ANNUAL REPORT 2024-2025
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 2024/25 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, 2024/25 maintained a continued focus on pathway transformation to improve the quality of care, access and outcomes for patients, working with Integrated Care Systems to deliver both the national and local priorities for care.

The aim of the Networks is to deliver the national priorities for care identified in the NHS Long Term Plan as well as working with partners to identify and resolve regional issues. This year has seen a strengthening of joint working with systems, providers, other networks, voluntary and third sector organisations and patients to transform pathways of care, enhance equality of access and to optimise treatment and outcomes.

The focus for 2024/25 has been on elective recovery and urgent and emergency care pathways. Deliverables and outcomes for the networks have sought to support these objectives and provide demonstrable improvements against key targets.

I am pleased to report that across the Networks we achieved most of the key objectives planned for 2024/25, and more details can be found in corresponding sections of this report. I particularly wanted to highlight the following areas of work:

1. The implementation of Hybrid Closed Loop systems for the management of Type 1 diabetes in children, pregnancy and adults.
2. The agreed regional focus on hypertension case-finding and treatment optimization with all 6 integrated care systems working together.
3. The capacity, demand and dialysis occupancy measure for renal replacement therapy which has highlighted the future requirements for the region.
4. The vocational rehabilitation service delivered across Hertfordshire and West Essex as part of the SQuIRE programme, which has had a significant impact on the number of stroke survivors returning to work.
5. Stroke pre-hospital video triage is now live in 11 of the 15 stroke centres in the region. This represents a huge achievement in the ambition to expand the service across the region to achieve coverage at all stroke centres. Over 2,300 patients have been video triaged since the programme began.
6. Improvements in access to complex imaging in accordance with the National Optimal Stroke Imaging Pathway (NOSIP) has ensured that all patients have rapid access to rapid CT/CTA 24/7 if clinically indicated. Supported by AI, this has both expedited and

increased referrals to mechanical thrombectomy services.
7. Conclusion of the Long Covid workstream with services being moved into business as usual in the ICBs.
8. Establishment of a regional MDT for patients with Interstitial Lung Disease, working with colleagues in Health Innovation East.
9. The development of a non-medical prescribers community of practice in the cardiac network which has a NHS Futures page and holds fortnightly webinars. The Futures page has 773 members and is engaging in joint working with other networks.

We acknowledge that some areas still need improvement, and we continue to work closely with providers and systems 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 the focus on rehabilitation based in the community across all long term conditions.
- Promoting the identification, coding and early appropriate management of patients with chronic kidney disease.
- Furthering our work to reduce ED attendances and hospital admissions through integrated care pathways and optimal management of patients with long term conditions.

There have been a number of challenges to the networks and the systems as a whole this year, including the financial landscape in healthcare, and the ongoing organizational changes at both NHSE and Integrated Care Systems. 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.

With a new Government, there are opportunities for the networks to engage with systems to deliver the new Ten Year Plan with a focus on the 3 principles of focusing on prevention, embracing technology and digital solutions and moving care from acute to community models.

As always, our patients have been generous in sharing their time with us 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 and information analysts, 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 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, whereby 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 focuses on the prevention and treatment of both Type 1 and Type 2 Diabetes in order to reduce risk of complications and implement new technologies and pathways of care.

The detailed aims of the Networks are to:

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

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

Regional Team

Helena Baxter
Head of CVD, Respiratory, Diabetes and Renal Clinical Networks and Transformation

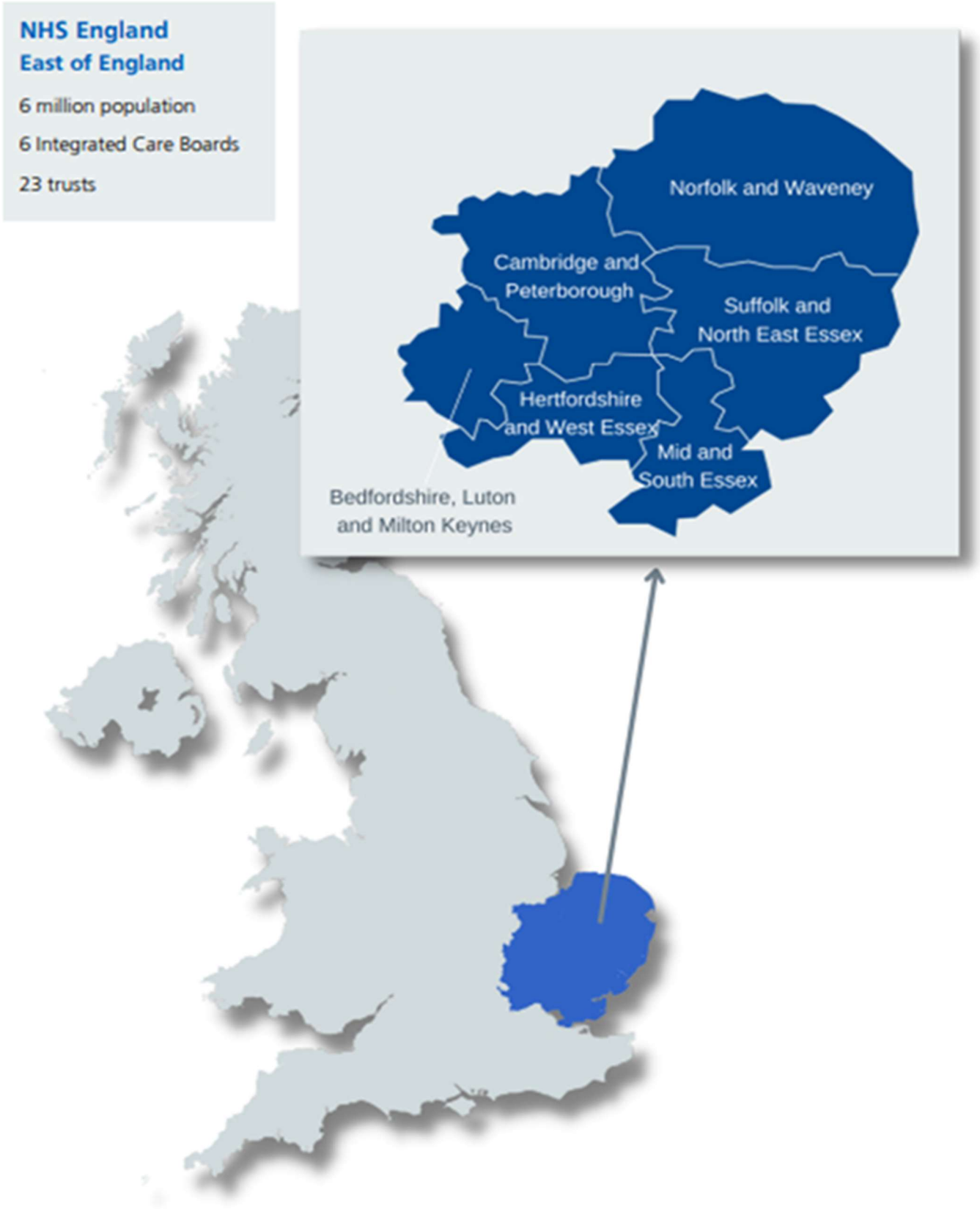
Ryan O'Neill
Senior Informatics Data Analyst

Nicola Hawdon
Patient Engagement and PPV Lead

Paula Sumray
Business Co-Ordinator/Executive Assistant

Amanda Harrington
Business Support Officer

Claire Doney
Business Support Officer



1. CVD Prevention

CVD Prevention Clinical Advisory Group

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), regional Public Health, Clinical Networks, Local Authority NHS Health Check commissioners, 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

Hypertension and cholesterol management were detailed in the 2024/25 Priorities and Operational Planning Guidance. National targets for all areas were increased for 2024/25 to reflect the importance of ongoing improvements in risk reduction for cardiovascular disease.

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) (to June 2024)

Dr Suzanne Tang
Consultant in Public Health – Prevention, NHSE (Co-Chair from June 204)

Helena Baxter
Head of Cardiac, Stroke, Respiratory, Diabetes and Renal Networks, NHSE East of England

Nick Pringle
Senior Advisor, Health Innovation East (to Feb 2025)

Kate Foxwell
Programme Manager, Cardiac Network

Amanda Harrington
Business Support Officer

CVD Prevention priorities 2024/25

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 80% by March 2025

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 65% by March 2025.

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 95%

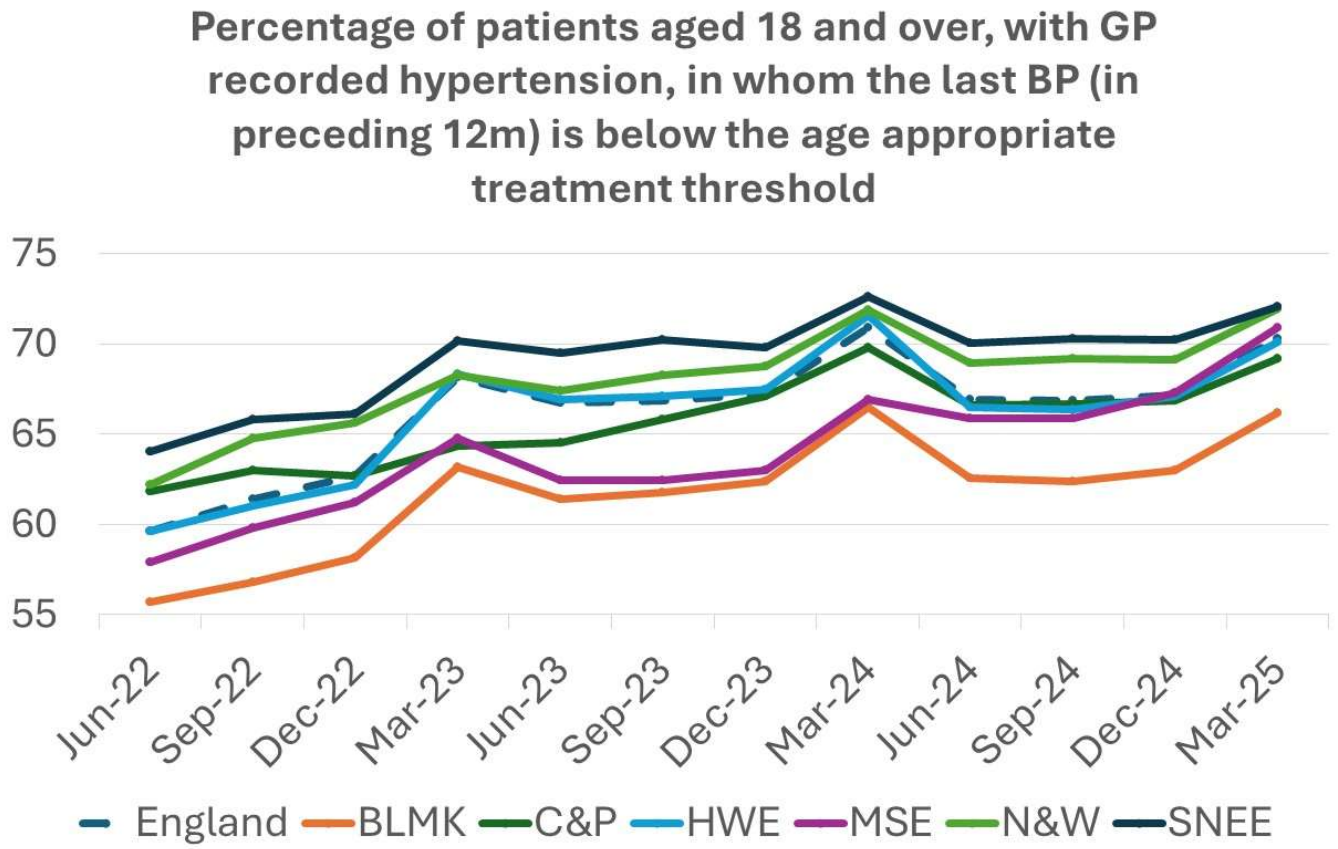
Progress and key achievements

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.
In 2024/25, the membership of the CVD Prevention CAG was widened to include Local Authority representatives to support working and engagement across the whole system in increasing NHS Health Checks (NHSHC).

2. Hypertension

High blood pressure is known to be a key risk factor in coronary heart disease, stroke and chronic kidney disease. The East of England region has been making steady progress on hypertension case finding and age-related treatment to target, however there is variation across the systems and improvement towards the 80% target of BP optimisation appeared to have slowed over the course of the year.



Data source: CVD Prevent March 2025.

The dip in performance noted after March 2024 was, in part, due to a change in data collection and reporting in CVD Prevent. In June 2024, the indicator was adjusted to include home and ambulatory BP readings. Analysis of GP practices showed wide variation across systems as well as across region for treatment to age appropriate threshold with a range of 40.6% to 92%. Although the percentage performance suggests a levelling or a dip, in real terms 181,465 additional patients were identified as having hypertension between March and December 2024, and 128,590 more patients were treated to target.

In December 2024, the Regional Leadership Team and all ICB medical directors agreed to a focus on hypertension. The CVD Prevention CAG increased meetings to monthly with task and finish groups assigned to deliver against the 6 key recommendations, led by Dr Frankie Swords, Chief Medical Officer at N&W ICB;

- Develop a region-wide communications campaign
- Engage ICP and ICB Chairs to support collaborative working and prioritising hypertension
- Population Health Management (PHM) approaches to increasing case-finding – high risk cohorts, NHS Health Checks (NHSHC), annual check for people with severe mental illness (SMI) and learning disabilities and autism (LDA)
- Evaluate effectiveness of different PHM approaches
- Develop regional guidelines and toolkit for BP optimisation
- Develop PHM approaches to identify gaps, inequalities and opportunities

By March 2024, the regional guidelines had been agreed and signed off by the Clinical Advisory Group. These are now going through local governance processes in all ICBs for adoption.

The communications group has developed localised campaigns to address local needs with plans for launch in May Measurement month and for World Hypertension Day.
Health Innovation East linked with York Health Economics Consortium (YHEC) to evaluate the effectiveness of PHM approaches. The final report is due in May 2025.
All systems are signed up and engaged with working groups to address hypertension needs in each system, together with data showing the case-finding numbers to be achieved in order to meet the ambition of finding 80% of people with hypertension by 2029.

ICB	**Target QOF prevalence for 80% diagnosis rate – ALL AGES**	Current prevalence gap to target – ALL AGES	Number of additional people to diagnose	Estimated time to achievement
Mid and South Essex ICB	**17.7%**	2.22%	28763	5 years
Bedfordshire, Luton and Milton Keynes ICB	**15.9%**	2.20%	25202	1-3 years
Suffolk and North East Essex ICB	**18.5%**	1.68%	18124	1 year
Hertfordshire and West Essex ICB	**16.1%**	2.22%	36925	1 year
Norfolk and Waveney ICB	**19.1%**	1.55%	17057	3 years
Cambridgeshire and Peterborough ICB	**15.8%**	2.36%	24940	TBC
East of England	**17.1%**	**2.07%**	**151736**	

Developed by Dr Sam Williamson, Associate Medical Director, Herts and West Essex ICB.

An important part of hypertension case finding is through uptake of NHS Health Check programme for eligible cohorts. Whilst EoE performs well against national benchmark, regional Public Health team has undertaken scoping work with commissioners to understand barriers and challenges in delivery of the programme, which has informed the development of an action plan for 2025/26 to further improve uptake and outcomes of NHS Health Checks. This has been co-produced with the East of England Association of Directors of Public Health (ADPH), however successful delivery will require collaborative efforts from across the NHS and local government. The action plan will focus on the following key areas:

- Primary care engagement with the programme
- Understand outreach models (including health kiosks) and explore opportunities for improvement
- Develop best practice approach for communication of NHSHC results undertaken via outreach providers back to primary care
- Strengthen LA access and use of primary care data, through ICB PHM approaches
- Develop best practice approach for service user communication of results following an NHS Health Check
- Regional evaluation of programme to understand impact and outcomes
- Scale-up good practice approaches e.g. public campaigns, use of bank staff

Additionally, work within the systems is continuing using new approaches to identify and manage patients with hypertension. These include;

- A case-finding and optimisation approach using Eclipse Software and community pharmacists in Norfolk and Waveney (N&W) due to start in May 2025.

- Lowestoft Healthy Hearts project with Suffolk Public Health using clinical pharmacists wot proactively engage patients to achieve BP thresholds via support and medicines optimisation.
- Extension of the dentist and optometrist blood pressure checks in Herts and West Essex, targeted work with GP surgeries and an ICB wide communications campaign (HWE)
- Development of videos and patient information for checking and reporting home BP readings in Mid and South Essex (MSE)
- SiSU health stations in Luton, Norfolk and Waveney and Suffolk and North East Essex (SNEE).
- Community outreach clinics in MSE to engage patients who are least likely to attend GP practices
- Direct support to individual practices with low performance to increase awareness and utilisation of resources to support hypertension management (Bedford, Luton and Milton Keynes).

Evaluation and extension of the regional work will continue in 2025/26.

> Joining the regional CVD networks has been a great support to our CVD prevention work in MSE. The network has provided a welcoming space for CVD leads and System colleagues to share good practice, troubleshoot system challenges and come together to work collaboratively. A good example of this would be developing a region wide Blood Pressure campaign, where the network has supported the connection of local ICBs which has led to MSE working closer with counterparts in HWE and SNEE to better utilise campaign resources and share consistent messaging and graphics across Greater Essex.
>
> **Rhiannon Vigor**
> **Health Inequalities and Prevention Manager – CVD Prevention Lead**
> **Mid and South Essex ICB**

3. Lipid management

The Operational Planning Guidance for 2024/25 increased the national ambition of treating patients with no recorded CVD and a QRISK of 20% or more with lipid lowering therapy from 60% to 65%. Additionally, across the East of England we set out to support the cholesterol management of those with CVD, through secondary prevention initiatives to improve lipid lowering therapy uptake, and cholesterol management through medicine optimisation. Work alongside Health Innovation East through the Lipid Optimisation and FH steering group help with these initiatives, including the Position Statement on Lipid Lowering Strategies.

