NHS England

ANNUAL REPORT 2023-2024
CVD, Respiratory, Diabetes and Renal Clinical Networks

NHS England, East of England

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Foreword

Foreword

The Cardiovascular Disease, Respiratory (CVD-R), Diabetes and Renal Networks are delighted to publish their 2023/24 Annual Reports. The reports highlight 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, 2023/24 maintained a continued focus on pathway transformation to improve the quality of care, access and outcomes for patients whilst undergoing organisational changes in NHS England and the Integrated Care Systems (ICS) to deliver a new operating framework.

The aim of the Networks is to deliver the national priorities for care as well as working with partners to identify and resolve regional issues. They work with systems, providers, other networks, voluntary and third sector organisations and patients to transform pathways of care, enhance equality of access and t optimise treatment and outcomes.

This year has seen also seen a strengthening in the partnership working with the Health Innovation Networks (HIN) and Public Health to align objectives, prevent duplication and provide better support to the systems.

I am pleased to report that across the Networks we achieved many key objectives during 2023/24, and more details can be found in corresponding sections of this report. I particularly wanted to highlight the following areas of work:

1. The expansion of the pre-hospital video triage project for patients suspected of having suffered a stroke.
2. The Cambridge University Hospitals Thrombectomy Service for stroke went live and is accepting patients in the East of England.
3. The development of region-wide pathways for Acute Aortic Dissection (AAD) and Transcatheter aortic valve implantation (TAVI)
4. The launch of the secondary care forum in diabetes, working closely with the GIRFT team to enhance in-patient diabetes care.
5. The reduction in use of SABA inhalers which improves patient outcomes and reduces carbon dioxide emissions.
6. 10 providers of pulmonary rehabilitation signed up for accreditation as part of the Respiratory Network project.
7. Innovative schemes being undertaken in systems (ICBs) to improve the detection and management of hypertension and high cholesterol.
8. A clear focus on stroke rehabilitation projects to progress the implementation of the Integrated Community stroke Service Specification (ICSS)
9. The adoption of remote monitoring across a range of cardiac specialties, including virtual wards, managing heart failure at home and safe waiting for procedures

10. The development of the Eastern Network for Kidney Inflammatory Disease (ENKID) – a multi-disciplinary forum for the discussion of complex cases.

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

- improving our rates of mechanical thrombectomy and thrombolysis in stroke and ensuring patients are admitted to a stroke unit within 4 hours where needed.
- continuing to improve the rates of achievement in the 8 care processes in patients with diabetes.
- Exploring capacity and demand for renal dialysis; and
- Furthering our work on hypertension and high cholesterol detection and management to meet the national targets.

There have been a number of challenges to the networks and the systems as a whole this year, including the organisational changes, industrial action, and the financial landscape in healthcare. I would like to thank all the network teams, the clinical leads, ICB staff, clinicians and out voluntary and 3rd sector providers and other partner organisations who have given their time and expertise to supporting the improvements in care. Over the course of the year, the networks have been testing different models to engage patients in service improvement and transformation and we thank those who have shared their lived experience to bring measure and focus to the work we do.

The Networks are supported by a small central team of business support officers, a Senior Information Analyst, and a Patient Engagement Officer, all of whom have made a valuable difference to the way in which the networks are able to function and evaluate their work.

I look forward to continuing our work with all our teams, partners, and stakeholders 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, Diabetes and Renal Networks and Transformation
NHS England – East of England

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 CVD 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. Renal Clinical Network - a new network which was commissioned by Specialised Commissioning in 2022/23. The network team were recruited in 2023/24. This network aims to improve quality of care, patient access and equity of access for renal patients in the region.

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

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Nicola Hawdon
Patient Engagement and PPV Lead

Paula Sumray
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Business Support Officer

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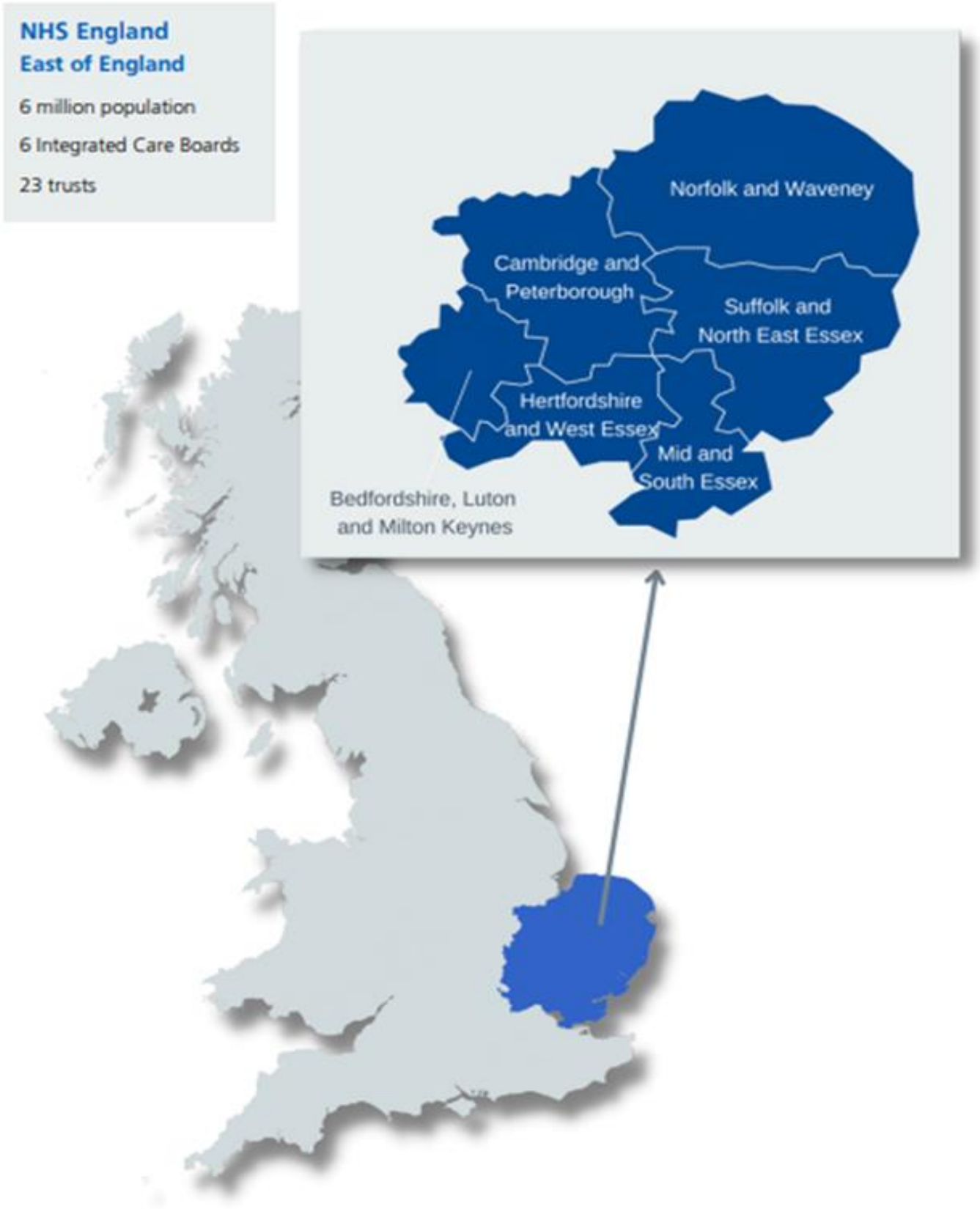

1. CVD Prevention

CVD Prevention

The CVD Prevention Clinical Advisory Group (CAG) is not a network in itself. There are elements of prevention in all the clinical networks, and the advisory group was developed to pull together the prevention aims and objectives of the cardiac, stroke, diabetes and renal networks.
The advisory group comprises clinical and operational leads from the Integrated Care Systems (ICS), Public Health, Clinical Networks and Health Innovation East.
In 2019, the NHS Long Term Plan set out new commitments for action that the NHS will take to improve prevention of ill-health. The ambition is to reduce 150,000 heart attacks, strokes and dementia cases over the next 10 years by improving the detection and management of three key conditions that drive cardiovascular disease:

- Atrial fibrillation
- High blood pressure
- High cholesterol

These were detailed in the 2023/24 Priorities and Operational Planning Guidance

Clinical Advisory Team

Dr Chirag Bakhai
GP and Primary Care lead for the Cardiac and Diabetes Networks (Co-Chair)

Dr James Hickling
GP and Deputy Medical Director for Quality Assurance and Governance, Mid and South Essex Integrated Care System (Co-Chair)

Helena Baxter
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Amanda Harrington
Business Support Officer

CVD Prevention priorities 2023/24

1. **Hypertension**: support systems to improve detection/treatment:
- Increasing detection of hypertension continuing to address health inequalities and deliver Core20PLUS5 approach.
- Increase the percentage of patients with hypertension treated according to NICE guidance to 77% by March 2024

2. **Cholesterol management:**
- Improve detection of high cholesterol in all populations, continuing to address health inequalities and deliver Core20PLUS5 approach.
- Increase the percentage of patients aged 25-84 years with a QRISK score (CVD risk score) greater than 20% on lipid lowering therapies to 60% by March 2024.

3. **Atrial fibrillation:**
- Improve detection rates of atrial fibrillation in all populations, continuing to address health inequalities and deliver Core20PLUS5 approach.
- Increase the percentage of patients aged 18 and over with atrial fibrillation and a CHA2DS2-VASc score of 2 or more treated with anticoagulant drug therapy to 90%.

Progress and key achievements

1. Regional leadership and co-ordination

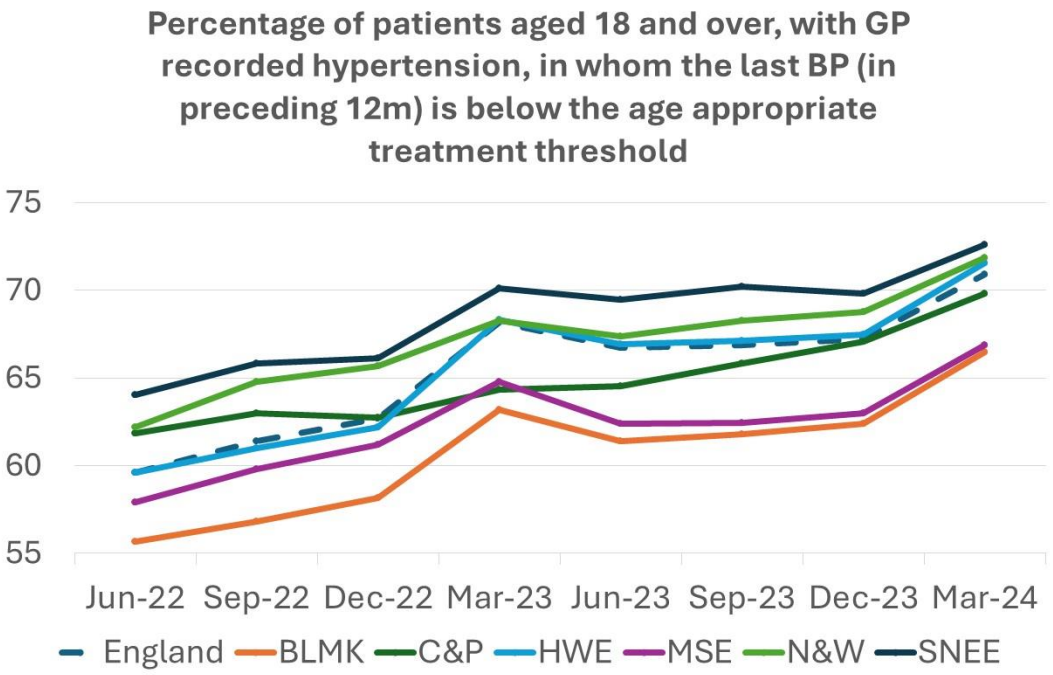
Regional leadership for CVD prevention is through the clinical advisory group which brings together multi-professional stakeholders from all providers and commissioners in all six ICSs, along with regional partners in Health Innovation East and the regional Public Health Directorate. The CAG meets quarterly to update members on the work of the network, understand challenges in each system, review regional data, share best practice and support systems to achieve national targets. In addition, 1:1 meetings are conducted with each participating ICB to enable deep dives into specific areas and discuss plans and challenges in more depth.
The overall aim of the Clinical Advisory Group is to collaborate across the networks to develop an aligned strategic vision and action plan for CVD prevention, ensuring everyone is working to the same objectives and avoids unnecessary duplication.

2. Hypertension

High blood pressure is known to be a key risk factor in coronary heart disease, stroke and chronic kidney disease. Considerable work has been undertaken in the region to improve detection and management of hypertension, with a particular focus on high-risk population groups. These schemes include:

- Development of a population health management (PHM) approach in Cambridgeshire and Peterborough (C&P) to risk stratify, identify and provide support for people at risk. The programme is designed to prioritise practices in deprived communities. The programme is due to go live in early 2024/25.
- Norfolk and Waveney (N&W) are also using a PHM-based approach to case finding for atrial fibrillation, hypertensin and high cholesterol.
- Bedford, Luton and Milton Keynes (BLMK) have developed local data packs for individual PCNs, identifying unwarranted variation and key actions to improve practice. They have also developed a hypertension pathway to streamline and simplify NICE guidelines, empowering patients and optimising blood pressure control more rapidly.
- Mid and South Essex (MSE) utilised some regional funding to extend their BP@Home programme. An additional 2,000 home blood pressure monitors were provided to 80 practices with the highest need based on CVD risk and high levels of deprivation. This is due to be evaluated in early 2024/25. In addition, MSE has also been part of the InHIP programme, delivering 5 outreach events to increase hypertension amongst high-risk CVD patients in the community.
- BLMK were awarded funding from the national CVD Prevention Programme to support a broad programme of work to improve hypertension treatment to target in the most deprived areas. In addition, a range of community engagement activities were planned to increase awareness of hypertension. This programme will be evaluated in 2024/5.
- Hertfordshire and West Essex (HWE) were also awarded funding from the national team to develop a communications campaign in targeted communities, provide training to ensure blood pressure checks are carried out at every opportunity (Making Every Contact Count). HWE has also been using innovative community-based models of delivery for NHS Health Checks, such as mobile community buses, and are undertaking a pilot to expand eligibility of the NHS Health Check to a younger cohort aged 30-39 years from a Black, Asian or minority ethnic group. So far, nine GP practices are recruited to undertake active case finding and sending out invitations for a Health Check as a community clinic.
- Suffolk and North East Essex (SNEE) are supporting the detection of hypertensive patients by rolling out SiSU health stations across priority areas and communities. These digital health check machines will support case finding, intervention and self-empowered health improvement. SiSU health stations have also been rolled out in Luton in community settings and high footfall areas.

Progress has been made over the year against the target for effective management of hypertension, rising from an East of England average of 68.15% in March 2023 to 70.08% in March 2024. This remains slightly below the England average of 70.92%, but far from the national ambition of 77%. In terms of patient numbers, an additional 57,670 patients in the region have been identified as having hypertension (March 2023 – March 2024; CVD Prevent), and 62,870 additional patients have been treated to target.



Further work also needs to be undertaken in terms of hypertension case finding to ensure that there is a reduction in unmet need.

3. Lipid management

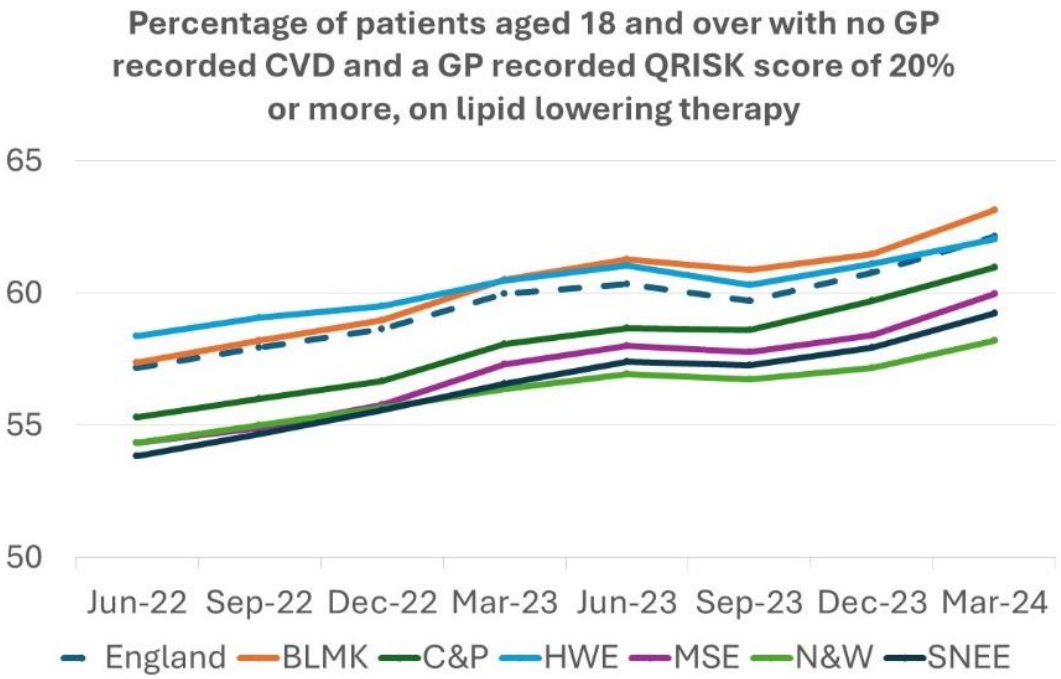
One of the key areas of focus in the Operational Planning Guidance for 2023/24 was the management of high cholesterol.

In addition to the PHM work described above, which also addresses lipid management, other areas of improvement in the region include:

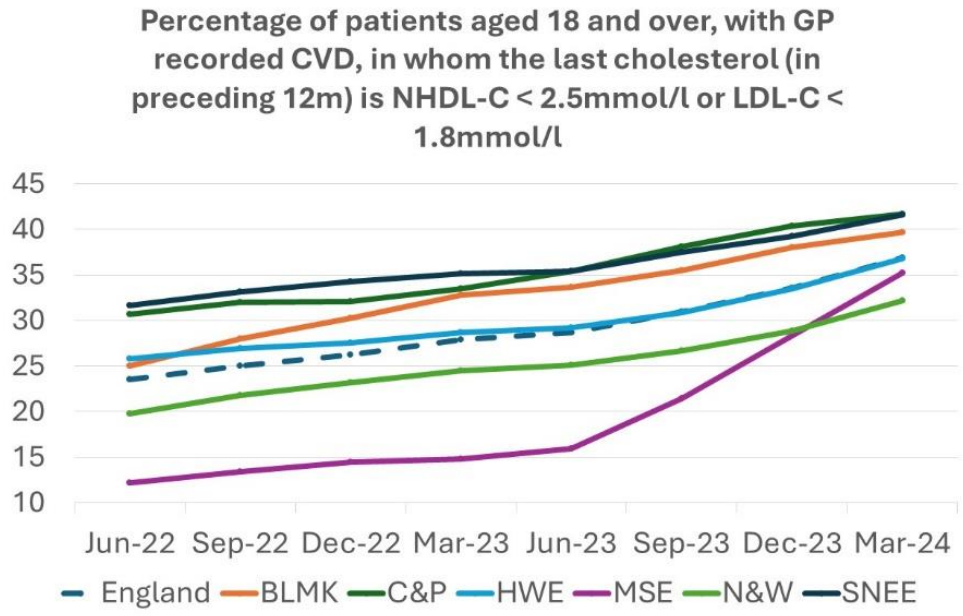
- A quality improvement incentive scheme in N&W offered to primary care to manage the identified high-risk patients as well as attending ICB-led training and upskilling to support adherence to the latest lipid management guidelines.
- MSE has developed a Lipid Quality Outcomes Framework (QOF) extension which was offered to practices with the highest CVD need and highest deprivation. So far, 37 practices have signed up for the scheme.
- SNEE are running a Healthy Hearts project focused on improving lipid management for people with learning disabilities and severe mental illness at high risk of CVD. They are also developing a community lipid management clinic and statin switch project to support controlling lipids in high-risk patients.
- BLMK commissioned a community lipids clinic to support secondary prevention which has been demonstrably successful in improving lipid control for those referred. BLMK is now one of the best performers for lipid management.
- In HWE, an Integrated Lipids Service (ILS) is being developed which aims to provide a specialised service in the community to streamline cholesterol patient care from general practice with limited onward referrals to secondary care for complex patients.

- C&P is supporting a pilot project for PocDoc – a point of care lipid test to support the detection of hyperlipidaemia.

The work across the region has shown an improvement in 2023/24 in terms of lipid management for patients at risk of cardiovascular disease and the secondary prevention of those with known cardiovascular disease.
For the two key indicators, the East of England region achieved the target of 60% for those patients at risk, but without recorded CVD, moving from 58.13% in March 2023 to 60.43% in March 2024 (CVD Prevent).

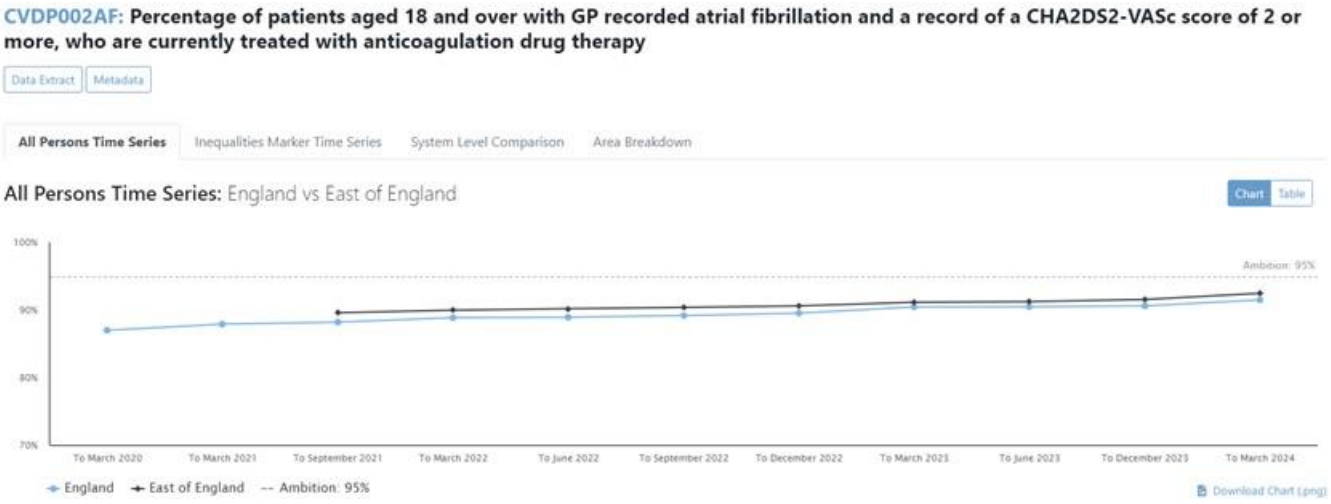


Similarly, the East of England achieved the target of 35% for those patients with recorded CVD whose lipids are within the target range, improving from 27.75% in March 2023 to 37.48% in March 2024 (CVD Prevent).



4. Atrial fibrillation (AF)

Atrial fibrillation is an area where the East of England has performed relatively well compared to the England average. Over 90% of patients with recorded atrial fibrillation are treated with anticoagulant drug therapy.
Last year (2022/23), there were a lot of schemes running to identify patients with atrial fibrillation and the network funded some remote monitoring equipment to support this. This year, there has been less of a focus on AF with the majority of work focusing on the population health management, hypertension and cholesterol indicators. However, the work in 2022/23 has continued with some areas looking into the discharge medicines scheme (DMS) in pharmacies being used to support patients with their anticoagulant medication (SNEE). This work will be evaluated in 2024/25.
There are still areas to cover in terms of identification of patients, secondary prevention in stroke and in achieving the 95% target for patients receiving appropriate drug therapy. This will be addressed in the 2024/25 plans.



Sharing Best Practice

Alongside the regular CVD Prevention CAG meetings, the team (Clinical networks, Health Innovation East, Public Health) have organised face to face events focusing on lipid management and a number of webinars:

- HWE primary care hypertension training: UCLP frameworks
- Bitesize: How I achieved the QOF indicators in 6 months
- Heart UK Tackling Cholesterol Together (face to face full day event)
- CVD Prevention – Lipids Management (face to face event, half day)

Challenges

The CVD Prevention work faced several challenges in the last year

- Organisational restructures at NHSE and in the ICBs led to changes in portfolios and a loss of continuity for some areas.

- Data – CVD Prevent data is used to look at the regional picture and to compare between ICBs and other regions in the nation. This provides an excellent and consistent data source, but not all practices (c. 4%) in the region are signed up to CVD Prevent. This affects the validity of the regional data and may impact the health inequalities data.

- Systems have reported limited funding as a challenge to initiate or sustain improvement work in CVD prevention. Whilst some funding is made available nationally (through the national CVD Prevention team and Health Innovation East), this is often at short notice, towards the end of the financial year and is non-recurrent.

