

4. Asthma:

Key Objective 1: To review, consider and design adjustments to the asthma referral and patient pathways to secondary and tertiary care, supporting their implementation. So that patient's receive the best quality asthma care.
Key Objective 2: To support systems in ensuring that asthma medicines are optimally used to promote good asthma care, improve asthma control, and prevent asthma attacks.
Key Objective 3: To support the accelerated access for severe asthma patients to timely and appropriate expert care and biologic treatment through novel population-level patient identification, engagement & triage solutions.
Key Objective 4: To encourage the transition to inhaled therapy greener inhalers where clinically appropriate, by supporting the best use of devices with a lower carbon footprint.

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5. Community Acquired Pneumonia:

Key Objective 1: To support systems in the consistent use and application of risk scoring for at risk patients with complex neuro disabilities, learning disabilities and autism.
Key Objective 2: To support the reduction in the number of preventable LeDeR Review pneumonia deaths.
Key Objective 3: To support the improvement in pneumonia, flu & COVID vaccination rates in vulnerable groups.

2023-24 will also see the transition of the Long COVID programme into the Respiratory Clinical network.

Network Budget

The network receives funding from the national team for staffing and additional monies to support targeted system programmes.

1. Staffing:

Funding Allocation Description	**Amount**
Network staffing	£200,000

2. Service development funds (to ICBs):

Funding Allocation Description	**Amount**
To be used either to support ARTP accreditation or the development of local diagnostic services.	£100,000
Additional spirometry funding	£55,000

3. Pulmonary Rehabilitation Specific Funding (to ICBs)

Funding Allocation Description	**Amount**
10% Allocation to the East of England Regional Team for PMO / Communication support:	£155,739
Funding to perform targeted work at local level to improve PR services equity of access, reduce health inequalities, and work towards the NHS Long Term Plan objectives.	£900,000
PRSAS Accreditation Project:	£100,000
Innovation projects that support the transformation of PR:	£400,000
Total amount:	**£1,557,394**

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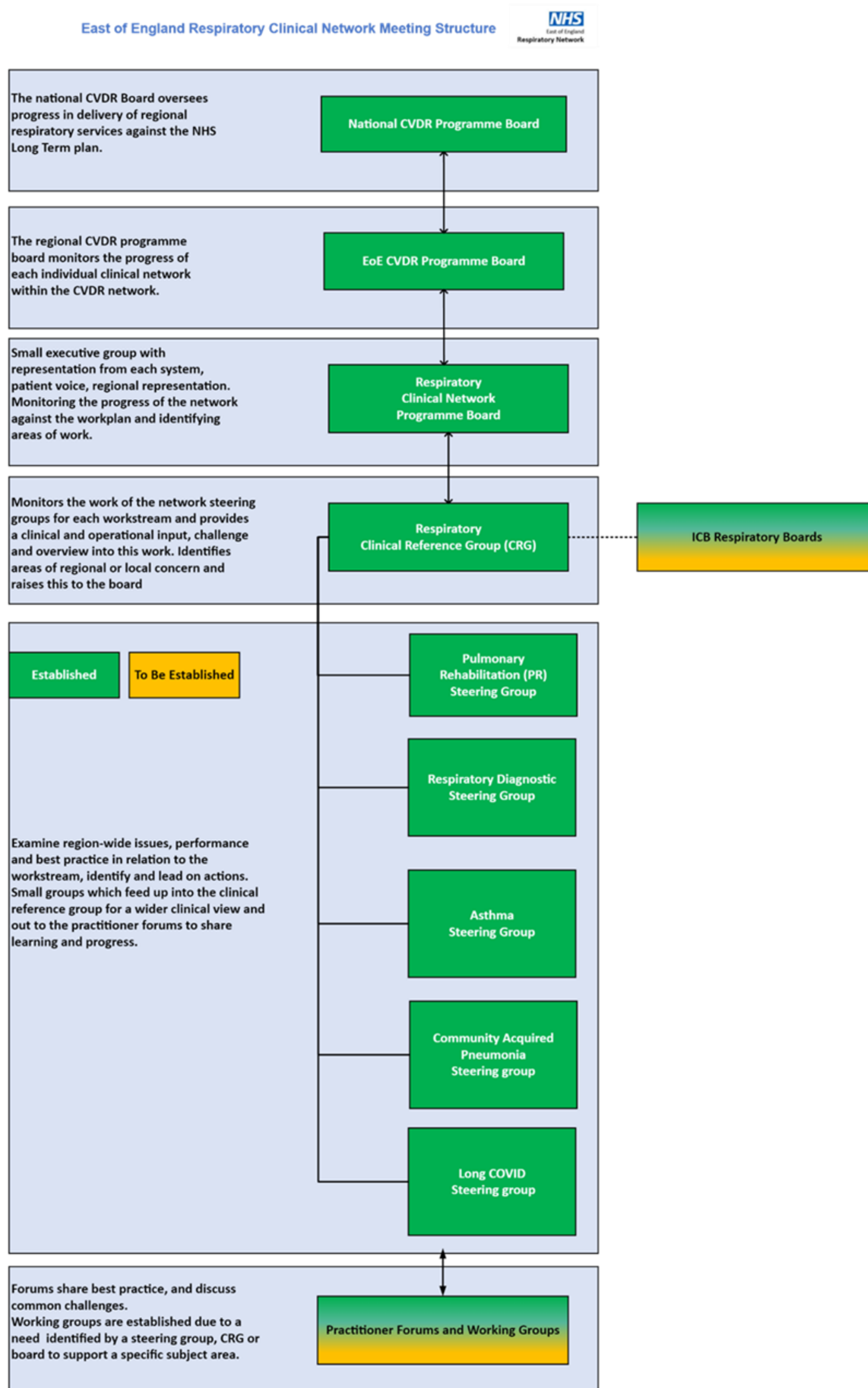
Network Governance

The network's governance structure was strengthened by further developing the network's programme board - revising board membership and reporting templates to ensure alignment to other oversight boards. New steering groups were established, and existing ones developed and strengthened. Stakeholder engagement with systems and partners remained strong throughout 2022/23 with support forums for initiatives such as Acute Respiratory Infection (ARI) hubs provided to systems.



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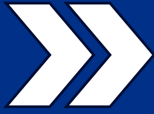

4. Long Covid Network

Long COVID Network

The Long Covid network was set up in 2021. Long COVID encompasses both ongoing symptomatic COVID (4-12 weeks after infection) and Post-COVID Syndrome (12 weeks after infection). In October 2020, the Five Point Plan for Long COVID confirmed that £10 million will be invested to set up specialist Post-COVID Assessment Services (PCAS) across England, to complement existing primary, community, and rehabilitation care. Regions were also required to provide a regional tertiary hub for Children and Young People diagnosed with Long COVID who needed further support than was available locally.