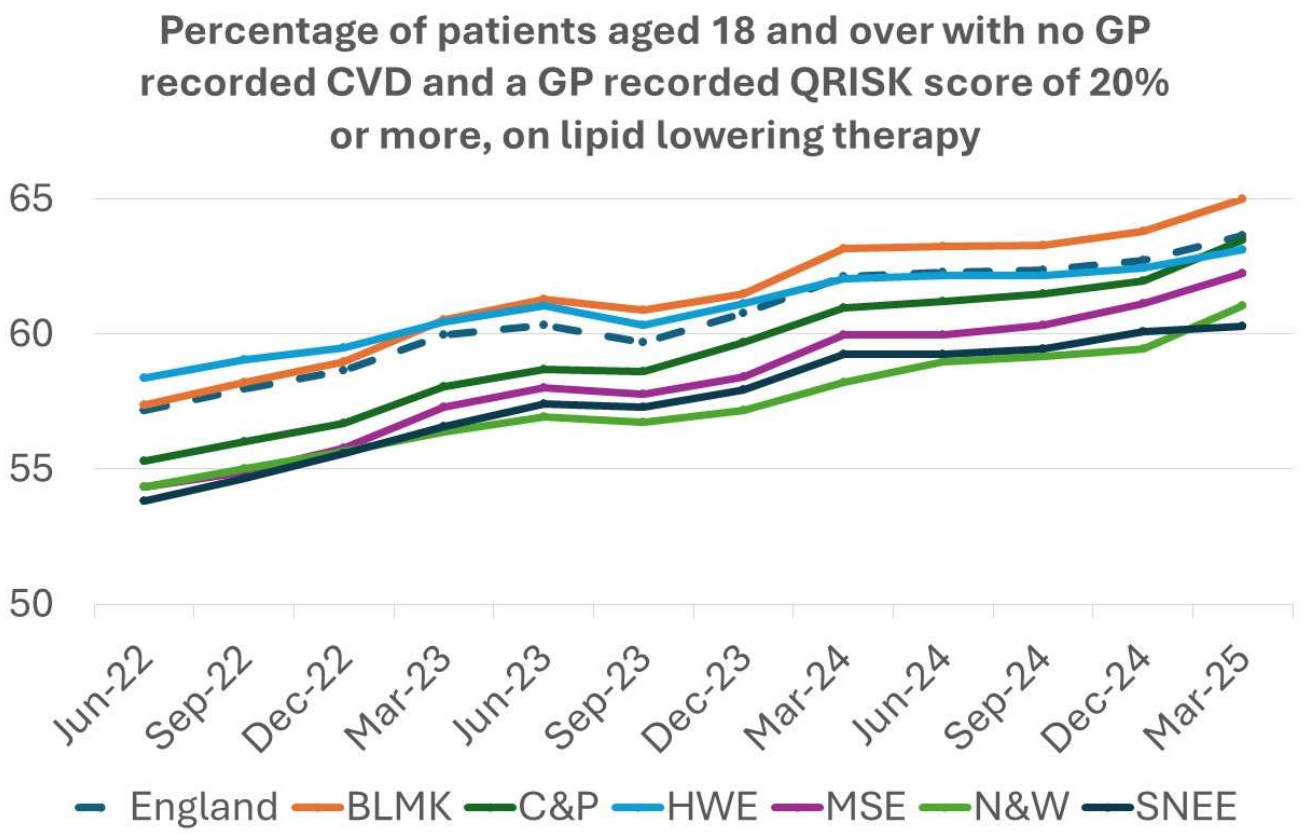
Areas of improvement in the region include:

- Cambridgeshire and Peterborough launched their *Your Healthier Future* PHM programme initially looking at managing cholesterol, with a focus on high risk patient identification and

text messaging to encourage patients to engage in lifestyle changes and lipid lowering therapy.

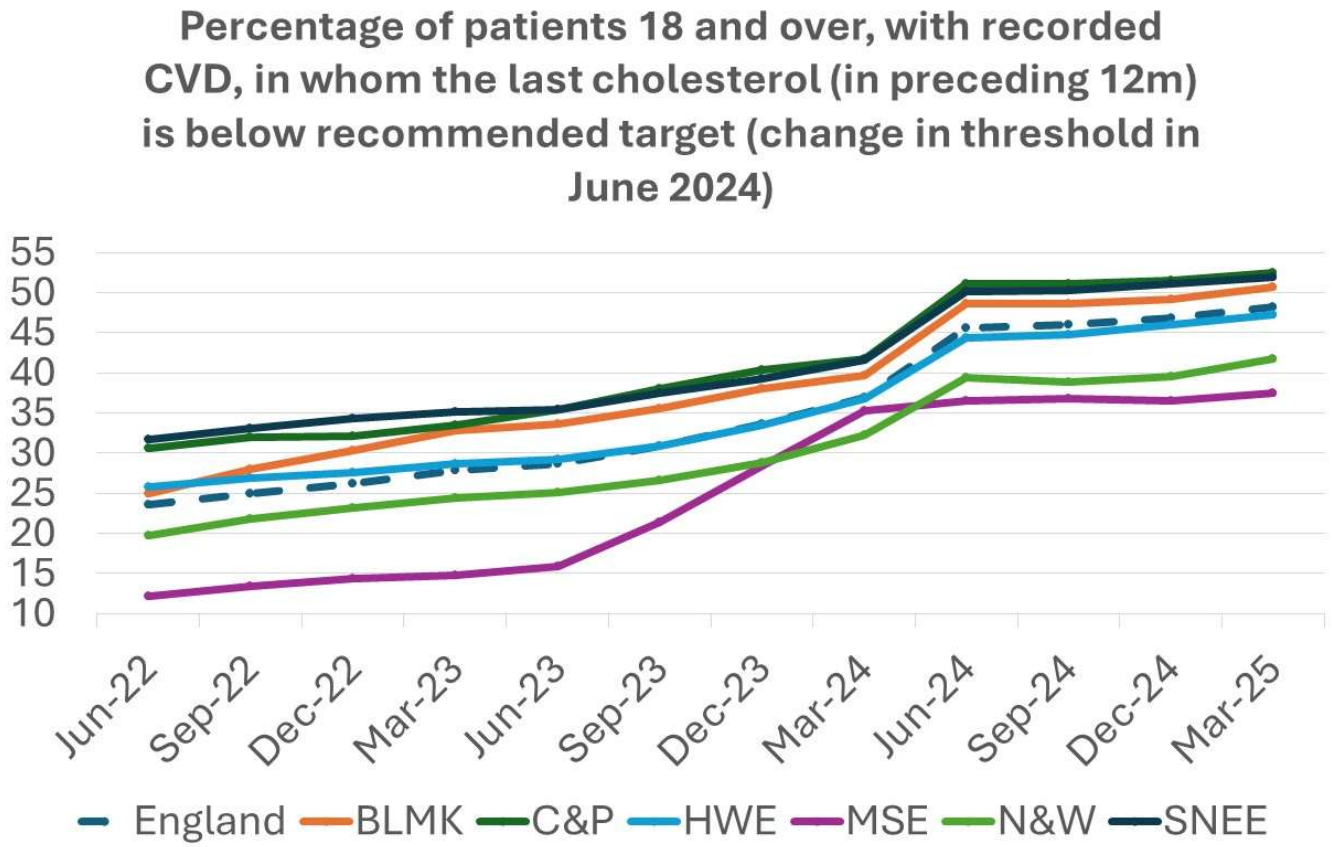
- Norfolk and Waveney ran a *Healthy Hearts* project in Lowestoft focusing on primary prevention in an area of higher prevalence of hyperlipidaemia. The system also secured on-going funding following the successful pilot of the Familial Hypercholesterolaemia Hub that remotely detects and manages possible instances if FH via its digital FH Hub: an innovative service managed and delivered by a clinical nurse specialist in FH and led by a consultant lipidologist at Norfolk and Norwich University Hospital.
- In 2023/24, Mid and South Essex (MSE) ICB commenced a Quality Outcomes Framework (QOF) extension in areas of highest need. This involved training and education with GP practice staff and focused on specific practices with the highest CVD need. This scheme has seen some practices doubling their percentage performance and this improvement can be seen in the regional attainment graph from CVD Prevent.
- MSE have also commenced a project looking at secondary prevention following an admission with heart disease. This project is being led by the cardiologists in the ICB.
- SNEE have been 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 working with GP Primary Choice in North East Essex to case find patients who are not optimised on a lipid pathway and support those identified as high risk.
- BLMK developed local data packs for all PCNs identifying unwarranted variation and key actions to improve practice. A successful pilot of a community lipids clinic was not continued due to budget constraints, however incentivisation for primary care has continued.
- In HWE, a pilot is being undertaken of expansion of NHS Health Checks in Black, Asian or minority ethnic backgrounds reducing the age to 30-39 years (smokers +/- BMI>30). They have continued with the development of the integrated lipids service to provide a specialised service in the community from general practice. This service is aimed at those with CVD not meeting cholesterol targets on lipid lowering therapy, patients with CVD and persistent statin intolerance and those with suspected familial hypercholesterolaemia (FH).

The work across the region has shown an improvement in 2024/25 in terms of lipid management for patients at risk of cardiovascular although further focus is needed in order to attain the national ambition of 65%



Data source: CVD Prevent March 2025

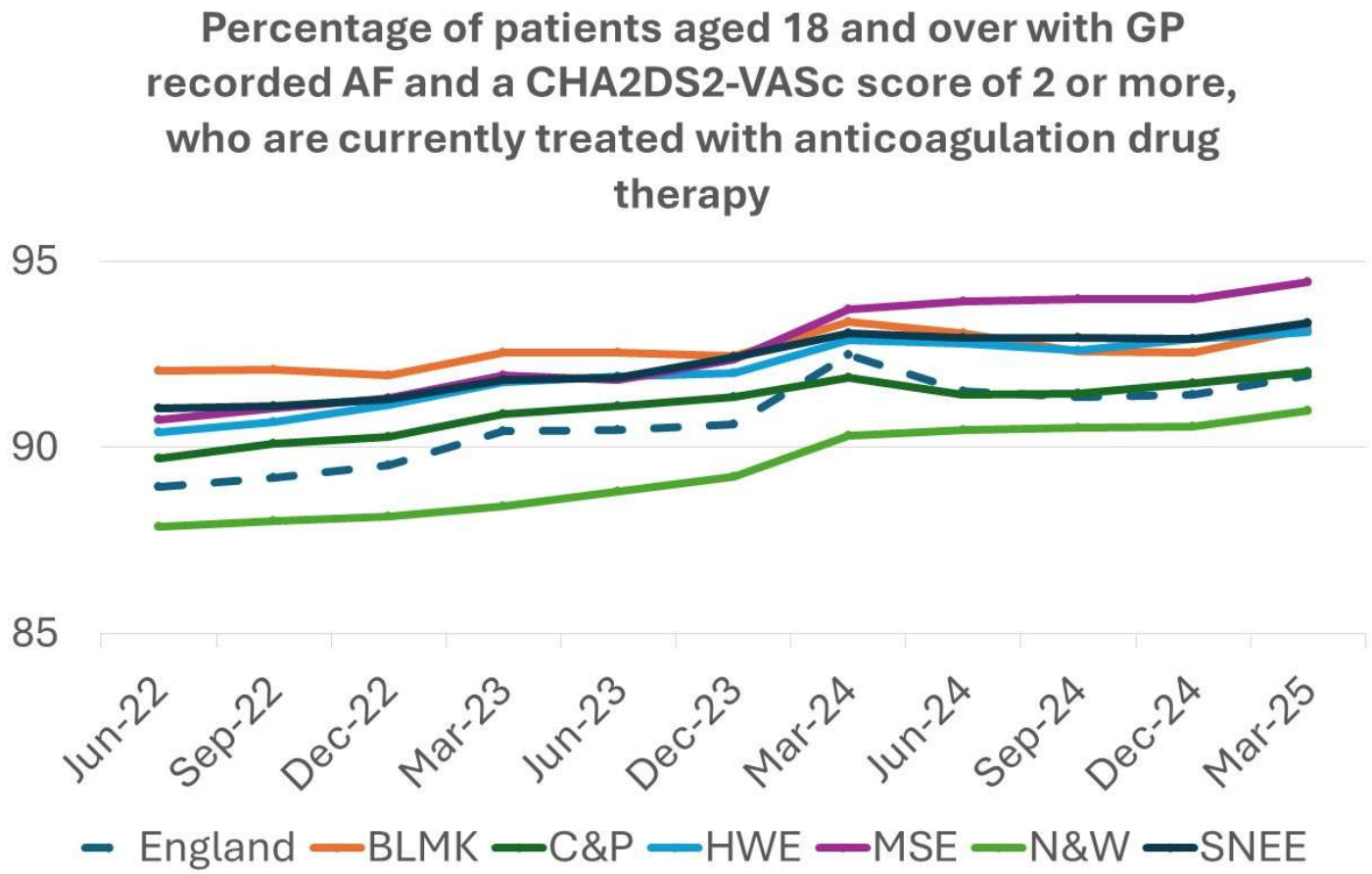
The picture is similar for patients with known cardiovascular disease being treated to recommended targets.



Data source: CVD Prevent March 2025

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, but falling slightly behind the national target of 95%.



Data source: CVD Prevent March 2025

The majority of the work of the CVD Prevention CAG for 24/25 focused on the cholesterol and hypertension elements, and no specific focus areas were identified for atrial fibrillation. System and regional achievement continues to be monitored and discussed at CVD Prevention CAG meetings.

5. Sharing Best Practice

Alongside the regular CVD Prevention CAG meetings, the team organised 2 face to face events. These took place in June and December (hypertension focus). These events encourage wider engagement with the systems and focus on reviewing the data and showcasing work from each of the systems. The events are well-attended and are considered to be of great value to the systems. Additionally, Health Innovation East and Public Health webinars and events are advertised and reviewed through the CAG.

Challenges

The CVD Prevention work faced several challenges in the last year;

- Financial challenges across the systems impacting some of the ambitions if the CVD prevention work and resulting capacity constraints in some ICB teams.

- Primary care – multiple competing pressures and concurrent workforce constraints.

- Wider case-finding in hypertension – considerable progress with pharmacy led case finding and BP@Home but issues in some areas recording this into GP systems.

Areas of Focus for 2025/26

1. Hypertension
-Focus on case finding to work towards the ambition of 80% of people with hypertension identified.
-Continue to work with systems to improve treatment to target rates (NICE guidance) to work towards ambition of 80% by March 2026.
- Increase annual health checks for people with severe mental illness and/or learning disabilities and autism.

2. Cholesterol management
- Increase the use of PHM to identify patients at high risk
- Work with systems to achieve prevention targets for those patients:
    -with existing cardiovascular disease treated with lipid lowering therapy (95%), and
    -those at risk of developing cardiovascular disease (65%) by March 2026.

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. Chronic Kidney Disease
- working with renal network and prevention leads to focus on identification and coding of patients with CKD
- Improving the management of cardiovascular risk factors (hypertension and cholesterol) in patients with CKD.

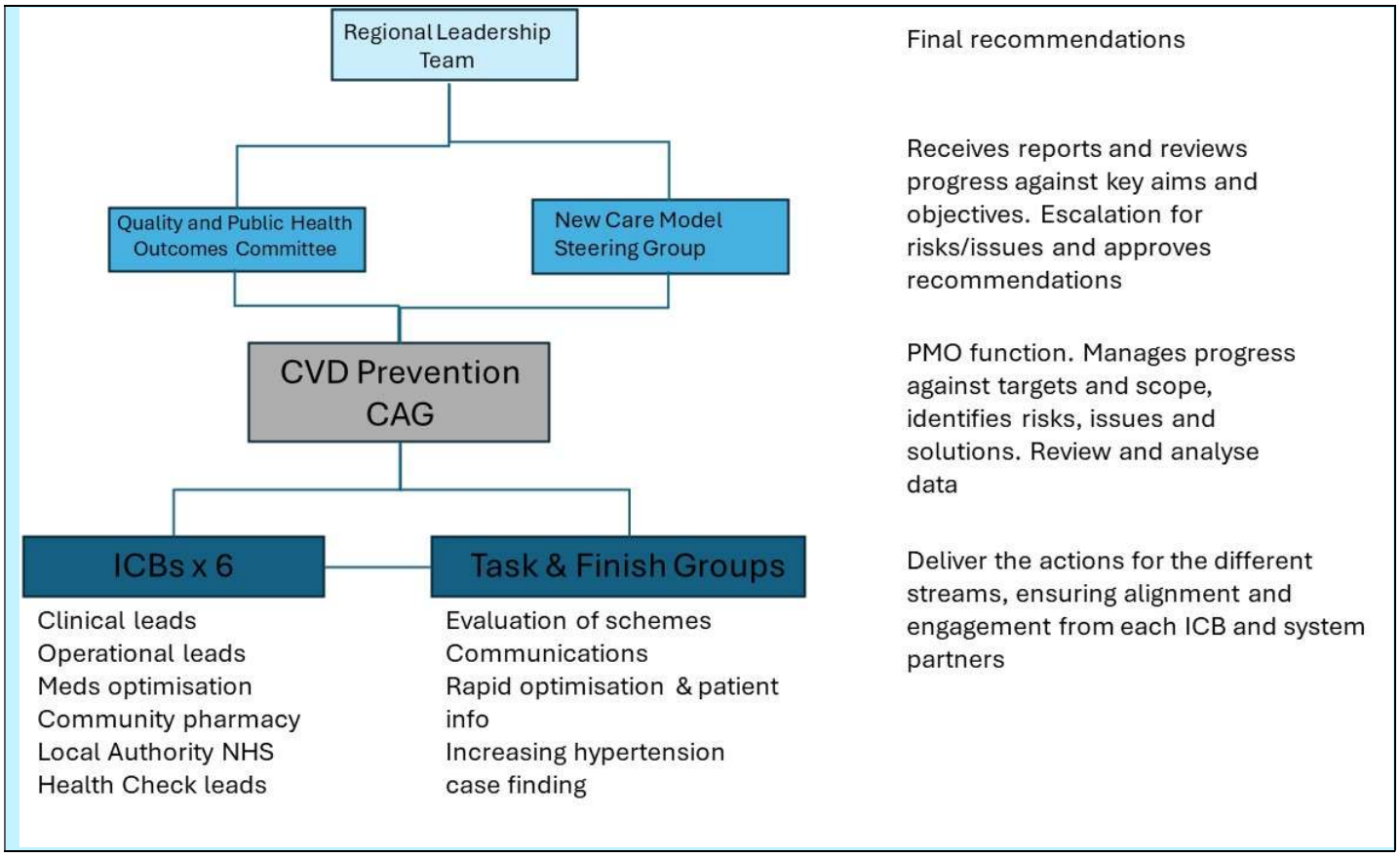
5. Scaling up
-Widening the regional work in hypertension to include lipids, atrial fibrillation and CKD.
- Identify clinical cost-effectiveness of schemes for scaling up, adoption and spread from the evaluation.

Governance

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

- Through the networks (Stroke, cardiac and renal)
- Medical Directorate Governance

In December, the regional hypertension focus was linked in with the New Care Models work. The CAG acted as the PMO for this work and the following governance structure for the hypertension work was agreed;



There is no specific network funding allocated to the prevention workstream.

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

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

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

Dr Rebecca Schofield
Clinical Lead, Heart Failure and Diagnostics (until June 2024)

Dr Rudy Duehmke
Clinical Lead, Heart Failure and Diagnostics (Commenced role November 2024)

Dr Cliona Kenny
Clinical Lead, Heart Failure and Cardiac Rehab (Commenced role January 2025)

Dr Chirag Bakhai
Clinical Lead, Primary Care and CVD Prevention

Mr Narain Moorjani
Clinical Lead, Cardiac Surgery

Mr David Jenkins
Clinical Lead, Cardiac Surgery

Miss Alessia Rossi
Clinical Lead, Cardiac Surgery

Kate Foxwell
Programme Manager

James Fishlock
Project Manager - Cardiac Rehab and Surgery

Amanda Harrington
Business Support Officer

Nick Pringle
Programme Manager for Specialised Commissioning (from February 2024)

Mansi Khadia
Project Officer

Amanda Harrington
Business Support Officer

Network Priorities for 2024/25

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. (See section on CVD prevention)

Additional priorities for the East of England network include:

1. Improved referral pathways into cardiology outpatients and better communication between primary and secondary care
2. Increase of Discharge Medicines Service referrals in region
3. Establishment of Non-Medical Prescribers Community of Practice for all NMP's within region.

Network performance and achievements

For 2024/25, the network had a series of workstreams designed to ensure we met the outlined priorities across:

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

A key focus was to improve communications within specialities across the region. The Network is ideally placed to be a conduit for bringing professionals together and to support this, we have spent time improving our NHS Futures page, making it fit for purpose and useful as a communication tool for clinicians. Over the past year we have increased the membership from 50 to 231 and have generated numerous conversations, allowing clinicians to seek answers and information from their counterparts and avoiding duplication of effort. Clinicians can see where there are educational opportunities hosted by the network, can share learning, access standard operational protocols and look at group and educational presentations and recordings. We have had positive feedback from across the region and plan to ensure this platform continues to be updated and remains relevant and useful.

We have also taken great strides to collaborate with other Networks and partners across all our workstreams such as ICB's, Health Innovation East and industry partners to collaborate, reduce duplication of work and ensure all our efforts are shared far and wide, across the region and clinical disciplines, as well as developing partnerships with charitable sector stakeholders such as Pumping Marvellous.