Areas of Focus for 2024/25

1. Hypertension
-Using data to improve detection rates for hypertension to ensure unmet need is being addressed
-Continue to work with systems to improve treatment to target rates (NICE guidance) to reach 80% by March 2025

2. Cholesterol management
- Improve detection rates of patients with high cholesterol
- Work with systems to exceed prevention targets for those patients:
    -with existing cardiovascular disease (35%), and
    -those at risk of developing cardiovascular disease (65%) by March 2025.

3. Atrial fibrillation
-identify areas where targeted detection is required, including patients who have experienced stroke.
- Achieve 95% of patients with recorded AF treated with appropriate anticoagulant therapy

4. Health Inequalities
-To continue to focus on health inequalities in all aspects of CVD prevention, strengthening Population Health Management approaches to identify populations at risk and inform targeted and tailored interventions.

5. Scaling up
-Work with systems to ensure projects and schemes are evaluated to understand their outcomes, effectiveness, and value for money.
- Identify effective and cost-effectives schemes for scaling up, adoption and spread from the evaluation.

Governance

The Clinical Advisory Group is not a network with its own governance structure. It reports to several areas:

- Through the networks (Stroke, cardiac and renal)
- Directly to CVDR Board
- To the national team via the CVD Prevent national meetings
- To the Health Inequalities Working Group

2. 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

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Dr Rebecca Schofield
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Dr Chirag Bakhai
Clinical Lead, Primary Care and CVD Prevention

Kate Foxwell
Programme Manager

James Fishlock
Project Manager - Cardiac Rehab and Surgery

Amanda Harrington
Business Support Officer

Network Priorities for 2023/24

Long Term Plan Ambitions:	**Cardiac Pathways Improvement Programme Priorities:**
1. Increase detection of familial hypercholesterolaemia to 25% 2. Greater access to echo 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 with the aim of 77% of people identified with hypertension being treated to target 2. Increase access to diagnostics, i.e. NT pro-BNP, Cardiac CT and echocardiography 3. Reduction of P2/P3 waits in cardiac surgery and elimination of 52 week waits. 4. NSTEMI & STEMI treatment targets 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. Implementation of the Acute Aortic Dissection toolkit 8. Improved access and increased uptake in cardiac rehab 9. 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.
4. Use of Discharge Medicines Service

Network performance and achievements

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

1. Diagnostics
2. Acute Coronary Syndrome
3. Surgery
4. Heart Failure and Breathlessness
5. Cardiac rehabilitation

CVD Prevention is covered in the CVD Prevention section.

1. Diagnostics

The focus of the diagnostics work for the network in 23/24 has been to ensure 100% coverage of NTproBNP across the region, reducing waiting lists for echo and understanding the regional offer for cardiac CT.

NT ProBNP

The Network included NTproBNP funding for Milton Keynes within the targeted heart failure funding stream, which would provide 100% coverage across region.

Echocardiography

The Network continued the work from 22/23 on trying to be more creative in order to reduce waiting times for patients and manage capacity pressures and workforce. The network has been working collaboratively with the NHSE diagnostics team and ICB colleagues to help address these challenges.

Key achievements for 23/24 include:

1. Continuation of the steering group with a wide range of stakeholders.
2. Focused echo trial funded in Norfolk and Waveney to improve capacity through the use of protocol driven, focused echo for heart failure.
3. Continuing the rollout of the Harmony project – this is a joint venture with Astra Zeneca to standardise referrals and active clinical triage in heart failure. This is now established in one provider in Cambridgeshire and Peterborough (C&P) ICB, and a launch planned for all providers in Norfolk and Waveney (N&W) ICB.

East of England Providers, Echocardiography Waiting List Performance (% 6 week waiters), April 2018 – February 2024

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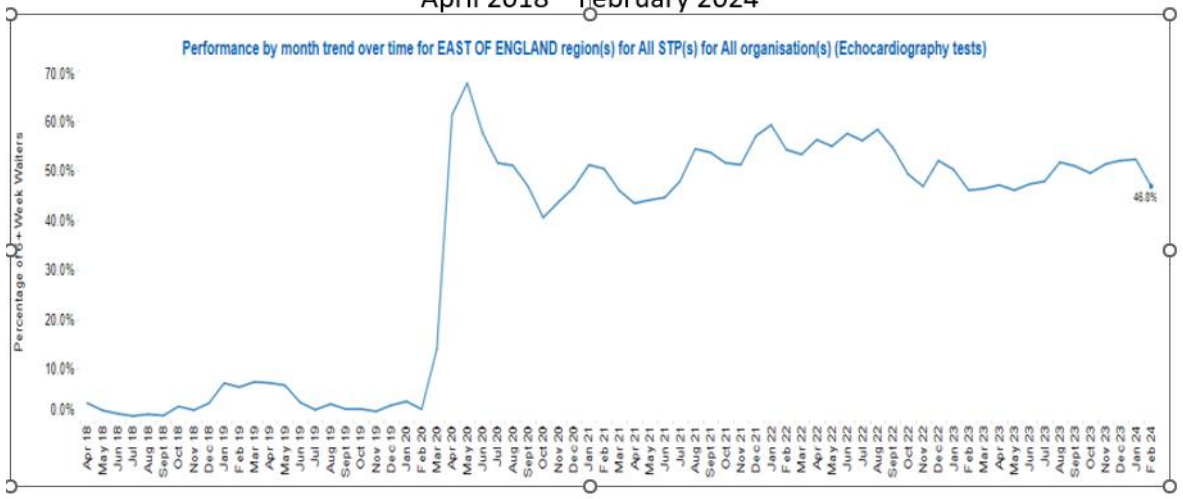


Despite engagement from our system partners, the echo waiting list has continued to be challenging, with increasing demand. The Network funded a Norfolk and Waveney proposal to test the use of focused echo at the weekends to see if a shorter version of an echo would fully answer the diagnostic needs for some referrals, thereby increasing capacity for scans. This has been piloted at James Paget initially to ensure the procedure and the governance is robust. Initial results show that the majority of focused echo tests performed has answered the diagnostic questions and very few patients have needed a full diagnostic echo.

Focused Echo Pilot Results

- 123 focused scans completed
- Each session increased by 4 scans to 18 scans per session with two physiologists
- 5 patients required a full scan; however, these were done on the day in their appointment
- Waiting time for referral to echo reduced from >6 months to <1 month
- 10 patients had heart failure with reduced ejection fracture of <35% and were fast tracked. to heart failure nurse specialist within one week.

This innovation is now set to be rollout system wide, and results socialised not only in region but also nationally.

2. Cardiac CT Angiogram

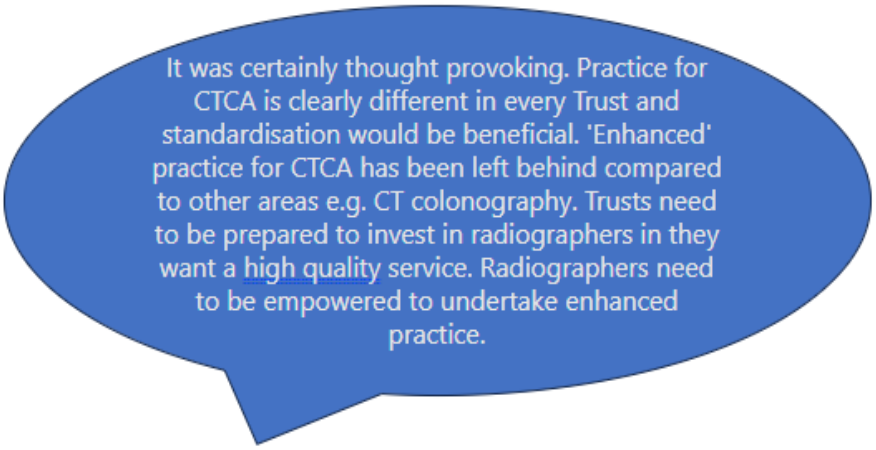
Systems identified CTCA as an area of diagnostics needing increased capacity and investment in 2022 and therefore the steering group continues to meet and address capacity and demand concerns.

Key Achievements for 23/24 include:

1. Completed survey of CTCA services across the region including questions on workforce and training, demand and capacity, scan preparation, reporting and equipment. This has

been the basis on which all other actions have fed off including the call for dose audit and GIRFT discussions.

2. Face to face education event for radiographers looking at best practice, advancing the skills of the workforce, different ways of working and radiographer led clinics. This was attended by over 50 radiographers from across the region and really showcased the enthusiasm to improve services within the region. Feedback was very positive and the workstream changed focus as a result of suggestions made in evaluation.
3. Buddy visits have taken place for two services with more to follow to allow for sharing of ideas and best practice.
4. Patient Group Directives have been shared on futures to allow more services to consider radiographer led clinics
5. Work has commenced on the radiographer online training package.
6. The futures website has been revamped to allow for improved communications between services across the region.
7. Capacity for CT TAVI in the region can be a challenge for this time critical condition. Q4 2024 will see the first patients from Southend having their TAVI CT performed locally (closer to home) and analysed and interpreted in the cardiac centre as per standard of care.



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

Improving services and understanding patient flow through heart attack centres has been a key priority for the network this year. The Network has been working with all centres and the ambulance service (EEAST) to ensure we have accurate data collection to gain a clear understanding of the regional gap to meeting the national targets and initiating service improvement programmes.

Non-ST-Elevation Myocardial Infarction (NSTEMI)

The network funded three ACS projects last year, all of which are progressing well.
The ACS pathway in Cambridge and Peterborough has now been running for a year and results show they are much closer to reaching the national target of referral to treatment within 72 hours, with reductions seen in both acceptance to referral time and time to transfer. This has been largely due to improved communication between the PCI (Specialist) centre and the local referring hospitals and running a 7-day service with a 7-day hot lab capacity shared with the Primary PCI service. Evaluation is ongoing with plans to improve their treat and return capability to improve patient flow and increase capacity.

The Essex Cardiothoracic Centre now has an established PCI/ACS specialist nursing team and is collecting comprehensive NSTEMI data, along with using a virtual wards platform to facilitate the surveillance and early discharge of patients while they await procedures (ATLAS protocol pilot). The Ortus i-health app is also used for STEMI early discharge, elective complex PCI patients as well as surgical waiters allowing clinicians to track patients and look out for “red flag” symptoms enabling “smart procedure scheduling”. The learning from this has been disseminated across the region to allow other systems to adapt and adopt. The TAVI team have also developed a TAVI risk scoring system again with the aim of prioritising waiting list scheduling in a safe and efficient manner. (Abstract presented at London valves and manuscript under review in *Circulation.*

Norfolk and Waveney have used their project manager to map the NSTEMI pathway for their patients across The Norfolk and Norwich (NNUH) and James Paget localities. This post has been instrumental in collecting the baseline data to understand delays in the pathway. The system has used part of the funding to trial bespoke transport services from James Paget to NNUH to see if this improved presentation to treatment times for patients. The additional transport provision commenced in December 2023. During the first month of operation there was a significant improvement with 40% of patients in JPUH patients meeting the 72-hour target – compared to the previous 12-month average of 12.18% attainment. However, as the transport service was only available three set days a week, utilisation of this resource was way below what was expected.

Transport is only one element, and the project is also looking at patient flow and communication between providers to reduce time to referral and time to transport metrics. The Network has secured further funding for one year to continue this work and ensure an increase in patients being treated within 72 hours regardless of where they present.

Out of Hospital Cardiac Arrest

The tertiary lead for the network, Dr Thomas Keeble, has continued the work from last year to improve the pathway for patients having an out of hospital cardiac arrest in Essex CTC region. In conjunction with BCIS (British Cardiovascular Intervention Society) an algorithm has been developed to ensure patients presenting with out of hospital cardiac arrest are taken to the correct health care facility in order to try and drive-up access to immediate cardiology input, assessment and care to increase survivorship.

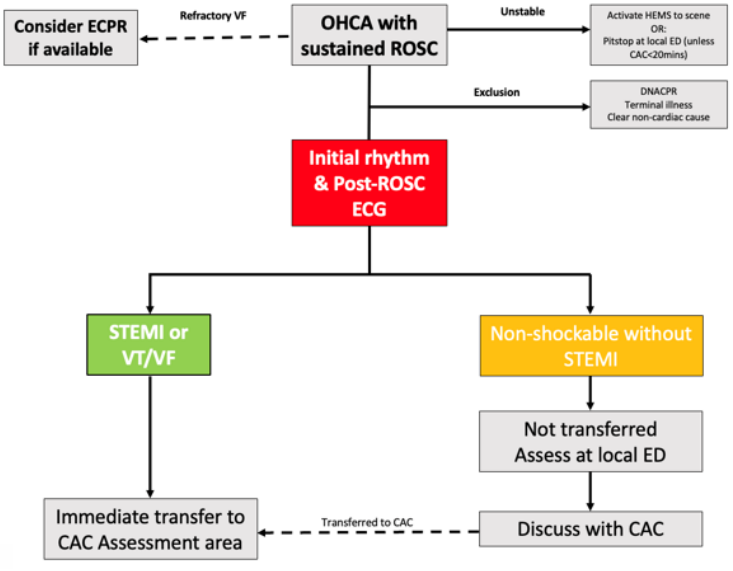


*Figure above shows the BCIS OHCA algorithm

Full analysis of the pilot has now been completed (manuscript currently under review at EHJ), with a demonstrable improvement in survival rate for patients with a shockable rhythm or STEMI and no difference for patients with a non-shockable rhythm. The Kaplan Meier curves below show that there is early separation, and that the BCIS algorithm patients (shockable rhythm and STEMI going to a cardiac centre) do better than the historical cohort where there was no standardised conveyance

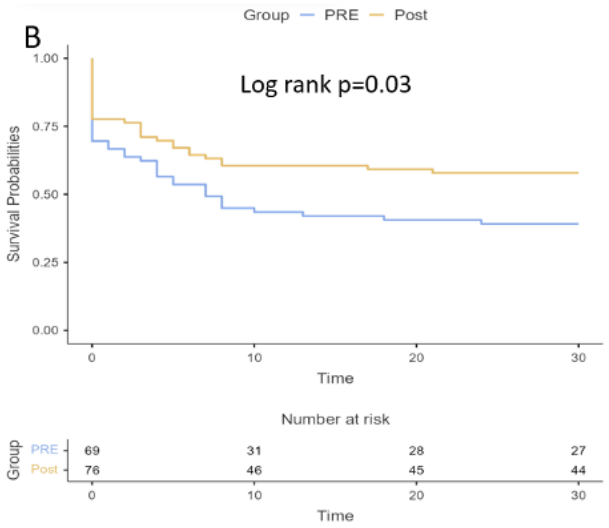


Figure showing KM curves of historical cohort (Pre) versus BCIS algorithm cohort (Post) 30-day survival. Statistically significantly better in the BCIS treatment algorithm group with a survival rate of 58% versus 39% at 30 days in all shockable rhythm patients.

The network funded pilot project has proven that a simple OHCA conveyance algorithm is safe and feasible working with pre-hospital partners. Not only that but it improves survival and offers more survivors bespoke rehabilitation services.

Cost effectiveness of the programme was also evaluated with independent health economics analysis showing favourable outcomes, and an average cost saving per patient treated with the BCIS algorithm of £23,321.

	Current practice	Conveyance algorithm and NPS	Incremental Δ
Costs of ICU stay (£)	2,300,954,580	712,999,746	-1,587,954,834
Costs of hospital ward stay (£)	388,753,707	450,102,764	61,349,057
Costs of Ambulance (£)	31,896,813	29,981,622	-1,915,191
Costs at admission (£)	21,143,336	20,640,546	-502,790
Costs post-assessment (£)	44,211,455	45,703,700	1,492,245
Costs of neuroprognostication (£)	0	13,670,120	13,670,120
Total cost (£)	9,501,353,592	7,635,638,327	-1,865,715,265
Average cost per patient (£)	118,767	95,445	-23,321

	Current practice	Conveyance algorithm and NPS	Incremental Δ
Total life years lived	271,413.84	297,705.96	26,292.12
Total QALYs lived	142,995.94	171,045.92	28,049.98
Total QALYs lived per patient	1.79	2.14	0.35

Following these results, the algorithm has been adopted for the Essex CTC. The results have been shared widely across the region and nationally with the aim of developing the infrastructure for wider adoption at our key cardiac centres in the East of England. The Welsh intensive care society and the Welsh health boards are highly likely to roll out a similar algorithm based on our pilot data. We are also currently seeking funding for a randomised controlled trial of the algorithm.

4. Surgery

The aim for the surgical workstream this year has been to eliminate 52 week waits for surgery. This has been achieved although has been hampered by fluctuating staffing levels and industrial action. The Network has surgical representatives from both surgical centres and good engagement from their operational managers. Learning has been taken from London and their surgical dashboard has been replicated within the East of England to give a greater oversight of regional waiting lists.

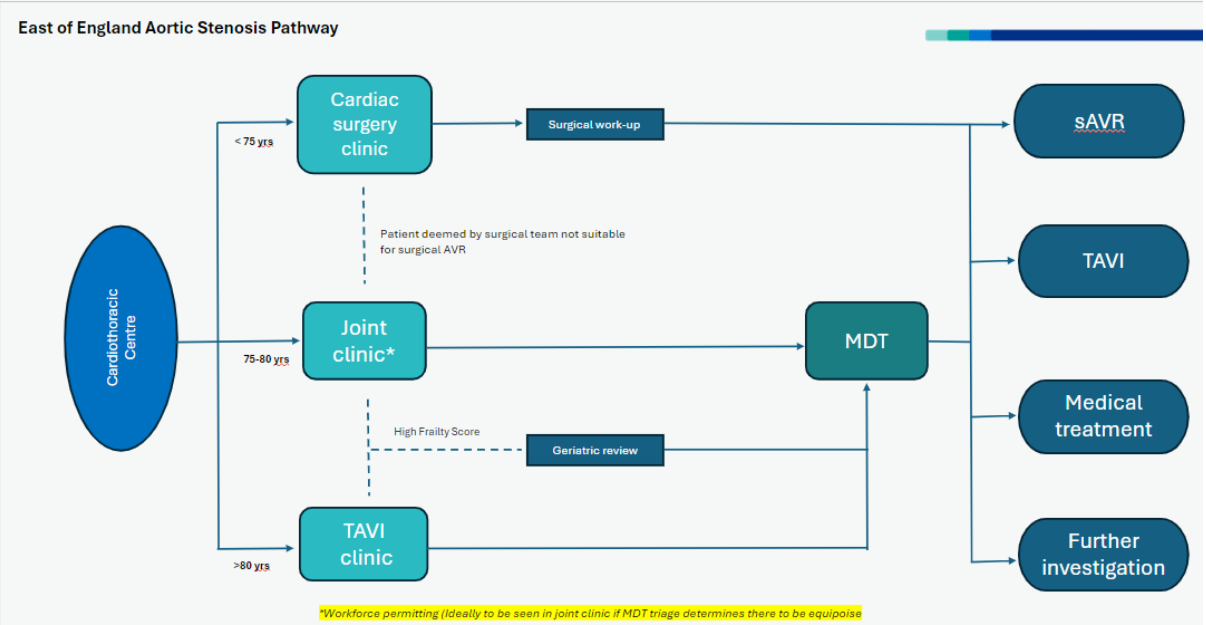
Essex CTC have commenced a trial of the Watch pathway where surgical patients are remotely monitored at home whilst waiting for surgery, freeing up acute beds but closely monitoring for any deterioration. This pilot will be continued in 2024/25 with evaluation and learning shared across the region.

Acute Aortic Dissection (AAD)

A multidisciplinary task and finish group was set up to embed the AAD national toolkit to improve the management of patients diagnosed with AAD. Advice has been sought from the imaging network around image transfer and funding was granted for a regional coordinator. Two pathways are being designed for the region, one for type A and mixed AAD and the other for type B patients. Work has also commenced on regional rotas. This work will continue throughout 2024/25.

Transcatheter Aortic Valve Implantation /Surgical Aortic Valve Replacement

Much work has taken place to understand demand and capacity for Aortic Valve Stenosis management and a pathway has now been developed which clearly shows how patients are managed within the region.



There is clear disparity across the region in waiting lists for TAVI and therefore the group is looking at the reasons for this and how sharing standard operating procedures and ways of working might help to reduce the variation:

	Centre A	Centre B
Referral to TAVI	28 weeks	13.9 weeks

Work is underway to ensure that there is a regional data collection to understand in real time the waiting lists for TAVI and SAVR. This will help inform clinicians as to which pathway would be best for their patients especially those who are suitable for both pathways.

5. Heart Failure and Breathlessness

Heart failure and breathlessness has been high on the agenda regionally within ICB's and nationally. Through the network, expert clinicians came together to develop a titration document for managing heart failure medications for use in community, primary care and acute settings. Designed last year, this has been shared across the region and is being used and adopted in at least one provider already with others very keen to use it.

The national funding package was shared between six providers this year with the caveat that every pilot chosen was:

- sustainable
- evaluation would be useful for dissemination across the region, and
- would improve services for heart failure and address inequality

Milton Keynes was provided with funding to start NT proBNP testing in their lab. This would mean that there was 100% coverage within our region, improving the detection rate of heart failure and meeting our national ambition.

There was also funding for two community multidisciplinary team clinics, one in Ely PCN and one in North Norfolk, both targeting populations with high incidence of heart failure, improving patient experience of heart failure services and ensuring they have the support, knowledge and treatment to live well with their long-term condition.

The Network was also keen to test how technology might support patients with heart failure. A pilot was funded in BLMK to achieve early optimisation of heart failure medications with support of DOCCLA monitoring for patients with both heart failure with reduced ejection fraction (EF 40% or below) as well as those with preserved ejection fraction. The pilot aim was to test titration to optimum therapy within 8 weeks.

Funding was also allocated to Herts and West Essex for a project manager to map
heart failure services across the system to understand current shortfalls in provision and have targeted innovation and transformation around inequality and inequity of service.

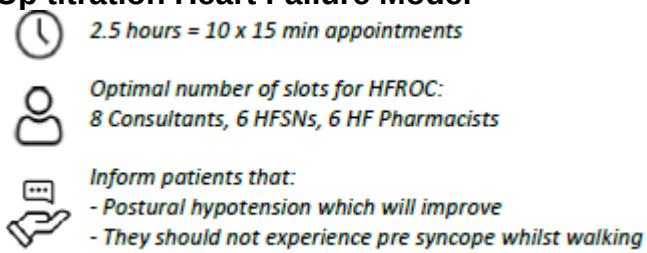
All these projects are in place and have been evaluating as they proceed. In order to disseminate learning across the region, the Network has set up a Heart Failure Clinical Advisory Group in conjunction with Health Innovation East. This group meets once per quarter and will invite all funded projects to present their findings and future plans as well as use this time to show case all innovation happening across the region as well as discussing risks and challenges identified.

Along with the funded projects, the network continues work on areas reported last year.

Managing heart failure @ home / Virtual wards community of practice
The Network continues to host a merged Managing Heart Failure@home and virtual ward community of practice and has been mapping technology platforms across the region, offering providers time to showcase their chosen equipment providing peer review and unbiased user information. It is clear that each provider is working slightly differently, and these discussions have been useful in trouble shooting and sharing ideas. The number of patients managed by such schemes is increasing year on year, not only allowing for easing the acute bed constraints but also an improvement of patient experience by allowing for care to be provided at home with increased patient autonomy.

Act on Heart Failure Project
Work continues in collaboration with Astra Zeneca to improve heart failure services in BLMK. A Rapid Up-titration Heart Failure Clinic Model has been designed with a view to treating patients who have either had a recent admission to hospital, an urgent Heart Failure presentation or have been seen in the rapid access heart failure clinic. Astra Zeneca has provided the project management and designed the pathway with the ICB and provider clinicians.

Up titration Heart Failure Model



The model testing is set to commence imminently.
The Network has continued to collaborate with the palliative care network and the respiratory networks to hold educational webinars for the management of people with breathlessness. This work is planned to continue in 24/25 and aims to encourage the use of advance care planning and open communication with patients living with long term conditions.

6. Cardiac Rehabilitation

The network aim for cardiac rehabilitation this year has been to increase the number of eligible people accessing it by offering a variety of platforms, bringing rehabilitation closer to home and offering more opportunity for heart failure rehab in order to meet the national set targets.

A scoping exercise of all cardiac rehab service across the region was completed to determine gaps in services This was used to allocate this year's funding to increase services for those patients where there is perceived inequity of access, along with increasing the options available for rehabilitation and supporting innovation.

Eleven applications for funding were successful covering 4 of the 6 of the systems. Also supported was a regional proposal for patient focused literature and website to promote cardiac rehabilitation as a valuable treatment to enable patients to live well after a cardiac event. These projects are now underway and will be evaluated in 2024/25. The Network has given all services the opportunity to present their innovations in either virtual or face to face meetings and we have seen an increase in the use of virtual platforms as an additional offer for patients.

The region has also seen an improvement in services obtaining accreditation. 8/23 services are now accredited from 7/23 last year. However, there are now only 2 services across region who are failing completely, and this is due to not submitting the data. These services have plans in place and are being supported to submit. In addition, a further 2 services have improved their NACR status to achieve amber. They have plans in place to achieve green accreditation in the next round.