Services provide both assessment and tailored rehabilitation for Long COVID patients using Multi-Disciplinary Teams (MDTs) comprising a range of professionals reflecting the spectrum of symptoms that Long COVID patients may encounter. The model is a biopsychosocial approach to treatment, with medical, psychological, and social assessment and treatment for our patients.

Funding for the network continued into 2022, with the East of England receiving £8.9m to provide continuing assessment, support, and treatment for Long COVID patients in our region.

In previous years, the programme sourced clinical leadership from the Respiratory Network's Clinical Lead, Respiratory Consultant Dr Jonathan Fuld. In August of 2022, the regional programme was successful in recruiting a Long COVID Clinical Champion to provide dedicated clinical support to the development of services alongside the network leadership.

Network Priorities for 2022/23

In 2022/23, the Long COVID programme focussed on clinical and operational quality improvement, addressing health inequalities, and establishing a peer review programme.

Our specific priority areas were:

1. Operational performance and improvement
2. Key interventions to reduce patient waits and inappropriate referrals
3. Peer Review Programme
4. Health Inequalities in accessing and attending Long COVID services
5. Investigating barriers to the uptake of services
6. Raising awareness about Long COVID services to patients

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Network Team

Dr Ellen Makings
Senior Responsible Officer

Dr Jonathan Fuld
Clinical Lead for the Long COVID Programme until January 2023

Sarah Fowler
Long COVID Clinical Champion from August 2022

Kirsty Goddard
Long COVID Programme Manager

Network Performance and Achievements

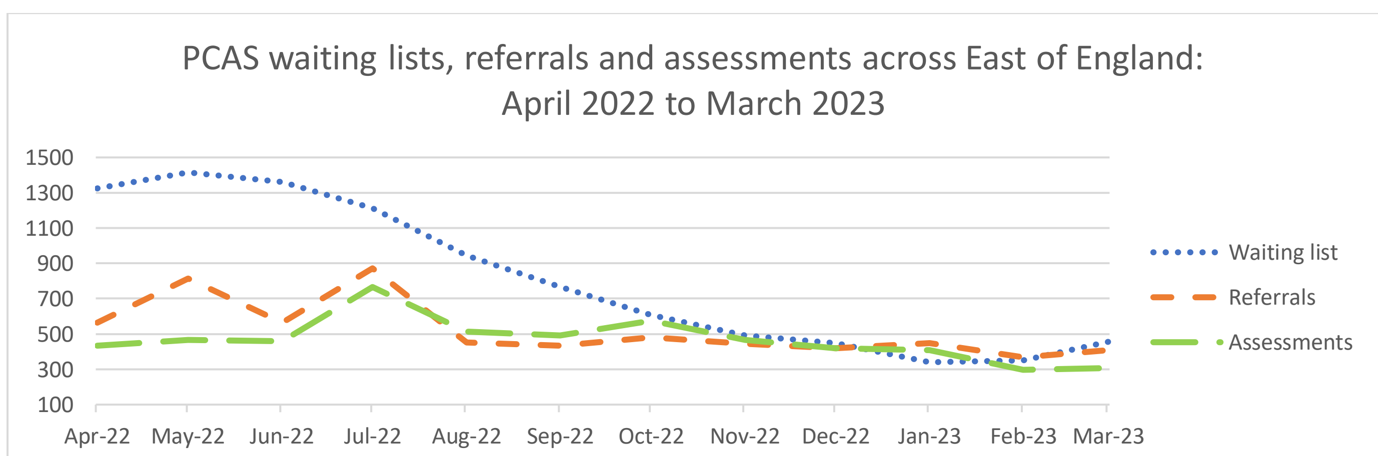
1. Operational performance and improvement

Bi-monthly steering groups and quarterly 1:1 meetings with both provider and commissioner were held for each service, addressing performance challenges, and improving operational performance. By Quarter 3 of 2022/23, all services in the East of England were reviewed as meeting all aspects of the national quality assurance proforma, confirming services were delivering to each aspect of the set service specifications for post-COVID services.

National key performance indicators for post-COVID services were set for two areas: 'waiting time until assessment' and 'referral rejection rates:

The East was the first region to eliminate 15-week waits excluding patient choice or DNAs (Did Not Attend). Other key data includes:

- In March 2023, the East of England had 389 patients waiting for assessment as compared to 1,415 in May 2022.
- 74% of patients were seen within 6 weeks of referral, compared to 40% in April 2022.
- 4.2% of referrals to services were rejected as inappropriate in March 2023, down from 13.6% at the same point in 2022.