> Our relationship with the East of England Cardiac Network is a model that others could emulate. While the outcomes desired by all stakeholders may seem straightforward—essentially, common sense—achieving those outcomes can sometimes feel like navigating a complex path filled with obstacles. The Pumping Marvellous Foundation has collaborated with the Network for several years since the COVID pandemic, and their sharp focus helps to address many of the challenges we face. This collaboration enables all stakeholders to work together with minimal friction, resulting in significant benefits for both the healthcare system and patients. It also helps to maintain momentum. Working with this team has been one of the highlights of my experience in the NHS. (**Nick Hartshorne-Evans BEM, CEO Pumping Marvellous)**

1. Diagnostics

The focus of the diagnostics work for the network in 24/25 has continued from the previous year to prioritise

1. 100% coverage of NTproBNP across the region.
2. Reduce waiting lists and improve access within 6 weeks for echocardiography.
3. Optimise the regional offer for cardiac CT.

NT ProBNP

The Network provided funding for Milton Keynes to have access to NTproBNP and though this has not been completely successful, the trust has utilised some of the offer by providing tests within the acute setting. NT Pro BNP is available across the rest of the region.

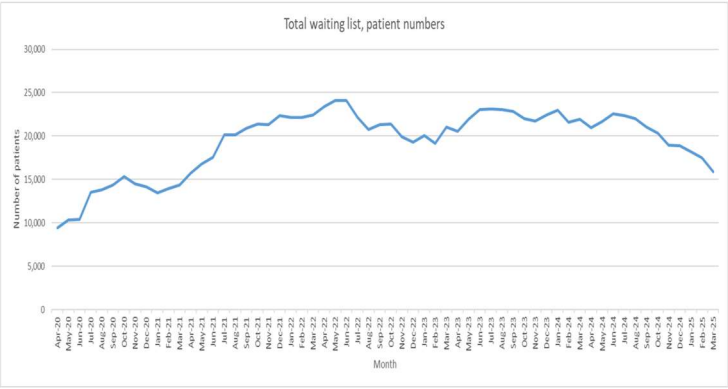
Echocardiography

Quarter 4 saw the echo waiting list fall below 20,000 patients for the first time since the COVID pandemic together with sustained reduction in people waiting longer than six weeks. This can be, in part, attributed to innovation happening across the region, such as the focused echo pilot at The James Paget Hospital in Norfolk and Waveney. These scans can be completed in 30 minutes and are diagnostic of heart failure. The results showed that by using focused echo scans for patients specifically with an elevated NTproBNP, they could perform an extra 4 scans per session and reduce the waiting time for referral to scan from >6 months to <1month. The plan is to roll this out to Queen Elizabeth Hospital and the Network has shared the findings and standard operating procedures across the region and on the futures page to encourage other trusts to consider adoption of this model.

Other examples of innovation have been rigorous referral triage in Cambridge and Peterborough and ICB deep dive support to reduce long waiters in Herts and West Essex.

Additionally, the network collaboration with Astra Zeneca on delivering the Harmony Project came to an end during 2024/25 with evaluation showing that though in the East of England, it did not have the same level impact on echo waiting lists as demonstrated in previous projects such as in Scotland, it has helped in creating links with system clinicians, enabling ongoing conversations and a focus on standardising referrals.

East of England Provider Total, Echocardiography – Waiting List Performance (Number Of Patients), April 2020 – March 2025

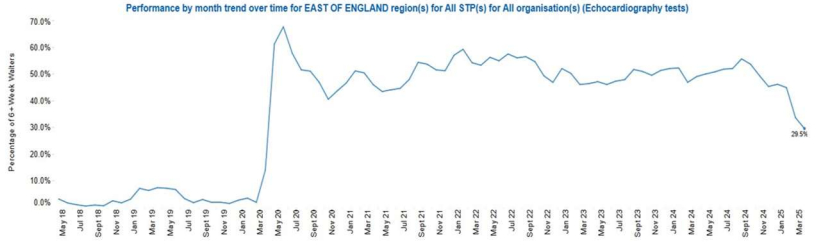


Most recent 12 months

Month	Number	% Change from previous month
Apr-24	20,932	-4.6%
May-24	21,690	3.6%
Jun-24	22,568	4.0%
Jul-24	22,343	-1.0%
Aug-24	21,988	-1.6%
Sep-24	21,047	-4.3%
Oct-24	20,364	-3.2%
Nov-24	18,977	-6.8%
Dec-24	18,853	-0.7%
Jan-25	18,172	-3.6%
Feb-25	17,513	-3.6%
Mar-25	15,859	-9.4%

Source: NHS Diagnostics Waiting Times & Activity Dashboard, Diagnostics Waiting Times and Activity Dashboard: Performance Summary - Tableau Server (england.nhs.uk)

East of England Providers, Echocardiography – Waiting List Performance (% 6 week waiters), April 2018 – March 2025



Last 12 months

Month	% of 6 week waiters	% Point Change from previous month
Apr-24	50.0%	1.0%
May-24	50.7%	0.7%
Jun-24	51.8%	1.1%
Jul-24	52.0%	0.2%
Aug-24	55.6%	3.6%
Sep-24	53.6%	-2.0%
Oct-24	49.3%	-4.3%
Nov-24	45.3%	-4.0%
Dec-24	46.1%	0.8%
Jan-25	44.8%	-1.3%
Feb-25	33.6%	-11.2%
Mar-25	29.5%	-4.1%

Source: NHS Diagnostics Waiting Times & Activity Dashboard, Diagnostics Waiting Times and Activity Dashboard: Performance Summary - Tableau Server (england.nhs.uk)

2. Cardiac CT Angiogram

The Network established a CTCA steering group to focus clinicians on improving access to services and identifying gaps in provision.

Key Achievements for 24/25

1. A regional radiation dose audit leading to improvement recommendations and safer exposure for patients. This will be repeated in 4 months to ascertain success.
2. Completion of a regional survey, mapping current practices and facilities
3. A second CTCA education event for radiographers with full attendance across the region.
4. Clinicians now using our Futures page as a means of regional communication with sharing of Patient Group Directives, Standard Operating Procedures and information leaflets.
5. The region has signed off a standard protocol for CTCA acquisition in TAVI and is hoping to run a pilot using this in DGH's, allowing for patients to gain their scan much closer to home but avoiding duplication of acquisition and reporting.
6. CTCA in Ely CDC was also trialled and though possible, it was felt that this would only be suitable for a few select patients due to the risk of beta blocker administration, the lack of emergency care access and the higher dosing needed with a lower grade scanner. At present, further CTCA here is not planned.

We have encouraged providers to engage in peer visits with other services who have extended roles to share learning and explore the possibilities of radiographer led reporting in the next financial year.

The Network secured virtual systems reviews by the National Cardiac transformation team for each ICS in the East of England. The outcome of these visits provides a set of regional GIRFT recommendations for cardiology spanning diagnostics, including echo, CTCA and Cardiac MRI, on which to base future quality improvement and innovation projects. These recommendations will be worked through in the next financial year and will give a basis for business cases for providers. Work is already underway with increasing services in Suffolk and North East Essex and they are piloting

drugless CTCA acquisition in Newmarket Community Diagnostics Centre (CDC) to enable more patients being able to access a diagnostics scan much closer to home.

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 providers and East of England Ambulance Service Trust (EEAST to ensure we have accurate data collection to gain a clear understanding of the regional position in terms of meeting the national ambition of STEMI call to balloon <120mins target and NSTEMI 72 hour target.

Non-ST-Elevation Myocardial Infarction (NSTEMI)

Work has continued with providers to obtain monthly data for the NSTEMI dashboard. There is now regional overview of numbers of patients being treated within 72 hours. This, along with the GIRFT recommendations, will be the basis of targeted efforts in the next financial year.

In addition, we have worked with Mid and South Essex to deliver an NSTEMI pathways day bringing together all referring centres, cardiologists, specialist nurses, cardiac rehab, ICB colleagues and others, to unpick the pathways and find possible areas of improvement. This has led to optimisation of the service, including flexible scheduling and a standardised referral for all.

The day also highlighted the need to consider secondary prevention provision and therefore the same set of clinicians and stakeholders have come together in a series of face-to-face meetings to consider improvements in secondary prevention, reviewing the current data and designing a mutually beneficial pathway and protocols to ensure patients are receiving the most effective care post cardiac event. This work is ongoing but outcomes such as a QR code in all clinical settings for instant referral into smoking cessation services are already in place and being utilised.

Next steps for this work is to follow the same format for the rest of the region for both NSTEMI and secondary prevention pathways to ensure optimisation of pathways.
Royal Papworth has continued to develop their rapid NSTEMI pathway for transfer from district general hospital to cardiac centre, resulting in the delivery of a seven day service from 7am -7.30pm.

The Initiative has reduced average referral to accepting times from 2.76 days to 1.43 days (Jan 2024) and the dashboard is now showing that all patients on the pathway are treated within the 72 hour target.

Essex CTC has introduced the ATLAS pathway for NSTEMI patients. This uses virtual monitoring on the Ortus platform to allow for selected patients who meet a safe threshold to be discharged home whilst they await their procedure.

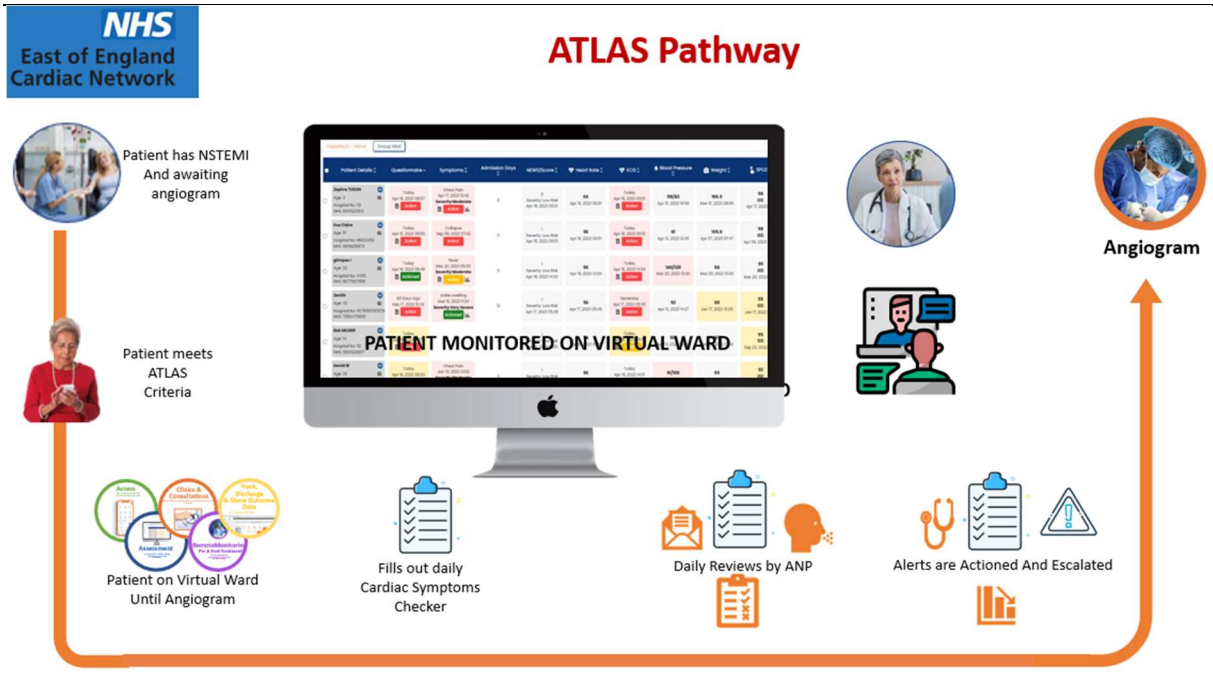


Image by Barts Health NHS trust

As expected, this has led to increased bed availability and evaluation of ten patients found 906 bed hours were saved by sending these patients home to wait, which equates to £19,631 in costs saved. Add to this the fact that in all ten patients, they used their own transport to come back to hospital, allowing for utilisation of hospital transport elsewhere and that patients are able to wait in the comfort of their own home whilst being rigorously monitored to ensure safety, the Atlas project definitely demonstrated its validity and worth as an alternative to inhouse waits for selected cohorts. . Learning from this has been shared across the region for further scale and adoption.

ST elevated Myocardial Infarction (STEMI)

The Network has been working with EEAST and providers to review and agree the PPCI regional agreement. This work is now completed and the document has been approved at the Cardiac Network board and shared with trusts.

EEAST continue to review their call to door times for STEMI and report into the ACS steering group. Work has commenced on improving communications between ambulance crew and tertiary centres with an aim to have a regional escalation guidance in the next financial year.

A STEMI education event has been postponed to June but will see cardiology and ambulance staff come together to consider case studies and where improvements can be made.

Next steps will be to have a STEMI dashboard to show call to door times across the region, including pathway breakdowns of on scene times; call to door times and door to balloon times. This will help demonstrate a contemporary view of regional adherence to the 120 minute call to balloon target and help identify any variations in the pathway, thus adding to the continued exploration of PPCI provision across the region and decision making around additional service provision.

Implement STEMI Pathway	Data period	Region value	Peer average	National value
Percentage of patients admitted for PPCI with a call to balloon times recorded at less than 120 minutes	Q2 2024/25	30%	N/A	29%
Percentage of patients admitted for PPCI with a call to balloon times recorded at less than 150 minutes	Q2 2024/25	61%	N/A	56%
Percentage of patients admitted for PPCI with a door to balloon times recorded at less than 60 minutes	Q2 2024/25	77%	N/A	61%

Image Source: Model hospital

Out of Hospital Cardiac Arrest

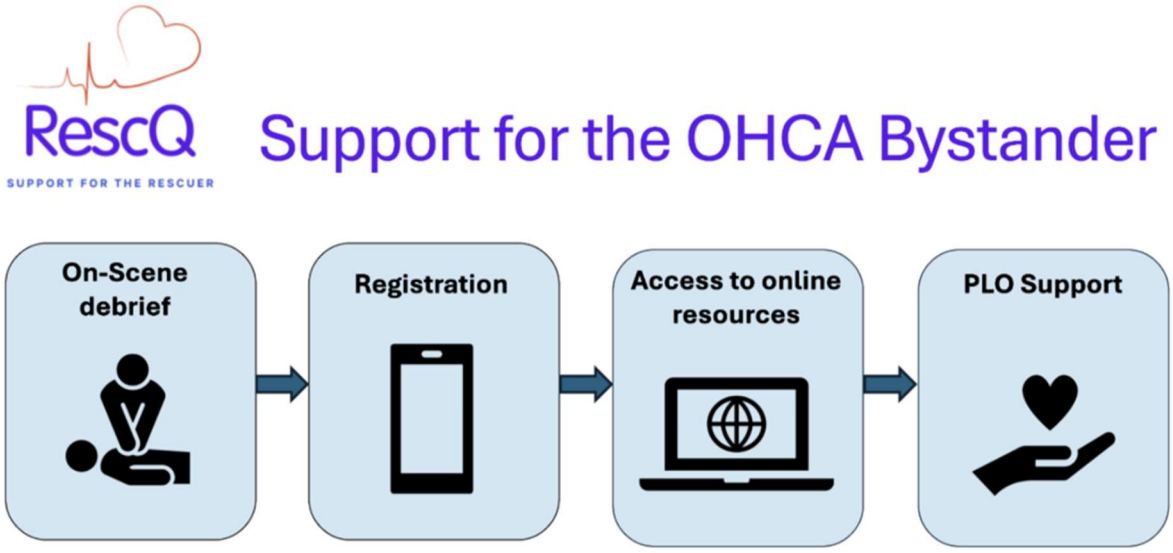
Work has continued this year on the out of hospital cardiac arrest algorithm at Essex Cardiac Centre. The evaluation shows an increase in survival rate from 18.7% to 33.3% in those patients eligible to go to the cardiac centre as well as a clear cost reduction.

	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

This work has now been published nationally and shared across the region. As a result, work has commenced on understanding the regional neuro prognostication provision. The aim is to ensure there is regional equity for all patients requiring prognostication. A review of pupillometry has been completed and funding for equipment released where needed.

Additionally, using funding from the Cardiac Network, Essex Cardiothoracic Centre has designed an app called **RescQ: Supporting the 'Forgotten Bystanders' in Out-of-Hospital Cardiac Arrest,** the first digitally driven, UK initiative dedicated to supporting bystanders right from the scene of the cardiac arrest.

When someone collapses from a cardiac arrest, it's often a bystander who calls 999, starts CPR, and witnesses the most critical moments before emergency services arrive. These individuals – often untrained, sometimes under 18 – are profoundly impacted yet rarely supported.



Bystanders are identified and offered support via RescQ by the EEAST land ambulance clinicians, who then register them into the RescQ app. The process is simple, quick and requires only a cell phone number or email address, prompting an immediate text or email to the bystander with details of RescQ and a link to the dedicated website, which has useful resources and videos recorded with real life bystanders, cardiac arrest survivors and medical professionals to guide the user on what to expect emotionally in the first few days and weeks of the event and how to cope with any negative emotions. Bystanders also have the option to request further personalised support if needed.

The platform is now ready to scale regionally and nationally — changing the way we care for *all* affected by cardiac arrest, not just the patient. Next steps will be to evaluate the app usage, gain user testimonial and review accordingly. Full year end evaluation will be ready in the next annual report.
Further plans for the next financial year will be a mapping of catheter lab activity to ascertain whether there is comprehensive provision across the region, where the gaps are and if there are areas of capacity which could be better utilised.

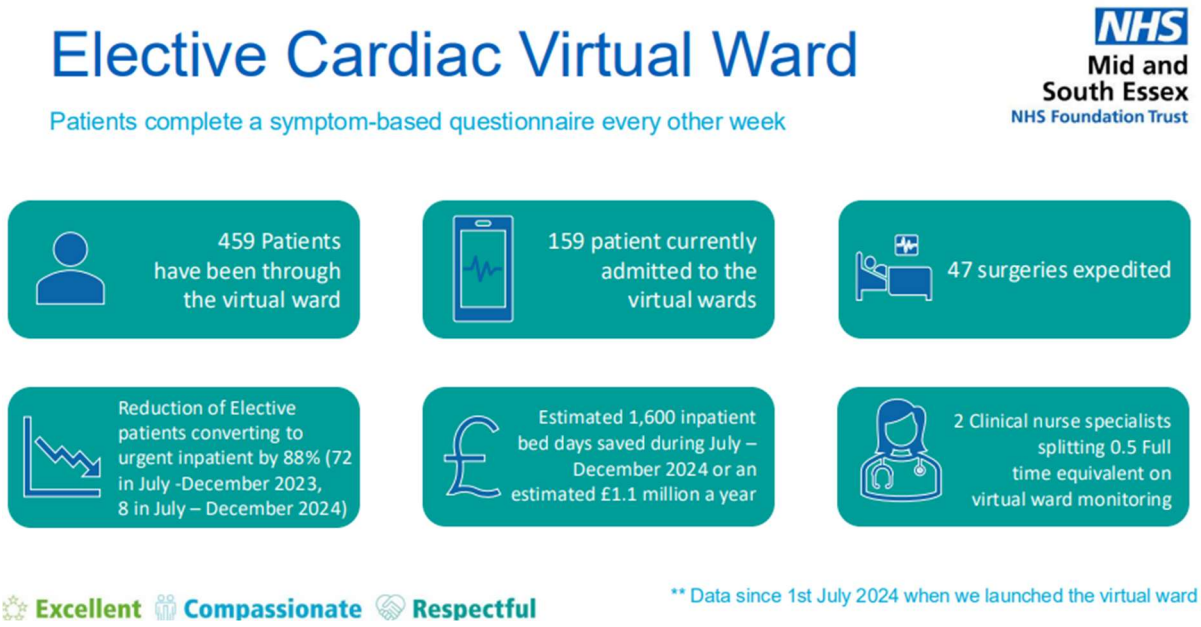
4. Surgery

In the East of England, we have two Cardiac surgical centres, Roya Papworth and the Essex Cardiothoracic Centre. The aims for the surgical workstream this year have been to reduce waiting times on surgical lists, continued implementation of the acute aortic dissection toolkit and ensure that the aortic stenosis pathway is functioning within region with a clear understanding of regional surgical/TAVI data position. The Network data analyst has collaborated with the tertiary centres to design a dashboard, accessible to all with an NHS.net email, which shows contemporary waiting list and clearance times for cardiac surgery and Transcatheter Valve replacement. Both centres have agreed to provide the data on a monthly basis and though not complete, will be fully functional by quarter one of the next financial year. This will then give The Network a basis on which to not only measure waiting list performance and improvement, but also how we are performing compared to national centres and allow referrers to make informed decisions on which treatment pathway to choose, where to refer to and to manage their patients' expectations around surgery waiting times.