Patient Information Platforms
To capture feedback from patients, a series of questionnaires and focus groups were held with people who had declined the offer of cardiac rehabilitation. Working with Norfolk and Waveney ICB and patient representative's; patient focused literature, videos and a website were co-produced in order to promote the function and benefits of cardiac rehabilitation.

Website-https://cardiacrehab-eastofengland.nhs.uk/

This work was presented at a face-to-face event in November and all services were provided with a pack of posters, leaflets and information on the website. To date, most services have made use of the posters and leaflets. There have been on average 37 – 40 views of the website per week with 61% of these new users.

Sharing Best Practice

The Cardiac network has undertaken various activities to share best practice amongst our providers across the region. Five face to face events were held this year:

1. **CTCA**: radiographers from across the region were invited to come to this learning event which covered the whole CTCA pathway. The network asked for suggestions of future training requirements and how the attendees felt that services could be optimised. This has shaped the workstream milestones for the next year.

2. **Cardiac rehab**: This event was as a follow up from the previous event and was very well attended by practitioners across the region. The topics covered included nurse prescribing, Spontaneous Coronary Artery Dissection (SCAD), writing business cases and management of patients following an unwitnessed cardiac arrest. The Network will follow up with webinars and further face to face meetings as needed

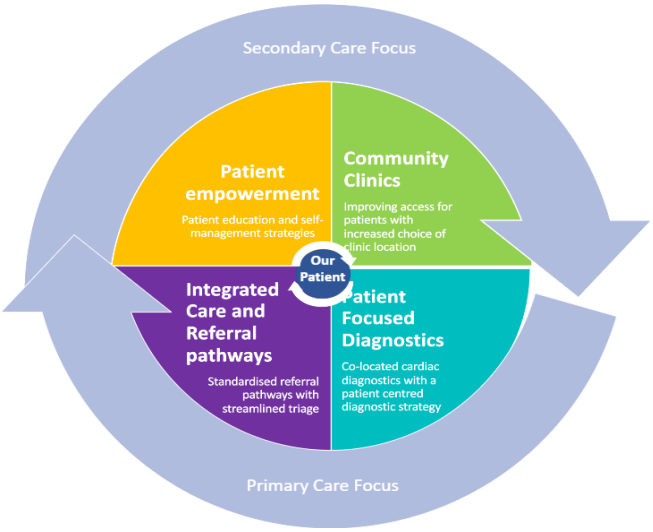
> "Nice to meet people from other teams and areas that we refer patients into. Some excellent info on SCAD and discussion around HIIT and cardiometabolic health with sitting behaviours."

3. **OHCA**: This event, attended by around a hundred people from various professional backgrounds was a review of best practice when managing patients who have an out of hospital cardiac arrest. It was a platform to present the evaluation of the work completed in Essex CTC to encourage a wider adoption of this pathway and a chance for clinicians to hear from patients who have experienced cardiac arrest. This event led to further requests for webinars around neuroprognostication and The CARE clinic which is a clinic designed specifically for holistic management of patients following an out of hospital cardiac arrest.

4. **Virtual wards using i-Ortus:** Held at Peterborough Hospital and attended by heart failure clinicians across the region, this event included experts from London as well as those in the East of England to demonstrate how they have successfully used the i-Ortus platform to manage patients on virtual wards following a heart attack, awaiting treatment, on surgical waiting lists and patients with heart failure. It showcased the versatility of the platform and the scope of possible future practice.

The Network has also held 3 further webinars over the past year to spread good practice:

1. **Integrated Community Cardiac Service**: Our secondary care clinical lead, Rebecca Schofield presented her service in NWAFT where 6 GP cardiologists are employed to better manage outpatient appointments. They have been delivering on average 9.3% of the cardiology outpatients' appointments over the past year, reducing the wait for patients and providing a holistic service for those who they see.



2. **Out of hospital cardiac arrest, first 6 hours, conveyance:** As a result of the feedback from the Out of Hospital Cardiac Arrest face to face event, Dr Thomas Keeble (the Tertiary care lead for the network) and team held a webinar exploring the first 6 hours of an arrest, the

ideal scenario and conveyance to the appropriate hospital depending on the category of arrest.

3. **Heart Failure advanced care planning, Respect forms**: In conjunction with The Respiratory and Palliative care networks and following on from the success of the difficult conversations webinar last year, this webinar explored advanced care planning and how to help people have their views heard and recorded in a timely manner. The webinar considered how to recognise when someone is ready to have the discussion and how to record patient wishes.

The Network has also set up a quarterly leads meeting with other Network Managers across the nation to learn from work in other areas and share good practice. The network has already worked with the North East and North Cumbria in cardiac rehab, has adapted London's cardiac dashboard to be used within the East of England and has invited The Midlands team to talk about their experiences in setting up a rota for Acute Aortic Dissection.

Key challenges

Industrial action: has proved challenging for many providers, particularly for restoring cardiac surgery and cardiac intervention procedures.

Echo waiting lists: continue to be a national as well as regional challenge and we will continue working with the imagining networks and ICB's to find innovative ways to tackle the backlog and manage echo moving forward.

NHS England and ICB restructures: There have been a few changes in personnel and focus following restructure programmes. The Network has concentrated on overcoming the challenges, worked on relationships with systems and kept the workstreams on track by ensuring meetings have been timely, focused and productive.

Network priorities for 24/25

National priorities in Cardiac Programme:
1. Reduce waits for referral, treatment and harm (P2, P3), perioperative programmes
2. Heart failure and heart valve disease: early diagnosis, improved access to diagnostics, treatment closer to home.
3. Acute pathways: Out of hospital cardiac arrest increased survival, improved heart attack treatment times, reduced emergency admissions.
4. Cardiac rehab: targeting systems where BACPR standards are not being met and increasing access and quality of services.
5. National Priorities in Prevention
- 80% of people with hypertension treated to NICE guidance targets
- 65% of people with CVD risk of 20% or above treated to target.
6. Outpatients workstream looking at streamlining the referral process across the region and reducing outpatient waiting times.

Network Budget

The cardiac network receives funding from the national team for staffing

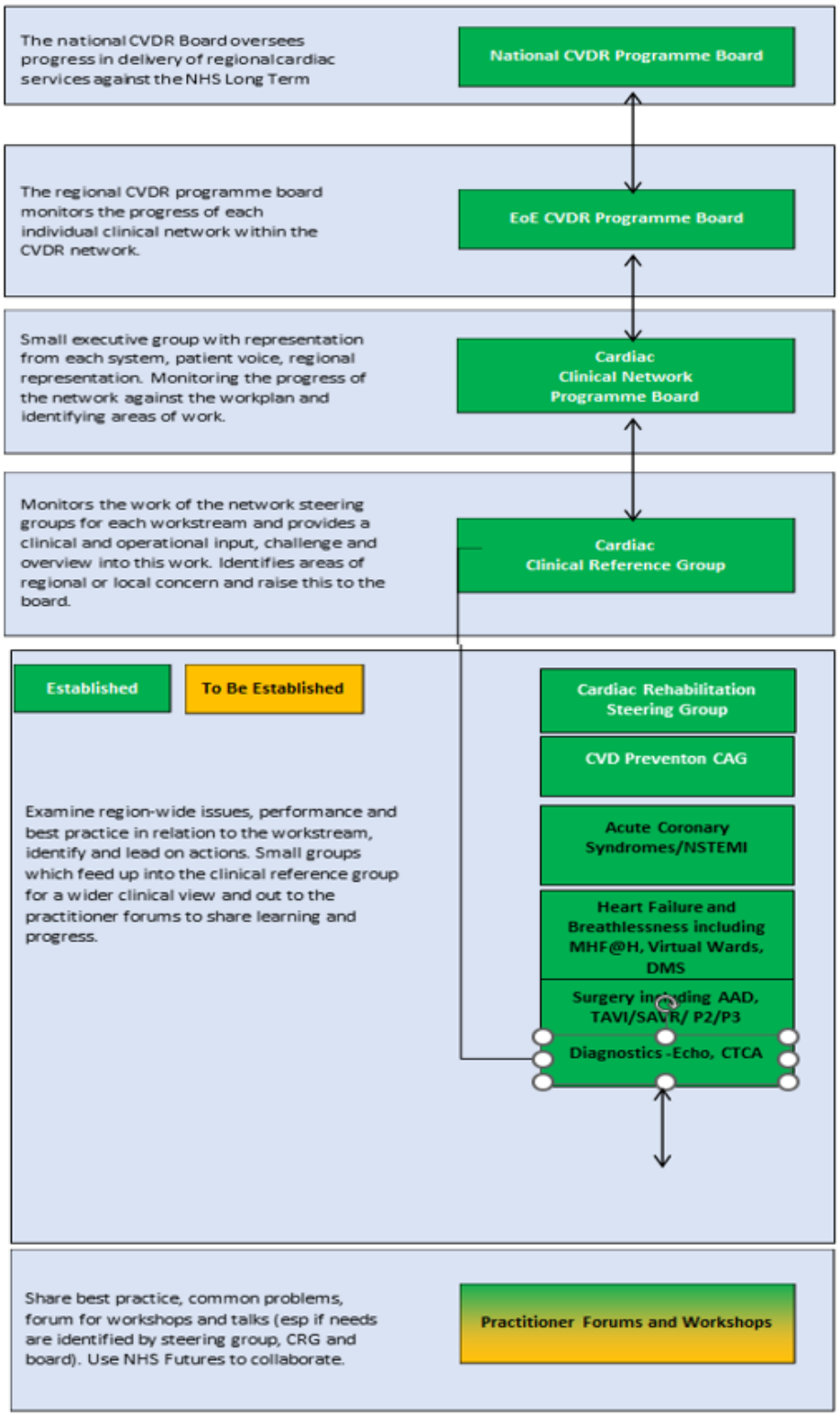
1. Staffing budget. Staffing budget

Funding Allocation Description	Amount
Network substantive staffing	£127,964
PMO support costs	£93,491
Clinical Leads	£110,525
Patient/carer representatives	£93

2. Targeted funding from National for specific projects (to systems)

Funding Allocation Description	Amount
Heart Failure	£508,516
Cardiac rehabilitation	£1,044,910

Network Governance



3. Integrated Stroke Delivery Network

Integrated Stroke Delivery Networks

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 across the EoE
5. Reduce inequalities and improve outcomes for people who experience a stroke in EoE
6. Support compliance with both NICE and RCP stroke guidelines

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

Dr Robert Sherwin
Senior Responsible Officer, Integrated Stroke Delivery Regional Networks

Dr Paul Guyler
Clinical Director for Stroke Services, East of England

Joanna Clayden
Senior Programme Manager, East of England ISDNs

Charlie Dorer
SQuIRe Lead, East of England

Dawn Monaghan-Patel
Quality Improvement Manager, North ISDN, Regional Project Lead

Anne Bruton
Nurse Clinical Lead

Dr Kneale Metcalf
Physician Clinical Lead

Dr Rayhaan Rahaman
NOSIP Clinical Lead

Paula Sumray
Business Co-ordinator

Claire Doney
Business Support Officer

Network priorities 2023/24

2. Prevention:

- 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 in relation to 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.
- To analyse service capabilities in relation to the National Optimal Stroke Imaging pathway (NOSIP) and commence an improvement initiative pertaining to computed tomography (CT) and computed tomography angiography (CTA).
- 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 sustain quality improvement action plans in relation to the acute care key performance indicators.

4. 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 and promote the preparedness of the 2024 dataset changes.

5. Workforce:

To 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.

6. 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.

7. Community Needs-led Stroke Specific Rehabilitation: Support the continued implementation of the Integrated Community Stroke Service Model and service development to meet the national target of a minimum of 75% of patients accessing a needs-led stroke specialist rehabilitation pathway by 27/28. This will involve both QI and Catalyst Funded projects covering aspects of the ICSS and also ensure that stroke survivors are appropriately offered a comprehensive holistic and person-centred six-month post-stroke review and that this is documented on SSNAP.

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 23/24. 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. NOSIP 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 CVD Prevention 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 promoted joint education and training sessions for frontline crews in relation to the pre-hospital pathway and identifying stroke mimicking symptoms. This involved promoting the benefits of populating the standardised regional pre-alert proforma by ambulance crews throughout these learning sessions.

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

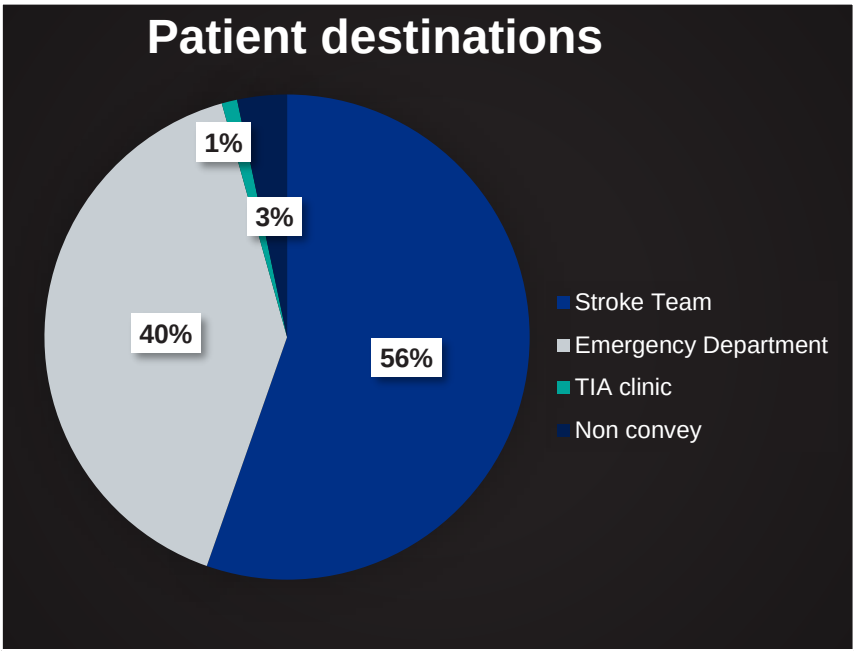
Following a successful bid for further national funding, Stroke Video Triage advanced into Phase 2 of the project in October 2023. Phase 2 has seen significant expansion within the East of England with the addition of five more funded sites. Basildon University Hospital, Broomfield Hospital, Southend University Hospital and Watford General Hospital implemented nurse-led triage models, whilst Lister Hospital utilised the remote triage model supported by University College Hospital operating through the Northeast London and North Central London networks. There are now 9 sites live within the region.

The cornerstone of Pre-Hospital Stroke Video Triage is to facilitate patients getting to the right treatment destination first time, thereby improving key metrics for stroke patients and enhancing the assessment of patients presenting with acute neurological symptoms.

Results show that Stroke Video Triage has real benefit for patients, pre-hospital clinicians and in-hospital teams when compared to standard practice with particular emphasis presented here to reducing the mimic burden on stroke teams, reducing door-to-imaging times and the accuracy of the decision making facilitated by Stroke Video Triage.

<u>Reduction in mimic burden</u>

- 55% of patients are directed to the Stroke Team for further assessment.
- 40% of patients are directed to the Emergency Department to be managed by the Medical Team with no further input from the Stroke Team.
- 4% of patients are not conveyed to hospital and referred for management in the community.
- 1% of patients are referred to the TIA clinic.



The Sprint Audit (2021) estimated that the median time taken to assess patients who are later diagnosed as stroke mimics is 60 minutes. The average Stroke Video Triage call length is 8 minutes representing a significant time saving for stroke teams in the face-to-face assessment of stroke mimics.

Door-to-imaging

Door-to-imaging times (standard practice)	
EEAST average for stroke patients	**01:21**

Door-to-imaging times (Stroke Video Triage)	
All suspected stroke patients	**00:40**
Direct-to-CT	**00:09**

Across all sites that have implemented Stroke Video Triage the average door-to-imaging for suspected stroke patients that are eligible for the Direct to CT pathway is 9 minutes. This represents a saving of 1 hours and 11 minutes when compared to standard practice.

Accuracy

Sensitivity & specificity of triage decision	
Sensitivity	**94%**
Specificity	**60%**
Sensitivity of standard practice	80%
Sensitivity of FAST	77%
Specificity of FAST	60%

The sensitivity of video triage leads to fewer false negatives than the two most used pre-hospital stroke screening tools in the UK, indicating that Pre-Hospital Stroke Video Triage leads to fewer missed stroke diagnosis than standard pre-hospital practice.

A full project evaluation is in progress and will be completed in October 2024.

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) in 2022 enabling eight of the region's providers to access this service and are on schedule to continue service expansion commencing with a seven-day service realised in 2023. A business case to support the recruitment of staff was successful in winter 2023. This will support the continued development to a 24/7 service in 24/25.

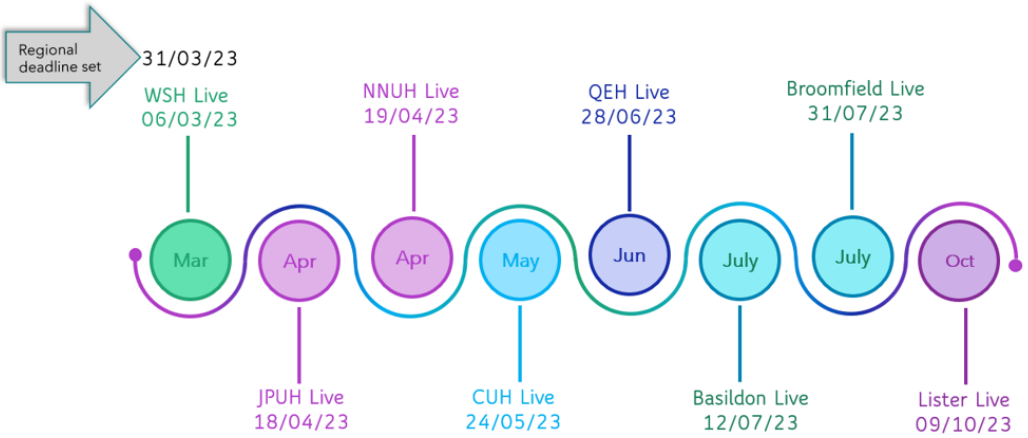
Repatriation (MT).
Timely repatriation of patients from MT centres back to the local referring hospitals is essential to maintaining capacity at the comprehensive stroke centres (CSCs) providing MT intervention. The ISDNs developed, and have continued to monitor the efficacy of, the regional repatriation policy which went live in May 2022. Monitoring of the efficacy of the repatriation policy has continued throughout 23/24.

5. Stroke AI Procurement and Implementation

The regional project to procure and roll-out stroke AI reached its final milestone on 9th October 2023 with the last stroke centre going live with AI stroke imaging software. This means all acute stroke centres within the East of England are fully compliant in adopting AI technology.

Regional Implementation and incremental go-lives

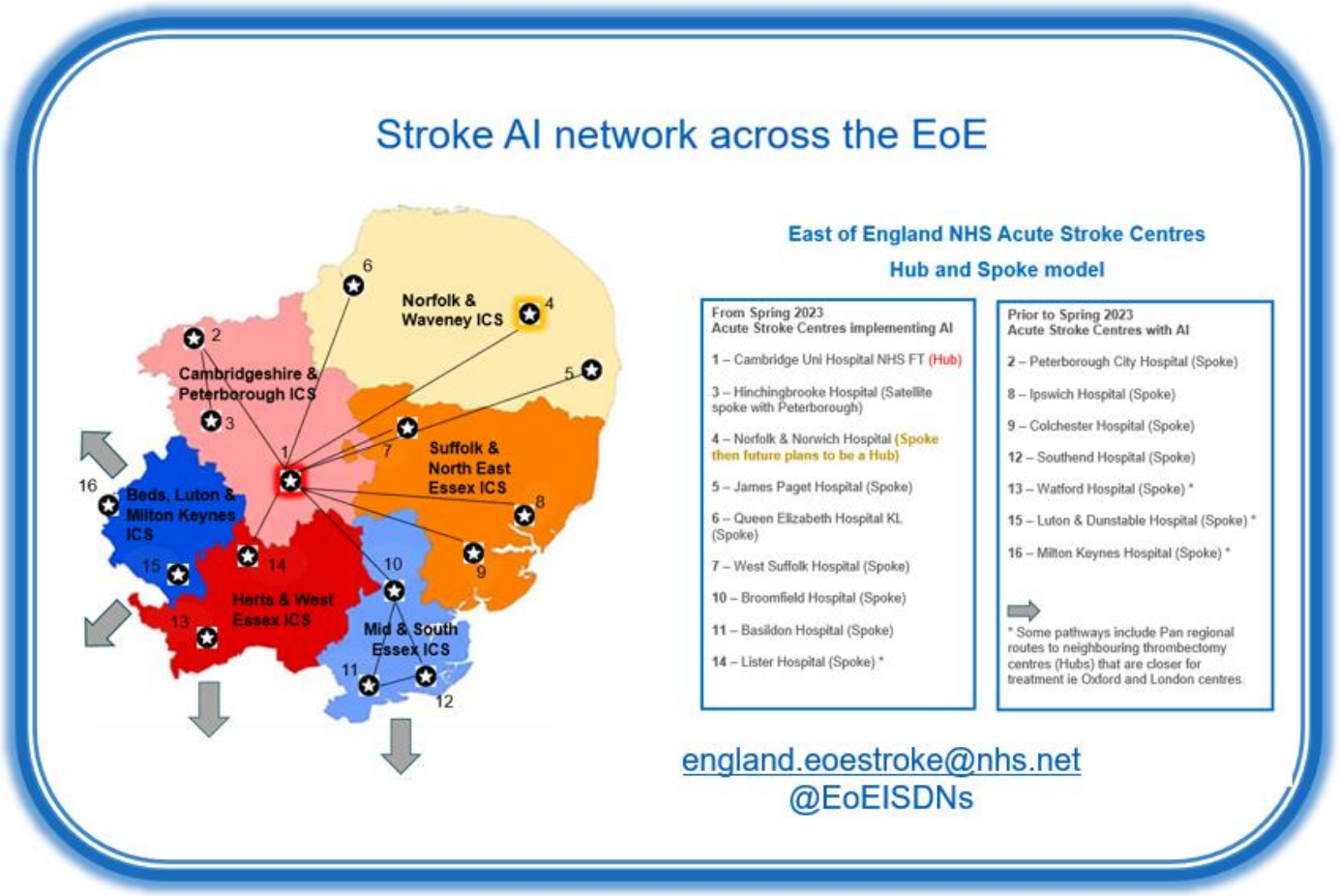
- Regional contract signed by Brainomix & Contracting Authority on 05/12/23
- Regional target set for all Trusts to deploy by 31 March.
- Giving 4 months for implementation (average 3-12 weeks indicative of other areas).
- Weekly implementation calls carried out, facilitated by the ISDN and supplier to keep on track.



The first region to utilise the new NHS Shared Business Service (SBS) procurement framework: AI in Neuroscience Software for Stroke Decision Making Support.

> "The procurement and deployment of Brainomix and networked AI across the East of England allows our consultants to access scans and images remotely and securely, meaning that stroke centres can immediately discuss stroke patients together, delivering more consistent treatment decisions and faster patient transfers, particularly to Cambridge University Hospitals NHS Foundation Trust as the primary comprehensive stroke centre and hub for the region. This will enable more patients to get the right treatment, in the right place, at the right time, to help save lives and prevent people from severe disability."
>
> **Dr Paul Guyler, Clinical Director, East of England ISDNs**

Out of 15 centres in the region, 13 are utilising the same AI stroke technology (Brainomix) networking the region to the main comprehensive stroke centre, CUH (Hub) as well as cross boundary Hub connectivity as and when interim pathways are utilised. The remaining 2 centres are utilising a different AI software package (Rapid AI) due to existing referral pathways. All 15 centres are supported through the regional contract.



AI software is supporting timely clinical decision making for thrombolysis and thrombectomy treatment in the region and early indications are showing promising door-in-door-out (DIDO) times from spokes referring into the primary CSC in region using AI - *recognising numbers are low at the time of auditing and AI will not be the only influencing factor.*

DIDO (over 4 months)	Mean – Hrs : mins	Numerator
Using AI (Jun-Sept)	00:23	14
Not using AI (Feb-May)	02:23	5

The AI project has been transformational for the acute centres across the East of England, particularly for those in more rural areas who can now draw on the network capability of a Hub and Spoke model.