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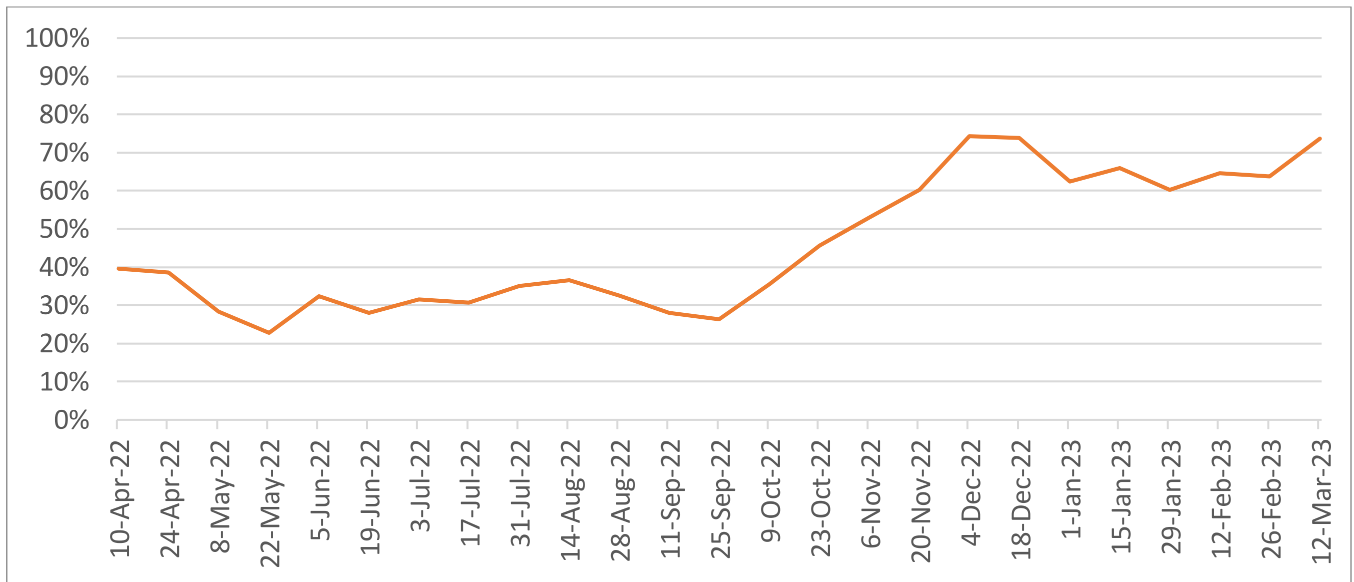
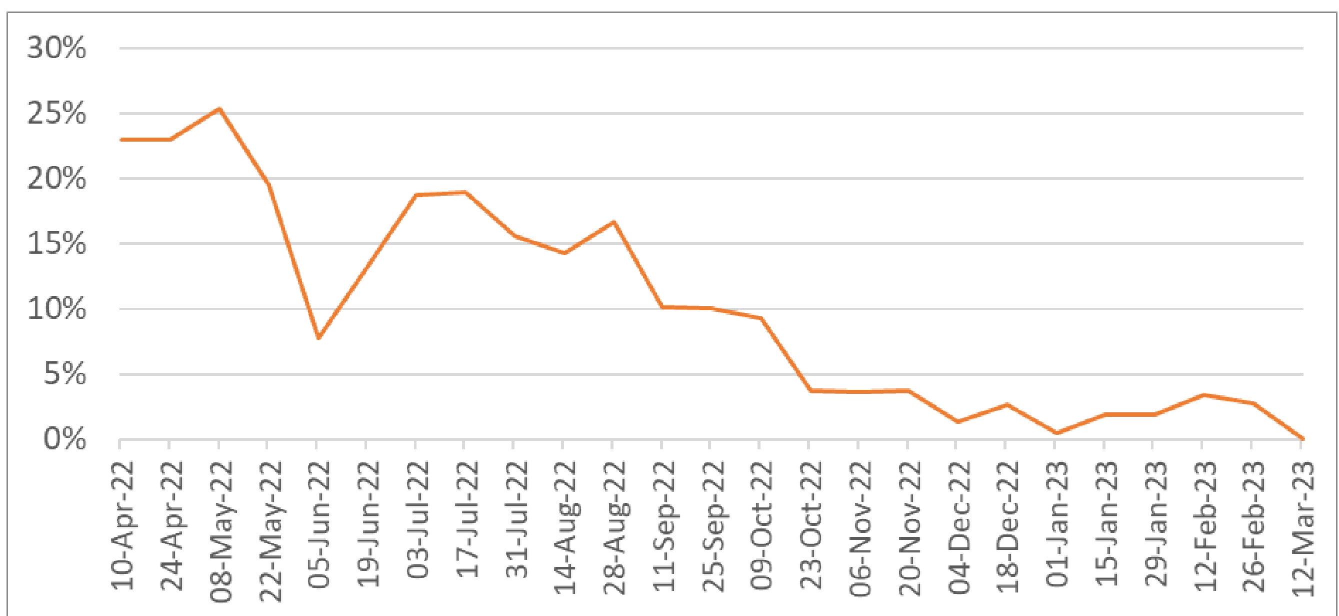
Percentage of patients receiving initial assessment within 6 weeks of referral



Percentage of patients receiving initial assessment more than 14 weeks after referral



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2. Key interventions to reduce patient waits and inappropriate referrals:

Work in Mid & South Essex and Norfolk & Waveney to reduce waiting times had a significant and sustained impact, facilitated by network discussions focused on causes of patient waits and possible solutions.

Rejection rates – Cambridgeshire & Peterborough (C&P), Herts Valleys and East & North Herts (ENH) had challenges with high rejection rates. Herts Valleys audited their rejections and found that most were due to incomplete referrals from Primary Care. They adapted their referral form so that referrals could not be completed unless all information and test results had been included. Rejection rates fell in accordance. Using this learning, both C&P and ENH were able to then adjust their referral processes allowing patients a better journey to appropriate care. While work is ongoing in C&P, ENH managed to reduce rejection rates from an average of 30% in Q3 of 22/23 to an average of 16% in Q4, with the last two reporting points showing rejection rates of 4% and 0% respectively.

Alongside work to improve operational performance, clinical workshops held on a bi-monthly basis covered a range of topics to encourage services to continue to develop and provide tailored, high-quality care for patients with Long COVID. Topics included:

- Managing Complex Patients
- Long COVID Buddies and Community Engagement
- Trainee AHPs in Long COVID services
- Complex Long COVID Rehabilitation from a Patient Perspective
- Long COVID and Mental Health
- Physical Activity to Achieve Occupational Outcomes
- Staff Welfare and Daily Staff Debriefs

The Network established informal communities of practice for GPs working as GP leads in services and linking together our Speech and Language Therapists providing advice to Long COVID services.

Our service leads established strong informal communities over 2022/23, meeting to share learning and challenges outside of the formal steering group and assurance structures. This has been facilitated through the work of the network provided a culture of open collaboration and encouraging innovation, and the work of our Clinical Champion to encourage self-assessment and scrutiny by services.

3. Peer Review Programme

A Peer Review Framework was developed using examples from the London Long COVID programme and respiratory network ARCU peer reviews. With the collaboration of the steering group, this was rolled out across the region in December 2022 with an aim to complete by end March 2023. The Peer Review programme was limited to adult services.

Services were asked to complete structured self-assessments looking at the assessment and rehabilitation aspects of their work, from referral to discharge. Services were then matched with another service who were identified as having different strengths and weaknesses and asked to review that service. They were also matched with a separate service who then reviewed them.

Services are expected to complete their final discussions in May 2023 and submit action logs to the regional team recording their planned actions as a result of their peer reviews. These will then be