In addition, the Network hosted a regional surgical meeting to consider the national team's publication of Cardiac Surgery Think Tank Recommendations. This was a great opportunity for both centres to come together and showcase their innovative practices and participate in shared learning.

Both centres have patient flow at the forefront of their efforts, with Royal Papworth concentrating on increasing the number of surgical patients being admitted on the same day of their procedure (third highest numbers in the country), thus reducing bed days and improving patient experience, as well as increasing the number of nurse-led, rapid recovery beds in ICU. Presently, this is not possible at Essex CTC due to challenges around staffing and space to bring patients in, however, they have looked to initiatives they able to implement.

For example, they shared their Watch pathway, in which elective surgical patients are admitted onto a virtual ward and given the Ortus app to highlight any deterioration in their health, thus allowing management of risk, whilst also enabling some prehab to take place. Early evaluation of this pathway shows a clear reduction of elective patients converting to emergencies, as well as a reduction in bed days as shown below.

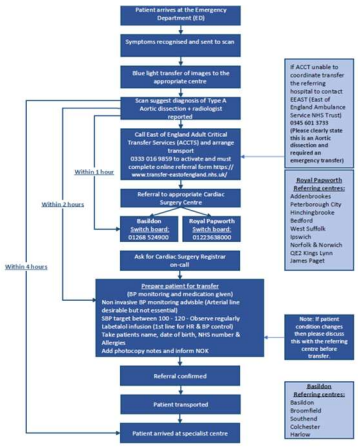


This work will continue in the next financial year and both centres will look to see where they can implement each other's successes.

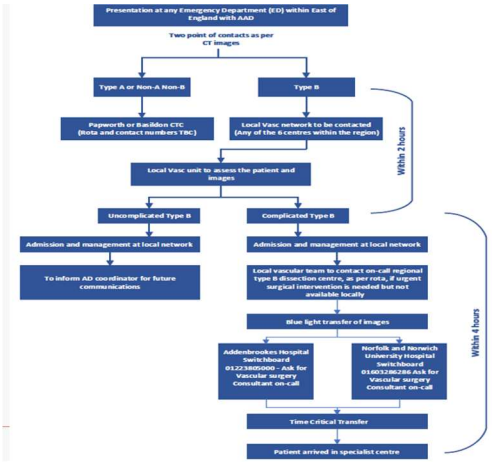
Acute Aortic Dissection (AAD)

It has been a very busy year for the AAD workstream and there are now agreed regional pathways for both type A and type B aortic dissections.

Type A Pathway



Type B Pathway



These pathways have been launched at a face-to-face event for emergency and ICU departments and have been circulated across the region. They have also been shared with neighbouring networks to ensure that any patient going out of region will have equity in care. These pathways will undergo further work and assessment in 2025/26 to include referring centres and to ensure implementation is embedded in the region.

To ensure the ongoing socialisation of the pathways, as well as data collection, at the end of 2023/4 the network funded an AAD coordinator (commencing Sept 2024) and has launched a repository of patients, working with the Adult Critical Care Service and the surgical centres to ensure data is correct and no patient is missed. She has also been visiting vascular centres with the vascular clinical lead to discuss the type B rota which will allow for a single point of contact for clinicians who need advice on how to manage critical patients as outlined in the toolkit. Once finalised, the rota will be shared across the region and all referrals will go via this route, ensuring that clinicians can access expert advice easily avoiding delays having to phone around centres.

Next steps will be to work on a type A rota and ensure there is a continued education package made available for the region to support the pathways, rotas and to *“think aorta*” when patients present in ED.

Transcatheter Aortic Valve Implantation /Surgical Aortic Valve Replacement

With the pathway in place, 2024/25 was focused on data collection and ensuring the success of the regional aortic stenosis pathway.

At the request of radiographers working in district general hospitals, the Network has produced a TAVI acquisition protocol to support clinicians in completing CTCA for TAVI within local hospitals. This not only alleviates the strain on waiting lists in tertiary centres for this procedure but also

ensures that patients are not asked to go on long journeys to have a diagnostic test which could be obtained locally. We have been working with providers to pilot this across DGH's and hope to successfully and carefully pilot this into 2025-26 to ensure that patients can not only receive care closer to home, but also focus on where patients can obtain TAVI CTCA faster to support with tackling referral to treatment targets.

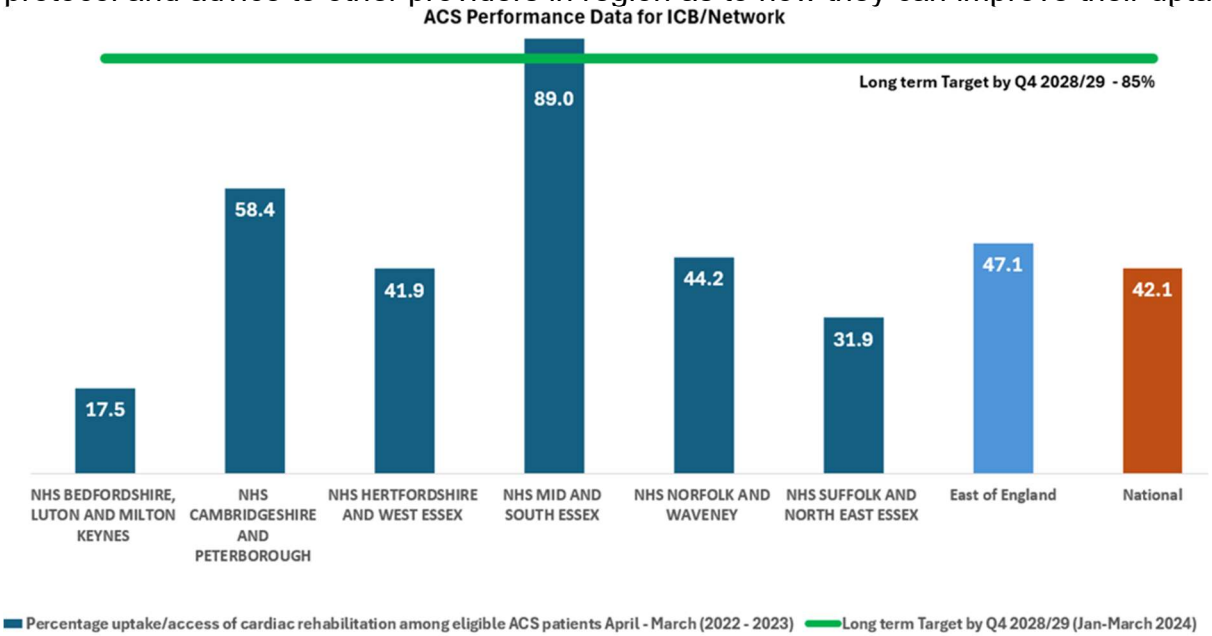
Essex CTC, supported by the Network, obtained funding through regional diagnostics to pilot fast tracking of patients to TAVI where aortic stenosis was shown on echo. This should eliminate the need for referral via cardiology and should result in patients receiving their treatment in a much shorter time period, as well as optimising utilisation of cath lab capacity. This work is ongoing and will be evaluated and published in the next financial year, however, early data indicates a time from echo to referral into specialist services from 83 days to 4 days, with 57% of those identified being asymptomatic.

The Network is also working with the centres to look at outcomes data to ensure safety of procedures and understand where improvements could be made. Key clinicians have been identified, and the data points are being agreed.

4.Cardiac Rehab

This year, the Network has been focusing on increasing the number of eligible patients receiving cardiac rehab, increasing the number of options available for cardiac rehab and to support more services to reach certification from the British Association of Cardiovascular Prevention and Rehabilitation (BACPR). There are now 13/21 services across East of England who have gained certification from 8/21 last year. Of those not yet certified, five have attained amber status and should achieve certification in 2025/26. The Network will continue to support these providers in reaching their goal and have arranged buddy visits and training from NACR in more efficient data input.

Mid and South Essex trust has been recognised nationally as a centre with the most uptake of cardiac rehab for patients following acute coronary syndrome. They have presented nationally on this work, as well as at our regional educational event and have provided the standardised operating protocol and advice to other providers in region as to how they can improve their uptake numbers.



Despite this success in ACS rehab, heart failure rehab provision remains low across the region with some areas not commissioned to provide a service. The Network has mapped where these services are and has encouraged areas to use the online, free Pumping Marvellous heart failure rehab programme, especially after clarifying with NACR that signposting to this service will be added to the data numbers. Pumping Marvellous has all the postcodes from the region and will be able to audit how many patients are commencing rehab from the East of England.

It is not all gloom for heart failure rehab, however, with one of the services in Norfolk and Waveney funded by The Network receiving the much coveted “You’re Simply Marvellous” award from Pumping Marvellous for their work supporting a young patient with heart failure through her rehab journey. The Network is very proud of this work and is in conversation with the ICB to see how funding can be continued for such a successful

This year’s education event saw presentations from NACR and certified service providers around successful, accurate and efficient data input into NACR, as well as presentations on secondary prevention, nurse prescribing and the Pumping Marvellous Heart Failure rehab virtual offer. This was in response to the key regional issues raised by the steering group and will help influence work over the coming year.

Following feedback from this event, a community of practice for non-medical prescribers (NMP) in cardiology was set up to tackle inequality in supervision for NMP’s, ensure access to useful training and education and act as a communication conduit for NMP’s across the region. In the next financial year, the Network will host a face-to-face event for NMP’s, allowing for networking and protected time for education.

Because of the success of this community of practice, the Network also joined forces with the Workforce and Palliative care networks to set up a Futures page for all NMP’s within region, with fortnightly webinars on varying topics such as governance and deprescribing. There is a programme in place for the next year and there are currently over 900 NMP’s signed up to the Futures page, allowing for peer-to-peer communication and support.

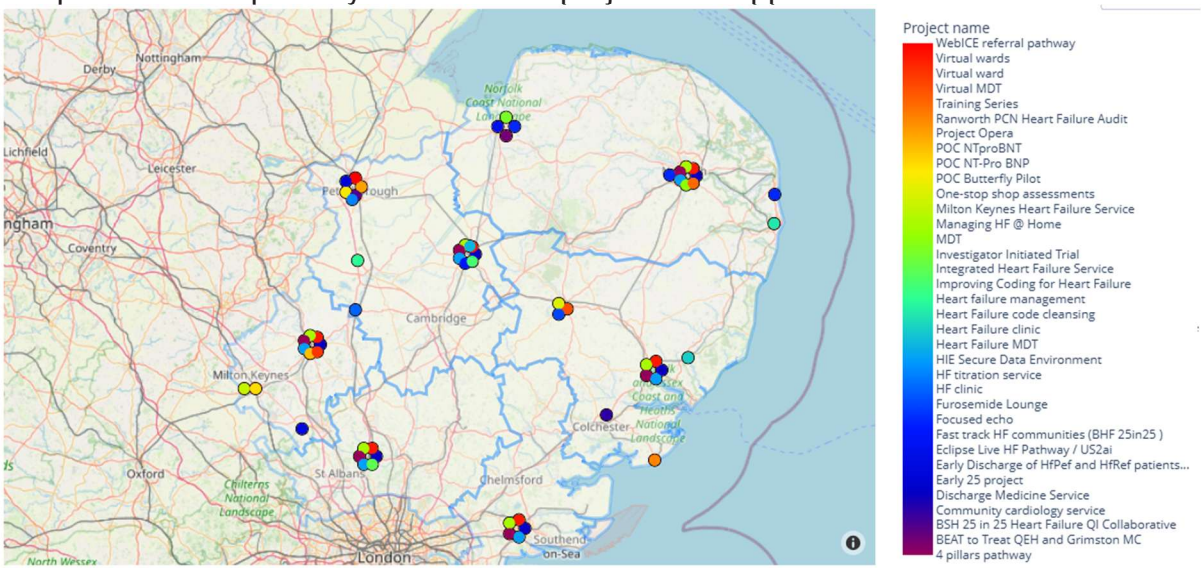
With limited resources and funding for cardiac rehab, it has been imperative that services and systems think about how they engage third sector providers in helping manage patient need. The region secured only a small amount of national funding to boost psychological support services for cardiac rehab and therefore had to consider alternative ways to help clinicians and patients. To this end, the Network held a face-to-face event looking at management of psychological needs in long term conditions in conjunction with the respiratory and palliative care networks. There were presentations around tender conversations, the use of talking therapies, occupational therapists in

cardiac rehab and also social prescribers and how they might be useful for helping patients cope with having a long-term condition. The presentations were well received and there is to be a further webinar on social prescribing early next year to be uploaded onto the futures page which will reach those unable to attend the day.

Finally, as a further response to limited resources, the Network has held joint meetings with providers in each ICB, allowing them to come together and understand cardiac rehab provision within each system. It was felt important to capture unreported work and therefore each provider was asked to map three patient journeys to illustrate the additional work involved when managing patients holistically. This mapping exercise will be collated into reports and presented at ICB board meetings to evidence where additional resources could be targeted.

5. Heart Failure and Breathlessness

Heart Failure is a priority for many of the systems this year and The Network has endeavoured to support their work by sharing good practice and ensuring the futures page is kept up to date and can be used as a communication tool. Joint work with Health Innovation East (HIE) has proven very useful and we now have a map of heart failure projects on the futures page which enables users to see what the project is, who is running it and how to get in touch to support with innovative ideas scaling across the region. Every new project, is uploaded onto the map to ensure it is a comprehensive repository of innovative projects to support heart failure care.



This year also saw the commencement of the Heart Failure Clinical Advisory Group (CAG) to combine all the heart failure meetings into one informative opportunity for peer learning and sharing which has been well received across the heart failure community. Central to this is the work around early detection of heart failure and the use of technology to aid with this with HIE partners. Pumping marvellous is a noted third sector supporter of the CAG and provides not only the charity's perspective but also that of a patient. This helps to ground discussion and ensure any projects are aligned with patient needs.

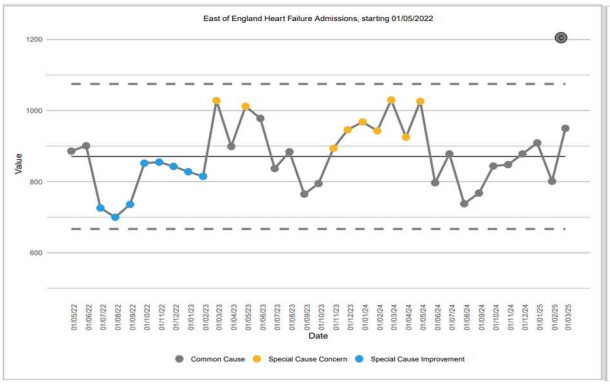
As noted earlier, evaluation of The Harmony project with Astra Zeneca was completed in quarter one and unfortunately did not have the anticipated impact on echo waiting lists, heart failure admissions and readmissions. This is because there was already rigorous triage in place for referrals in all ICBs in the region. There is, however, a standardised referral form has been developed and is

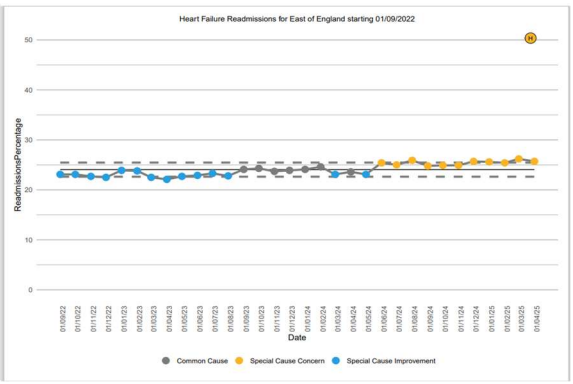
available for the adoption across the systems. This referral mandates the use of NTproBNP as a key criteria for heart failure referral. This will be used as part of the outpatients and referrals work when considering heart failure.

In September 2024, a Heart Failure Symposium was held with the CEO of Pumping Marvellous as keynote speaker. Clinicians from across the region came together for joint learning and networking with clinicians from the same systems meeting each other for the first time. At the end, delegates were asked for ideas on topics they feel the Network should bring to future CAG meetings and so we now have a comprehensive list of agenda items pertinent to our region.

The key theme of the workstream has been to utilise services already in existence, much in the same way as for cardiac rehab. The Network has continued to promote the use of the Discharge Medicines Service for patients coming out of hospital with Heart Failure and a change in medication. A word document has been developed for non-hospital employees which can be emailed to the community pharmacist if the clinician does not have access to online referral systems. The Network has also championed referral into social prescribing. Our aim is to reduce heart failure readmissions by ensuring more comprehensive support and communication between services once the patient is home.

Data has driven the workstream and our analyst uploads monthly data onto our dashboard outlining admissions, readmissions and length of stay for patients with heart failure. The Network shares key data points and learnings to each Heart Failure CAG to enable clinicians to see where their services are, celebrate success and act on the less favourable findings.





Admissions and percentage of readmissions are on the increase over the past few months and therefore we are exploring ways to reverse the trend. CVD prevent data, shows we have a detection gap of around 21,000 patients, possibly exacerbating emergency admission for those not recognising the symptoms of heart failure.

	QOF Heart Failure (23/24)			SUS Data Dec 23 - Nov 24					
Integrated Care System	Numerator	Denominator	Prevalence (%)	Admissions	Total Bed Days	Length Of Stay Per Admission	Total Spend	Spend Per Admission	Spend Per Patient (Full QOF List Size)
Bedfordshire, Luton & Milton Keynes	13,861	1,001,116	1.4%	1,476	15,698	10.6	£ 8,024,972.57	£ 5,436.97	£ 8.02
Cambridgeshire & Peterborough	9,251	1,038,953	0.9%	1,737	14,035	8.1	£ 6,029,083.49	£ 3,470.97	£ 5.80
Hertfordshire & West Essex	15,408	1,443,857	1.1%	1,934	17,668	9.1	£ 8,819,480.21	£ 4,560.23	£ 6.11
Mid & South Essex	16,064	1,576,375	1.0%	1,918	18,236	9.5	£ 8,506,284.29	£ 4,434.98	£ 5.40
Norfolk & Waveney	9,455	1,195,572	0.8%	2,103	20,521	9.8	£ 7,673,043.74	£ 3,648.62	£ 6.42
Suffolk & North East Essex	9,425	1,019,021	0.9%	2,117	18,110	8.6	£ 8,803,556.57	£ 4,158.51	£ 8.64
East of England	73,464	7,274,894	1.0%	11,285	104,268	9.2	£ 47,856,420.88	£ 4,240.71	£ 6.58

The Network continues to work with providers to find ways to optimise services and improve patient experience. In the next year we will be collaborating with QEHKL and HIE to trial early diagnosis

and treatment within 60 minutes in a GP surgery, as well as find ways we can adopt the pumping marvellous BEAT (breathlessness, exhaustion, ankle swelling, time for treatment) message within region to help people and clinicians recognise heart failure symptoms.