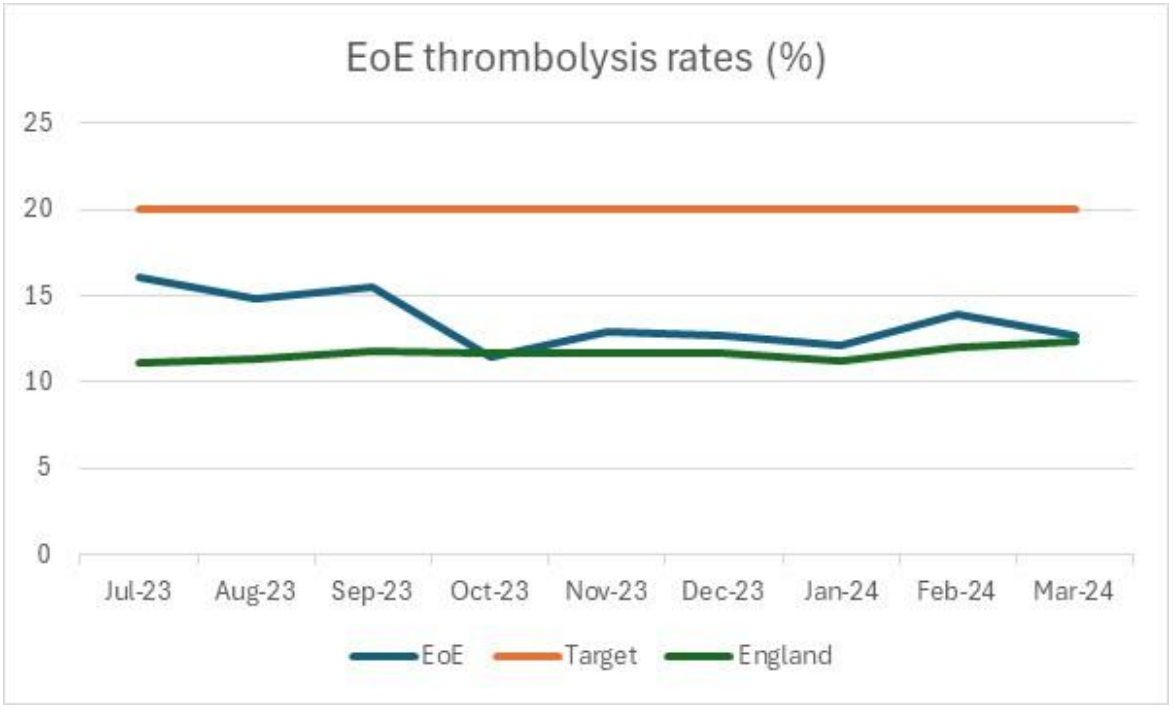
The ISDN had the opportunity to showcase this work at the UK Stroke Forum conference in December 2023 : *'A Regional Approach to Procurement In Stroke Services, Building a Stroke Artificial Intelligence (AI) Network Through ISDN Procurement And Collaboration In The East Of England (UK Stroke Forum Supplement - February 2024 [28 - 29] (nxtbook.com).*

Work will continue by overseeing contract reviews between the stakeholders, regional Contracting Authority, and the AI provider for 2024/25 and into the additional final year. Conversations will continue with the national clinical policy unit (CPU) team about sustainability as business as usual for AI funding.

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. 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 CAG has continued to promote the use of the recommendations, in particular those that are cost neutral.
- Thrombolysis- a successful workshop was held in June 23, bringing together over fifty clinicians and operational leads to discuss thrombolysis administration. Exploring many elements of the stroke pathway, key themes and opportunities for improvement were identified. These themes were further discussed at CAG meetings and a targeted project regarding Tenecteplase utilisation was commenced.



7. Rehabilitation Clinical Advisory Group

This CAG has been focussed on maintaining discussions across the end-to-end rehabilitation pathway while acknowledging the gap in the ISDN resource to complete projects.

The Rehab CAG has focussed on the following work in 23/24:

- Maintaining links with rehabilitation professionals across the different sectors for updates between region and the National Stroke Programme, including information exchange on the new SSNAP data set being introduced in 2024.
- Refreshing the Service Impact Analysis in early 2024 to review winter pressures and how this has changed rehabilitation delivery for in-patient stroke teams.

The main themes from the SIA were impacts on workforce (against updated national guidance and vacancies), frequency and intensity of interventions possible, reduced access to packages of care, significant pressures to discharge and high admission rates. Other factors mentioned were sickness due to flu and the impact of industrial action.

Work on the SSNAP data and how teams work with the update National Clinical Guidance on Intensity remain a focus for the ISDNs and will be part of the AHP Lead remit once this post is recruited.

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. Over 60 key findings were established, and 19 recommendations made. Recommendations relating to improved rostering of specialist nurses, lead specialist nurse recruitment and the use of national staffing models realised improvements in some trusts.
This work was built on further during 2023/24 by way of a dataset created to capture detailed information of the stroke unit nursing work force on a shift-by-shift basis.

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 commenced April 23 with information available in October showing a reduction of stroke specialist nurses used for ward cover and a greater appreciation for stroke specialist nursing skills on the regions stroke units.

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 2023 and March 2024, the work has included both 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. All six ICSs in region 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 ICB Stroke Leads, where they exist. The development of these plans has been supported by workshops to further share learning on how systems can learn across Providers and at a regional level. There are also monthly meetings by priority to give on-going support for clinical leads to develop QI changes at service level and share resources to improve outcomes and experience for those after stroke, their families, carers and staff.
    b. Quarterly meetings on the ICSS planning priorities are held with the ICB Stroke representatives to ensure that there is oversight and assurance from the system level for service developments. This is also a forum where ICB leads can share ideas and solutions from within their ICS. This allows solutions to be sought where significant variation of community stroke services exist.
2. Work continued 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 and their carers. Gaining PPV representation at a system level for projects was also a focus.
3. Supporting the implementation of the Integrated Community Stroke Service using a blended approach of telerehabilitation and face to face delivery, in line with National Clinical Guidance, was a key project with an evaluation of practice undertaken by UEA using a QI framework. This project included workshops and a questionnaire completed by stroke rehab clinicians, patients, and their cares, plus the Stroke Association. This is a complex area with many factors impacting service delivery method, not least, patient preference. This project allowed a robust evaluation with thematic analysis to be completed. These data were presented at a co-creation event in March 2024 with stroke rehab clinicians, Stroke ICB reps and a PPV rep on taking this work into clinical practice
4. Developing the Advanced Practice (AP) role and infrastructure in stroke rehabilitation within region continues with a role being piloted in Herts and West Essex. This is to inform how such workforce options can transform the stroke pathway and maximise patient outcomes. This workstream continues alongside the Regional Advanced Practice Faculty, University of East Anglia (UEA), and clinical teams to develop these roles for the stroke pathway at an ICS level. This role will also link to the delivery of the published Neurorehabilitation credential being delivered at UEA. The AP in stroke rehabilitation Community of Practice continues with further work on role descriptions and moving into a peer support network.
5. Psychological Care Level 1 continues as a focus across region with a project being run as part of the Stroke Specific Leadership Programme (GLASS) and funded via Catalyst monies. This work is based on formalising level one psychological care within the stroke rehabilitation pathway, through the accessibility and provision of standardised training for the workforce, and to consider models of consultation to address any gaps in availability of a qualified psychologist within stroke to support the stroke workforce across the pathway. This project is also piloting Clinical Associate Psychology (CAP) roles to support resources in delivery of psychological care in stroke rehabilitation.
6. Catalyst Projects round 1; - each focussing on a different component of implementation of the ICSS in region. There were 9 submissions from across all six ICSs in region; 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.

Catalyst Projects round two allowed a further three projects to be undertaken in the East of England, and included the following:

- **Mid and South Essex:** Psychological Care level 1 to describe and understand these needs and how to support the delivery of this by training and the CAPs roles (as outlined above).
- **Mid and South Essex:** Specialist Aphasia Service to augment MSE ICSS Teams- Using technology to Enhance Rehabilitation.
- **Norfolk and Waveney:** To pilot a model of voluntary sector delivery to ensure every person who has had a stroke has access to comprehensive Life After Stroke Support.

10. Patient and Public Voice (PPV)

The EoE Stroke Patient and Carer Assurance Group launched in June 2022 and continued their work in 2023/24. 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. Regular reporting at the ISDN boards was realised and the PPV leads positively influenced the utilisation of a standardised reporting template. Gaining representation of people who have had a stroke in all systems across region remains a focus in light of the new NHS ways of working.

11. Quality Improvement and Sharing Best Practice

- Monitoring of the SSNAP acute care key performance indicators (KPIs) continued throughout 23/24. This was achieved via reporting at the ISDNs board and at ICS stroke system meetings. Meetings.
- A standardised reporting template was introduced for use at the ISDN board meetings.
- 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 workshop to discuss thrombolysis treatment for ischaemic stroke.
- UK Stroke Forum, National conference- posters showcasing EoE ISDN projects and presentations given by the ISDN team. Topics included the regional procurement of artificial intelligence, therapy intensity in inpatient settings and prehospital video triage.
- European stroke conference-Munich, poster presented show casing the East of England project regarding prehospital video triage. This was a collaboration between the ISDNs and EEAST.
- 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. This has continued throughout 23/24.

12. National Optimal Stroke Imaging Pathway (NOSIP)

A national optimal stroke imaging pathway was developed[1] and published under the National Stroke Service Model in May 2021. This was based on best evidence and expert consensus at the time.

This pathway set out key areas for consideration relating to rapid access to appropriate brain imaging at the same sitting ideally 24/7.

Having conducted a snapshot analysis using the RightCare stroke self-assessment NOSIP tool in 2022, it was evident that the region had much work to do around meeting the NOSIP requirements of the pathway across all 15 acute stroke centres.

The ISDNs appointed a NOSIP Clinical Lead and Consultant Radiologist in May 2023 to support the region in working towards compliance of the various components of the NOSIP. The region hosted a NOSIP workshop in Q1 to commence this workstream which had input from national experts as well as regional teams sharing best practice. System meetings followed in Q2 with each ICS and their acute providers to work through local implementation and action plans in relation to full compliance of 24/7 availability of CT & CTA at the same sitting with associated reporting as the first steps.

Progress meetings were conducted with all acute providers in Q3 as well as some individual face to face meetings conducted by the Clinical Lead to offer support to some centres. Work also commenced with the two Imaging Networks in the East in Q4 to enable closer working, collaboration and reduce duplication.

The RightCare NOSIP tool was refreshed showing much improvement with the deadline to achieve full compliance of CT Head & CTA component of the NOSIP by Feb 2024. Nurse requesting protocols and standard operating procedures (SOPs) were developed and shared across teams where permission was granted to facilitate the seamless implementation of the NOSIP.

CT Perfusion and MRI imaging will be the next focus for 2024/25 which will include training opportunities for radiographers, radiologists, stroke physicians and stroke nurses. Planning for an in-person CT-P study day hosted by the ISDN was scoped and promoted in Q4 with the study day taking place at the end of April 2024.

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.

[1] stroke-service-model-may-2021.pdf (england.nhs.uk)

2. Stroke Artificial Intelligence

- The ISDN will continue to work with the Clinical Policy Unit to secure the additional and final year's funding to ensure the regional contract realises a 3-year term whilst facilitating discussions around sustainability beyond Year 3.

3. SQuIRe

- Ensuring engagement across all community stroke services as required to understand and define the current stroke pathways and workforces within ICS.
- 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 and therapy domains. The stroke unit domain performance has remained poor throughout 23/24 despite ISDN projects.

5. Admissions Pathway Improvement

- Variable executive sponsor to support optimising the stroke admission pathway. Lack of momentum in improvements in some areas. Trust capacity issues emanating from operational pressures impacting on stroke unit capacity has further highlighted issues in achieving the 4 hour to stroke unit target. The network continues to promote the need to protect stroke specialist beds robustly, underpinned and supported by agreed local protocols.

6. NHSE restructure

- The current NHSE restructure has hindered the ability to recruit into vacant ISDN roles significantly impacting capacity and clinical expertise (AHP). Indications are that this will continue to be a challenge in 24/25.
- The restructure created instability in the ISDN and SQuIRe leadership team leading to delays in project planning for the end part of 23/24 and the beginning of 24/25.

7. ICS restructures

- Significant restructures within ICSs/ ICBs across the region have influenced capacity for system engagement and in some instances has seen the loss of stroke specific ICS leads. It is expected that this disruption will continue in quarters one and two of 24/25.

Areas of Focus for 2024/25

1. Stroke Artificial Intelligence

-Oversee contract reviews led by the regional Contracting Authority with the AI providers during YR 2 (2024-25).

-Continue to work with the CPU to secure the additional and final year's funding to ensure the contract realises a 3-year term whilst facilitating discussions around sustainability beyond year 3.

2.Pre-hospital Clinical Advisory Group
- To reduce ED delays closer collaboration between stroke teams and ED departments will result in more timely access to stroke specialist treatment. Meet with ED clinical leads to help take this work forward.
-Continue to promote joint education and training sessions for frontline crews across the region in relation to the pre-hospital pathway and identifying stroke mimicking symptoms.
-Category 2 interfacility transfers to comprehensive stroke centres data collection to continue with shared outputs being presented at the CAG or shared with individual trusts to support with local service improvement opportunities and hospital processes.

3. Pre-hospital Stroke Video Triage (SVT)
-Wider adoption of the pre-hospital SVT across the region with new pilot sites. Work with systems to realise a sustainability plan. A full evaluation report to be presented at the end of October 2024.

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

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. National optimal stroke imaging pathway (NOSIP)
-Continue to work towards regional compliance in relation to the CT Perfusion component of the NOSIP and promote wider training opportunities for 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.

9. 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.

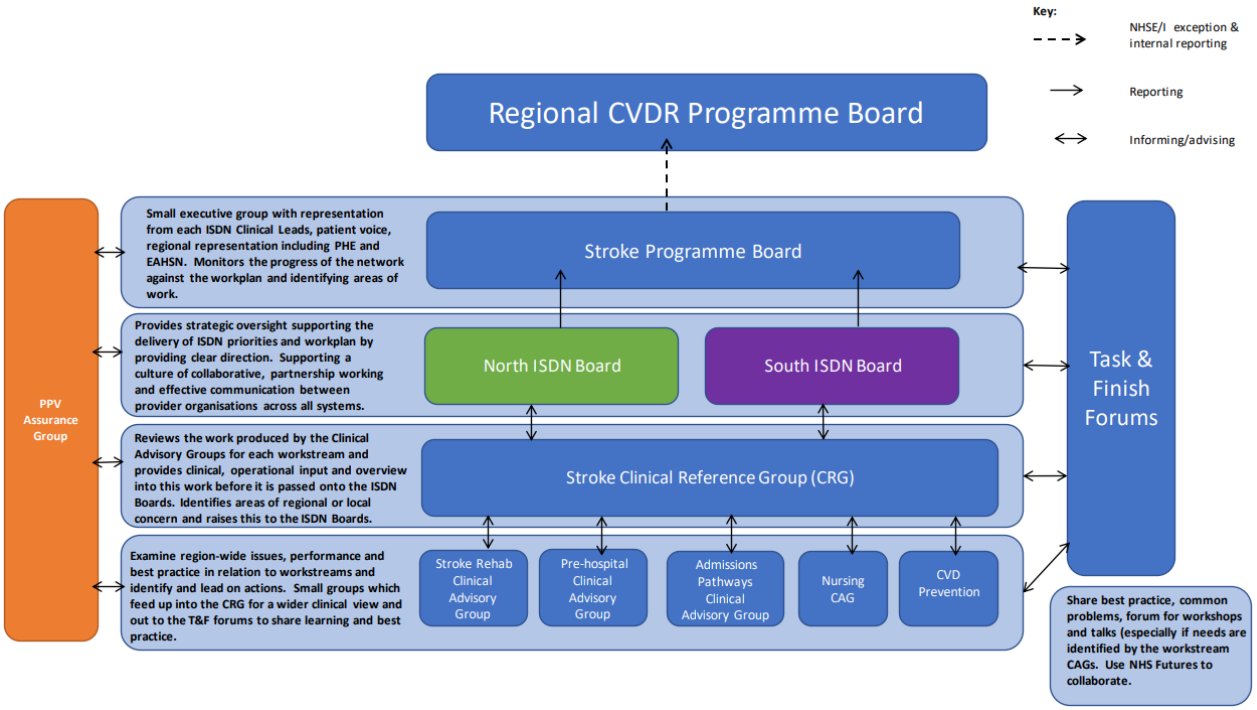
10. Patient Participation Voice
- Continue to support regional collaboration with PPV in line with NHSE and ICS new ways of working, encouraging PPV representation at system (ICS) and provider level to maximise input.

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. 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.

Network Governance

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



Network Budget

The stroke ISDNs and the SQUIRE role are funded through the national team, with additional funding available for systems for specific projects. Network costs have been lower this year as a number of vacancies have been carried through the New NHSE Change Programme:

1. Staffing budget

Funding Allocation Description	Amount
Network substantive staffing (inc SQUIRE)	£241,175
PMO support costs	£93,491
Clinical Leads	£74,797
Patient/carer representatives	£1,756

2. Targeted funding for specific projects (to systems)

Funding Allocation Description	Amount
Catalyst funding (SQUIRE)	£717,000
AI funding	£92,744
Stroke Video Triage pilot	£183,000

4. 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:

- The NHS will do more to detect and diagnose respiratory problems earlier
- Increase access to pulmonary rehabilitation, by expanding pulmonary rehabilitation services.
- To support those with respiratory disease to receive and use the right medication.
- To improve the NHS's response to pneumonia.

Additionally, the national specification for networks has included aims to:

- To support the development of a population health management approach to enable Integrated Care Systems to adopt a proactive approach in improving respiratory outcomes for their populations.
- Reducing health inequalities and improving equity of access by targeting interventions in areas of high deprivation, lower socioeconomic groups, and those with complex health needs.
- Improving the outcomes for common respiratory conditions through the implementation of evidence-based pathways for the diagnosis and management of respiratory disease across the region.
- Restoration of respiratory services post COVID-19 with an emphasis on remote monitoring and care closer to home.

Network Team	
Dr Ellen Makings Senior Responsible Officer, Medical Director for System Improvement	**Sarah Fowler** Long COVID Clinical Champion
Dr Robin Gore Clinical Lead, Asthma, Respiratory Diagnostics	**Alan Jensen** Quality Improvement Manager
Dr Abigail Moore Clinical Lead, Asthma, Diagnostics, ARCU & CAP	**Sarah Claydon** Quality Improvement Project Officer – PR Accreditation
Dr Sripat Pai Primary Care Clinical Lead, Asthma, Respiratory Diagnostics, CAP (September 2023 – present)	**Rebecca Hall** Quality Improvement Project Officer
	Claire Doney Business Support Officer

Network Performance and Achievements

"The EoE respiratory network has helped us in Norfolk and Waveney in many ways - by suggesting new initiatives, sharing best practice but particularly for our ICB helping us push some important pieces of work past all the bureaucracy which exists in the NHS. Alan Jensen has always been easy to contact and available to support when needed."

Daryl Freeman FRCGP
Respiratory Clinical Lead Norfolk & Waveney ICB

"I am particularly pleased to have been able to support the work of the respiratory network in the following areas:

Design and delivery of SENTINEL PLUS, which delivered a time-limited project in 2 ICBs to achieve enhanced detection of high SABAS-users in the community, support a switch to MART therapy, and enhance HCP asthma education. The success of the project means it can be used as a blueprint for ICBs to roll out, and improve SABA overuse, asthma control, and deliver environmental savings.

Ongoing work with ICBs to support a deprivation-targeted (risk stratification) approach to deliver spirometry recovery, which will complement the new services that may be delivered from community diagnostic centres with services from numerous local testing hublets for patients in difficult-to-access areas. This is a complex area, and the development of a coherent strategy is an exciting step towards eventual delivery.

Development of the network's asthma 'dashboard' to help ICS plan services. This has great potential to help planners of services for asthmatics across all severities of disease. Early data shows the gradual reduction in regional SABA use, a marker of improved asthma control and beneficial environmental impact.

Working with ECLIPSE and a commercial sponsor (Astra Zeneca) to develop a fast-stream case finding and patient assessment tool for those with the worst asthma. Not only will this help with the long delays to treatment that patients with severe asthma suffer but will demonstrate the power of community medicine data platforms to facilitate a change from a crisis-led referral mechanism to a risk-led proactive approach. It is exciting that our first partner ICB has agreed to proceed.

Working with the Children and Young People's (CYP) network and housing partners to bring professionals together to improve co-working, and thereby improve housing and health outcomes for those with respiratory disease.

It has been exciting to bring partners working in the field of interstitial lung disease (ILD) together with the first aim of setting up a regional MDT, with work towards defining regional pathways of care, including specialist and generic (e.g. PR, oxygen, palliative care). This will make a real difference to patients' journeys.

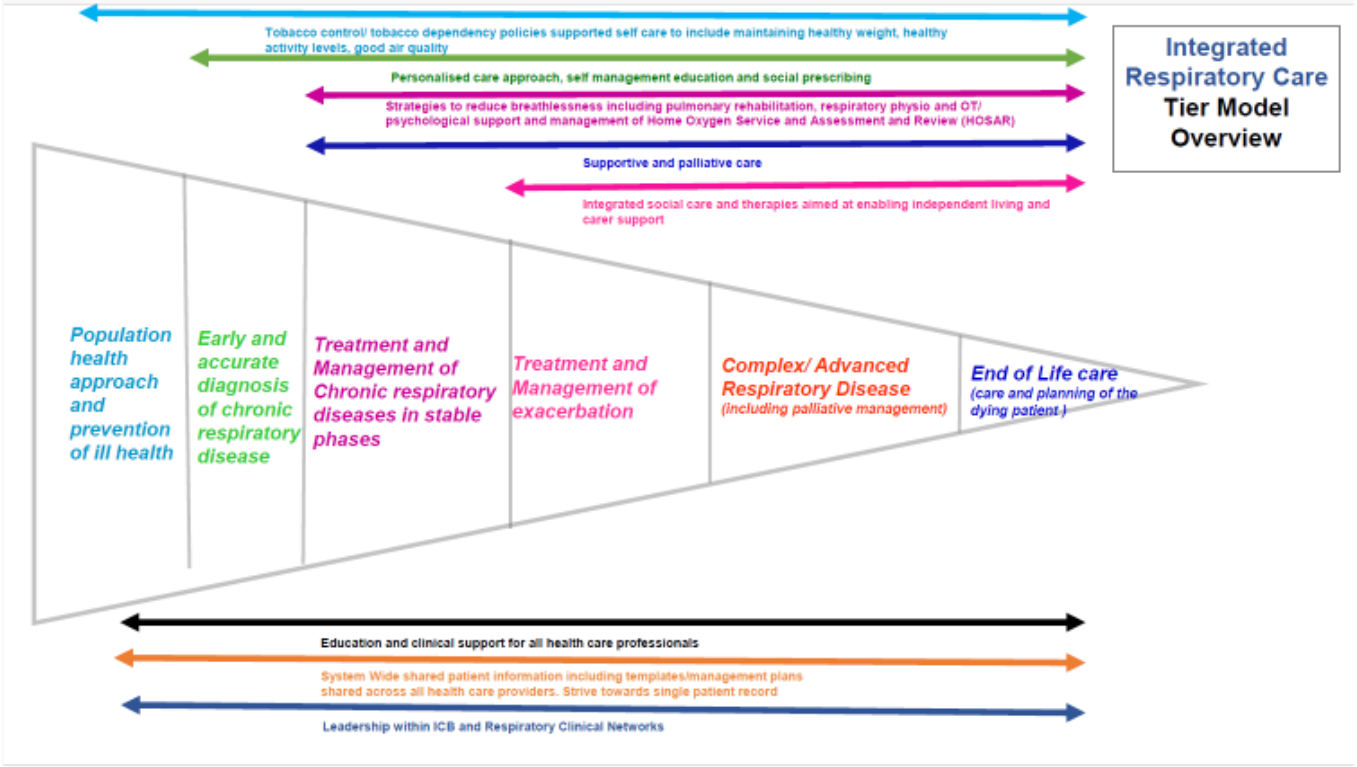
It has been a real pleasure to work with the dedicated project team at NHSE East of England, and to deliver clinically led strategically important projects for patients with respiratory disease."

Robin Gore
Network Clinical Lead

Key achievements in 2023/24 include:

- PPV Rep recruitment & inclusion in specific projects
- Development of a Health Inequalities plan
- Further development of respiratory data
- Delivery of the SENTINEL Plus project
- Investigation of pneumococcal vaccination plans for vulnerable groups
- Development of a Respiratory Diagnostic Models document
- Significant progress in the delivery of the network's PRSAS Accreditation project
- Supporting the continued transition of Long COVID Services

The national vision for integrated respiratory care, is that it should be patient centered, focused on ensuring care is seamless, proactive, coordinated, with strong clinical leadership, delivered within a multi professional team, which works together across organisations. This has led to the development of the integrated respiratory care pathway, which is an end-to-end pathway, which supports patients with all chronic respiratory conditions at all stages of their journey. This pathway aligns with the NHS long-term plan, Getting It Right First Time (GIRFT), British Thoracic Society (BTS) and Primary Care Respiratory Society (PCRS). The network will conduct a series of workshops in 2024-25 based upon the following Integrated Care Model's six stages of care.