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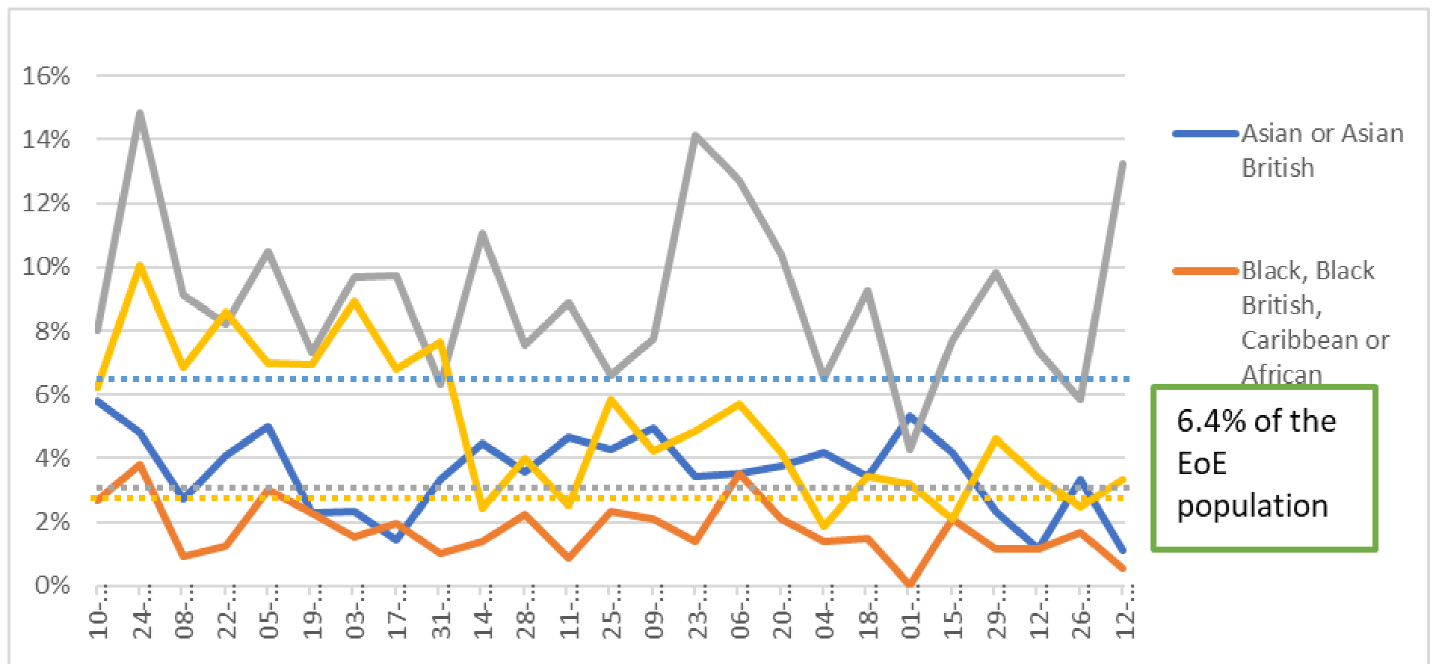
monitored and discussed in assurance meetings, with learning from reviews to feature as a key workstream priority for Long COVID in 2023/24.

4. Health Inequalities in accessing and attending Long COVID services

Demographics of service users across the region show those from deprived postcode areas and people identifying as from a Black, Mixed or Asian background are being seen at services at a proportionate rate for the regional population, when compared with census and IMD figures.

The next step is for ICBs to take on this work at a local level to identify their particular local communities and geographies who need extra work undertaken to enable them to access and use services. There is no consensus on a link between ethnicity and Long COVID at the time of writing, so the broad statistical aim would be for a percentage that matches the demographic ethnic breakdown of ICBs. However, work to improve services cannot rely on activity statistics only to demonstrate it is reaching and usable by a wide range of communities, so outreach work and patient and public involvement will be encouraged at ICB level in 2023/24 as a priority.

East of England: people of Black, Asian and Mixed Ethnicities receiving initial assessments at PCAS.



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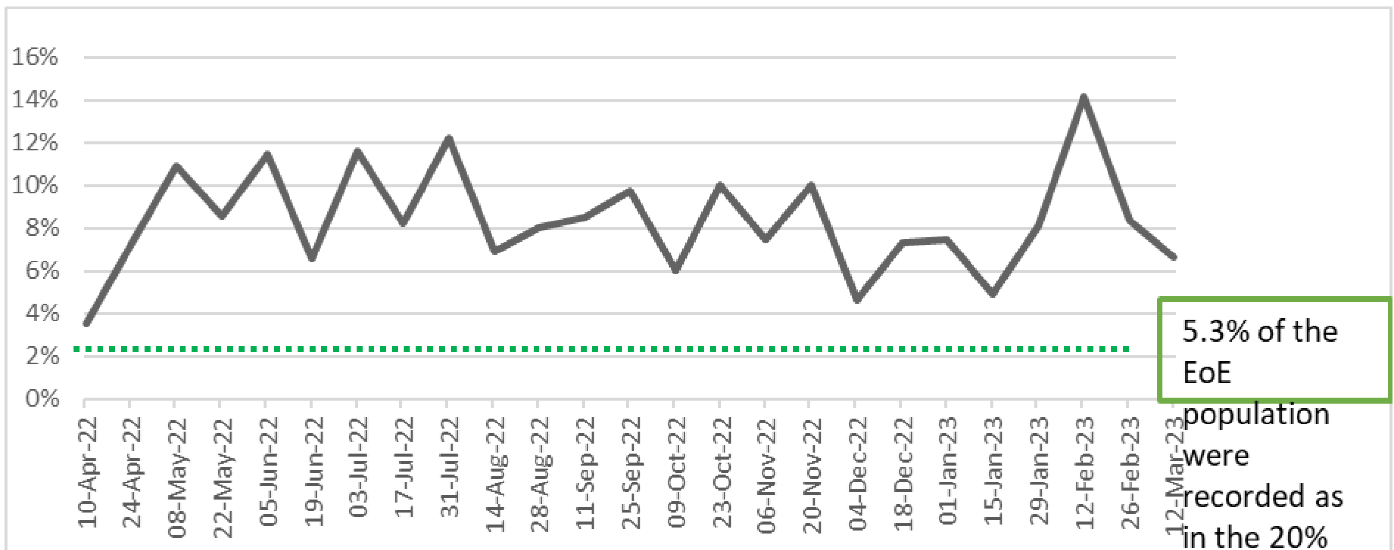
East of England: patients recorded as living in the most deprived quintile (20%) in England (by postcode check)



Key Challenges

In delivering our 2022/23 priorities, two key challenges for Long COVID services and commissioners and the programme were highlighted:

- A lack of certainty and clarity over funding. Long covid services have been established on a yearly funding basis from the national team since 2021.
- Workforce shortages across the region. Not all providers were able to offer substantive posts and absorb the risk of having to redeploy staff should funding end, which meant recruiting to fixed-term posts on a rolling yearly basis.

Priorities for 2023/24

Priorities for next year are focused on the transition of services from a programme function to a business-as-usual model within the ICBs.

This focus includes:

1. Supporting ICBs in the development of their future models of care,
2. Completing the peer review process and the development of action plans,
3. Monitoring the uptake and delivery of long COVID services,
4. Identifying areas of transferability of the model of care, e.g., Breathing pattern disorder, fatigue management, anxiety.

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Network Governance

The Long Covid Network reports directly to the regional CVDR Board and to the national team. Programme objectives and achievements are reviewed at the regional Long Covid Steering group and the Respiratory Programme Board.

Quarterly assurance meetings are held with each Integrated Care Board.