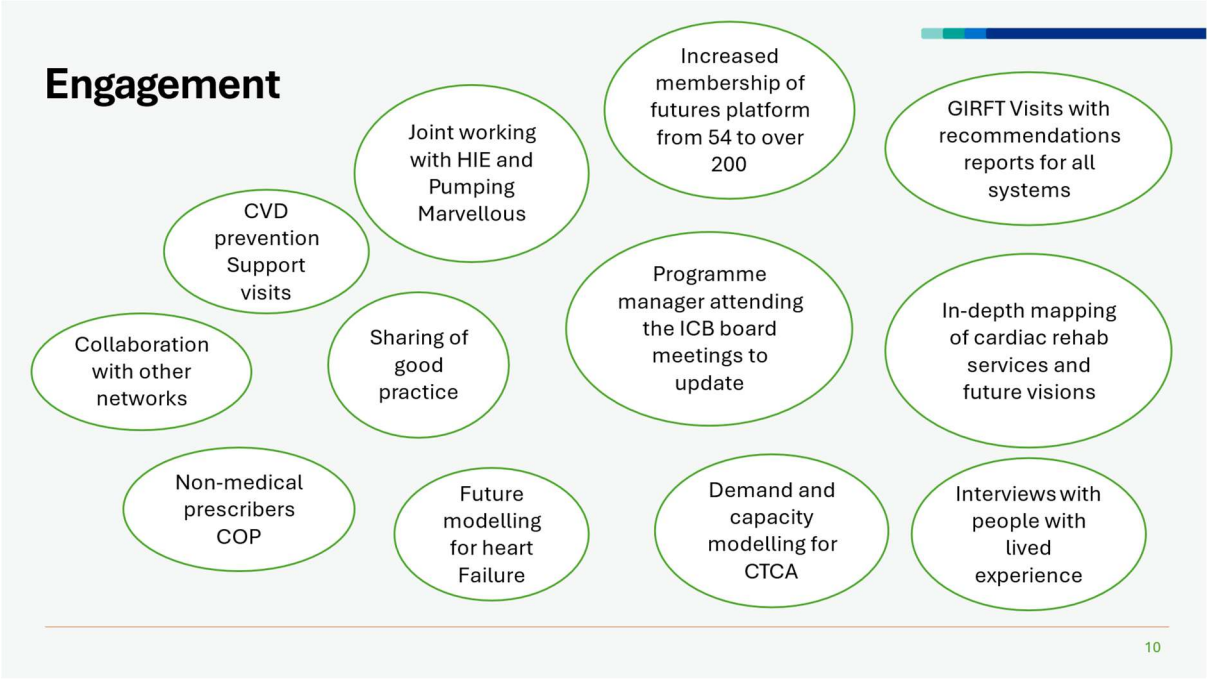
Image Source: Reproduced with permission from Pumping Marvellous

6.Outpatients and referrals

The Outpatients and referrals workstream is new for 2024/25 and it was agreed that the key areas for optimisation would be referrals into chest pain services, heart failure and palpitations, starting with chest pain in the first instance. A baseline data trawl was completed to gain an understanding of number of patients waiting for rapid access chest pain clinics and how long they wait for. However, it was also found that many of these patients are referred incorrectly and do not have cardiac originating pain. Therefore, having been approached by a doctor from Barts who was keen to trial a newly developed chest pain app, 5 services have signed up to a pilot where patients answer questions in the app about their chest pain presentation. The app then generates an advice letter, ascertaining if the pain is cardiac and then provides suggestions on the appropriate ongoing referral. This will be tested against findings from cardiology assessment to validate the findings and once this is completed, there will be trials in primary care to see if this could be used prior to referral into chest pain clinics to ensure correct treatment pathways are followed. The pilots are ongoing and will be evaluated in quarter one of the next financial year. The Network will then aim to look at heart failure and palpitations in a similar fashion.

Sharing Best Practice

The Network has ensured that engagement with systems, providers, patients, other networks and the third sector is at the forefront of all the work we have completed, with the goal of reducing duplication of work and ensuring ease of adopting good practice by showcasing home grown innovation.



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There have been six face to face events held this year:

1. CTCA education for radiographers
2. Cardiac rehab education and good practice showcase event.
3. Psychological support for patients with long term conditions learning event.
4. AAD pathways Launch day
5. Adverse events exploration day for acute coronary syndrome
6. Heart failure symposium

There was also a planning day in February with ICB leads to ensure all our plans were aligned and addressed local priorities as well as national. We will repeat this in September to revisit and reset plans for the last six months.

The Network has held some further webinars over the past year to spread good practice on the following topics:

- Neuro-prognostication
- Heart Failure management
- TAVI CTCA
- Discharge Medicines Service
- eChestpain App
- Soliton Sharing Platform
- Cardiac Rehab

All webinars have been uploaded onto the futures platform so that they can be viewed at any time.

The Network has also joined with the Workforce and Palliative care Networks to launch a futures page for all Non-Medical Prescribers across the region and are organising fortnightly bite-sized webinars on all different topics for people to attend if relevant. We have had one webinar so far with a talk from the chief pharmacist on Governance and legislation which was attended by over 150 clinicians. The webinars for the rest of the year are all booked in and will be recorded and uploaded onto the futures page for people to review at their leisure.

Further events for 2025-26 include a STEMI case study day; further webinars around CTCA and social prescribing; a face-to-face event for non-medical prescribers; echo and a face-to-face planning meeting spanning CVD Prevention and Cardiology with newly developed system partners and key stakeholders from each workstream.

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 despite a recent reduction in waiting lists, we will continue working with the imagining networks and ICB's to find innovative ways to tackle the backlog and manage echo moving forward.

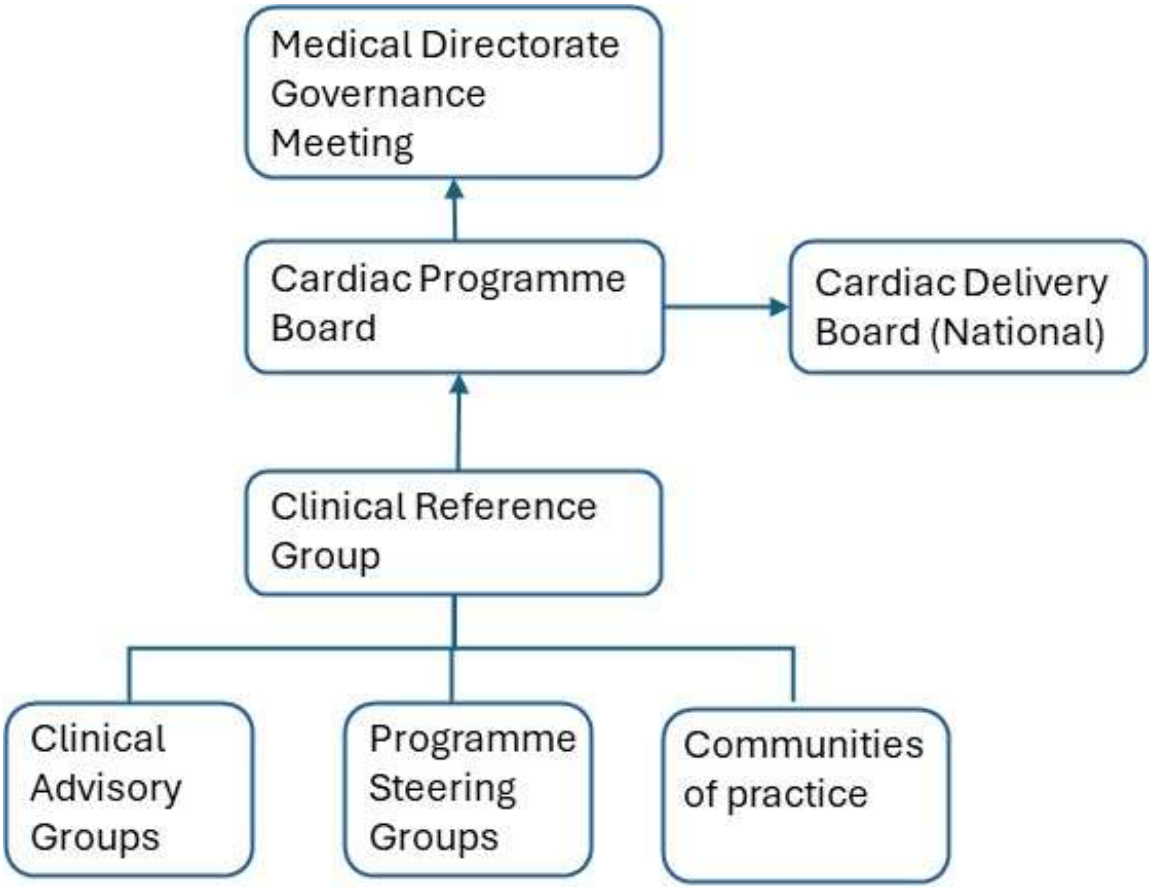
With both the NHS England and ICB restructures, there has been a few changes in personnel and focus, however, The Network has concentrated on overcoming the challenges, worked on relationships with systems and kept the workstreams on track by ensuring meetings have been timely, focused and productive.

Network priorities for 25/26

National priorities in Cardiac Programme:
1.Reduction in waits for diagnostics.
2, Increase 7 day service of diagnostics for inpatients.
3.Improve referral to treatment times with a focus on increasing the % of patients waiting less than 18 weeks for elective treatment in both cardiology and surgery to 65%.
4.Timely treatment for STEMI call to balloon <120mins and NSTEMI I treatment within 72 hours in line with national targets.
5.Improve early diagnosis and management of patients with heart disease.

Regional Priorities:
1. Support for non-medical prescribers
2. Adoption of BEAT within region
3. Reduction of detection gap in Heart Failure

Network Governance



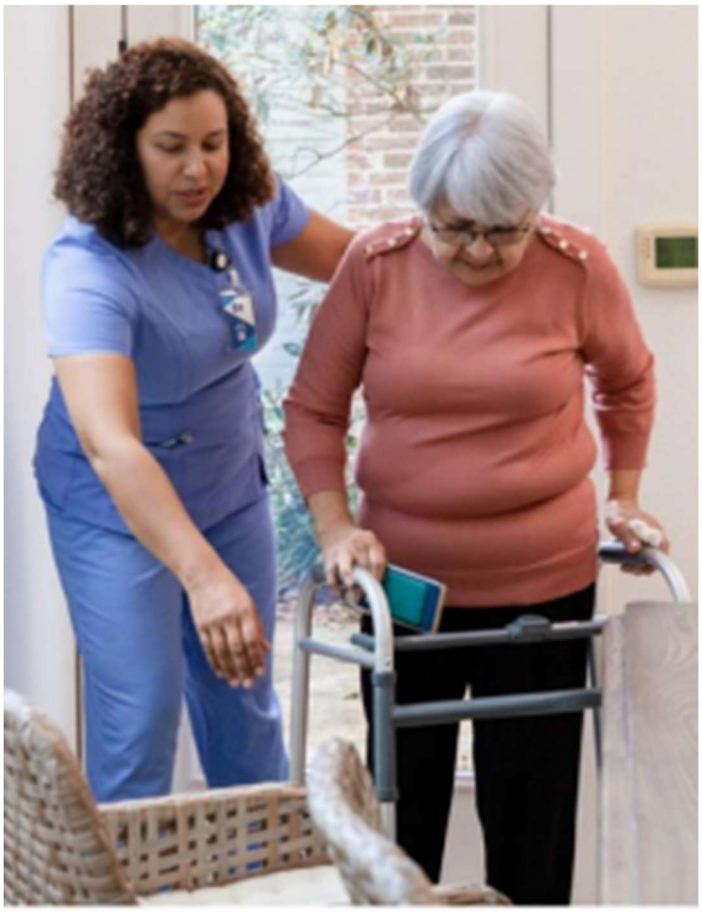
Network Budget

The cardiac network receives funding from the national team for staffing The network receives funding from the national team for staffing. All system transformation funding for specific programmes was sent directly to ICBs through the Service Development Funding arrangements (SDF).

1. **Staffing budget. Staffing budget**

Funding Allocation Description	Amount
Network substantive staffing	£154,560
PMO support costs	£80,742
Clinical Leads	£104,390
Patient/carer representatives	£327

Staffing costs are lower than expected this year due to late recruitment to posts following the NHSE restructure. Funding for the network is derived from the Cardiac Programme and the Specialised Commissioning Cardiac Programme.



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
Programme manager, North ISDN

Vacant
Programme Manager, South ISDN

Anne Bruton
Nurse Clinical Lead

Dr Kneale Metcalf
Physician Clinical Lead

Dr Rayhaan Rahaman
NOSIP Clinical Lead

Lizzie Dunn
AHP clinical lead (From Sept 2024)

Paula Sumray
Business Co-ordinator

Claire Doney
Business Support Officer

Network priorities 2024/25

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 end 2024/25 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 development at the Norfolk and Norwich Hospital.
- To oversee the regional AI contract reviews with providers and ensure the regional contract realises a 3-year term with a focus beyond this around sustainability and business as usual for providers.
- To support the introduction and use of Tenecteplase for thrombolysis for clinically suitable patients.
- Maximise thrombolysis rates working towards the LTP ambition of 20% of all stroke patients.
- To ensure access to highly specialised stroke units for patients with stroke in < 4 hours and for >90% of their stay.
- Development of a NOSIP dashboard to analyse service capabilities and compliance in relation to the National Optimal Stroke Imaging pathway (NOSIP). Continue to work towards compliance in relation to CT perfusion and promote wider training opportunities for clinicians (stroke & radiology) across the region.
- Oversight of regional Interfacility Transfers by reviewing quarterly data in collaboration with EEAST.
- Support acute stroke service providers in collaboration with ICSs 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 the sharing of training opportunities and a regional conference 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 including the 2024 dataset changes.

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 metric 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 24/25. These were:

1. CVD Prevention Clinical Advisory Group
2. Pre-Hospital Clinical Advisory Group
3. Pre-hospital video community of practice
4. Mechanical Thrombectomy
5. Stroke AI
6. Acute Care Stroke Admissions Improvement Clinical Advisory Group
7. Stroke Rehabilitation Clinical Advisory Group
8. Stroke Quality Improvement in Rehabilitation programme (SQuIRe)
9. NOSIP working group

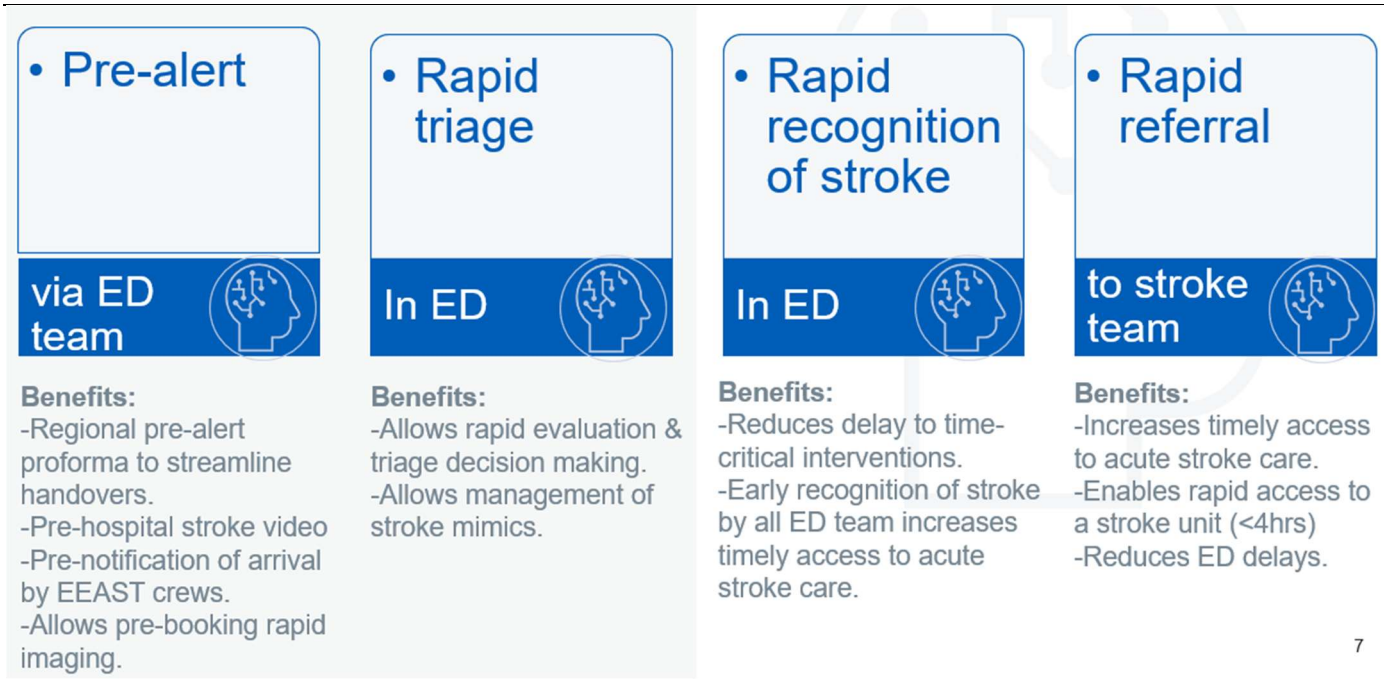
1. CVD Prevention Clinical Advisory Group

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.

ED engagement - The pre-hospital and admissions improvement workstreams jointly worked together in 24/25 to target areas that supported acute stroke care in the emergency department (ED) to optimise handovers and timely admissions to the stroke unit within 4hrs. There were 4 areas identified to support stroke care in the ED to realise the benefits if routinely carried out:

- Pre-alert
- Rapid triage
- Rapid recognition of stroke
- Rapid referral



All teams were surveyed on practices that were working well and what was not working so well (barriers) and developed seven key recommendations (see below). Stroke teams and ED departments were encouraged to adopt and embed these recommendations through closer collaborative working.

Key recommendations:

- ❑ Clear process for stroke pre-alerts - adopt regional stroke pre-alert proforma.
- ❑ Joint meetings held on a regular basis with ED & stroke teams.
- ❑ As part of the governance process hold case reviews for some complicated patients/breaches.
- ❑ Stroke team to provide stroke teaching in ED in relation to the stroke pathway.
- ❑ Stroke team to provide input at ED induction days.
- ❑ Bleeps/mobile numbers of stroke team are readily available and well understood.
- ❑ CD for stroke to work closely with counterparts in the ED.

The CAG leadership were able to meet with the regional emergency medicine (EM) clinical leads to showcase our work and highlight some quick wins to reduce some of the barriers and delays reported.