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

> *"I have really enjoyed the experience. Specifically, to CAP [Community Acquired Pneumonia] and people with learning difficulties. It is so gratifying to see so many people from diverse backgrounds so invested in aiming to make a difference in ameliorating this condition. I would highly recommend being a PPV."*
>
> ***Sefina Arif***
> ***Network PPV Representative***

The network made significant progress in its achievements around Patient and Public Voice (PPV). Four patient representatives were appointed to the network, successfully inducted, and aligned to workstreams that are of particular interest to them:

- Asthma & Respiratory Diagnostics - Phil Taverner
- Community Acquired Pneumonia (CAP) - Sefina Arif
- Pulmonary Rehabilitation - Michael Taylor (April 2023 – September 2023) & Stephen Jones (January 2024 – present)

Whilst recognising that having established PPV Representatives as members of the steering groups and board is a significant step forwards, the network wanted to ensure that PPV was included in specific projects. Therefore, specific PPV activities this year included:

- Online patient survey, face to face and virtual focus groups as part of the SENTINEL Plus project. With responses included in the end project report and used to help inform the recommended next steps
- Worked with SNEE ICB to hold a series of patient and public workshops around potential reasons why people decline PR and to identify actions we can take to make a quality improvement in that area, with a follow up workshop to be held in 2024-25
- Supported with the patient engagement element within the Lung Health@ home project. The early outcomes of this have been successful, with a reduction in Did Not Attends (DNA's) and improved attendance for Pulmonary rehabilitation class in a deprived area of Ipswich
- Included PPV Reps in the evaluation of Expressions of Interests (EOI's) for specific projects within Respiratory Diagnostics and PR
- Invited PPV Reps to attend and participate in face-to-face network events

2. Pulmonary Rehabilitation (PR)

"I have found it especially valuable being part of the network as the PR Day allowed networking and sharing information. It has been especially helpful to have accreditation updates and discussing issues around patients engaging in PR."

Ruth Barlow
Team Lead for Provide CIC's Long COVID service and ICS long COVID Lead
Chair of the network PR Steering Group

Pulmonary Rehabilitation (PR) is an exercise and education programme designed for people with lung conditions who experience symptoms of breathlessness. It 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 COVID-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:

This year saw the network continue to support systems, by championing the excellent work being undertaken within systems nationally and the sharing of national updates back into systems. The network maintained the regional steering group, data returns and annual face to face PR workshop to help foster a culture of shared learning.

The network supported systems with the delivery of their transformation plans by supporting ICBs to identify the funding for the transformation of PR services due to changes in the way that this funding was allocated to systems. The network also looked at capacity and demand modelling for PR services in the East of England and met with each ICB individually to review and discuss this work and the delivery of their transformation plans.

2) PRSAS Accreditation Project:

Accreditation is an important quality improvement standard for providers to achieve by 2027. The network supported accreditation by facilitating annual services calls with the Royal College of Physicians (RCP) and ensuring general accreditation updates were discussed and shared with all the providers within the region. As well as providing this universal support, the network continued to deliver its regional accreditation project. The project overall has been a success to date with most providers taking part in the project aiming to achieve accreditation within 2024-25.

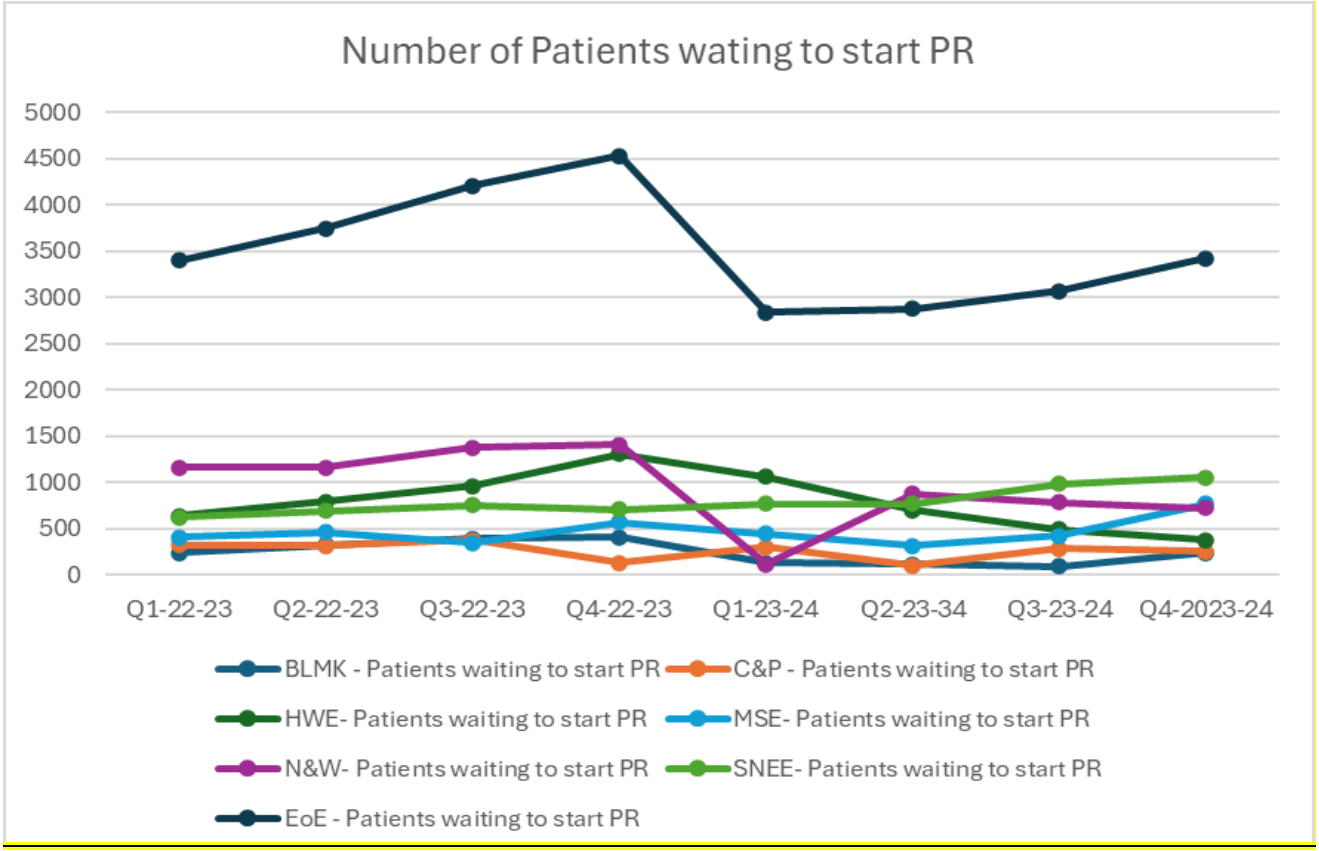
3) Innovation projects that support the promote transformation of PR:

The network funded and supported innovation projects such as the development of Bedford, Luton, and Milton Keynes' (BLMK) Patient Information Hub PR, supported patient, and public voice (PPV) projects and the national Lung Health @ Home project.

Norfolk and Waveney and Mid and South Essex ICBs were funded to support the developments of their hubs. However, due to challenges, colleagues were not able to deliver this project last financial year and are keen to progress this to complete 2024-25 financial year.

The network worked with SNEE ICB colleagues to enable Orwell PCN to be a fast follower site for the national Lung Health @ Home project that is developing a primary care PR search and prioritisation tool. The next steps for this work are to test and evaluate the wider impact of a personalised approach to increase access to PR through improved conversations and practical approaches to develop a sustainable model for wider implementation.

Through the funding and the network support, systems have solid foundation on which to build. The regional data returns show a slight improvement in the numbers of patients waiting to start PR, with a reduction across the year of about 1,000 patients waiting.



However, there needs to be a regional focus in 2024-25 on the number of patients completing PR courses as evidenced by a discharge assessment and that patients across the EoE are waiting no longer than 90 days on average to start their PR course.

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 some lung diagnostic tests resulting in long waiting lists, particularly for spirometry. This was compounded by having enough staff trained to an accredited level to be able to conduct spirometry testing
Through the network, national funding for spirometry was made available for each system to support the following:

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

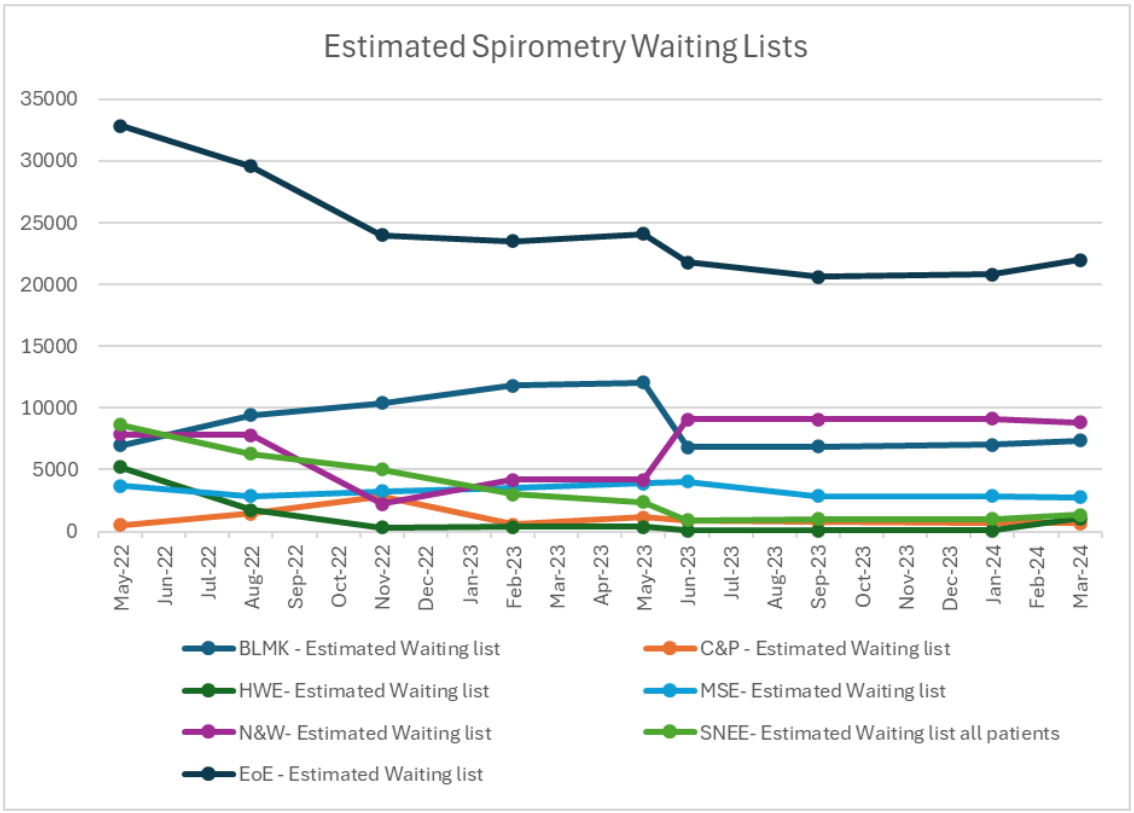
2) To ensure that systems have the optimal numbers of accredited practitioners performing spirometry tests and diagnosis of results and to share best practice across the region

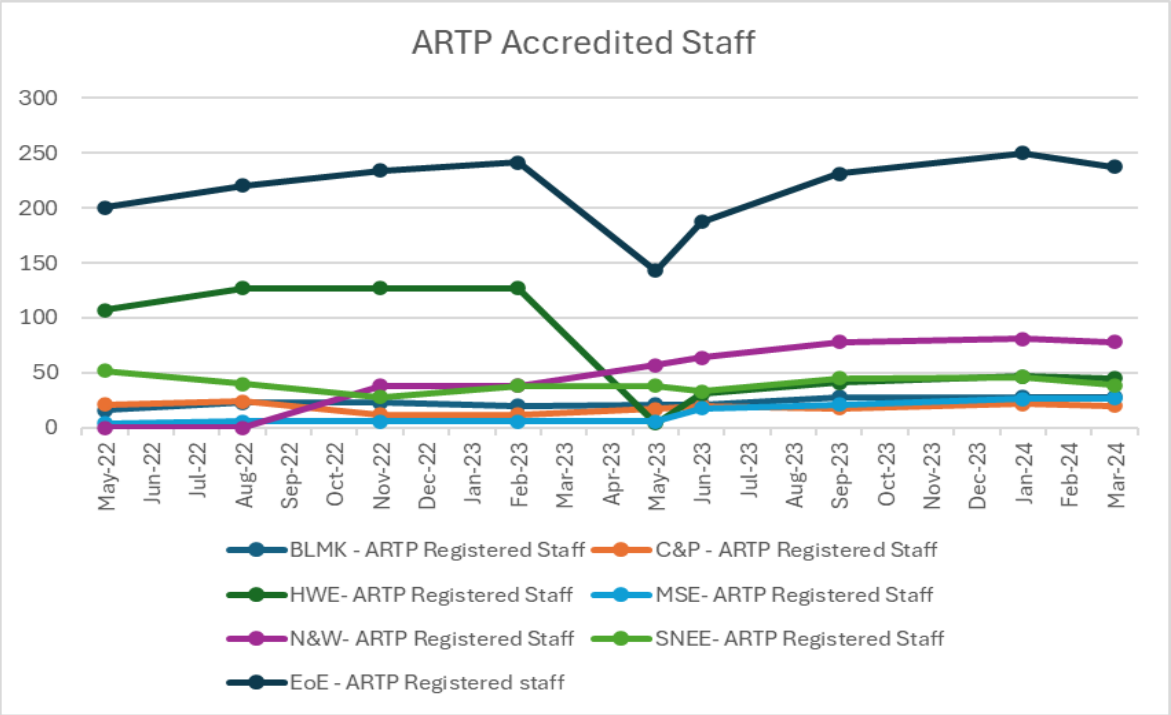
A mapping exercise was undertaken to understand the different models being used by ICSs including primary care network (PCN) based, locally enhanced services and mobile diagnostic hubs. From this a document was compiled for the region to provide:

- An introduction to the ICS
- A background to the diagnostic service being used
- Details about the service
- Infection prevention and control protocols and the estate in which the service is operating in
- The diagnostic tests being provided
- The workforce involved in delivering the service
- The training, support, and education provisions for staff
- Costs associated with running the model
- Governance arrangements
- The future of the service delivery

This document can be used alongside other resources to facilitate discussion and identify improvement opportunities or exemplars of good practice. It also provides the network with an information source for the East of England for sharing nationally, use within the region and to support discussions at the network's Respiratory Diagnostic steering group. It is also published on the network's NHS Futures site.

The network has also maintained its quarterly data return to support systems to understand their current waiting lists and progress towards achieving their optimal number of ARTP accredited staff. What has become evident from the quarterly data submissions is that despite all ICBs restarting spirometry testing within their systems, the numbers of patients that are awaiting a spirometry test remains high across the region and the number of accredited staff remains static across the region.





Following discussions at the regional Diagnostic Steering Group about how the network could potentially support systems further to tackle waiting lists. Quarter 4 of 2023-24 saw the successful initiation of a risk stratification project, in partnership with Prescribing Services Ltd (Eclipse). The project will continue into the next financial year with the objective of this project to run data searches within the Eclipse database to identify patients who are of highest need of a spirometry test and triaging these patients so that those of highest need are referred to spirometry diagnostic services first.

Two systems were supported by the network to secure additional national funding for projects that tackle health inequalities:

- Cambridgeshire and Peterborough (C&P) supported an additional clinic at Stamford Hospital for patients in the Lincolnshire area. Approximately 46% of the Lincolnshire population were being referred for lung function diagnostics tests at Peterborough hospital impacting the waiting list and causing increased travel times for patients. The clinic has demonstrated a reduction in both waiting times and travel times for patients.

- Suffolk and North-East Essex have worked in collaboration with Beacon House Primary Health Care for the Homeless in Colchester to deliver spirometry tests in the homeless community. This project has also had positive outcomes with 33% of patients who met the eligibility criteria being identified as having Chronic Obstructive Pulmonary Disease (COPD) and two patients have been successfully rehoused because of their diagnosis. There has also been support from the local smoking cessation service and 40% of patients have transitioned to using vapes.

5. Asthma

"SNEE ICB have worked collaboratively with NHSE to deliver the SENTINEL Plus pilot in Northeast Essex and we have seen fantastic outcomes including reduction in SABA use. We also set up a new patient engagement group to discuss the issues around asthma management and we had over 100 responses from a patient survey that was sent to primary care, which we never had before! NHSE supported us in developing the patient survey and troubleshooting. The success of the SENTINEL Plus pilot also helped us to build on the patient engagement element and NHSE identified new opportunities for us to engage with Lung Health @ Home project. The early outcomes have been successful. We have seen reduction in DNA's and improved attendance for a Pulmonary rehab class in an area that is deprived in Ipswich."

Alexis Johnys
Transformation Programme Manager (Respiratory, Long Covid, ME&CFS and NHS tobacco dependency treatment programme)
Suffolk and Northeast Essex (SNEE) ICB

Asthma is a long-term condition for many people, particularly if it first develops in adults. There is currently no cure, however the symptoms can usually be controlled with treatment. Most people will have normal, active lives, although some people with more severe asthma may have ongoing problems.

<u>The network focused on four objectives throughout 2023-24:</u>

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

The network reviewed the new RightCare toolkit for asthma and recreated the self-assessment tool for completion 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. From the responses received there were 3 potential areas that the network could support systems with:

- Optimal management and personalised care
- Experience of care
- Environmental factors for consideration

Environmental factors were agreed by the regional asthma steering group as the subject that the network should support systems with first. A webinar on cold and mouldy homes was proposed in collaboration with the Children and Young People (CYP) transformation Programme, Public Health, and housing. A Task and Finish group is being planned 2024-25 with CYP, Public Health and Housing to take this work forward

The network also wanted to explore ways to further support asthma education. A survey was undertaken in primary care which asked questions around people's confidence levels regarding the various aspects of delivering asthma care. 100 responses were received from across the region. The results were reviewed and discussed nationally. Areas of opportunity are being factored into projects in 2024-25, with education being a key principle.

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. Both Bedford, Luton, and Milton Keynes ICB and Suffolk and North-East Essex ICB were successful in their applications to participate in the SENTINEL Plus pilot. The project finished in September 2023, with a comprehensive End Project Report available on the network's NHS Futures site.

The key findings from the project are:

- Most people are open to moving to a new MART inhaler and regime
- Most people are open to moving to a new MART inhaler and regime when recommended by their asthma healthcare professional
- When patients are provided with more information prior to their asthma review, they are more likely to take up the offer of MART or change inhalers, because they have time to understand the new regime and how it can help them to manage their asthma

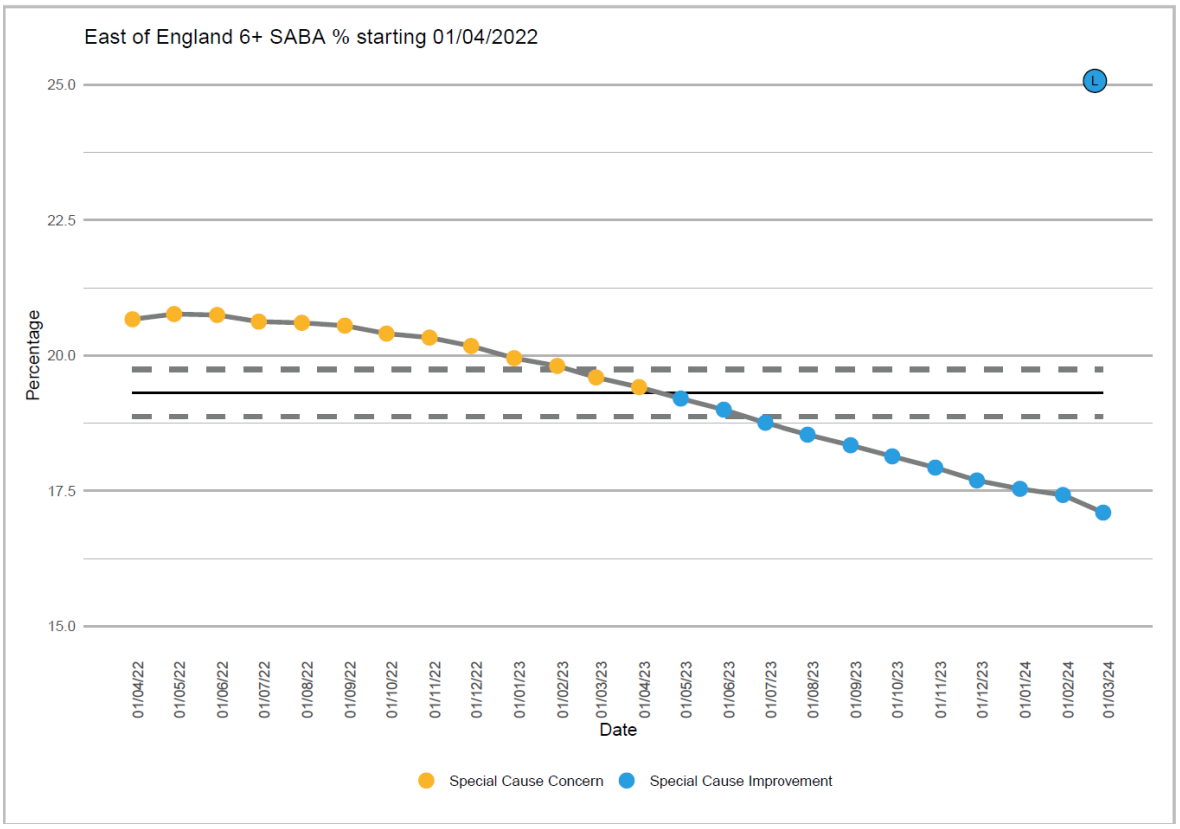
After the first 12 months that SENTINEL Plus was piloted within the EoE:

- 861 patients who were on six or more SABAs were transferred to MART.
- Based upon the agreed calculation of 28kg of CO2 per SABA not prescribed, the project removed nearly 75,000kg of CO2 emissions from the environment (equivalent to 37.5 return flights from London to New York).
- 151 healthcare professionals were educated about the importance of encouraging patients to swap to MART.
- In terms of 6+ SABA prescribing, in both ICBs that took part in this project there was a much faster decline in their average percentage of patients being prescribed 6 or more SABA inhalers after SENTINEL Plus has been implemented, as the below table shows:

BLMK ICB	**Time Period**	**ICB Average**	**Difference**
Six months before SENTINEL:	April – October 22	19.0% – 18.8%	-0.2%
First Six months after SENTINEL:	November – May 23	18.8% - 17.8%	-1%
SNEE ICB	**Time Period**	**ICB Average**	**Difference**
Six months before SENTINEL:	April – October 22	19.4% – 19.3%	-0.1%
First Six months after SENTINEL:	November – May 23	19.3% - 18%	-1.3%

The outcomes of our SENTINEL PLUS project are going to be published as part of the Royal College Physicians' (RCP) The Green Physician Toolkit.

6+ SABA use is a key metric for the asthma steering group and what we are seeing across the region is a special cause improvement in 6+ SABA use. From a regional perspective, in April 2022 the average percentage of patients being prescribed 6 or more SABA's was at 20.7%. When SENTINEL Plus began in November 2022 the regional average was at 20.3% and as of the latest data collection in March 2024 it had decreased to 17.1%



With the national lower threshold for performance 25% and upper threshold 15%, SABA prescribing within the East of England is clearly moving in the right direction and there are multiple contributors to this regional special cause improvement we are seeing including:

- The availability of the MART regime on formularies which is now embedded across the whole of the East of England
- Increased patient and clinician awareness of changing their inhaler
- The impact of Sentinel Plus across the two ICB's within our region

6 + SABA prescribing will continue to be a key metric for the network in 2024-25, as well as 3+ SABA prescribing, 2 + prednisone prescribing and asthma hospital admissions.

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

Severe asthma is a debilitating disease which has a significant impact on patients' lives, with biological treatments potentially being a transformative solution for this patient cohort. Despite this, the network is aware that in general there is currently a high unmet need with approximately only 1 in 5 patients receiving specialist biologic treatment and that access to these treatments is an area of health inequality.

The network partnered with Eclipse and AstraZeneca to form a project group to deliver the EMBRACE project which aims to deploy a digitally enabled pathway to efficiently identify, risk-stratify, and triage patients to specialised care without increasing workload in primary and secondary care. The network has identified an ICB to participate in the programme and this project is due to start in 2024-25.

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.

The work to deliver this objective was mainly undertaken as part of the SENTINEL Plus pilot, with environmental impact from the project shared with asthma steering group and as part of the end project report. With the project removing nearly 75,000kg of CO2 emissions from the environment (equivalent to 37.5 return flights from London to New York).

6. Community Acquired Pneumonia (CAP)

Pneumonia places a huge burden on the NHS, particularly during winter months with acute pneumonia admissions having risen by 35% in the last ten years. Pneumonia can make patients seriously unwell with a 30-day mortality rate of 5-10% for those hospitalised. Mortality rates become higher with increasing age and frailty and for those patients who are more vulnerable, including those with learning disabilities. 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.

The network focused on three objectives throughout 2023-24.

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.

A Task and finish Group was established to design a series of three webinars on the following subjects: experiences and importance of LD health check, the health check process, and onward referral pathways based upon the outcomes of LD Health Check. These webinars will be delivered to primary care colleagues in 2024-25.