Network Budget

The funding allocation for the Long Covid network comprises network support and staffing:

2022/23 EoE Long Covid funding total	**£8,994,000**
Network support	£100,000
Regional CYP tertiary hub	£285,000
ICB allocations	£8,609,000
Long covid comms	£25,000

"The network has been so helpful in providing information, and critical/constructive thinking around services that were built at speed. The network has been able to support and encourage thoughtful reflection to improve services while understanding constraints but is able to provide advice on how to overcome this."

Sally Wood, West Essex Post COVID Assessment Service

"Since becoming involved with the PCAS I have found the network very informative and a useful service which has provided myself and the team with knowledge and supporting references for post covid services within our area."

Adele Mancini - Planned Care and Community, NWICB

"The network has been instrumental in helping to shape the delivery of our service. It has offered tremendous support in steering our service by supporting our growth and development. It has also served as a place to learn, network, and upskill in leadership and management."

Ade Kehinde, Cambridge and Peterborough Post COVID Assessment Service Lead

"The introduction of the Peer Review Programme has provided a good opportunity to learn from other services, discuss challenges in providing PCAS and strengthen support between services."

Alison Wilcox, Covid 19 Rehab Coordinator, East & North Herts PCAS

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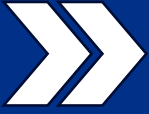

5. Diabetes Clinical Network

Diabetes Clinical Network

Our vision at the East of England Diabetes Clinical Network is to improve quality of life and outcomes for people with diabetes, and those at risk of type 2 diabetes. We do this by supporting clinicians, providers and commissioners to deliver excellence in all aspects of diabetes prevention and care; reducing inequality of access to optimal care; driving out unacceptable variation in pathways of care and sharing good practice. This is pursued through regional support for local management and national programmes.

The network has continued to develop excellent relationships with all 6 newly forming Integrated Care Systems (ICS) and other key stakeholders, including Diabetes UK.

In 2022/23, primary care/ICS business planning assurance processes were ongoing for the use of national funding with a focus on primary care, including the restoration of the 8 care processes and the promotion of diabetes prevention.

Network priorities for 2022/23

Priorities were similar to those in 2021/22, built on the Long-Term Plan, but with new national priorities for people with diabetes. Funding was available to ICSs to support the national programmes.

Priorities for use of national programme funding in 2022/23:

1. Restore the identification, monitoring, and management of all types of diabetes to pre-covid levels.
2. Increase primary care referrals to the NHS Diabetes Prevention Programme across all ICS *(LTP).*
3. Increase primary care referrals to the NHS Low Calorie Diet (LCD) programme pilots.
4. Support people with diabetes to access nationally commissioned digital structured education programmes *(LTP).*
5. Ensure that all trusts have a diabetes inpatient specialist nurse (DISN) service and all people with diabetes have access to a multidisciplinary footcare team (MDFT) if required, by March 2023 (*LTP):*
   - Following several years of national pump-prime funding, local sustainability plans should be in place to ensure that these services are locally funded from April 2023.

Other national and local priorities include:

6. Ensuring people with diabetes can access glucose monitoring (flash/continuous glucose monitoring) in line with new NICE guidance (NG 17, 18 & 28, April 22), increasing uptake and reducing variation across the region. This is known as ‘Tech in Diabetes’.
7. Offering continuous glucose monitoring (CGM) to all pregnant women with Type 1 diabetes and promoting participation in the National Diabetes in Pregnancy audit *(in conjunction with Maternity Clinical Network) (LTP).*
8. Improving outcomes for children & young adults with diabetes in conjunction with the NHSE Children and Young People (CYP) Network and the local CYP Diabetes Network *(LTP)* – the

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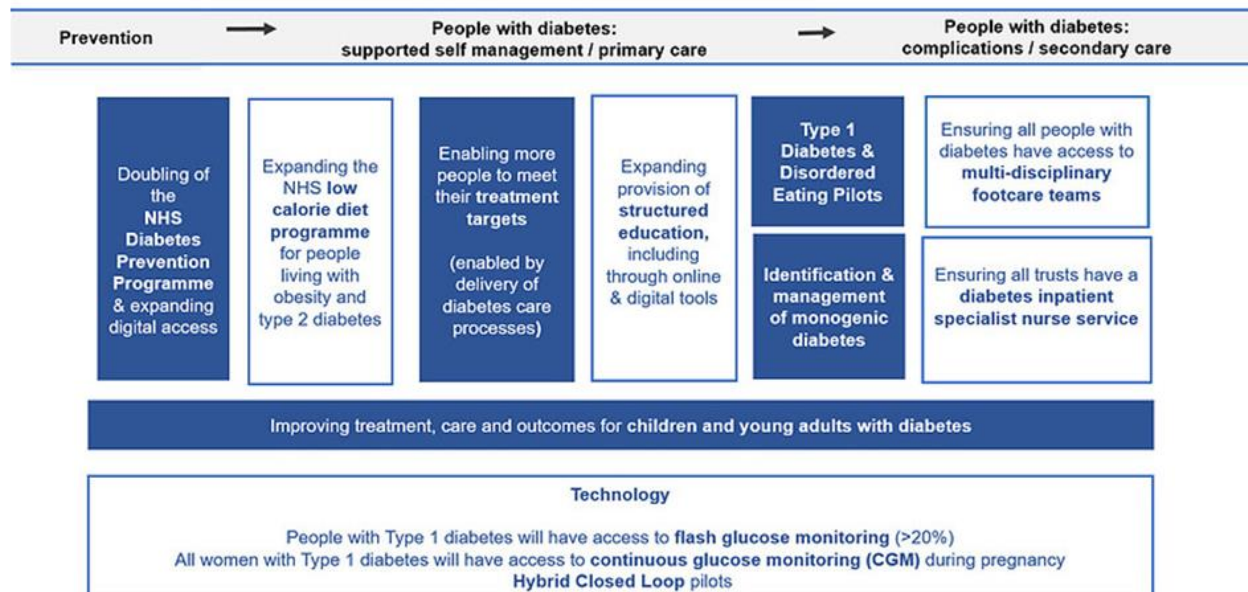
remit of the adult network was to review and recommend sites for Transition and Young Adult pilots with ongoing support for implementation.

9. Type 1 Disordered Eating (T1DE) pilots – were to be awarded by summer 2022 with ongoing monitoring and support.
10. Supporting appropriate referrals for genetic testing for monogenic diabetes.
11. Pilot of national diabetes care inpatient accreditation scheme - the DCAP scheme - for England and Wales with the Royal College of Physicians – funded by NHSE East of England for a pilot for testing in 9 sites in our region. Aim to standardise and improve care for inpatients with diabetes and to roll out nationally in 2023/24.