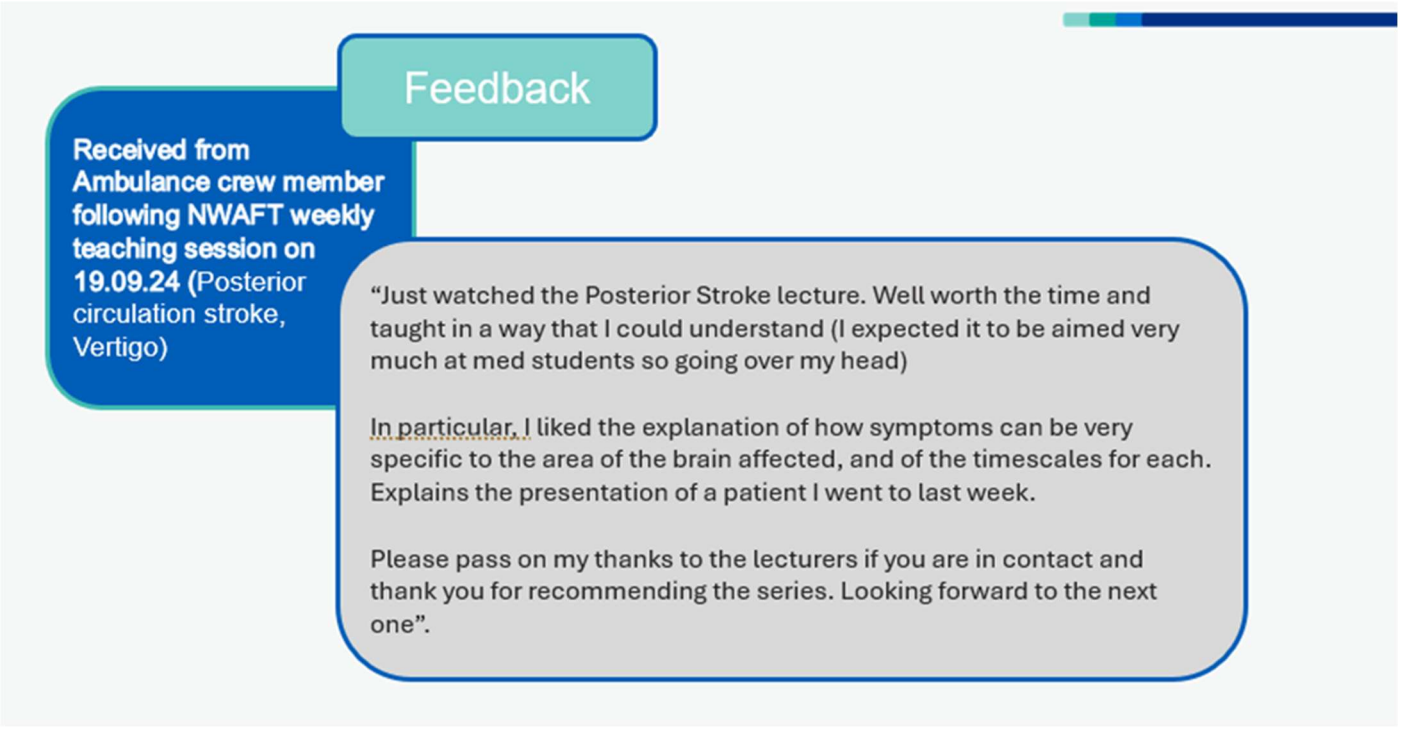
All stroke teams have developed plans for closer collaboration with ED departments and working proactively where they can to increase timely access to stroke specialist treatment and care for the patients they serve.

East of England interfacility transfers (IFT) – Teams have embedded the regional *interfacility transfer (IFT)* guide to aid clinicians in referring centres around the use of language with call handlers when requesting an emergency transfer to a thrombectomy centre. This is helping to improve response times for ambulance transfers.

Throughout 24/25 the CAG has monitored Category 2 interfacility transfers for thrombectomy data to improve door-in-door-out (DIDO) times and outputs are being presented at each CAG and shared with individual referring trusts to support local service improvement opportunities and hospital processes. The CAG monitors timings both in terms of arrival at hospital, time spent waiting while the patient is being prepared for transfer and the reasons for any highlighted delays. Over the past 12 months there has been significant improvement in the average time from ambulance arrival to patient leaving hospital having reduced by 5minutes, 21 seconds.

Year	Time (hrs:mins:secs)
Jan-Mar 2024	00:25:56
Jan-Mar 2025	00:20:35

Joint education & training - the CAG continued to promote joint education and training sessions throughout 24/25 for frontline crews and regional staff in relation to the pre-hospital pathway and identifying stroke mimicking symptoms. Over the course of the year, 68 teaching sessions were delivered by stroke teams on a weekly or monthly basis together with some in-person study days that were open to book. These teaching sessions have been well received, and the CAG has been capturing feedback, particularly from crews as per below.



A priority of the CAG continues to be oversight of the pre-hospital stroke video triage project (see details below) as more acute stroke centres deploy video triage within their services across the region.

3. Pre-Hospital Stroke Video Group

Following a successful bid for further national funding, Stroke Video Triage expanded significantly in 2024-25 into Phase 3 of the project which is to continue into 2025-26. The key areas of focus during this phase are the expansion of the project, to include increasing ambulance crew engagement to ensure that the pathway is utilised for all eligible patients and to embed the pathway as business as usual in the East of England.

Stroke Video Triage is now live at 11 of the 15 stroke centres in the region, with the 12th imminently setting their Go Live date. This represents a huge achievement in our ambition to expand the service across the region and we continue to work closely with key stakeholders to achieve coverage at all stroke centres.

Over 2300 patients have been video triaged since inception, with a 200% increase in utilisation of the pathway from February 2024-February 2025, exemplifying the success of workstreams associated with ambulance crew engagement.

Stroke Video Triage is concerned with ensuring patients reach the right treatment destination first time, expediting specialist stroke treatment and care and thereby improving the pathway of patients with acute neurological symptoms. The data collected in 2024-25 highlights a clear benefit for patients when compared to standard practice, to include faster hospital arrival to imaging, reduction in door-to-needle and improved detection of stroke in the pre-hospital setting as presented in the tables below. In addition, the data demonstrates key benefits for stroke teams in the reduction of mimic burden and improved hospital flow via a reduction in time patients are spending in the Emergency Department and a reduction in key ambulance metrics such as hospital arrival to handover and handover to clear.

Reduction in mimic burden

In 2024 Stroke Video Triage facilitated an estimated saving of **312 hours** in the face-to-face assessments of stroke mimics for stroke teams in the East of England this is the equivalent of over **8 working weeks**.

Reduction in time spent in the Emergency Department

Stroke Video Triage has led to prompter management in the Emergency Department with up to 15% more patients spending less than 4 hours from arrival at the Emergency Department to admission, transfer or discharge when compared to standard practice.

Triage accuracy

Sensitivity & specificity of triage decision	
Sensitivity	**95%**
Specificity	**61%**
Sensitivity of standard practice	80%
Sensitivity of FAST	77%
Specificity of FAST	60%

The superior sensitivity of Stroke Video Triage when compared to FAST, one of the leading stroke screening tools worldwide, represents a reduction in stroke patients misdiagnosed in the prehospital settings.

Improvements mapped against SSNAP performance metrics

As part of the Phase 2 Evaluation, data from all sites was mapped against key national stroke performance indicators with some of the findings from individual sites presented below.

Prior to Stroke Video Triage	Stroke Video Triage patients
Scanning key indicators	
Percentage of patients scanned within 1 hour of clock start	
77%	**100%**
Median time between clock start and scan	
00:35	**00:05**
Stroke unit key indicators	
Percentage of patients directly admitted to a stroke unit within 4 hours of clock start	
75%	**95%**
Median time between clock start and arrival on stroke unit	
02:27	**01:58**
Thrombolysis key indicators	
Percentage of all stroke patients given thrombolysis	
12.9%	**22.2%**
Percentage of all stroke patients who were thrombolysed within 1 hour of clock start	
40%	**100%**
Median time between clock start and thrombolysis	
01:05	**62%**

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 communication of MT availability/alternative providers to all acute providers in the East of England.

A joint steering group has been 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 have progressed to a 7-day service in early 2024. Expansion to a week A 24/7 service was realised in late 2024 with week B offering an 8-6 7-day service. A full 24/7 service is expected in the spring of 2025 dependent on successful interventionist training.

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. The repatriation policy was reviewed in 2024. Monitoring of the efficacy of the repatriation policy has continued throughout 24/25 with MT centres reporting continued success.

The percentage of all stroke patients receiving MT is monitored via the national SSNAP audit providing an insight into ASC MT completion rates as per the table below.

ICB	Provider	Total Strokes (April 23-March 24)	MT for direct admissions (April 23 - March 24)	MT / Total Strokes % (April 2023-Mar 2024)	Total Strokes (April 24-March 25)	MT for direct admissions (April 24-March 25)	2024-2025 MT / Total Strokes %
BLMK	L&D	764	30	3.93%	785	44	5.61%
BLMK	Milton Keynes	256	15	5.86%	234	10	4.27%
BLMK		1020	45	4.41%	1019	54	5.30%
C&P	Addenbrookes	778	44	5.66%	787	35	4.45%
C&P	NWAFT	798	21	2.63%	859	32	3.73%
C&P		1576	65	4.12%	1646	67	4.07%
HWE	The Lister	866	32	3.70%	855	35	4.09%
HWE	West Herts	653	30	4.59%	615	38	6.18%
HWE		1519	62	4.08%	1470	73	4.97%
MSE	Basildon	608	15	2.47%	580	25	4.31%
MSE	Broomfield	726	14	1.93%	762	19	2.49%
MSE	Southend	665	13	1.95%	629	15	2.38%
MSE		1999	42	2.10%	1971	59	2.99%
NWav	JPH	490	11	2.24%	494	22	4.45%
NWav	N&N	1007	32	3.18%	868	36	4.15%
NWav	QEKL	533	8	1.50%	375	9	2.40%
NWav		2030	51	2.51%	1737	67	3.86%
SNEE	Colchester	690	17	2.46%	667	8	1.20%
SNEE	Ipswich	622	6	0.96%	637	16	2.51%
SNEE	WSH	532	19	3.57%	608	21	3.45%
SNEE		1844	42	2.28%	1912	45	2.35%
Regional		9988	307	3.07%	9755	365	3.74%

SSNAP: https://www.strokeaudit.org/Results2/Clinical-audit/National-Results.aspx

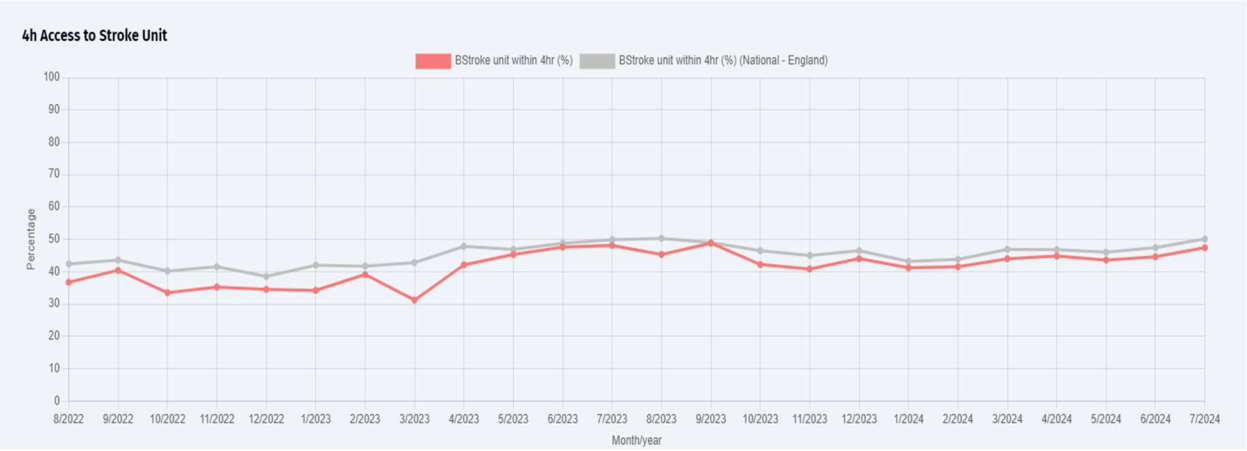
5. Stroke AI

Following the success of the regional procurement contract, all 15 acute stroke centres within the region continue to utilise stroke AI software with the ability to be networked and share AI images automatically to the respective comprehensive stroke centres being referred to. Work continued during 24/25 overseeing contract reviews between the stakeholders, regional Contracting Authority, and the AI suppliers. The ISDN was able to ensure the regional contract will realise a 3-year term as planned, which will come to an end during the course of 25/26. Conversations with the national clinical policy unit (CPU) team about sustainability for AI funding continued and plans will be put in place for stroke centres to embed future procurement of AI as BAU when the regional contract ends.

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 the continued use of SSNAP action plans to facilitate improvement projects and ICS awareness.
- Thrombolysis- Supporting the introduction of Tenecteplase use regionwide and share learning from the national thrombolysis in acute stroke (TASC) initiative.



Source: NHSEdashboard.info

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. In the absence of an AHP clinical lead for much of 24/25, the rehab CAG has continued with leadership from the regional SQuIRe lead.

The Rehab CAG has focussed on maintaining links with rehabilitation professionals across the different sectors for updates between region and the National Stroke Programme.
Information exchange on the new SSNAP data sent introduced in 2024, including the sharing of team preparedness for both the interpretation and data collection was key.

Work on the SSNAP data and how teams work with the 2023 National Clinical Guidance on Intensity remain a focus for the ISDNs and is now the focus for the AHP lead in post as of quarter four via the re introduction of the therapy responsiveness, intensity and frequency (TRIF) project. This project will continue in 25/26.

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

The SQuIRe programme continues to focus on the delivery of the Integrated Community Stroke Services Model (ICSSM) across the East of England. Between May 2024 and March 2025, Quality Improvement projects and Catalyst funded projects have been on-going to collect data and impact the delivery of needs-led, higher intensity stroke specialist rehabilitation pathways closer to home.

This workstream has included the following:

1. The work across region on priority areas within each ICS system now includes a dashboard to give greater visibility to aspects of the stroke pathway where evidence-based practice is achieved, partially achieved and areas where gaps still exist. This allows triangulation against other data sources of progress towards the delivery of the ICSSM.

2. Project level work on aspects of stroke rehabilitation have focussed on additional components of the ICSSM, for example Vocational Rehabilitation, as well as workforce development.
    a. Work to implement change with the Community Stroke Teams Leads and other partners have included regular meetings within ICBs, for systems who have focussed on stroke as a priority, and at a regional level. These meetings focus on supporting quality and assurance of delivery but also transformational change for improvement and impact on outcomes and experiences for those after stroke.
    b. Dissemination of stroke rehabilitation projects has further been supported with workshops, both virtually and face-to-face across region.
    c. Themed Communities of Practice in place for a number of aspects of stroke rehabilitation that link regions at a national level to extend peer support and allow sharing of learning from the 74 Squire projects across England. These CoPs also allow wider connections to be made and the building of links to maximise the spread of successful projects.
    d. Projects completed within the East of England have been showcased at a national level in the Quality Improvement Collaborative and at stroke conferences, such as UKSF24.

3. Building on the work with UEA last year and understanding how to best use blended rehabilitation approaches, telerehabilitation and face-to-face rehabilitation, has progressed within a number of the project areas including the delivery of Vocational Rehabilitation across Herts and West Essex, Intensive Aphasia Service across Mid and South Essex, a systemwide hub to improve the 6-month review follow-up across Suffolk and North East Essex, supporting Psychological Care training at level 1 for both patients and stroke rehab clinicians across region and a virtual role for specialist nursing within Norfolk and Waveney. Additionally, how teams use virtual aspects of education and training have further evolved. All these aspects of telerehabilitation bring services closer in line with National Clinical Guidance and the delivery of improved

responsiveness and intensity to enhance patient outcomes and give flexibility in service contact options.

4. The Advanced Practice role in Herts and West Essex has demonstrated significant improvements in patient outcomes in terms of their readiness and ability to engage in rehabilitation and for secondary prevention interventions, making every contact count. This role has also demonstrated gains in stroke MDT workforce education and confidence when working with those who have more complex needs after a stroke and their families, as well as linking with transformation of services closer to the national ICSSM across the system. This work has been completed jointly with the Regional Advanced Practice Faculty.

5. Catalyst Projects which cover different aspects of the ICSSM are at varying stages of completion in region. Below are brief summaries and illustrative quotes of what has been delivered and achieved.

- **Herts and West Essex:** Delivering an ICS wide Community Stroke Vocational Rehab Service, this service has now been funded for three years due to the success of the pilot and impact on supporting people to return to work after a stroke.

- **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. The project has now completed and shown support for teams working with increasing caseload numbers.

> *"Beneficial in that it is useful the assistant being multi skilled in that they are competent to support across the professions in a support capacity. TAP cannot replace qualified staff as they cannot hold the professional liability, but they do really help with improving and maintaining care quality and standards. I feel being multi skilled worker is an asset as they can address more than one issue in the same session supporting a more efficient service."*
>
> **Rehab Assistant, Mid and South Essex ICB**

- **Norfolk and Waveney:** Embedding the Community Stroke Rehabilitation Nurse role into the stroke pathway to enhance the MDT offer and improve patient outcomes. The project has completed in the West locality but continues in the East of the system. The role will be incorporated into discussions on the left shift to the community in N&W as part of the New Hospital build programme.

- **Suffolk and Northeast Essex:** Delivering six-month reviews with all eligible stroke patients coordinated via an ICS level Hub. This project has shown an increase of delivery from 29.6% of patients receiving a review to 85.4% as of September 2024. There have been additional benefits to partnership working and data sharing, as well as delivering a virtual project MDT.

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

- **Mid and South Essex:** The Psychological Care Level 1 project has now progressed development of two training modules on this topic covering fundamentals and more advanced aspects of psychological care. Two Clinical Associate Psychologists (CAP) have also been trained to support this delivery of care and work continues to define a consultation model of psychological care to see how the stroke workforce might deliver across wider services in a flexible but appropriately governed manner. This project remains on-going.

- **Mid and South Essex:** Specialist Aphasia Service to augment MSE ICSS Teams- Using technology to Enhance Rehabilitation. This project has made significant impacts on outcomes and experiences for those after stroke living with aphasia. They have also linked across the stroke pathway to provide expert support and education to all stroke MDT members. They have shown that delivering high intensity specialist therapy using a blended approach is feasible in the community.

- **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. Funding has not been secured to commission this service. This project has now ended but it will inform the system case for change for the stroke pathway in alignment to the New Hospital developments.

> *"He really improved with the group and definitely wouldn't have improved as much without it. He really gained confidence… working with other people in a public place. He is getting one to one therapy now at home but it's not the same... he's lost confidence. He would love to do it again."*
>
> **Stroke Patient Carer on the Service, Norfolk and Waveney ICB**

9. 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.

10. National Optimal Stroke Imaging Pathway (NOSIP)

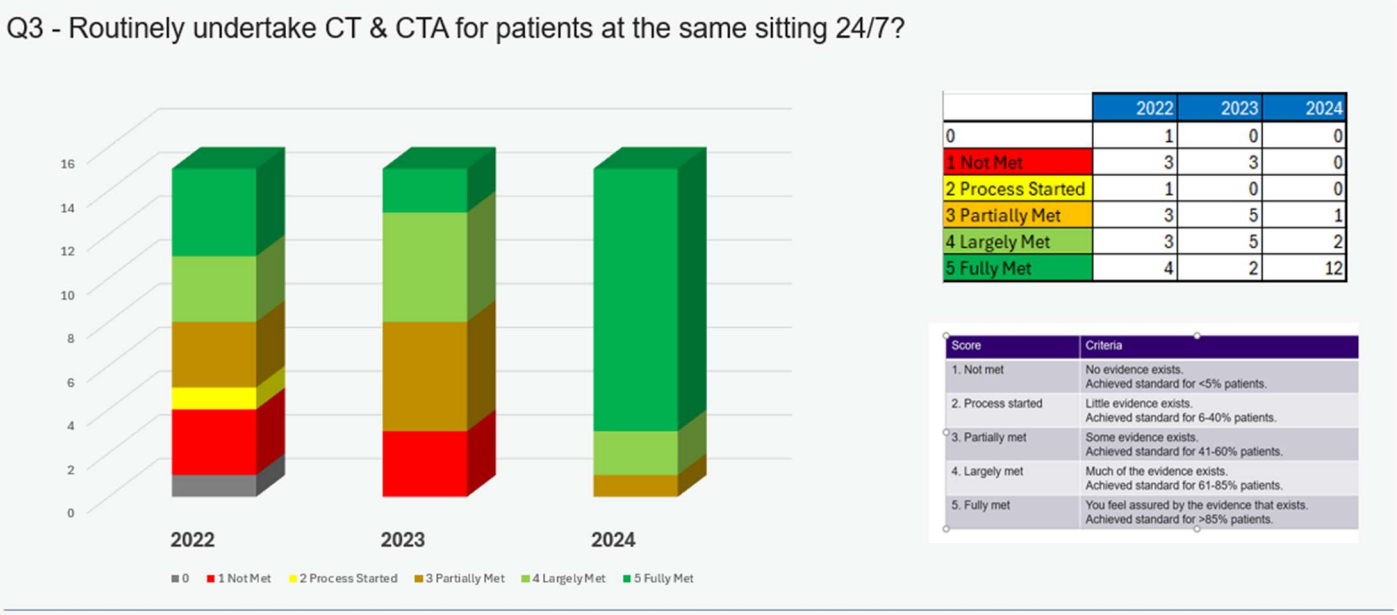
Timely imaging is critical in the management of acute stroke care. The regional NOSIP project has focused on implementation of CT, CTA and CTP imaging at the same sitting for eligible patients, with an emphasis of completing imaging within 20 minutes of patient arrival, supported by nurse requesting, and protocol driven radiographer vetting, 24/7.