2) To support the reduction in the number of preventable LeDeR Review pneumonia deaths.

The network has worked with the LeDeR network to understand the themes from the ICB annual LeDeR annual reports and the data that is available on the national LeDeR dashboard.
The regional themes identified from LeDeR annual reports and dashboard data were a need to improve:

- Recognising deterioration and frailty
- Making reasonable adjustments
- Accessing the right support
- Accessing appropriate services and pathways
- Good quality annual health checks
- Avoiding diagnostic overshadowing
- Improving uptake of vaccinations

In follow up to these initial findings, The LeDeR network and an acute hospital are undertaking separate deep dives into their individual data, with the findings expected to be presented to the regional CAP steering group in 2024-25, To identify further quality improvement initiatives.
The network reviewed the new RightCare toolkit for pneumonia and recreated the self-assessment tool for completion by local systems and services to reflect on the strength of their current service provision and to identify opportunities to improve care across the pathway. From the responses received there were 3 potential areas that the network could support systems with:

- Oral health
- Care homes and the education of care home staff
- Patient information (post-discharge/post-pneumonia information)

These have been built into the 2024-25 plan.

3) To support the improvement in pneumonia, flu & COVID vaccination rates in vulnerable groups.

One of the CAP steering group's initial objectives, was to understand the pneumococcal vaccination plans for vulnerable groups, because the most common bacterial cause of community acquired pneumonia is pneumococcal infection. Pneumococcal vaccination plans are not routinely created for patients with learning disabilities or other vulnerable groups. The network has engaged with the Regional Vaccination Operations Centre (RVOC) to discuss this topic with the CAP steering group to identify the key roles for ICBs in influencing secondary and primary care physicians to deliver the pneumococcal vaccine to patients:

- That ICBs develop vaccination plans for the pneumococcal vaccine, which takes into consideration areas of health inequalities to ensure that all patients who would potentially benefit receive this important intervention.
- That all clinical staff involved in the care of clinically vulnerable, particularly those with learning disability patients, make every contact count to engage in discussions around the importance of the pneumococcal vaccination.
- That all clinicians involved in the care of clinically vulnerable, particularly those with learning disability patients, keep themselves up to date with the immunisation schedules for routine, vulnerable and overseas vaccinations.
- That during seasonal immunisation programmes, the clinically vulnerable, particularly those with learning disabilities, are prioritised to ensure appropriate protection is given early.
- That every effort is made to ensure health records are kept accurate and up to date with vaccine status and contact information, so offers of clinics reach parents/carers with appropriate messaging to convey the importance of vaccinations.

In 2024-25 the network will be working with an ICB to improve their pneumococcal vaccination rates in vulnerable groups.

7. Long COVID

> *"The long covid network has allowed sharing best practice and knowledge and information about how teams continue with funding being a challenge."*
>
> ***Ruth Barlow***
> ***Team Lead for Provide CIC's Long COVID service and ICS long COVID Lead***
> ***Chair of the network PR Steering Group***

In 2021 the national team established a Long COVID network. Which supported systems to establish these services within the East of England.

Long COVID services can offer:

- Further tests to help diagnose or monitor symptoms
- Assessments for your physical and mental health
- Treatment for or help managing long COVID symptoms
- Referral to post-COVID rehabilitation for further support

In April 2023 the strategic direction changed from supporting the setting up of services, to supporting ICBs and systems to start moving these services to work as part of the existing care pathway for patients. Therefore, the Long COVID programme was able to transition into the main respiratory clinical network in May 2023.

The network focused on one objective throughout 2023-24.

1) Support the transition of Long COVID services to ICB responsibility.

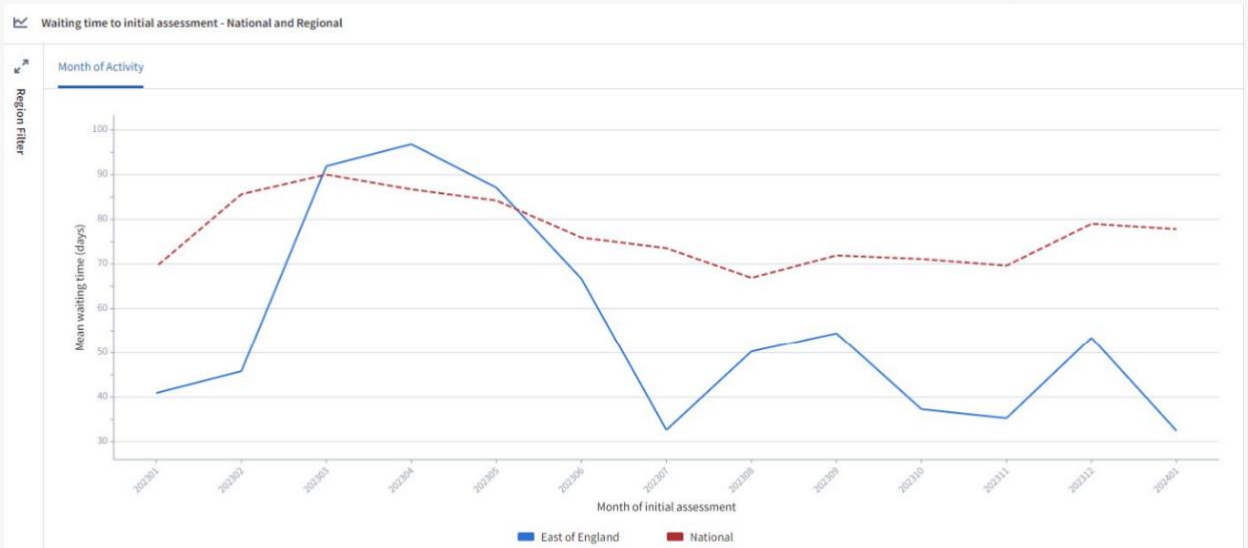
Adult Services

A series of peer reviews had been undertaken as part of the 2022-23 Long COVID delivery plan. The network ensured that any action logs that were completed as part of the peer review process were finalised, and any common themes were shared at Long Covid Steering Group. The network also created a Peer Review report that explained the peer review process, summarised the outcomes from the peer reviews and provided a series of recommendations for ICBs and providers.

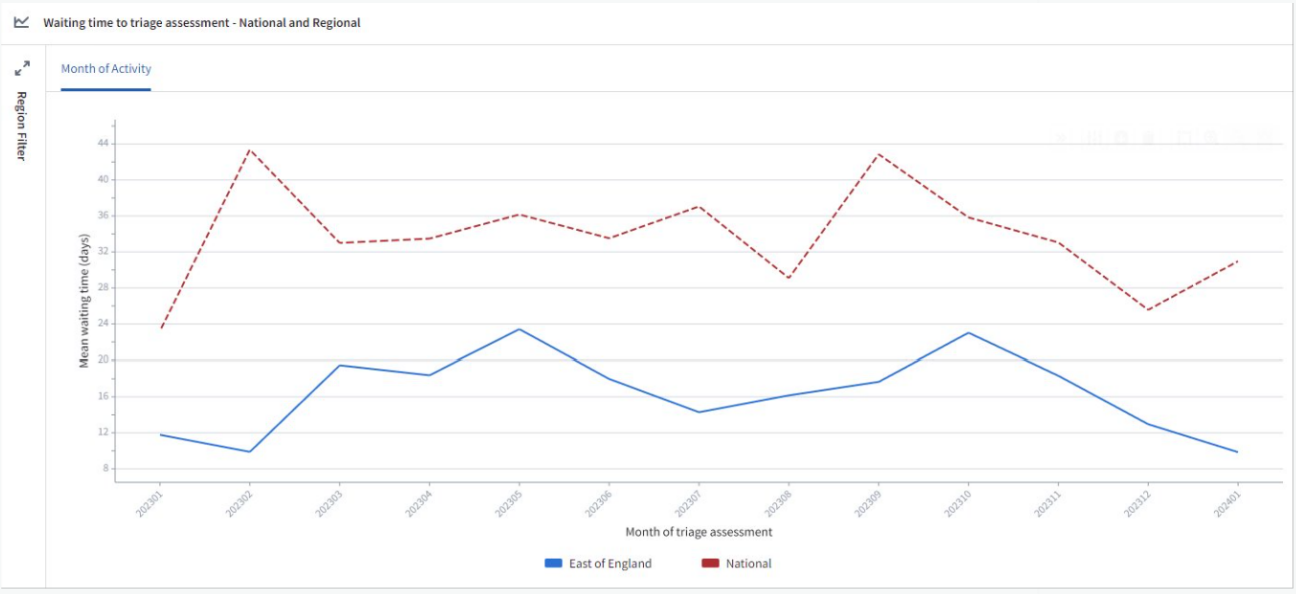
To support with the transition of Long COVID services, the network ran a regional data return to help the network and systems to understand the service demand, capacity and the future delivery of Long COVID services.

The overarching themes from the data return in terms of current service provision was that the region was not seeing any significant increase in referrals or patient activity and no patients were waiting longer than 15 weeks for an appointment. As well as this the activity trends between returns showed that in general there was a decrease in referrals and in the number of follow up appointments.

Waiting Lists



Average patient wait: Regional and National Comparison



Discussions regarding future plans for the services were held with the ICBs and will continue to do so through 2024-25.

Children and Young People's services

The CYP Regional Long COVID Hub was provided by Cambridgeshire University Hospitals NHS Foundation Trust (CUH). However, October 2023, CUH informed the network of its intention to stop providing this regional service at the end of this financial year due to the low numbers of referrals it was receiving from systems. The network therefore supported CUH's decision by ensuring that this was communicated both within region and nationally and worked with systems to ensure that all systems had suitable alternative pathways for their CYP populations. As well as this the network ensured that there were suitable arrangements in place for the 2024-25 CYP Long COVID funding.

8. Interstitial Lung Disease (ILD)

The network organised a face-to-face event in March 2024 with ILD clinicians from across the region in attendance to have conversations and improvement planning discussions for ILD care pathways based upon the new optimum integrated care pathway that has been developed by a national taskforce called One Voice ILD. This optimum integrated care pathway has been designed because the current ILD commissioning models are not fit for purpose and with increasing demand, they are not future proofed to ensure those eligible for treatment can receive it or tackle the growing inequalities of care. Based upon the outcomes of this event and initial conversations with key stakeholders, the network has established an ILD Steering group for 2024-25 with its initial objective being to ensure that patients have fair and equal access to treatment by supporting the development of ILD services.

Challenges

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

Data: The network has made significant progress in terms of data to inform plans and demonstrate outcomes. However, challenges remain in some areas with meaningful spirometry data remaining a significant challenge for the network to adequately identify capacity, demand and activity issues across the region.

Recruitment and resourcing: The NHSE restructure resulted in some delays to the recruitment of posts integral to the network restructure together with role changes to reflect new ICB structures in many systems affected the progress of some objectives.

Funding: Changes to the way that funding was allocated to systems was of challenge both for PR and Long COVID workstreams. The network worked with the national teams and systems help resolve these challenges.

Areas of Focus for 2024/25

1. Overarching Network Principles:
Key Principle 1: To enhance the support the network can provide to ICBs to help them to achieve the priorities within the East of England, by focussing on key enablers such as, PPV, education, data, and integrated care.
Key Principle 2: To collaborate with key stakeholders, such as charitable partners and other networks.
Key Principle 3: Throughout 2024-25 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.

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 work towards a minimal SABA prescribing ambition within the East of England.
Key objective 3: To support systems in ensuring that asthma medicines are optimally used to promote good asthma care, improve asthma control, prevent asthma attacks and (where clinically appropriate) encourage the transition to inhaled therapy greener inhalers, by supporting the use of devices with a lower carbon footprint.
Key objective 4: 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.

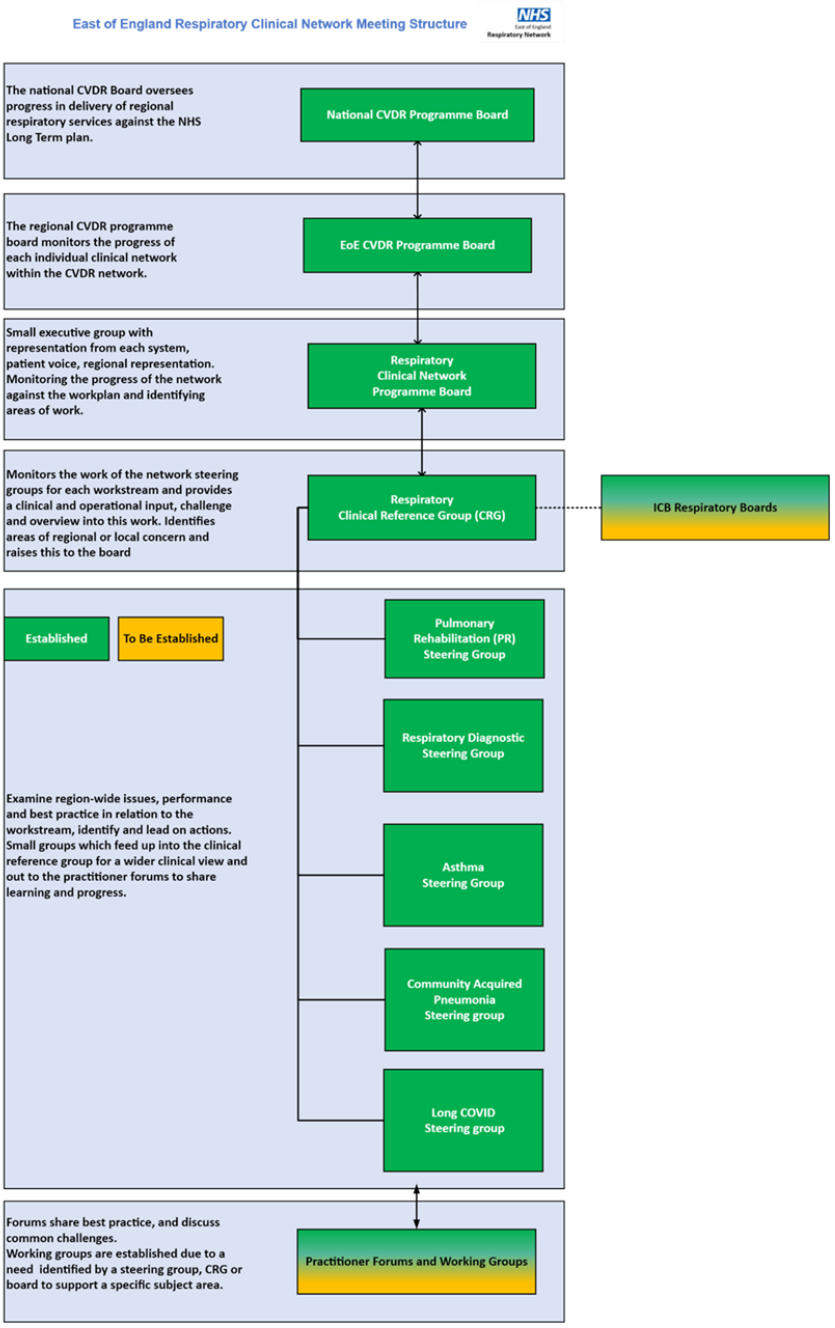
5. Community Acquired Pneumonia:
Key Objective 1: To support systems to make improvements to the LD annual health check.
Key Objective 2: To support the reduction in the number of preventable pneumonia deaths
Key objective 3: To support the improvement in pneumonia vaccination rates in vulnerable groups

6. Long COVID:
Key Objective 1: To support the transition of Post COVID services to BAU models by April 2025

7. ILD:
Key Objective 1: To ensure that patients have fair and equal access to treatment by supporting the development of ILD services.

Network Governance

New steering groups were established, and existing ones developed and strengthened. Stakeholder engagement with systems and partners remained strong throughout 2023-24 with support forums for initiatives such as Acute Respiratory Infection (ARI) hubs provided to systems.



Network Budget

The network receives funding from the national team for staffing and additional monies to support targeted programmes in the systems:

1. Staffing budget

Network Staffing

Funding Allocation Description	Amount
Network substantive staffing	£202,459
PMO support costs	£93,491
Clinical Leads	£32,286
Patient/carer representatives	£1,104

Targeted funding for specific projects (out to systems)

Funding Allocation Description	Amount
Spirometry Training	£100,000
PR Quality Assurance	£90,000
Localised projects in pulmonary rehabilitation	£55,000

5. Renal Clinical Network

Renal Clinical Network

The East of England (EoE) Renal Clinical Network was commissioned by specialised commissioning NHS England East of England in 2022-23, the network team were recruited in 2023-24. In line with the Renal specification, the purpose of the network is to improve the quality of care for renal patients in the region, improve patient experience and equity of access to care. Priorities set out for the renal network include.

- Supporting restoration and recovery of renal services
- Promoting equity of access, addressing, and reducing health inequalities
- Increasing the autonomy and wellbeing for those living with kidney disease
- Improving the quality of care, including outcomes and patient experience, across the whole care pathway
- Collaboration within the network and sharing learning with stakeholders.
- Value in healthcare

The network achieves these aims by providing strategic oversight and direction in line with the NHS Long Term Plan, the National Renal Get It Right First Time (GIRFT) recommendations and the recommendations of the Renal Services Transformation Plan (RSTP). The role of the renal network is to focus on priority service areas to bring about improvement in the quality and equity of care and outcomes of their population, present and future. By connecting commissioners, providers, professionals, and patients across the renal pathway of care the Network also facilitates sharing best practice and innovation and assists with the measurement and benchmarking of quality and outcomes to drive improvement.

Network Team

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

Dr Praveen Jeevaratnam
Clinical Lead, EoE Renal Clinical Network

Mansi Khadia
Renal Network Manager

Gail Murray
Commissioning Manager, East of England Specialised Commissioning

Lauramay Lawrence
Nursing Lead

Harwinder Singh
Admin Support (from July 2023)

Dr Vivian Yiu
Acute Kidney Injury Lead

Dr Poorva Jain
Chronic Kidney Disease Lead (from August 2023)

Dr Dominic Summers
Transplant Lead

Dr Michael Fawzy
Dialysis Lead

Dr Gowrie Balasubramanian
Systems Working Lead

Olivia Kanka
High-Cost Drug Optimisation Lead (from November 2023)

Dr Rachel Jones
ENKID Clinical Lead (from October 2023)

Network Priorities

Our vision at the East of England Renal Clinical Network is to improve care and quality of life for people with kidney disease, supporting early identification and prevention of kidney diseases. The network aims to deliver excellence in all aspects of care and will achieve this by working collaboratively with patient representatives, professionals, providers, and commissioners with each Integrated Care System (ICS) in the East of England. The network will encourage quality improvement initiatives; identify and reduce inequality of access to optimal care; drive out unacceptable variation in pathways of care and share good practice.

The network aims have been agreed nationally and are underpinned by the Renal Services Transformation Programme (RSTP) and the outcomes of the Renal Medicine Get It Right First Time (GIRFT) specialty report. These are:

- Reducing variation across pathways of care by harmonising the patient journey, using data to provide evidence for change.

- Reviewing, standardising and implementing clear pathways, establishing a baseline of current practice and encouraging opportunities to identify quality improvement initiatives across the following identified workstreams:

    - Acute Kidney Injury (AKI)
    - Chronic Kidney Disease (CKD)
    - Dialysis
    - Systems Working
    - Transplantation
    - Eastern Network for Kidney Inflammatory Disease (ENKID)
    - Nursing
    - High-Cost Drug Optimisation

Underpinning the priorities, the objectives for the network are to:

- Ensure that renal patients are treated in the right place at the right time, improve patient experience and improve equity of access to care.
- To deliver a joint approach to support the implementation of the identified Renal Network priorities.
- Improve and standardise delivery of renal care across the region.
- Disseminate and implement best practice across the region.
- Influence and implement national policies and pathways and adapt to local priorities.
- Encourage clinical engagement between renal services and other related clinical services/specialties.
- Work with key stakeholders to focus on quality improvement, reduce unwarranted variation, and ensure sustainability and viability of renal services.

East of England Region

The East of England Region has 7 dialysis centres and 14 satellite dialysis sites. The region has 1 transplant centre (Cambridge University Hospitals NHS Foundation Trust) and 2 work up / follow up units (Lister Hospital and Mid and South Essex NHS Foundation Trust).

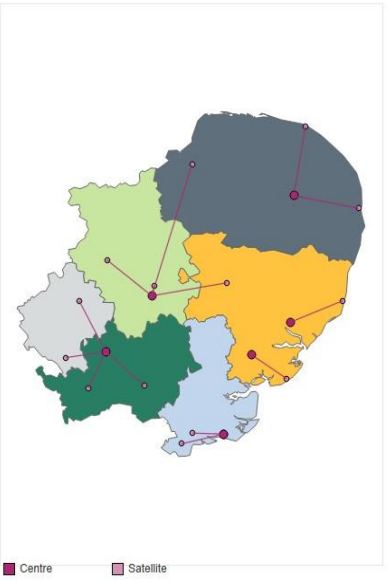
Dialysis - Centres and satellites

NHS England

Within the East of England region there are currently **7 centres** and **14 satellite sites** providing dialysis services.

East of England | Dialysis centres & satellites

NHS Cambridgeshire and Peterborough ICB	Hinchingbrooke Health Care NHS Trust	Hinchingbrooke Hospital	RQQ31	Satellite	
	Cambridge University Hospitals NHS Foundation Trust	Addenbrooke's Hospital	RGT01	Centre	
		Cambridge Dialysis Centre	RGT1Y	Satellite	
NHS Mid and South Essex ICB	Basildon and Thurrock University Hospitals NHS Foundation Trust	Basildon University Hospital	RDDH0	Satellite	
		Orsett Hospital	RDDH1	Satellite	
	Mid and South Essex NHS Foundation Trust	Mid and South Essex NHS Foundation Trust (Site Unknown)	RAJ00	Centre	
		Southend Hospital	RAJ01	Centre	
NHS Norfolk and Waveney ICB	James Paget University Hospitals NHS Foundation Trust	James Paget University Hospital	RGP75	Satellite	
	The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	The Queen Elizabeth Hospital	RCX70	Satellite	
	Norfolk and Norwich University Hospitals NHS Foundation Trust	Cromer Hospital	RM131	Satellite	
		Norfolk & Norwich University Hospital	RM102	Centre	
NHS Hertfordshire and West Essex ICB	The Princess Alexandra Hospital NHS Trust	The Princess Alexandra Hospital NHS Trust (Site Unknown)	RQW	Satellite	
	West Hertfordshire Teaching Hospitals NHS Trust	St Albans City Hospital	RWG03	Satellite	
	East and North Hertfordshire NHS Trust	Bedfordshire Renal Unit	RWH06	Satellite	
		Lister Hospital	RWH01	Centre	
		The Chiltern Kidney Centre	Z9H2M	Satellite	
NHS Suffolk and North East Essex ICB	Clacton Dialysis Unit	Clacton Dialysis Unit	GCX02	Satellite	
	East Suffolk and North Essex NHS Foundation Trust	Colchester General Hospital	RDEE4	Centre	
	West Suffolk NHS Foundation Trust	West Suffolk Hospital	RGR50	Satellite	
	Ipswich Hospital NHS Trust	Aldeburgh Hospital	RGQ03	Satellite	
		The Ipswich Hospital NHS Trust	RGQ02	Centre	



List of centres and satellites is based on submitted lists from regions in April 2023.

Network performance and achievements

The Network has made significant progress in 2023-24 by developing and enabling effective collaboration through governance arrangements, providing a forum for sharing of best practice and promoting effective clinical leadership with the aim of achieving continuous improvement. Eight workstreams clinical leads were identified and appointed:

Key themes highlighted from the network launch event - What support would the ICSs/Trusts/Providers like from the EOE Renal Clinical Network?

"Integrating services and work collaboratively" "Trust visits".

"Networking and create awareness of new practice".

"To highlight the need for MDT working and input"

"Data to support future service development."

"Help with data for benchmarking".

"Linking up units with best practice results with those needing improvement" Receiving some key performance data highlighting best practices from various units in the region would be beneficial".

Patient Reported Experience Measure (PREM)

The kidney PREM is run by The UK Kidney Association in partnership with Kidney Care UK. The measure is collected annually and is open to all patients receiving care at a renal centre in the UK.

The network shared the findings of the UK Kidney Association led Patient Reported Experience Measures (PREM) report and encouraged PREM Champions within the region to participate and improve the feedback for the PREM survey 2023-24. The network facilitated a regional webinar on Using the Patient Reported Experience Measure (PREM) to promote quality improvement initiatives.

Engagement with patient representative – UK Kidney Care Association

The network programme board has representation from the National Kidney Federation allowing an opportunity to influence ongoing network objectives and priorities. Some of the regional priorities highlighted through regular meetings with the UK Kidney Care Association leads addressed the following regional variations.

- Dialysis capacity and infrastructure
- Hospital transport & variation in implementation of the reimbursement offer for patients using their own transport for in centre haemodialysis.
- Transplant patients travelling long distances as we have one centre for transplant and 2 centres for follow up.
- Psychosocial support across the region
- Patient support groups / peer support networks

"We at Kidney Care UK have been delighted to work with the East of England Renal network. The network leads interest in patient-centred work, and consulting with us on dialysis transport survey has been straight to the point."