Network Team

Dr Rob Sherwin
Senior Responsible Officer

Professor Gerry Rayman
Secondary Care - Clinical Lead

Dr Chirag Bakhai
Primary Care - Clinical Lead

Clare MacArthur
Quality Improvement Manager (until June 2023)

Mansi Khadia
Quality Improvement Project Officer (until May 2023)

Abbie Bardell
Quality Improvement Project Officer (from June 2023)

Amanda Harrington
Business Support Officer

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"“Diabetes UK have enjoyed working collaboratively and productively with East of England NHS England on a number of projects and initiatives.
As an integral member of the East of England Strategic Diabetes Oversight Group and Network, along with our excellent direct working relationship with the NHSE Quality Improvement team, we have been able to share and develop initiatives and enhance patient experience across the region.

“People across the region will have benefited from our joint work, leading towards improved health outcomes and in equalising variations in care. These have included: - Three face to face Living with Diabetes Days – Mid and South Essex ICB (Southend) 13th June, Cambridge, and Peterborough ICB (Cambridge United) 19th July and Norfolk and Waveney ICB (Norwich) 26th Sept. Also, one virtual event coming up in Diabetes Week with Suffolk and Northeast Essex ICB on 14th June. The plan from these as well as evidencing patient experience, is to start some peer support groups locally to provide ongoing support following the events. Planning has started for the distribution of patient info packs across the region which have also been funded by the network. Each ICS will receive 1000 packs (6000 in total). These will include vital information for newly diagnosed patients including the new care to expect leaflets and local signposting to support services (Talking Therapies, structured education etc). All this has been possible thanks to our collaborative work with the NHS East of England Network.”

Peter Shorrick
Head of Midlands & East of England at Diabetes UK

DiABETES UK
KNOW DIABETES. FIGHT DIABETES.

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Network Performance and Achievements

1. Using diabetes data in planning, monitoring and evaluation

Using diabetes data in the planning, monitoring and evaluation has led to the consistent use of the best data in ICB business planning and appropriate use of funding. Through persistent use and promotion of relevant diabetes data in all meetings, with one-to-one walk-throughs with Integrated Care Board (ICB) leads to promote the latest diabetes dashboards, and frequent circulation of updated regional data, there has been a noticeable shift in ICB thinking.
Much validated national data is available quarterly and now being used for planning, but 5/6 ICBs are using local dashboards for data that is more live, to evaluate ongoing projects such as the 8 Care Processes.

2. Increasing provision of 'routine' care processes

We have increased the provision of 'routine' care processes with a focus on reducing variation and targeting inequality – the East of England generally tracks above the England average for these metrics.

People with Type 1 diabetes *who received all 8 CPs in East of England Jan – Dec 2022:* ***32.9%*** *(England average = 31.1%)*	***People with Type 2 diabetes*** *who received all 8 CPs in East of England Jan – Dec 2022:* ***46.3%*** *(England average = 46.2%)*

ICB (patients who had received all 8x Care Provisions in 2022)	People with type 1 diabetes	People with type 2 diabetes
ENGLAND AVERAGE	**31.1%**	**46.2%**
BLMK	29.3%	45.1%
C&P	33.7%	46.6%
HWE	31.4%	45.2%
MSE	27.7%	36.0%
N&W	29.1%	48.2%
SNEE	47.5%	58.3%

3. Increasing referrals to Diabetes Prevention Programme and new focus on reducing inequalities

Overall, referrals and first attendance to a recognised diabetes prevention programme in the East of England more than doubled between Q3 in 2020/21 and Q3 2022/23. Inequalities are also being addressed.

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Systems are working in collaboration with providers to increase uptake of referrals, targeting inequalities linked to deprivation and particular groups including:

- ✓ People where English is not first language (C&P)
- ✓ Travellers (MSE)
- ✓ Those from Black and South Asian communities
- ✓ Inequality due to deprivation (everywhere)
- ✓ Reducing inequality success from N&W highlighted nationally

Low Calorie Diet Programme referrals and uptake have increased in the two pilot sites – Bedford, Luton and Milton Keynes (BLMK) and Mid and South Essex (MSE). BLMK are high achievers in the first wave of pilots, however MSE had a delayed start but are starting to show significant improvement:

	Started pilot	**Indicative target and date** TDR: Total Diet Replacement phase	**Low Calorie Diet TDR starts by April 2023** *(rounded at source)*
BLMK	Sept 2020	750 TDR starts by May 2023	555
MSE	Feb 2022 (delayed until April 22)	500 TDR starts by Jan 2024	100

4. Multi-disciplinary Footcare Team (MDFT) and Diabetes Inpatient Specialist Nurses

All Trusts in the East of England have now achieved the NICE Guidance ensuring provision of a multi-disciplinary foot care team and provision of diabetes inpatient specialist nursing. National funding for these programmes will cease in April 2023 and so work is on-going with the providers and systems to promote sustainability of these services going forward.

5. Glucose Monitoring

NICE approved glucose monitoring technology policies were in place in all six ICBs by March 2023. The East of England was the lowest region in terms of availability of technology for patients at the beginning of 2022, but this has improved considerably over the course of the year. (see table below)

The network supported ICBs with their policies, providing information for drafts, discussing the benefits and disadvantages, and championing the NICE guidance in meetings leading to high-level discussions and including the national team.

Results for Flash glucose monitoring in people with Type 1 diabetes by end of Q3 (December) 2022:	England = 73.3% East of England = 58.6%

Data also shows that there is equitable access for patients between the most deprived and least deprived groups.