Initially, many regional trusts lacked routine CTP services and expertise, hindering compliance with this pathway so this was identified as a key priority for 24/25.

Regional NOSIP compliance and progress -

In December 2024 the region updated the Rightcare self-assessment toolkit for hyper-acute imaging. Results indicated that the routine use of CT, CTA undertaken at the same sitting 24/7 has significantly increased during 2024, with 93% (14/15) of providers reporting fully/largely compliant and 1/15 trust working towards full compliance of this element of the NOSIP pathway.

This has been largely aided by defined nurse requesting protocols and standard operating procedures (SOPs) which have been embedded into services as business as usual.

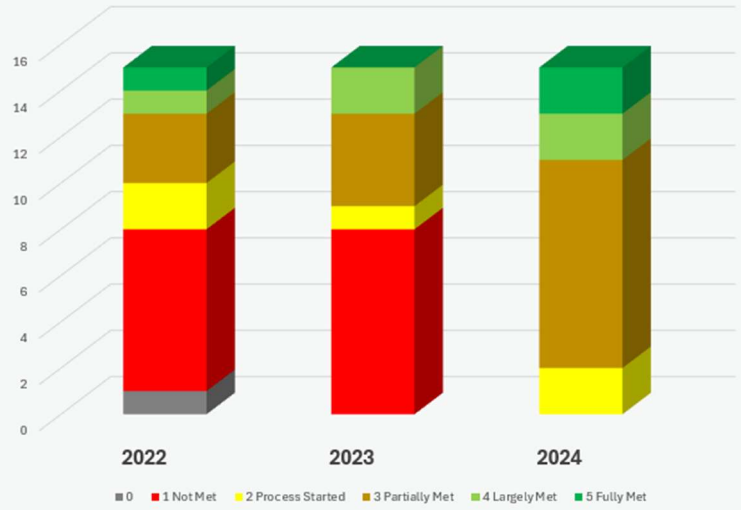


	2022	2023	2024
0	1	0	0
1 Not Met	3	3	0
2 Process Started	1	0	0
3 Partially Met	3	5	1
4 Largely Met	3	5	2
5 Fully Met	4	2	12

Score	Criteria
1. Not met	No evidence exists. Achieved standard for <5% patients.
2. Process started	Little evidence exists. Achieved standard for 6-40% patients.
3. Partially met	Some evidence exists. Achieved standard for 41-60% patients.
4. Largely met	Much of the evidence exists. Achieved standard for 61-85% patients.
5. Fully met	You feel assured by the evidence that exists. Achieved standard for >85% patients.

The routine use of CTP undertaken at the same sitting as other imaging, 24/7 has also significantly increased throughout 24/25, with 60% (9/15) of trusts now offering a CTP service. The remaining 40% (6/15) of trusts without CTP services are currently developing implementation of CTP and it is anticipated further compliance will be realised by Q3 of 25/26.

Q4 Routinely undertake CT, CTA & CTP for patients at the same sitting 24/7?



	2022	2023	2024
0	1	0	0
1 Not Met	7	8	0
2 Process Started	2	1	2
3 Partially Met	3	4	9
4 Largely Met	1	2	2
5 Fully Met	1	0	2

Score	Criteria
1. Not met	No evidence exists. Achieved standard for <5% patients.
2. Process started	Little evidence exists. Achieved standard for 6-40% patients.
3. Partially met	Some evidence exists. Achieved standard for 41-60% patients.
4. Largely met	Much of the evidence exists. Achieved standard for 61-85% patients.
5. Fully met	You feel assured by the evidence that exists. Achieved standard for >85% patients.

This has been achieved through the appointment of a NOSIP clinical lead, a dedicated radiologist who acted as a facilitator and champion for regional stroke services and radiology departments to work in a collaborative way. This clinical leadership has bridged the radiology-stroke divide to optimise acute stroke imaging pathways. This has included:

- Peer-to-peer learning to increase stroke physicians' ability to interpret and action the results of a CTP scan (*recognising CTP is a low frequency study so building clinical confidence may not be rapid).*
- Increasing the reporting of CTP scans in-house or by external 3rd party providers.
- Supporting providers encountering hardware barriers and/or upgrades with business case input.
- Promoting training opportunities for radiographers, radiologists, stroke physicians and stroke nurses (including in-person and virtual sessions).
- Targeted monthly educational sessions focusing on the interpretation of CTP imaging relevant to NOSIP are in place. Case discussions with a local neuroradiology team provides a platform for hospitals interested in initiating or expanding their CTP services. This fosters collaboration and knowledge sharing among regional hospitals to improve stroke care.

Having explored the use of an accessible library of example CTP cases (iCode) for the region to utilise, this should be available for teams to access early 25/26.

Regional NOSIP dashboard -

During Q2 the ISDN launched a regional dataset to capture information from providers around a number of key indicators, in line with NOSIP. This will inform and give greater insights as to whether imaging is being conducted rapidly and simultaneously at presentation ie within 20 minutes. This will support teams ahead of the new hyperacute key assessment domains being introduced by the Sentinel Stroke National Audit Programme (SSNAP) in early 25/26.

The regional benchmark dataset covers 6 months between Sept 24-Mar 25 and includes all patients assessed by the stroke team requiring imaging, regardless of final diagnosis to highlight the volume and activity stroke team's encounter.

73% (11/15) of the region's trusts have been participating with the data collections, with the remaining 27% (4/15) reporting resource issues and pressures at the time. There has been excellent engagement from teams that are involved with responsive data queries being answered in a timely manner, month on month, to ensure data quality is realised.

An analytics Power BI (PBI) dashboard has been created and 1:1 preview sessions have been conducted with all participating teams to go through the insights in detail and highlight some key areas of focus. The dashboard drills down at regional, ISDN, ICS and provider level and informs on the % of cases achieving the key performance indicators relating to NOSIP. The dashboard enables dynamic real-time visual analytics to pinpoint trends and outliers which can be filtered by presentation type i.e. ambulance, self-presenters and inpatient to monitor stroke imaging workflows.

The study has analysed over 8,500 cases to date across all presentation types highlighting variation of between 6.3% - 38.8% of cases scanned within 20 minutes. High self-presenter rates have been identified as impacting the lower attainment cases. Advanced imaging is happening simultaneously with 73.9% of CT angiograms carried out within 10 minutes of the initial CT scan and 74.5% CT perfusions, when applicable.

This benchmarking tool will enable teams to be empowered to deliver faster, more coordinated, and outcome driven stroke management by identifying potential bottlenecks and refine internal processes.

Challenges

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

1. **Mechanical thrombectomy.**
- Regional MT service development continues to progress but remains behind schedule leading to a reliance on MT services in London. This in turn results in increased travel times for some patients.

2. **SQuIRe**
- The financial situation of the ICBs and working alongside them to keep the focus on stroke rehabilitation and the gains made to date.
- A lack of funding options and delivery models for community in relation to updated stroke rehabilitation pathway guidance.

3. **SSNAP**
- Continued challenges in relation to the SSNAP audit performance region wide in the stroke unit domain and therapy domains. The stroke unit domain performance has remained poor throughout 24/25 despite ISDN projects. System wide increases in activity for both stroke and non-stroke has negatively impacted access to stroke speciality beds.

4. Admissions Pathway Improvement

- Variable provider executive sponsorship to support optimising the stroke admission pathway. Lack of momentum in improvements in some areas. Trust capacity issues emanating from winter-related pressures impacting on stroke unit capacity exacerbated by the inability to protect or ring fence stroke specialist beds.

5. NHSE restructure

- The NHSE restructure hindered the ability to recruit into vacant ISDN roles significantly impacting capacity and clinical expertise in the AHP clinical lead role and the ISDN Programme Manager role. These remained vacant for the majority of 2024/25, limiting the volume of improvement work that could be undertaken by the network.

Areas of Focus for 2025/26

1. Stroke Artificial Intelligence
-Continue to work with stakeholders around sustainability and business as usual beyond the regional 3-year contract coming to an end.

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 monitor Category 2 interfacility transfers to comprehensive stroke centres data and share outputs via the CAG and with individual trusts to support with local service improvement opportunities and hospital processes.
-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.

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.

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

5. National optimal stroke imaging pathway (NOSIP)
- Continue to work towards regional compliance in relation to CT Perfusion service provision across all stroke centres and support those that have hardware challenges. Continue to promote CT Perfusion training opportunities for the region.

6. 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 improve the referral rates of all patients that are clinically eligible to receive mechanical thrombectomy across the EoE.

7. SQuIRe
-The East of England (EoE) ISDNs priorities for the SQuIRe Regional Quality Improvement (QI) initiatives will continue via regional groups.
-Supporting the ICSS development across the 6 ICSs including delivery of 6-month reviews in line with the need to increase the number of patients accessing a needs-led stroke specialist rehabilitation pathway by 27/28 (national, regional metric reported via P&LTC Board). This also supports the national guidance on the Standardising health services linking to Neighbourhood health Guidance (NHSE January 2025).

-Embedding and sharing learning from Catalyst and QI Projects which broadly focus on telerehabilitation, workforce training and education.

8. 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.

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Network Budget

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

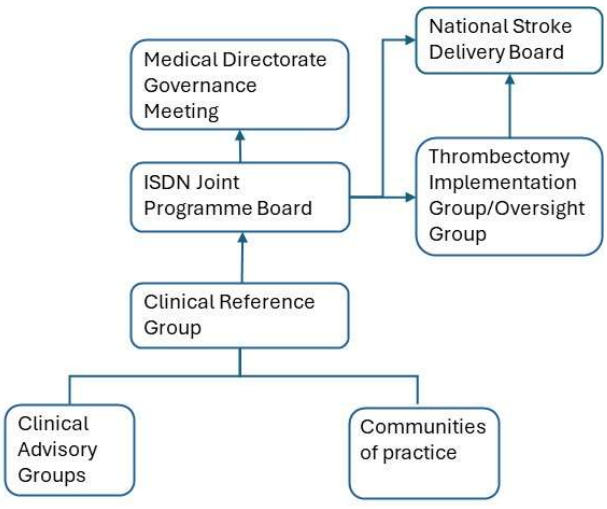
1. Staffing budget

Funding Allocation Description	Amount
Network substantive staffing (inc SQUIRE)	£262,090
PMO support costs	£80,742
Clinical Leads	£87,932
PPV	£177

2. Targeted funding for specific projects (to systems)

Funding Allocation Description	Amount
AI funding	£259,056
Stroke Video Triage pilot October 23-October 24 October 24-October 25	£183,000 £192,673

Network Governance



SQuIRe workstream embedded within the ISDN governance

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 in respiratory care with respect to the goals of the NHS Long Term Plan, 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
(April 2024 – September 2024)

Dr Edward Morris
Interim Senior Responsible Officer, Regional Medical Director & Chief Clinical Information Officer (October 2024 – present)

Dr Robin Gore
Clinical Lead, Asthma, Respiratory Diagnostics, ILD, Long COVID, ARCU

Dr Abigail Moore
Clinical Lead, PR, CAP, ILD, Long COVID, ARCU

Dr Sripat Pai
Primary Care Clinical Lead, Asthma, Respiratory Diagnostics, CAP, Long COVID

Alan Jensen
Programme Manager - Respiratory

Sarah Quigley
Quality Improvement Project Officer

Abbie Bardell
Quality Improvement Project Officer

Claire Doney
Business Support Officer

Network Performance and Achievements

"It has been a pleasure to work alongside colleagues from the EoE Respiratory Network. Ensuring our work in N&W is aligned to regional priorities is essential to ensure delivery and implementation"

Daryl Freeman FRCGP
Respiratory Clinical Lead Norfolk & Waveney ICB

'The progress that we have made through our various workstreams has been strategically impactful and delivered through engagement with our colleagues across the region. I have personally been involved in the development of our regional asthma pathway document, the delivery of the webinar series on LD health checks in pneumonia care, the spirometry risk stratification project, and the integrated care workshops. Bringing together partners across our region who have a similar passion for improving the respiratory care of our patients, has been both stimulating and inspiring. It has been a pleasure working with the dedicated team at NHSE East of England delivering these important projects.'

Dr Sripat Pai
Network Clinical Lead

I am really pleased to have been involved in a series of exciting projects with a true regional scope. These are shaping and improving healthcare delivery at a regional level. The respiratory network is a unique and valuable forum for joint working between commissioners, project managers and clinicians.

The establishment of the regional interstitial lung disease (ILD) MDT project means that physicians treating patients with a progressive, life-limiting condition can access specialist opinion more easily. This will lead to more effective regional shared care arrangements, prompter access to specialist care and treatments and an improvement in patient pathway experience.

The development of the regional asthma document with the regional CYP team means we now have a single 'how-to' asthma document for the whole of the region which pulls together principles of good care, treatment guidelines, and formularies.

I was pleased to support ARCU peer reviews this year. This gave me the opportunity to review and share clinical experience and challenges with peers, and helped validate our aims to improve respiratory outcomes across the region.

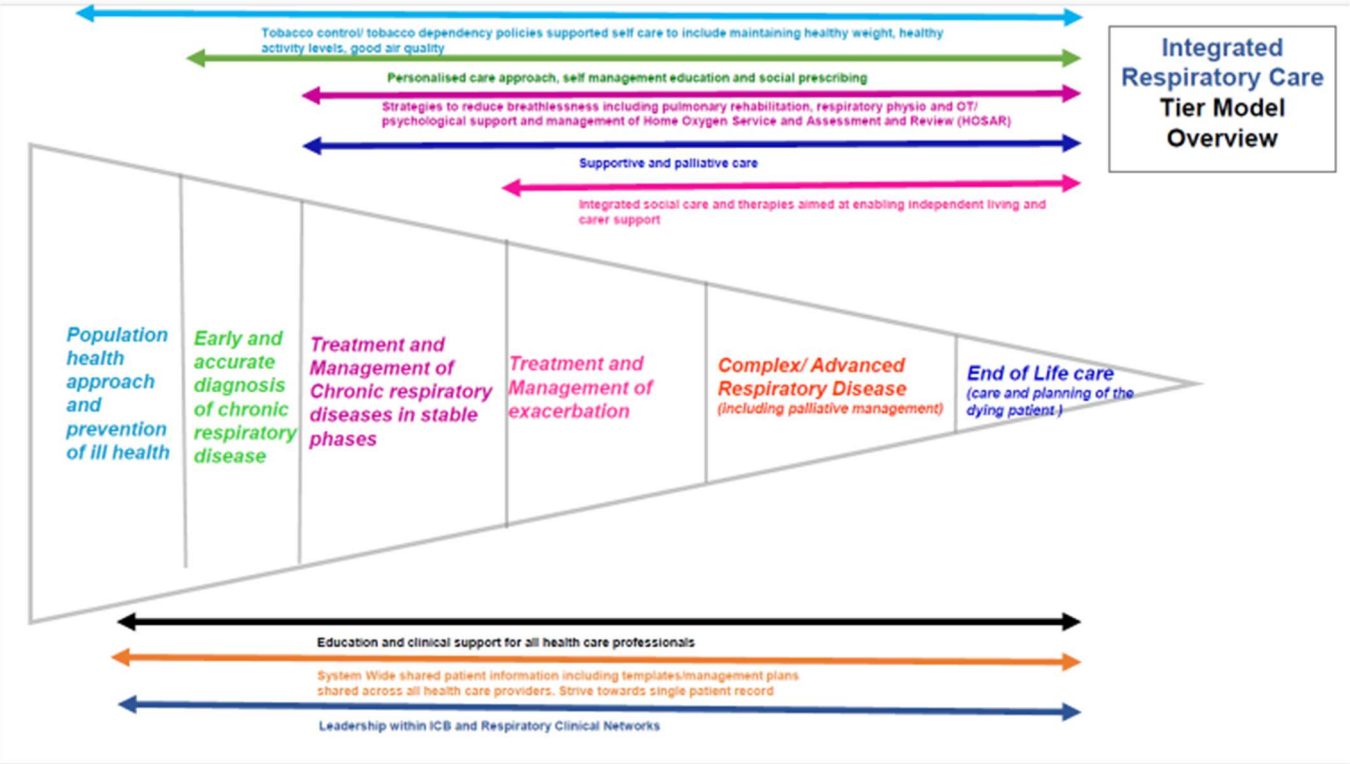
The series of webinars on annual learning difficulty health checks and the prevention of pneumonia is an important initiative which we hope will reduce the disproportionate mortality from pneumonia seen in this most vulnerable patient group.

The respiratory data dashboards are key to helping us frame discussions with all regional partners. For asthma, the instigation of the SENTINEL-Plus programme (last year's report) has, along with other factors, led to a regional reduction in SABA use – a key national priority and marker of good asthma management. We are now moving on to focus on admissions and oral corticosteroid use. The dashboards will highlight areas of greatest need and help us focus our strategies such as the spirometry risk stratification project, and the new project on 0-1 day admissions for pneumonia, as well as helping ICBs identify their own priorities.

Finally, a thank you to our PPV reps, who have worked tirelessly to support all our initiatives this year, and who have been crucial to good strategy development.

Dr Robin Gore
Network Clinical Lead

The national vision for integrated respiratory care is that it should be patient centered, focused on seamless, proactive and coordinated care 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 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).

In 2024-25 the network conducted a series of workshops based upon the following Integrated Care Model's six stages of care. Following the positive feedback received from these workshops The network will continue to deliver these workshops in 2025-26, to enable all stages of the above diagram to be discussed.

Key achievements in 2024-25 include:

- Establishment of a regional interstitial lung disease (ILD) Multi-Disciplinary Team (MDT).
- Completion of the regional pulmonary rehabilitation (PR) accreditation project.
- Development of a regional Asthma Care and Medicines Optimisation document.
- Delivery of a series of webinars for primary care colleagues on the important role that. annual learning disabilities (LD) health checks has in pneumonia care.
- Spirometry risk stratification project.
- Development of data dashboards.

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

For me, the most positive thing this year has been the engagement with the Children and Young People's network and local authorities on the question of indoor air pollution and the possible next step of extending that to outdoors as well. It shows a willingness to work with non-NHS colleagues on primary prevention.

Phil Taverner
Network PPV Representative

The network retained the patient representatives that were appointed to the network in 2023-24, and continued to align them to workstreams that are of particular interest to them:

- Asthma & Respiratory Diagnostics - Phil Taverner
- Community Acquired Pneumonia (CAP) - Sefina Arif
- ILD & PR - Stephen Jones

Whilst recognising that having established Patient and Public Voice (PPV) representatives as members of the steering groups and board is a significant step forwards, the network wanted to ensure that PPV continues to be included in specific projects. Therefore, specific PPV activities this year included:

- Online patient survey, as part of the ILD steering group's health inequalities work. With responses used to help inform the network's programme plan.
- Supported King's College London's Chronic Obstructive Pulmonary Diseases (COPD) Patient Voice Project by facilitating a regional patient focus group, with key themes considered as part of objective setting for 2025-26.
- Themes from Asthma and Lung UK (A+LUK's) annual survey were presented at regional programme board and considered as part of objective setting for 2025-26.
- PPV Rep included as a member of the evaluation panel of Expressions of Interests (EOI's) for innovation projects within Respiratory Diagnostics.
- Recruitment of a PPV Rep for the 2025-26 COPD workstream.
- Invited PPV Reps to attend and participate in face-to-face network events.