"We were able to bring kidney patients experiences directly to the network, as well as the work of the Kidney Care UK patient support and advocacy team. The network also helped in addressing the psychosocial needs of people with kidney disease".

Fiona Loud
Policy Director Kidney Care UK

Psychosocial stocktake:

The network undertook an audit from the main EoE renal units to identify the provision of psychosocial support across the region. We were unable to gather the information from all the units but from the units that we did receive an update, there was clear variation in the provision of psychological support available for patients which varied across the trusts.

Renal Network workstreams

1. Eastern Network for Kidney Inflammatory Disease Programme (ENKID)

The network supported the ENKID programme and secured funding for the Multi-disciplinary Team coordinator role and Clinical Leadership role. The ENKID functions support:

- Regular bi-monthly MDT meetings for complex case discussion in collaboration with NHSE Pharmacy to ensure appropriate use of High-cost drugs.
- Forum for expert discussions on complex renal autoimmune cases and high-cost drug approval.
- Kidney focused MDTs for rare autoimmune disease.
- Better governance, documentation of advice and follow up.
- Potentially enables delivery of care closer to home.
- Standardise care pathways for inflammatory disease affecting the kidneys.
- Equity of access to high-cost drugs.

2. High-Cost Drugs and Medicine Optimisation

The primary objective of the pharmacy workstream is to ensure equity of access to high-cost drugs and novel medication in nephrology for all patients in primary care and secondary care.

The network has established a pharmacy steering group, which has excellent engagement across the region. The group discusses the latest guidance, implementation of local policy, identifies areas of variation within the region and shares best practice. The steering group is attended by pharmacy leads across all the EoE renal units.

The network recruited a High-cost Drug Optimisation lead in October 2023. Key achievements include:

- Collaborating in data collection for new drugs in nephrology (Avacopan and Roxadustat), presenting the findings at the Royal Pharmacy Group conference.
- Establishing Green Formulary status for dapagliflozin/empagliflozin for all ICBs across the region.
- Sharing implementation plans/guidelines for drugs
- Updating the CKD pathway for primary care
- Establishing a collaborative approach to issues and risks.

3. Renal Nursing

The workstream aims are:

- To enable effective collaboration of nurses across the region.
- To identify nursing challenges through an established nursing community of practice forum.
- To work collaboratively to identify gaps, shared learning and explore opportunities for improvement initiatives.
- To develop study days for nurses across the region. Two events were held in 2023/24.

A workforce and training needs assessment was undertaken to identify education and training needs.

4. Acute kidney Injury (AKI)

The aim for year one of the AKI workstream was to establish oversight of current services and sharing of resources to inform a regional service specification for AKI.

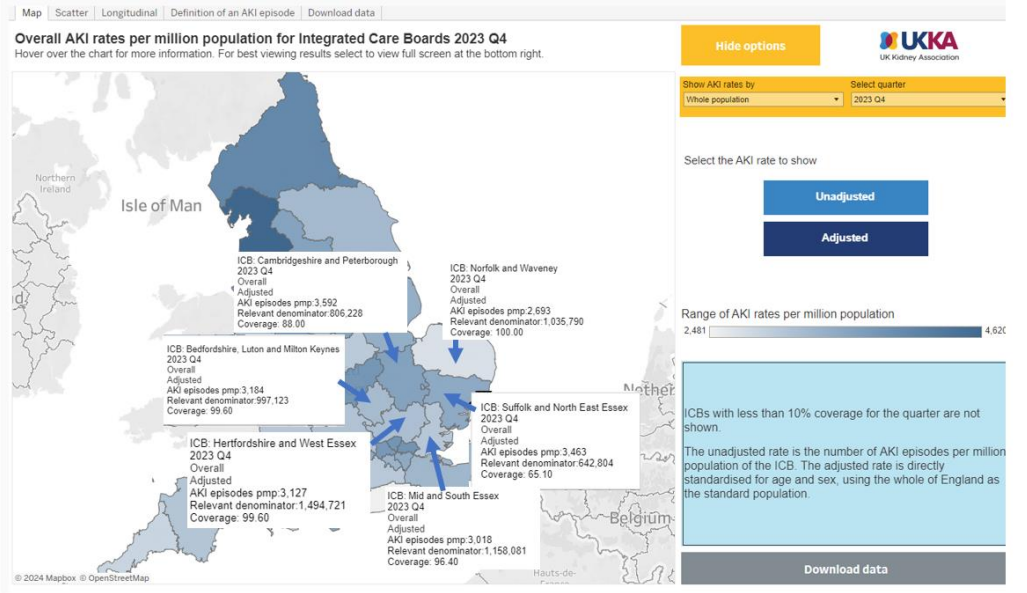
The network conducted a baseline audit to develop a deeper understanding of AKI services across the region. A regional resource library was developed for patient information leaflets, medication guidance cards and guidelines for regional colleagues to access and utilise the EoE Renal FutureNHS webpage.

A steering group has been established with a view to standardising the management and care for AKI across the region. The purpose of this AKI steering group is to share best practice and learning, identify and develop regional objectives for AKI, develop standardised materials together and identify and address, gaps and develop mitigation plans. The baseline audit identified key themes, including:

- Post discharge care, early identification, education
- Training and education for multi-professional colleagues
- Sick day rules and educating patients, carers, primary care and community teams
- Wider communication and plan for AKI focus week via social media etc.
- Engagement with community, GP and primary care colleagues
- Aligning local priorities with the renal toolkit
- AKI focus week

A webinar on AKI detection, management, and next steps was attended by 130 colleagues across primary and secondary care. The webinar provided an opportunity to discuss potential areas for closer working with secondary care to enable earlier detection and management, as well as any educational materials for colleagues, patients, and their families.

Overall AKI rates per million population for the 6 ICB's in the region



Data source: UKKA Data Portal

5. Chronic Kidney disease (CKD)

CKD affects 6-10% of adult population (~ 3 million significant CKD) and risk increases with age. An estimated 30% of people effected are not coded in the GP record. 1% progress to end stage while the majority die from cardiovascular events as CKD is a risk factor for cardiovascular disease. The priorities for CKD workstream are to raise awareness, improve identification, recording and coding for people living with CKD.

CKD prevalence data for the East of England region

Indicator: Percentage of patients aged 18 and over with GP recorded CKD categories G3a to G5

Integrated Care System	Sep-23			
	Numerator	Denominator	Value (%)	Statistical Significance
Bedfordshire, Luton and Milton Keynes	6,760	18,485	36.6	Lower
Cambridgeshire and Peterborough	8,860	20,255	43.7	Higher
Hertfordshire and West Essex	13,175	39,365	33.5	Lower
Mid and South Essex	10,385	34,870	29.8	Lower
Norfolk and Waveney	16,750	38,965	43.0	Higher
Suffolk and North East Essex	17,020	40,440	42.1	Higher
East of England	**72,950**	**192,380**	**37.9**	-
England	**781,925**	**1,933,034**	**40.5**	-

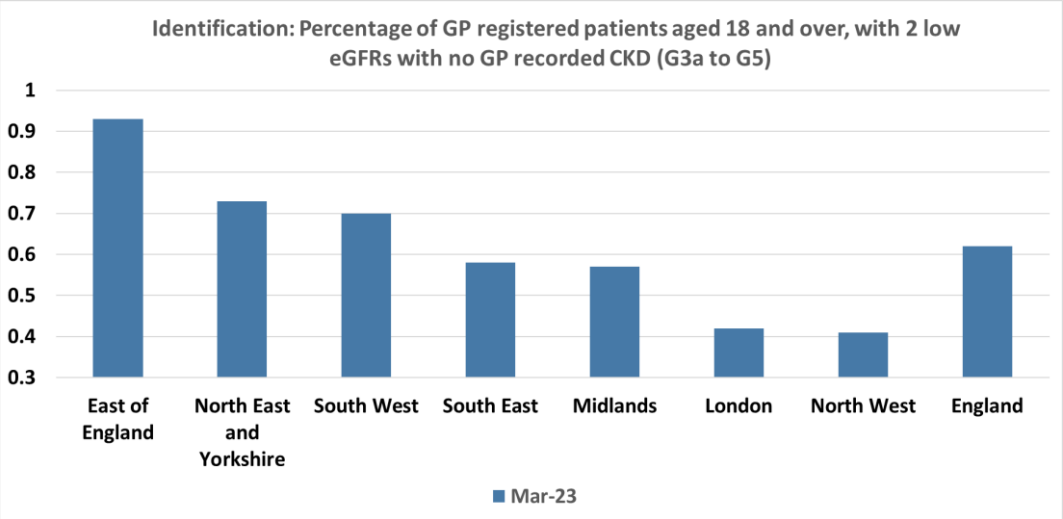
Key
Statistically similar to benchmark (East of England)
Statistically significantly higher than benchmark (East of England)
Statistically significantly lower than benchmark (East of England)

Data source: CVD prevent data

A CKD webinar was facilitated by the network and attended by 154 colleagues across both primary and secondary care. The webinar provided information on simplifying CKD management and how to work collaboratively to improve outcomes for patients with CKD, with a key focus on improving recognition and identification of chronic kidney disease. Areas covered in the webinar were:

- Identifying CKD patients and the Kidney Failure Risk Equation (KFRE)
- Simplifying CKD treatment and targets
- Benefits to the patients (and cost effectiveness)

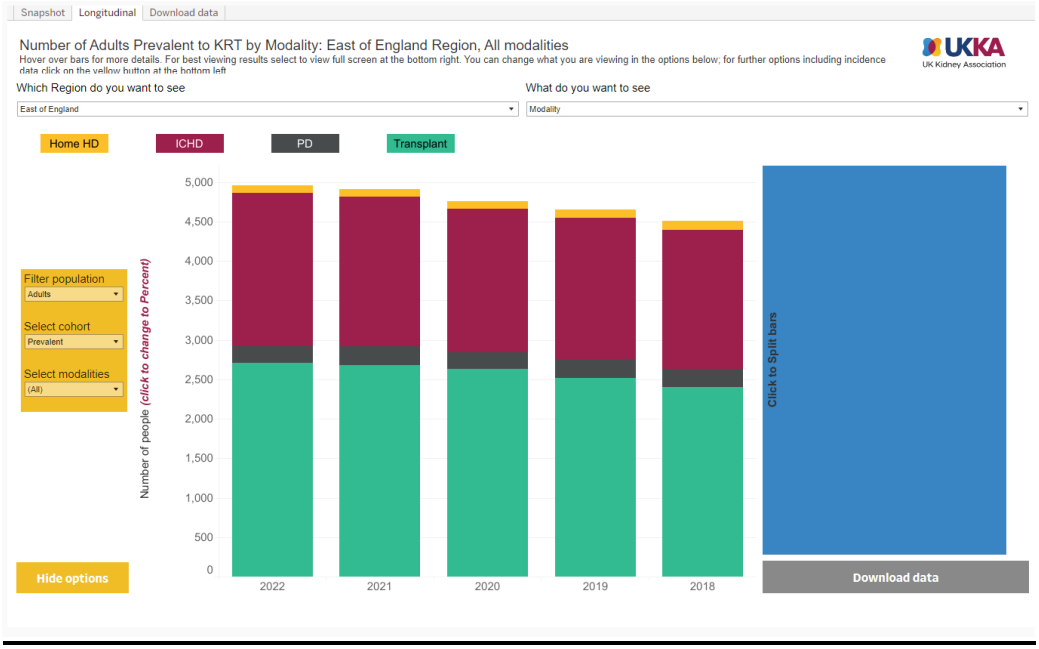
An area of concern is the potentially low identification and recording of CKD. This will be an area of focus for the workstream going forward. The region has a seemingly low prevalence (CVDPrevent), but a potentially high unrecorded diagnosis of CKD on baseline assessment.



Data source: CVD Prevent

6. Dialysis

There are more than 4900 patients who require kidney replacement therapy in the East of England. The number of patients on home dialysis is low compared to the national target of 20%, which puts increased pressure on dialysis units.



Data Source: UKKA Data Portal

The network established a Dialysis Task and finish group to identify, assess and mitigate the barriers to improving the uptake of home dialysis within the region including;

- Evaluating the regional resources and standardised patient education information through the FutureNHS repository – including Advance Kidney Care Pathway & unplanned pathway (Patient choice and education options).
- Baseline information in September 2023 to identify whether all units had guidance/process in place for utility reimbursement for patient on HHD (home haemodialysis) and PD (peritoneal dialysis). All 5 renal units in the region had a process in place for reimbursement.
- Baseline assessments were developed and completed by regional leads to identify current provision of vascular access across the region and uptake of home dialysis. Following the baseline assessments, the network initiated Vascular task and finish groups to share the findings and engage with providers to establish improvement opportunities and share best practice. The aim of the task and finish groups is to identify variation, challenges and barriers, and to develop Quality Improvement programmes for the region.

Data source: UKKA Data Portal

7. Transplant

The overall objectives for this workstream are:

- To improve access to transplantation - fairer, faster and more effective.
- To improve the evidence base for recipient selection using networkwide collaboration.

The network facilitated and organised a regional Transplant Education Symposium in March 2024 with attendees from full wider multidisciplinary team. The education day included an initial discussion on the transplant referral pathway guidelines for the region. A transplant subgroup will be initiated in 2024/25 to agree regional referral guideline. The referral guidelines aim to minimise the variation in pre-referral tests and investigations to the transplant centre.

8. System working

The systems working workstream looked specifically to improve quality of care to minimise progression of kidney disease and improve experience across the kidney patient journey in EoE.

Funding was secured through the innovation funding process for “Embedding patient activation in advanced kidney care”, which supports and encourages patient selfcare.

The transport task and finish group was established and aimed to identify ways to improve current transport services for incentre haemodialysis patients. The group included leads from dialysis units , transport providers and Integrated Care Boards (ICBs). A survey was distributed to patients attending weekly incentre haemodialysis sessions to gather their opinions on current transport provisions and explore alternative options.

The survey results provide useful insights into patient preferences for transport to haemodialysis sessions but should be viewed cautiously. The sample size is small, representing only a portion of the patient population attending incentre haemodialysis so it may not fully reflect the broader experience.

- **Response Rate**: Out of 170 respondents, 71% indicated that they use hospital transport or transport provided by the dialysis unit as their preferred mode of travel.
- **Preference for Hospital Transport**: Among those who use hospital transport, 80% stated that it was the only mode of transport they would choose, even if they were offered reimbursement for fuel or travel expenses.

In summary the survey indicated that there is a **high dependence on Hospital Transport:** Most patients rely on hospital or dialysis unit-provided transport and show a strong preference for it.

Limited Interest in Alternatives: Even with the option of reimbursed travel costs, most patients prefer the convenience and reliability of the provided transport service.

Limited clarity and knowledge about whether the dialysis unit offers **travel reimbursement.**

9. Sharing Best Practice

The network held a variety of face-to-face events and webinars during 2023/24

Face to face events:

- Renal Clinical Network Launch and Research Event, 23rd May 2023.
- Renal Nurse study day, 19th October 2023.
- Renal Clinical Network and Research Event, 30th November 2023.
- Renal Nurse study day, 29th February 2024
- Transplant Symposium,19th March 2024.

Webinars:

- PREMS QI event - Joint webinar with Kidney Quality Improvement Partnership (KQIP) on 14th February 2024 attended by PREMS champions from EoE renal units.
- CKD virtual webinar on 23rd January 2024 joined by 154 colleagues.
- AKI virtual webinar on 13th March 2024 joined by 130 colleagues.

Key Challenges

Data: Obtaining appropriate data to support the network priorities of establishing baselines and to identify and monitor variation remained a challenge throughout 2023-24. Renal units across the region have different clinical systems and the functionality of collecting live data into the Renal Registry is not yet established across the region. The network encourages providers to review and

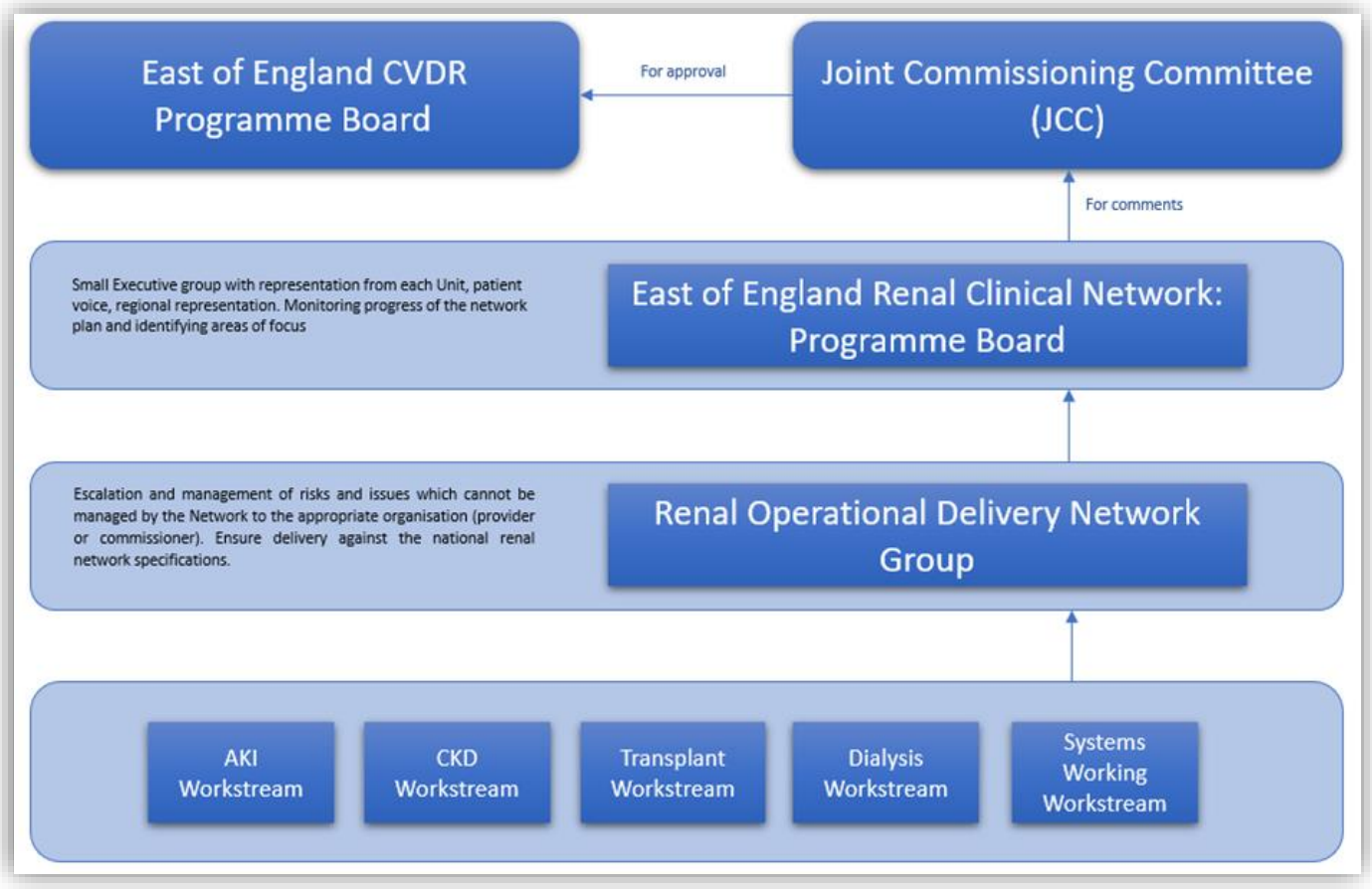
align clinical systems to the data feed requirements that will be established in 2024-25 and is set out by the UK Renal Registry guidance letter.

Recruitment: Delays in recruitment to key posts impacted on the progress of the overall objectives of the network.

Delegation of renal services to the ICB: Renal dialysis was one of 59 Specialised Services to be delegated from Specialised Commissioning to the East of England ICBs. With this change in the commissioning of services and the development of a new renal network, identifying and engaging with the appropriate person in each of the ICBs has been challenging. ICB commissioning and promotion of integrated services for renal patients is key to the improvements required in the renal pathway.

Network Governance

The network plan was agreed and signed off at the CVDR programme board and shared with Joint Commissioning Committee for sign off. The network programme board meets quarterly to review network progress against the work plan, review any risks and steer strategy.



Areas of Focus for 2024/25

1. **Overall Network Plan**
- Develop 2024-25 plan
- To promote RSTP developed self-assessment questionnaire toolkit (SAQ) resources and guides to the renal units and speciality workstreams, AKI, Transplant, CKD, and Dialysis. RSTP Self-assessment questionnaire toolkit (SAQ) - The SAQ has been developed for use by both clinical and non-clinical, who could be providers, commissioners, renal network members and other system partners who are keen to drive improvements withing renal services.
- Workforce analysis
- Progress update on Innovation projects

2. **Eastern Network for Kidney Inflammatory Disease 'ENKID' programme**
- Share learning and outcome of the programme

3. **High-Cost Drugs and Medicine Optimisation**
- Green Formulary status for finereone for all ICBs across the region.
- Establish channels with the ICB for potential education with primary care re CKD pathways.
- Ensure equal access to high-cost drugs across the region.

4. **Renal Nursing**
- Workforce capacity – establishment against standards and vacancy rates. What does the variation look like across the region. Issue with recruitment/retention.
- Skills gap analysis
- Exploration of advanced nursing roles
- Feedback from patients – what do patients see as gaps in service, what could be improved.

5. **Acute Kidney Injury (AKI)**
- Identify focused quality improvement projects
- Sick day guidance
- Increase frequency and availability of AKI education for multiprofessional teams across the region
- Establish regional AKI follow-up criteria and Improve discharge process and follow up for patients with AKI
- Regional AKI focus week

6. **Chronic Kidney Disease (CKD)**
- Improve CKD recognition and coding
- Identify and engage with Primary care leads to promote the uptake of UACR
- Working with the CVD Prevent team, campaign to raise awareness for UACR and eGFR testing
- Accessing data about Urine ACR in primary care and improving uptake
- Improving uptake of KFRE in primary care

7. **Dialysis**
- Undertake Dialysis demand and capacity using PLCM dataset
- Improve access to home dialysis and reduce the variation in uptake of home dialysis across the region
- Promote shared care access
- Education and share best practice i.e. Lister home dialysis education is working very well
- Improve access rates

8. Transplant
Optimising the model of care and transplantation pathways to address waiting times and embedding a transplant first approach to improve patient outcomes
- Stakeholder meeting for referral pathway guidelines
- Development of referral guidelines
- Analysis and presentation of repatriation data post-transplant
- Transplant Education Symposium in March 2025
- Ongoing support for Pharmacy group with Dailiport roll out
- Further development of research programme if successful with grant

9. Systems Working
- Provide support and share learning from the outcomes of the innovation projects funded by the network

Network Budget

The Renal Network is funded through Specialised Commissioning on a recurrent basis with additional funding provided for the ENKID workstream.

Due to delays in recruitment to network posts, an underspend was accrued over two years. It was agreed by the Network to ask for Expressions of Interest from each of the 6 systems for Quality Improvement projects that would improve renal care for our patients. 14 applications were received and evaluated, this included projects demonstrating quality improvement initiatives / trial period for activity that will lead to improvement in area of care, equity of access, health inequalities, integrated approach, service delivery, education and workforce development.

The following 6 projects were selected through a fair evaluation process:

- Improving Access to Kidney Transplant using Dietary & Lifestyle Interventions, ENHT - £6,357
- Embedding patient activation in advanced kidney care, MSEFT and ENHT - £50,000
- Development of a Renal Simulation Programme, ENHT - £14,400
- Web-based renal referral portal, ENHT - £42,210
- CKD – Reaching out to primary care, ESNEFT- £48,054
- Kidney Beam - An exercise and lifestyle management app designed to help people like you live well with kidney disease. Free to access for the entire EoE region - £19,800.

Network staffing:

Funding Allocation Description	Amount
Annual allocation for staffing the network and support staff	£191,590 (excluding hosting fee)*
Underspend 21-22	£88,442
Underspend 22-23	£194,484
23/24 funding	£191,590 (excluding hosting fee)*
Total available funding in 23-24	£474,516

*Hosting fee = £12,000

6. 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 Integrated Care Systems (ICS) and other key stakeholders, including Diabetes UK.

In 2023/24, 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, promotion of diabetes prevention, Type 2 Diabetes Remission, and roll-out of the Type 2 Diabetes in the Young Programme.