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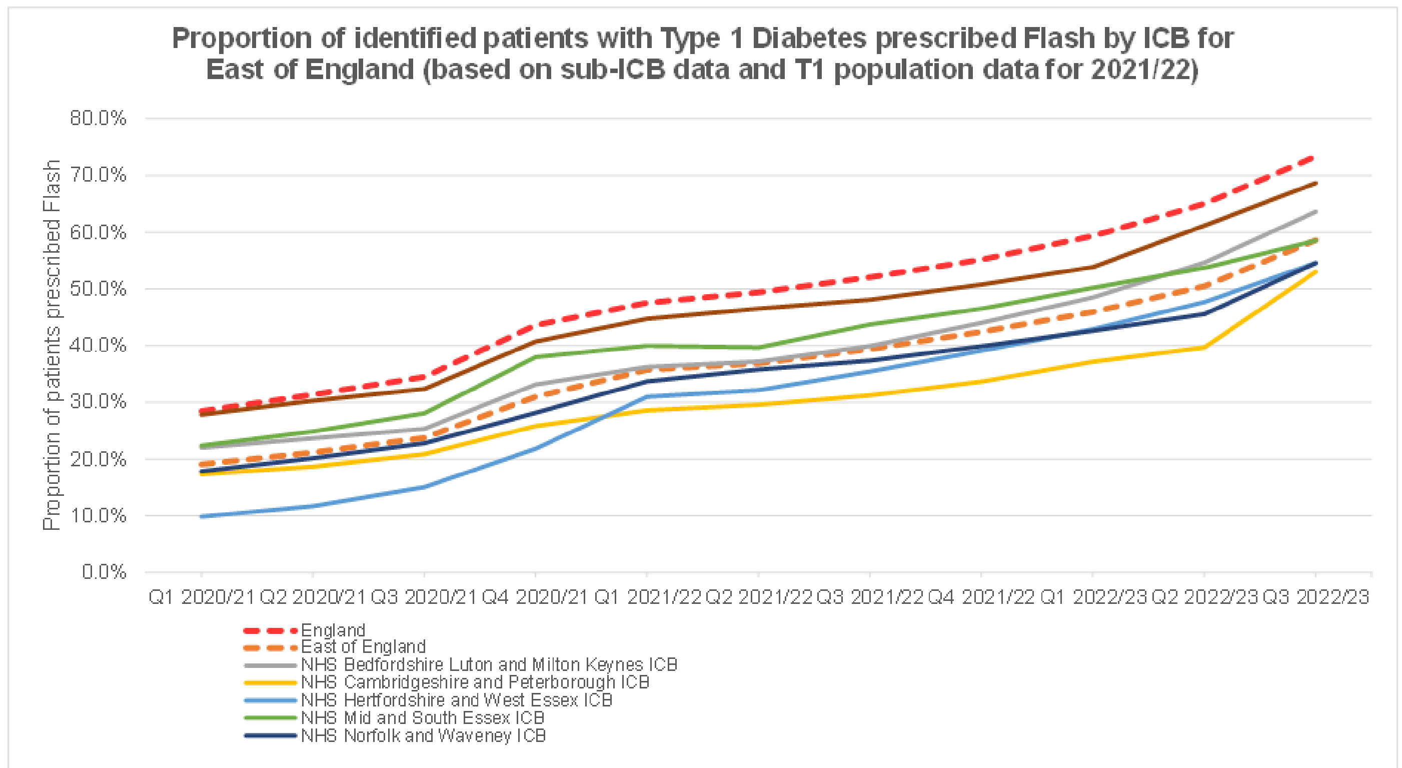

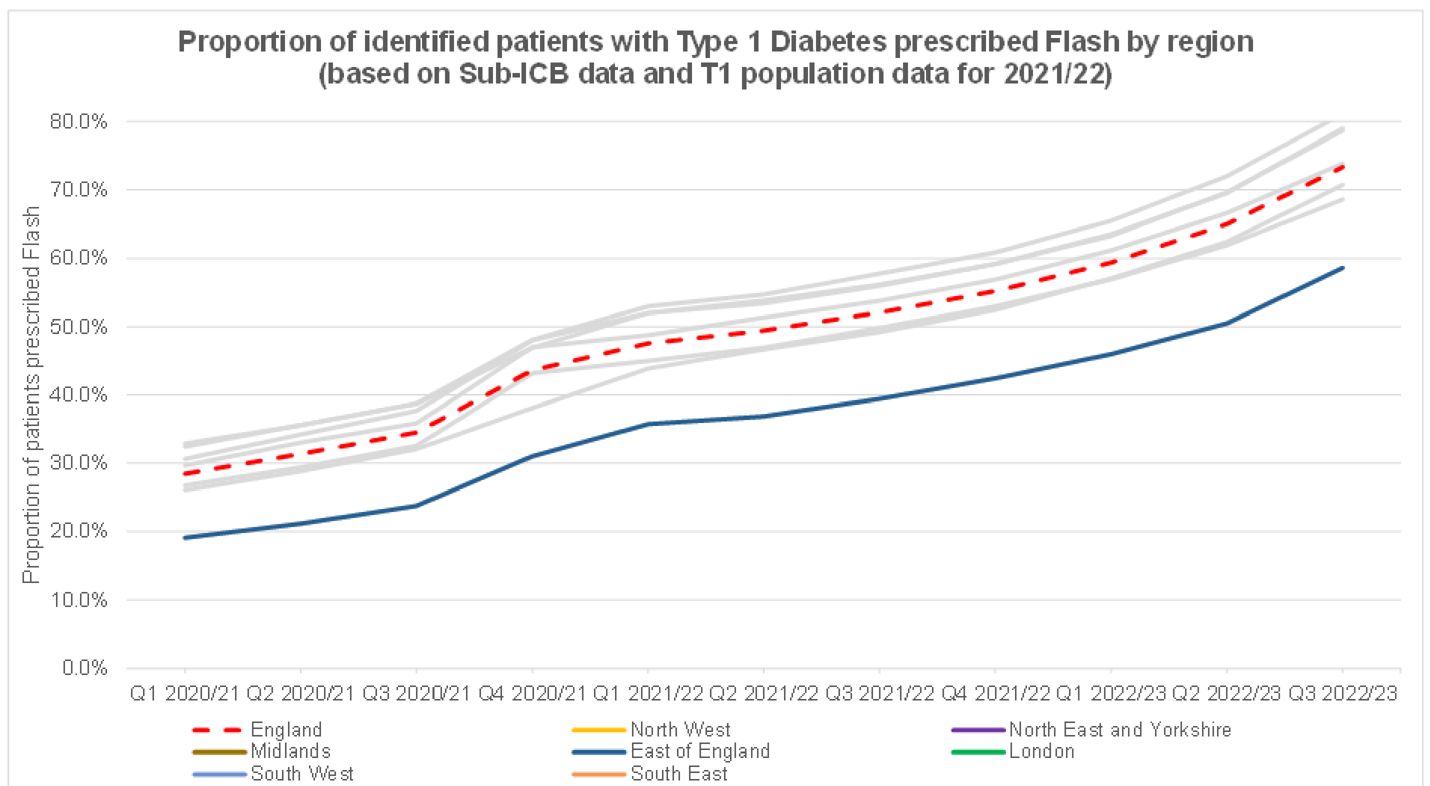

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6. Other highlights:

- **Continuous glucose monitoring (CGM) in Type 1 pregnancy -** The offer and provision of CGM in Type 1 pregnancy – East of England performs well overall, and it is now devolved to Local Maternal and Neonatal Service monitoring. In Q4 of 2022/23 those offered (offered/eligible) was at 68.85%. and the uptake was 53.46%.

- **Children and Young Adults with diabetes:** Full participation in the planning and oversight of the national programmes. In 2022/23 the adult diabetes network staff managed the expressions of interest process for the Children and Young Adults (CYA) team, including a young person's panel. The network continued to work with the two successful sites on their new services according to the specification – Ipswich and East Suffolk, and Norfolk and Norwich.

- **Type 1 Disordered Eating pilot (from Sept 2022):** The network managed the regional expression of interest process and Norfolk & Norwich were successful in gaining funding for the pilot, with ongoing support for the implementation and reporting to the national team.