Network priorities for 2023/24

Priorities were similar to those in 2022/23, 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 2023/24:

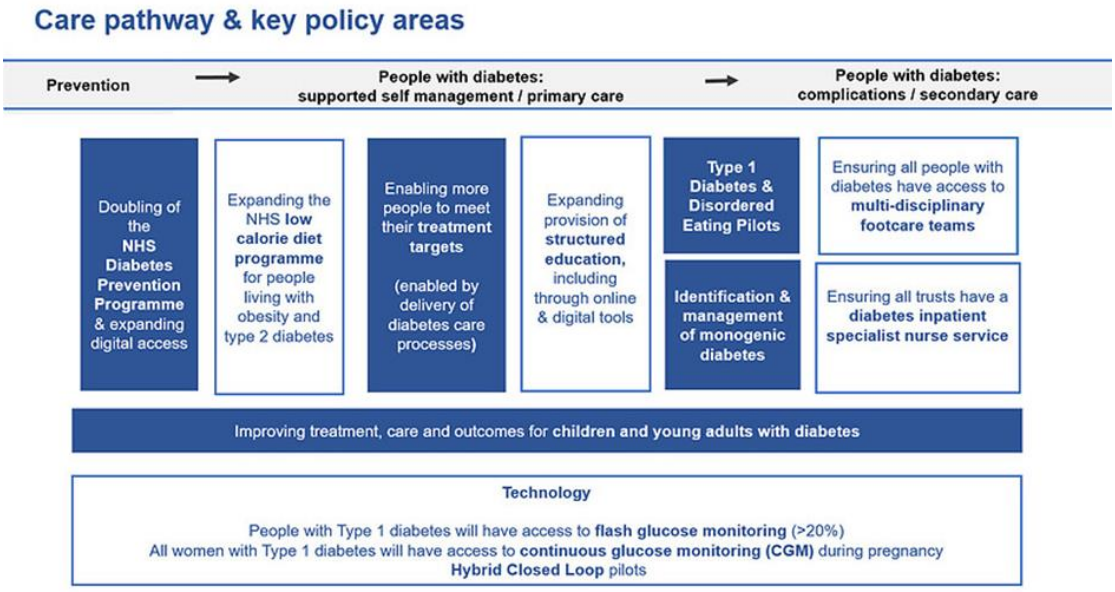
1. Restore the identification, monitoring, and management of all types of diabetes to pre-covid levels.
2. Increase primary care referrals to the NHS Diabetes Prevention Programme across all ICBs *(LTP).*
3. Increase and support uptake of primary care referrals to the NHS Type 2 Diabetes Remission (T2DR) programme.
4. Support people with diabetes (aged 18-39) to access nationally commissioned Type 2 Diabetes in the Young (T2Day) programme.
5. Support people with diabetes to access nationally commissioned digital structured education programmes *(LTP).*

Other national and local priorities include:

6. Ensuring people with Type 1 diabetes can access Hybrid Closed Loop systems for managing blood glucose levels in line with new NICE Guidance (TA 943, December 23).
7. 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.
8. 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).*
9. 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

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

10. Type 1 Disordered Eating (T1DE) pilots – awarded summer 2022 with ongoing monitoring and support.
11. National roll-out of the 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.
12. Increase the delivery of the Diabetes 8 Key Care Processes and achievement of 3 Treatment Targets.
13. Secondary care pathways – offer a face-to-face launch event for the East of England Secondary Care Forum and develop regional quarterly meetings with topics to be covered based on feedback from the launch event.



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

As an integral member of the East of England Transformation Board and Clinical 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. Diabetes UK have enjoyed working collaboratively and productively with East of England NHS England on several projects and initiatives.

Collaboratively with East of England NHSE organised a Footcare Conference in April, with over 100 Healthcare Professionals & Commissioners attending. We secured commitment of over 50 pledges from delegates to improve footcare across the East of England and to assist with the re-establishing of a new regional Footcare Network to reduce foot ulcerations and minor and major amputations. Also, collaboratively delivered a Secondary Care Conference in December, with 80 Healthcare professionals and commissioners attending, with Keynote presentations from Professor Partha Kar and Professor Gerry Rayman.

We have been supporting Mid & South Essex Integrated Care Board over the last six months to improve numbers of patients having their annual reviews & 9 care processes that have not attended Primary Care practices during the last 2 or 3 years.- Mid & South Essex Integrated Care Board set up a Transformation Team, and Diabetes UK have supported this team at a series of events, resulting in over 1,000 diabetes reviews being undertaken, resulting in a significant increase to those receiving the 9 Care Processes. Worked with BLMK on a preconception initiative, involving the upskilling of pharmacy staff, co designing a leaflet which has been adopted by ICBs across the region, and translated into South Asian & Eastern European languages.

Diabetes UK Midlands & East successfully delivered their Diabetes in Pregnancy UK Conference in November to over 800 healthcare professionals. East of England NHSE were very supportive in promoting the conference across the region's ICBs and Maternity Units, and the preconception work was showcased by Sanhita Chakrabarti, Deputy Medical Director at BLMK. Also, Diabetes UK worked with BLMK and their four Healthwatch organisations in running a successful Community Champion programme.

We held a Living with Diabetes Day in Norwich in collaboration with Norfolk & Waveney Integrated Care Board. 80 people with diabetes attended, and the event was part of a wider Patient and Public Involvement initiative funded by East of England NHS England, which Diabetes UK have been delivering over the last year. This has included as part of the Patient & Public Involvement funding from East of England NHSE, organising over 12 Living with Diabetes Days. Another part of the initiative was the provision and distribution of 6,000 patient information packs across the six East of England ICBs, supporting and empowering patients with a knowledge of what care to expect, and signposting to local services including Talking Therapies.

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

DIABETES UK
KNOW DIABETES. FIGHT DIABETES.

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.

3. Increasing provision of 'routine' care processes

We have increased the provision of 'routine' care processes with a focus on reducing variation and targeting inequality. All ICBs have shown significant improvement in care process attainment - the East of England generally tracks above the England average for these metrics (see below tables for comparison).

ICB (patients who had received all 8x Care Provisions in Jan 2022 – Mar 2023)	People with type 1 diabetes	People with type 2 diabetes
ENGLAND AVERAGE	**40.5%**	**57.8%**
MSE	36.5%	46.5%
BLMK	38.1%	56.6%
SNEE	59.3%	70.0%
HWE	40.6%	56.9%
N&W	38.8%	59.0%
C&P	42.7%	57.9%

People with Type 1 diabetes *who received all 8 CPs in East of England Jan 2023 – Mar 2024:* ***46.8%*** *(England average = 44.3%)*	***People with Type 2 diabetes*** *who received all 8 CPs in East of England Jan 2023 – Mar 2024:* ***62.2%*** *(England average = 62.3%)*

ICB (patients who had received all 8x Care Provisions in Jan 2023 – Mar 2024)	People with type 1 diabetes	People with type 2 diabetes
ENGLAND AVERAGE	**44.3%**	**62.3%**
MSE	34.4%	46.1%
BLMK	45%	62.1%
SNEE	64.3%	73.9%
HWE	46.9%	64.7%
N&W	42%	61.9%
C&P	48.2%	64.5%

3. Increasing referrals and uptake to the Diabetes Prevention and Type 2 Diabetes Remission Programmes with a focus on reducing inequalities

Overall, referrals and first attendance to a recognised diabetes prevention programme in the East of England more than doubled between Q4 in 2022/23 and Q4 2023/24. Inequalities are also being addressed.

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)
- ✓ Self-referral for people with a history of GDM to the Diabetes Prevention Programme (everywhere)
- ✓ Those from Black and South Asian communities
- ✓ Inequality due to deprivation (everywhere)
- ✓ Reducing inequality success from N&W highlighted nationally

Type 2 Diabetes Remission Programme referrals and uptake have increased regionally. Following on from the pilot phase of the programme whereby BLMK and MSE were involved, this intervention is available to the eligible population across all of England, and as of April 2024; all six ICBs are now delivering the initiative. BLMK were high achievers in the first wave of pilots, however MSE had a delayed start but are showing significant improvement:

	Started Programme	**Indicative profile and date** TDR: Total Diet Replacement phase	**Type 2 Remission TDR starts as of April 2024** *(rounded at source)*
BLMK	June 2023	500 TDR starts by June 2025	300
MSE	Feb 2024	500 TDR starts by Feb 2026	100
C&P	September 2023	500 TDR starts by September 2025	80

4. Type 2 Diabetes in the Young (T2DAY)

All ICBs in England are supporting systems to deliver improved outcomes for people with early onset Type 2 Diabetes (EOT2D) aged 18-39 years old. The majority of adults with EOT2D are cared for exclusively in Primary Care, and as the National Diabetes Audit (NDA) shows prevalence increasing yearly, the programme was developed.
The aims and intended outcomes; For people aged 18-39 years (inclusive):

1.) 1-2 extra reviews (i.e., additional to what would usually be provided for routine care) with a suitably qualified healthcare professional.
2.) to improve care of people with EOT2D and optimise glycaemia, cardiometabolic risk factors and weight, with the aim of reducing long-term complications and morbidity
3.) to support preparation for pregnancy for women with type 2 diabetes of reproductive potential who are not using contraception

National funding for this programme will continue into 2024 and work is on-going with the primary care providers and systems to promote sustainability of the service going forward.

5. Technology in Diabetes

Hybrid Closed Loop (HCL) – 'Artificial Pancreas'

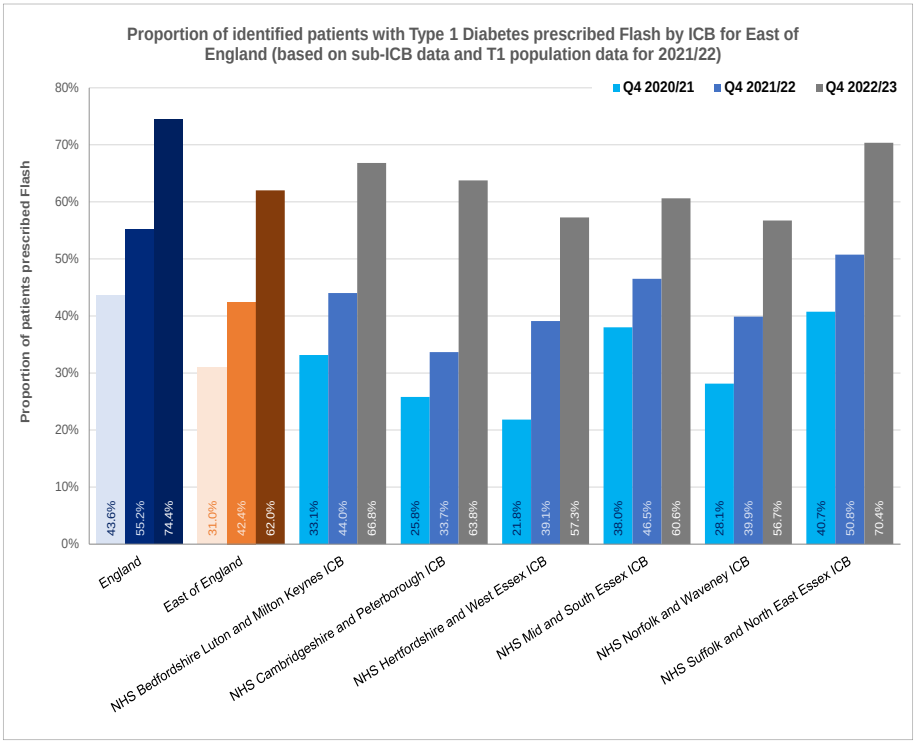
NICE approved Hybrid Closed Loop technology policies were in place in all six ICBs by December 2023. HCL technologies are the next technical advancement linking continuous glucose monitoring (CGM) and insulin pump technology, sometimes referred to as an 'artificial pancreas.' The network supported ICBs with their policies, providing information for drafts, discussing the benefits and disadvantages, and championing the NICE guidance in meetings leading to high-level discussions, including the national team.

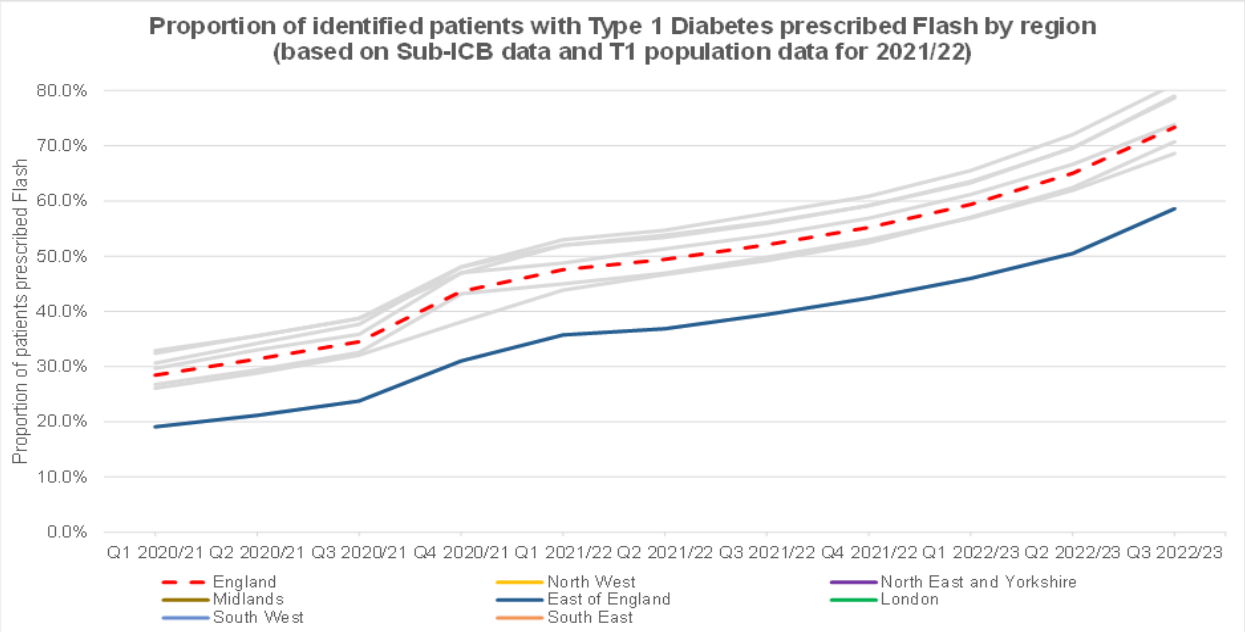
Continuous Glucose Monitoring (CGM) and Flash Glucose Monitoring (FGM)

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. By the end of March 2023 (Q4), Flash glucose monitoring in the East of England was **62%,** against an England average of **74.4%.** Due to issues with the National Diabetes Audit (NDA) Dashboard the more recent FGM metrics have not been available since March 2023.

Results for Flash glucose monitoring in people with Type 1 diabetes by end of Q4 (March) 2023:	England = 74.4% East of England = 62.0%

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





NHS England's Getting It Right First Time (GIRFT) programme has worked closely with the East of England NHSE to complete GIRFT diabetes reviews across all 6 ICB's in the Eastern region. Trusts have demonstrated good progress on rolling out many of the recommendations presented in the GIRFT Diabetes National Report. Mid and South Essex ICB also volunteered to be a pilot site for the new GIRFT Children and Young Adults Diabetes work stream. Feedback from the pilot review has helped shape the content of future reviews.

James Paget Hospital and Ipswich Hospital have both presented on their diabetes perioperative care pathways at GIRFT national webinars and are regular attendees at the monthly GIRFT Periop DSN meetings, along with West Hertfordshire Hospital. Several trusts in the East have also been involved in developing a best practice GIRFT pathway for the management of people with diabetes undergoing emergency surgery. This pathway was presented by the GIRFT team at the East of England Specialist Diabetes Forum in December, along with a workshop on self-administration of insulin and a workshop on the GIRFT diabetes interactive pathways.

The GIRFT team has also been working closely with Ipswich Hospital on writing up a quality improvement initiative on the effectiveness of a Community Diabetes Specialist Nurse (DSN) working with District Nurses to optimise insulin therapy. This has been shown to demonstrate significant savings, reduce district nursing workload and reduce patient harms, and the GIRFT programme is now looking to potentially develop this work nationally.

Emma Page
Workstream Delivery Manager, Diabetes, Getting It Right First Time (GIRFT)

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. Between January 2021 and December 2023, those offered (offered/eligible) was at 68.3%. and the uptake was 86.9%.
-
- **Type 1 Disordered Eating pilot (from Sept 2022):** The network managed the regional expression of interest process in 2022/23 and Norfolk and Norwich were successful in gaining funding for the pilot. After issues with staff recruitment and finding adequate clinic space, the pilot opted for a virtual delivery of service and the go live date was delayed until November 2023. By the end of March 2024, the T1DE pilot had received 14 referrals from the Norfolk and Waveney area, with 3 patients having completed initial assessment and on the care pathway. The network continues to provide ongoing support and assurance, including reporting to the national team.

- **Secondary Care Conference:** Conference and launch event for the East of England secondary care forums, with a focus on secondary care pathways and GIRFT recommendations including 7 day working, DEKODE, self-administration of insulin (SAM) and emergency surgery pathways, outpatients, encouraging further uptake of the DCAP accreditation process and management of complications.

- **Primary and Community Care Diabetes Conference:** Conference and launch event for the East of England nurse's forum, with a focus on structured education and NHS England funded initiatives such as DPP and T2DR.

- **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 by initiating 121 support visits to talk through ICB achievements and issues and has promoted in the use of local and national data with many of the ICBs creating diabetes databases to track progress.

Sharing Best Practice

A key highlight for the Network was hosting a 'Secondary Care' Conference in collaboration with Diabetes UK in November 2023, 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 several webinars for providers across the region.

Other key highlights include:

- The high-performing North-East Essex Diabetes Service (for primary care outcomes), care process attainment, and reducing community nursing visits.

- Mid & South Essex (for fast recovery and improvement in care process achievement) were highlighted in national forums.

- Cambridge and Peterborough for patient engagement via SMS messaging for Structured Education and their success in targeting those from disadvantaged groups.

- Norfolk and Waveney for exploring barriers and enablers to uptake in the Diabetes Prevention Programme (DPP) for ethnic minorities and people living in deprived areas.

- 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/Boards led to loss of traction in some areas of work for 2023/24.

- Lack of funding and capacity at Trust level resulted in poor uptake to the Diabetes Care Accreditation Programme (DCAP) in the East of England, with only one service signed up. Despite this, participating pilot sites (9 sites in our region) found the process helpful and have used the programme as a springboard to make improvements and a case for change in their hospitals.

- Clinical Leadership has been funded Nationally in a ring-fenced allocation to the systems for the past few years. Some systems are without clinical leadership or have clinical leads for reduced hours, resulting in system pressures to alleviate some of the challenges and create positive change. Workforce remains a struggle in many areas of diabetes care, including podiatry services. Many posts are unfilled, and this is leading to capacity issues within many systems.

Network Priorities for 24/25

1. Continue to increase the uptake in diabetes prevention through the Diabetes Prevention (DPP) and the Type 2 Diabetes Remission (T2DR) programmes.

2. Improve patient outcomes by improving uptake of the Type 2 Diabetes in the Young programme (T2Day), structured education programmes and increasing the number of patients completing the 8 care processes.

3. Supporting the national pilots for transition of care from children to adult services and Type 1 Disordered Eating (T1DE) and commence discussions with N&W ICB regarding sustainability plans.

4. Bringing a focus to the on secondary care pathways via the secondary care forum and GIRFT recommendations including 7-day working, DEKODE, self-administration of insulin (SAM) and emergency surgery pathways, outpatients, perioperative pathway (IP3D) encouraging further uptake of the DCAP accreditation process and management of complications via:
    - Improving the Perioperative Pathway for people with Diabetes (IP3D) event
    - Set up of the Self-Administration of Insulin (SAM) working group
    - Promote and encourage DCAP uptake at ICB Board meetings
    - Encourage and influence Trusts to sign up to DEKODE and Emergency Surgery Pathway GIRFT projects

5. Improving the uptake of technology for Type 1 diabetes - continuous glucose monitoring, increasing the number of insulin pumps for patients meeting the criteria and reviewing uptake to Hybrid Closed Loop systems in line with NICE Guidance via NDA data.

6. Sharing best practice – enhancing the current sharing events to include supporting the Non-Medical Prescribers quarterly meetings and supporting ICBs to identify uncoded patients via PCN level reporting to understand issue and how to prioritise. Relaunch of the footcare forum.

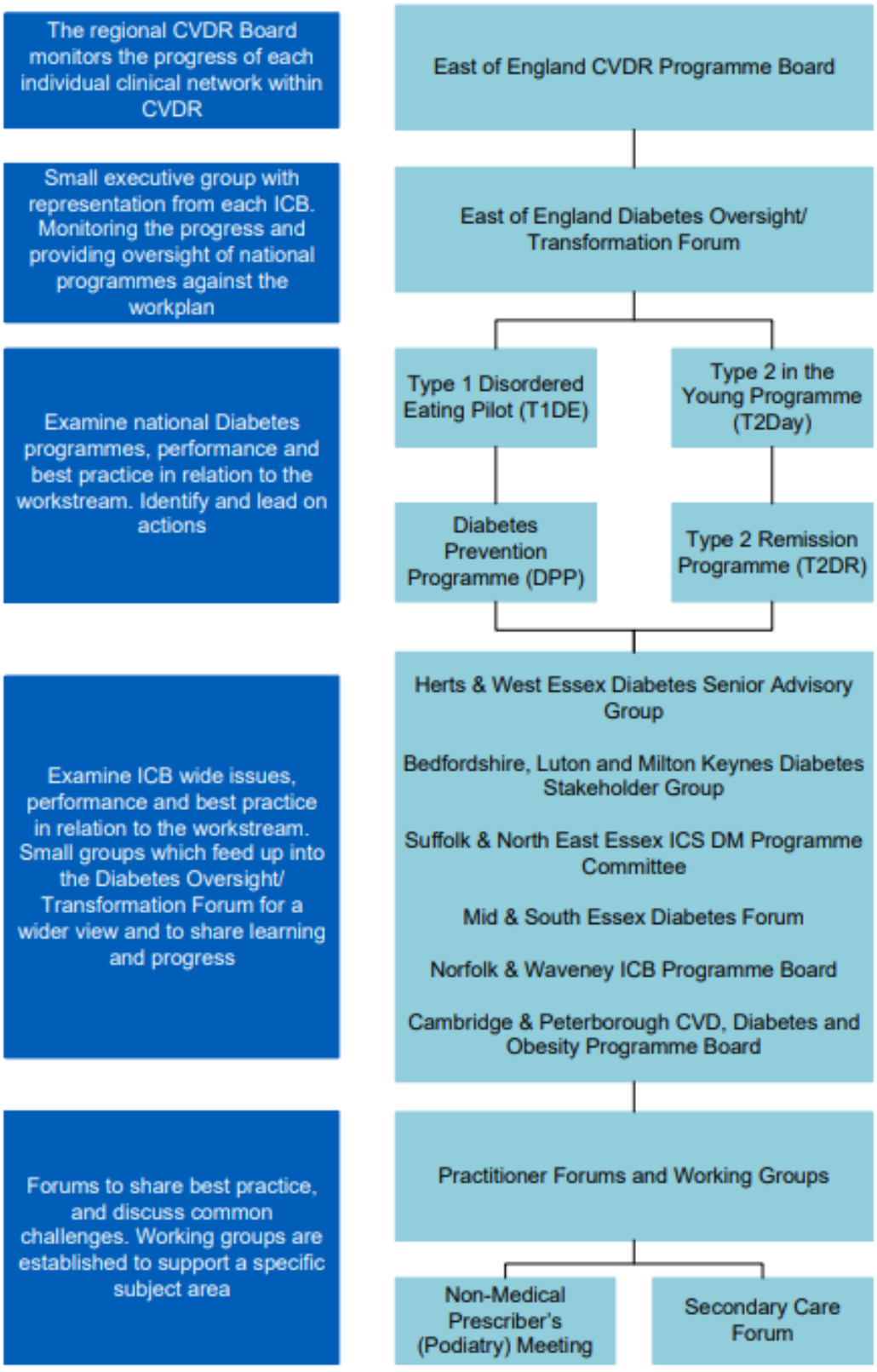
7. Workforce – linking with colleagues in the Workforce, Training and Education directorate to collaborate on plans to address workforce shortages in the diabetes pathway in primary, secondary and community care.

Network Governance

Assurance processes were set up via quarterly regional Transformation Board (combining the Oversight 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 a technology meeting with ICBs and clinical staff to discuss the Hybrid Closed Loop NICE guidance/5-year implementation strategy for diabetes discussions and hosting the '*Secondary Care'* Conference.

Regular attendance and contribution by network staff to local ICB 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. Local escalation will usually involve discussion with the national team at an early stage.

East of England Diabetes Clinical Network Governance Structure



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
Diabetes Substantive staffing	£88,156
PMO costs	£93,491
Clinical Leads	£33,815

Network costs were lower this year as vacancies were carried over into the new financial year of 2024/25

2. Targeted funding for specific projects (to systems):

Funding Allocation Description	Amount
T1DE	£270,000

The majority of funding for specific projects has now been included as part of the ICB bundle, not coming through the regional team. This includes funding for projects such as T2DR and T2DAY.

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

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

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

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

Respiratory Clinical Networks:
www.future.nhs.uk/EOErespiratorynetwork

Renal Clinical Network:
East of England Renal Clinical Network - FutureNHS Collaboration Platform

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 Clinical Networks:
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Renal Clinical Network
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