- **Monogenic diabetes initiative:** this national offer of training and support for Trusts was disseminated, resulting in all Trusts now having trained monogenic specialists within their teams.

- **Diabetes Care Accreditation Programme (DCAP) - successful inpatient accreditation pilot** with the Royal College of Physicians and Diabetes UK in the East of England & Wales only. This pilot was supported and funded by East of England Diabetes Network. Nine Trust sites from our region took part in this pilot phase, leading to national launch of the full accreditation process in May 2023.

- **Productive NHSE relationships with all ICBs** enabling common issues to be addressed and discussed, supporting cross ICB confidence and sharing of good practice, learning from past initiatives and comparing achievements to reduce variation. The network has supported ICBs in the use of local and national data with many of the ICBs creating diabetes databases to track progress.

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Sharing Best Practice

A key highlight for the Network in this area was hosting a 'Transforming the Care of People with Type 1 Diabetes' Conference in March 2022, with over 60 clinicians and commissioners attending and all ICBs represented.

Additionally, we shared valuable information over the year with other regions in England and held a number of webinars for providers across the region.

Other key highlights include:

- The high-performing North-East Essex Diabetes Service (for primary care outcomes) and Mid & South Essex (for fast recovery and improvement in care process achievement) were highlighted in national forums.

- Mid & South Essex are also used as exemplars by the national diabetes team for achievement in the NHS Diabetes Prevention Programme, & their success in targeting those from disadvantaged groups.

- Both clinical leads are leaders in their fields with frequent presentations at national and international webinars and conferences; Professor Gerry Rayman is Joint Diabetes Clinical Lead at GIRFT amongst many other roles; and Dr Chirag Bakhai is also the National Clinical Lead for the NHSE National Diabetes Programme.

Key Challenges

The major restructure of the new Integrated Care Systems and Boards led to loss of traction in some areas of work for 2022/23.

The East of England had and continues to have the lowest use of diabetes tech in England for people with Type 1 diabetes. NICE guidance which came without funding meant a significant cost pressure for ICBs with difficult decisions to be taken, meanwhile pressure from service users was extremely high. There is a gap to fill before we will be near the other regions, however their increase will plateau, expected at about 80% for people with Type 1 diabetes. This was included in our Type 1 Transformation Day in March.

Multi-disciplinary foot teams and Diabetes Inpatient Specialist Nurse provision has been funded nationally in a ring-fenced allocation to the systems for the past few years. From April 2023, this national funding will come to an end presenting a challenge to some providers going forward. Workforce remains a challenge in many areas of diabetes care, with pressures in primary care and a shortage in the podiatry workforce generally. Many posts are unfilled, and this is leading to capacity pressures within many systems.

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Network Priorities for 23/24

1. The aims of the network will alter in 2023/24 as some of the oversight and assurance functions will shift more to the ICBs following the changes to national funding. To enable this, the Oversight Meeting will combine with the Programme Board to form a wider stakeholder group with the remit to further improve the diabetes care pathways and outcomes for patients in the East of England.

2. Continue to increase the uptake in diabetes prevention through the Diabetes Prevention Programme and the Low-Calorie Diet Programme (T2DR), expanding the offering across the region.

3. Improve patient outcomes by improving uptake of structured education programmes, increasing the number of patients completing the 8 care processes, implementing the early onset Type 2 diabetes programme (T2DAY) and supporting the national pilots for transition of care from children to adult services and the Type 1 disordered eating.

4. Improving the uptake of technology in pregnancy and Type 1 diabetes for continuous glucose monitoring, increasing the number of insulin pumps for patients meeting the criteria and preparing for the implementation of the hybrid closed loop systems.

5. Bringing a focus to the secondary care pathways and the GIRFT recommendations including 7 day-working, out-patients, further uptake of the inpatient accreditation process, management of complications and peri-operative management.

6. Sharing best practice – enhancing the current sharing events to include lunch and learn sessions, relaunching of the footcare forum, commencing a secondary care forum and events for nurses.

7. Workforce – linking with colleagues in the Workforce, Training and Education directorate to collaborate on plans to address workforce shortages in the diabetes pathway in primary, secondary and community care.

Network Governance

Assurance processes were set up via quarterly regional Oversight Group meetings and Diabetes Programme Board meetings, as well as meetings and webinars for specific projects and programmes. These meetings allow sharing of good practice around the region, including establishing the NICE guidance and policy for glucose monitoring technology in diabetes discussions and hosting the '*Transforming the care of people with Type 1 Diabetes'* Conference.

Regular attendance and contribution by network staff to local ICS diabetes meetings was instigated for assurance and for communication of potential pilots and funding for the region, for example, alongside championing national policy and guidance. Attendance at system meetings also enables the network to better understand issues, challenges, and achievements at a local level.

Twice-yearly Deep Dives are convened with national team to discuss progress and any areas of concern. Local escalation will usually involve discussion with the national team at an early stage.

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Network Budget

The Diabetes Network is funded by the national team with additional monies for pilots and system funding.

1. Network staffing:

Funding Allocation Description	Amount
Annual allocation for staffing the network and support staff	£314,000

2. Diabetes funding provided for national pilots:

Funding Allocation Description	Amount
Transition and Young Adults Pilots x 2 (part year funding with two full years to follow)	£176,000

3. Diabetes funding provided to ICBs for Transformation Programmes in the East of England:

Programme	2022/23 Funding
Multidisciplinary Footcare Teams	£1,022,000
Diabetes Inpatient Specialist Nurse Service	£1,253,000
8 Care Processes and 3 Treatment Targets	£2,187,000
Structured Education for people with diabetes	£184,000
Recovery Funding - additional - for 8 Care Processes	£724,000
Total transformation funding in 2022/23	£5,370,000
Pilot funding 2022/23 as above	£320,000

TOTAL	**£5,690.000**

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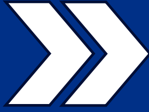

To find out more about the work of the East of England CVDR and Diabetes Clinical Networks, please visit our websites:

NHS England EoE Clinical Networks:
www.england.nhs.uk/east-of-england/clinical-networks/

Cardiac Clinical Network Microsite:
https://future.nhs.uk/NationalCardiacImprovement/view?objectId=31908688

Integrated Stroke Delivery Network:
www.future.nhs.uk/connect.ti/EastofEnglandStroke

Respiratory and Long COVID Clinical Networks:
www.future.nhs.uk/EOErespiratorynetwork

Diabetes Clinical Network:
https://future.nhs.uk/EOEDCNhttps://future.nhs.uk/EOEDCN

East of England CVD-R, Renal and Diabetes Clinical Networks
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Respiratory and Long COVID Clinical Networks:
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Diabetes Clinical Network:
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