2. Pulmonary Rehabilitation (PR)

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 and in 2024-25 the network focused on the following four objectives.

Objective 1: To work with services taking part in the network's accreditation project to achieve PR accreditation.

I was fortunate that my service was able to secure one of 10 places across the East of England, to be fast-tracked towards Pulmonary Rehabilitation Accreditation with the support of the network's Project Manager, Sarah Quigley.

The Project Manager role benefitted me immensely by providing:

- *Expertise and guidance on scheduling the many PRSAS tasks and meeting agreed deadlines*
- *Organisation and chairing of sessions with colleagues in nearby services to enable sharing of ideas and good practice*
- *A focal point for shared resources and documents across the region to prevent 'reinventing the wheel'*
- *Regular 1 to1 meetings to review progress and troubleshoot problem areas*
- *Proof-reading and review of specific documents to ensure they meet the relevant standards*
- *Practical advice and guidance to facilitate uploading of evidence*
- *A mock assessment day to check documents to be uploaded and prepare for site assessment*
- *Shared experience from other services at various stages of the Accreditation process to inform learning*
- *Guidance to support with the required Site Assessment day presentation*
- *Ongoing support after the assessment day to deliver on action points required*

Facing the Accreditation process as small service/sole practitioner is extremely daunting- not knowing where to start or who to ask for help. The PRSAS resources and templates can be helpful but it is not always clear what information is required to complete them or how to begin. Having support from a Project Manager with insight and information from 9 other services going through the same thing was invaluable in getting my service to Site Assessment- we simply would not have managed it without Sarah's support.

Helen Owen
Community Specialist Respiratory Physiotherapist, Pulmonary Rehab

The network initiated a project in October 2022, to support ten PR Providers through the Royal College of Physicians' (RCP) PR accreditation programme over a two year period, allocating part of the national funding for PR transformation to support the delivery of this project.
The costs associated with delivery of this project are:

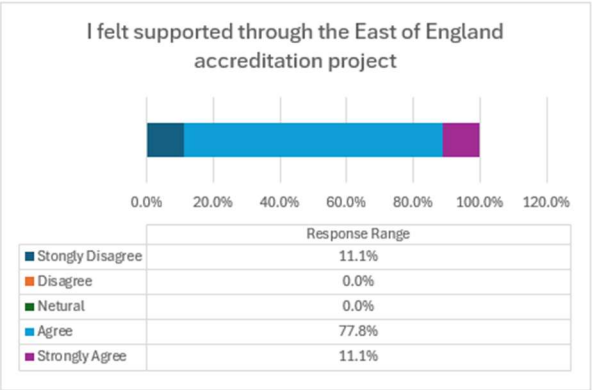
Cost Type	Amount
Regional project management costs	£123,000
Contribution towards 10 PR Provider's accreditation costs (RCP registration fees, general administration costs etc.)	£100,000
Total Project Cost	£223,000

The project ended in October 2024 and did not achieve its main objective of supporting at least six providers achieving accreditation status, with only one provider achieving accreditation. The network has subsequently evaluated the project's performance and identified that non-delivery was down to multiple different factors including:

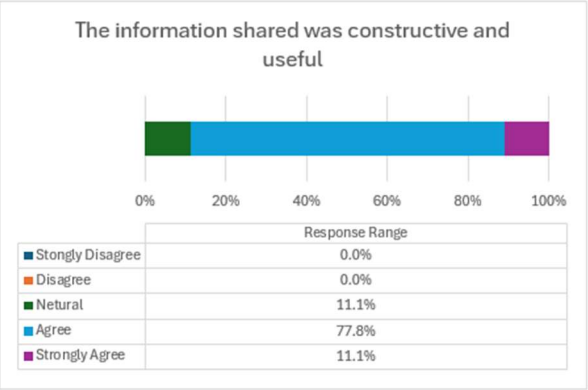
- At the time of project initiation it was understood that providers should be able to achieve accreditation status within two years. However, to allow for the RCP's evidence review and deferral processes, a two and a half to three year timescale would have been more realistic.

- The RCP Accreditation programme requires services to provide a high amount of documented evidence to demonstrate that they are delivering quality PR courses for patients. This creates a high additional amount of work for individuals, teams and services.
- Changes in the strategic direction of the five-year vision for PR with the removal of the national requirement that all services need to achieve accreditation by 2027.

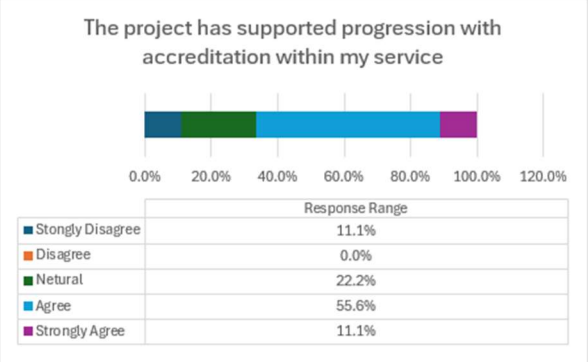
Although the main objective was not met in full, by March 2025 an additional two providers that took part in the project had achieved accreditation and there have been many other positives for the providers that took part;



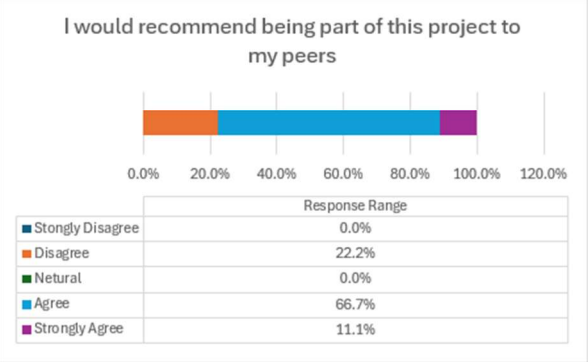
	Response Range
Stongly Disagree	11.1%
Disagree	0.0%
Netural	0.0%
Agree	77.8%
Strongly Agree	11.1%



	Response Range
Stongly Disagree	0.0%
Disagree	0.0%
Netural	11.1%
Agree	77.8%
Strongly Agree	11.1%



	Response Range
Stongly Disagree	11.1%
Disagree	0.0%
Netural	22.2%
Agree	55.6%
Strongly Agree	11.1%



	Response Range
Stongly Disagree	0.0%
Disagree	22.2%
Netural	0.0%
Agree	66.7%
Strongly Agree	11.1%

The network acknowledges that the RCP accreditation programme is the gold standard and therefore encourages all providers to progress with the accreditation programme. However, evaluation of this project has identified that not all services have the resources or the capacity in the short term to undertake the RCP programme. As a result, the network has developed a self-assessment tool based upon BTS standards and best practice, to support providers who are currently unable to complete the accreditation process and to provide assurance that standards are being met.

Objective 2: To Increase referrals, completion rates and reduce the wait time to start a PR programme.

The network has continued 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 and data returns, to help foster a culture of shared learning.

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.

Due to capacity constraints within systems, the network was unable to continue the delivery of the following two objectives:

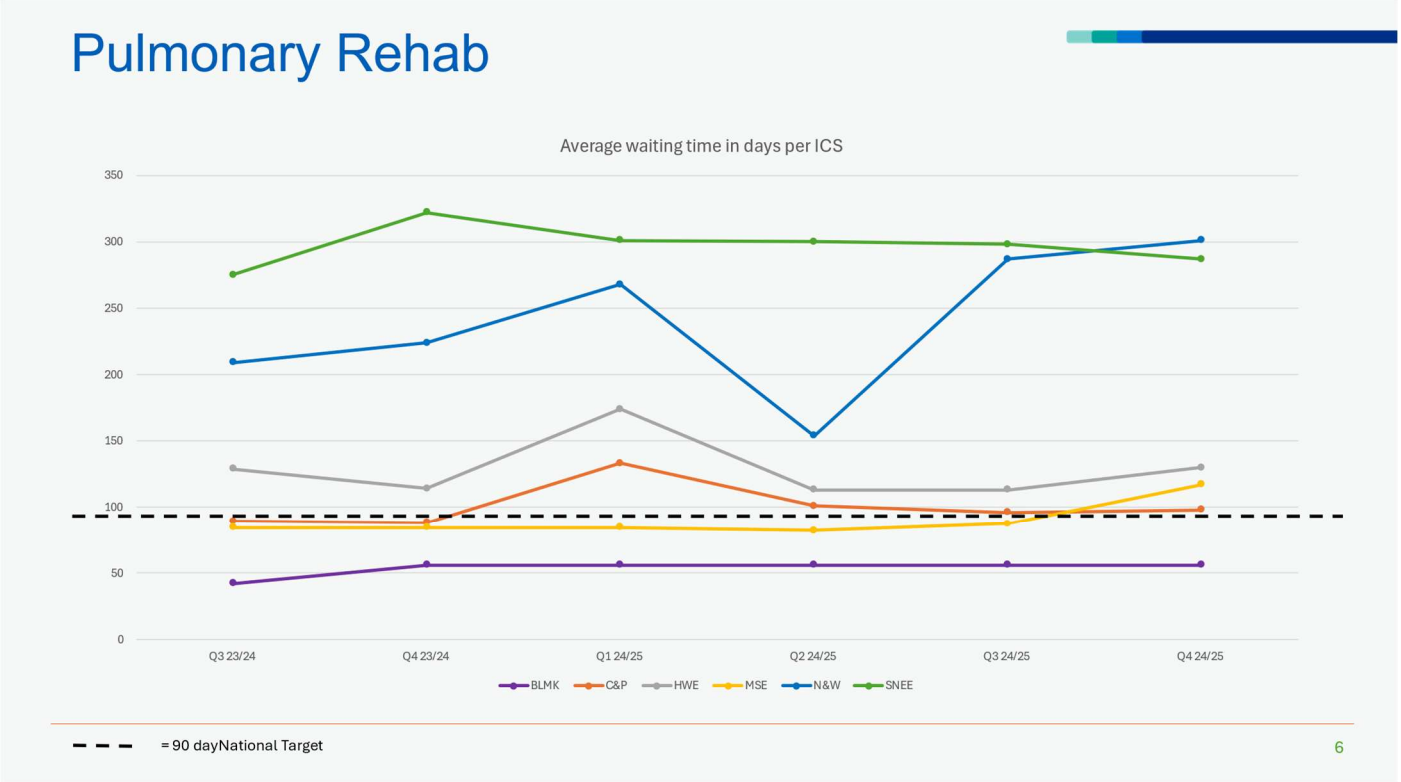
Objective 3:To support waiting list management and ensure prioritisation within the waiting list is established to meet the requirements of the patient.

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.

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

The network became aware of the work being done within BLMK to develop an information hub for PR patients. The network has supported this work with additional funding and helped to champion the hub both regionally and nationally. Additional funding was also awarded to N&W and MSE ICBs to develop their own versions of the hub. MSE have been able to successfully complete the development of their information hub this year and N&W are aiming to complete development of their hub in 2025-26.

The PR workstream is to be incorporated into the new regional COPD workstream from April 2025 (see areas of focus 2025-26 section for more detail). A key metric for the COPD group will be the PR national target of 90-day average waiting to start time. Due to patients in some systems waiting on average three hundred days to start their PR course. In addition the regional average waiting to start time has remained static between Q1 (159 days) and Q4 (149 days) as the below graph shows:



3. 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 systems not having enough staff trained to an accredited level to be able to conduct spirometry testing.

In 2024-25, 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

In addition to supporting the above. The network allocated part of the funding to the delivery of an innovation project to improve early and accurate diagnosis or scaling up of spirometry, that reduces health inequalities. Systems were invited to submit an expression of interest for panel evaluation. BLMK were awarded the funding for a project which looks to establish a hub and spoke model for spirometry in highly deprived areas, and looks to utilise new technologies to support delivery. The project is due to complete in September 2025, and the outcomes will be shared in next year's report.

In order to tackle waiting lists, the network set its sole objective for the diagnostic workstream as follows:

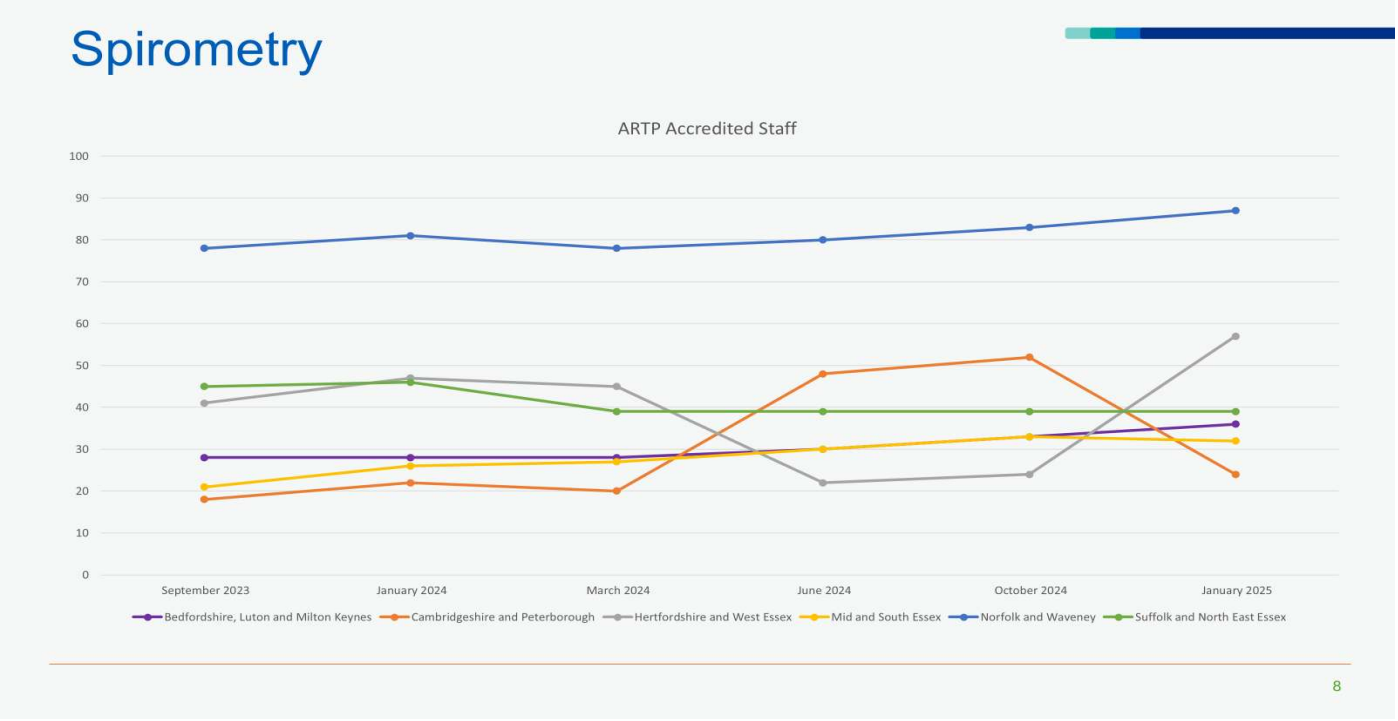
Objective 1: To ensure that patients have good access to accurate and timely diagnostic services across the region, including considering how health inequalities impact on access to services.

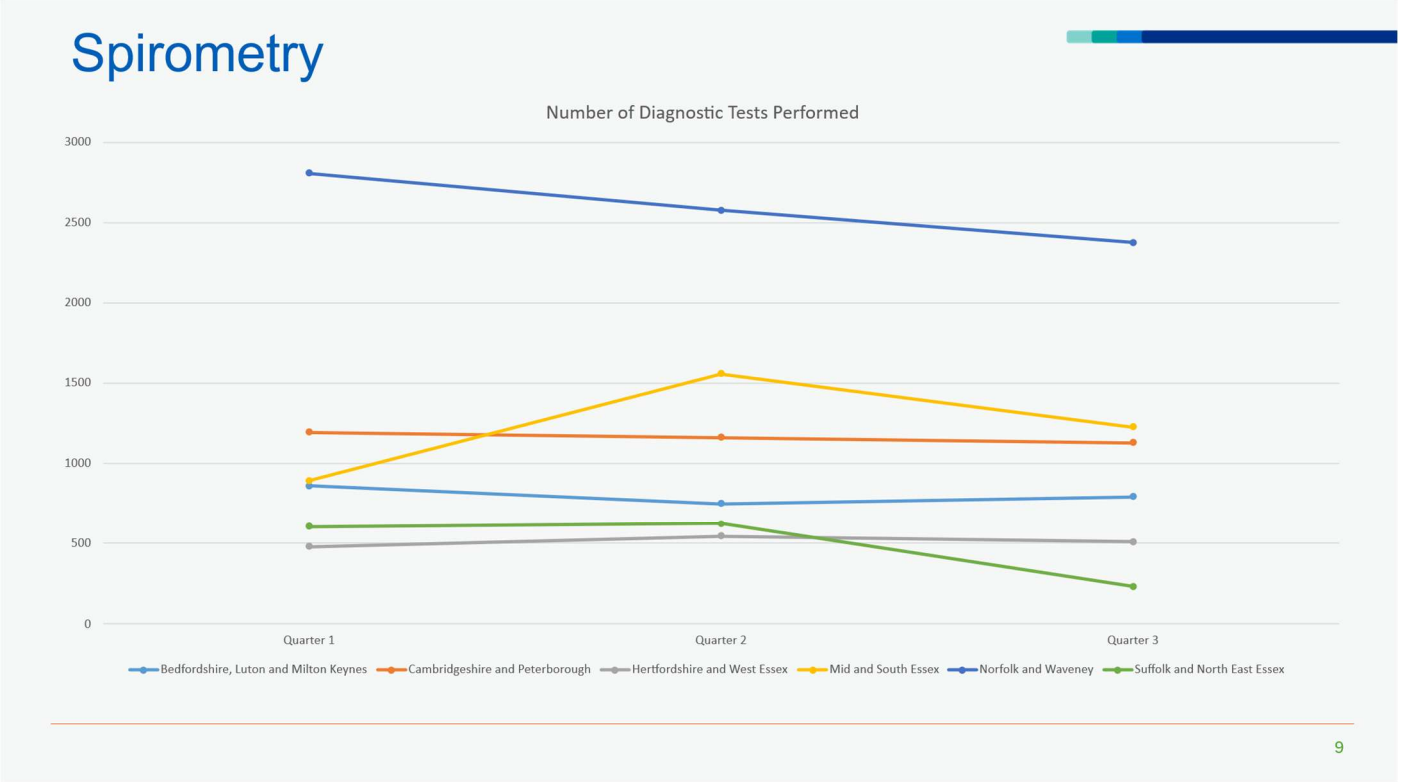
Following on from the successful initiation of a risk stratification project, in partnership with Prescribing Services Ltd (Eclipse) last year. The project group met regularly throughout 2024-25, with key progress made as follows:

- Determined the search criteria to be used to identify high-risk patients.
- Designed and tested the contents of a questionnaire to be sent to identified patients.
- ICB leads given access to their respective Eclipse dashboards.

The project is aiming go-live early next financial year and outcomes will be shared in next year's report.

The network also maintained its regional Diagnostic Models document and 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 in the majority of ICBs seeing an increase in accredited staff, the number of tests being performed has either stayed the same or decreased. Therefore in 2025-26 the network will support ICBs to have improved access to diagnostic services so that patients are not waiting any longer than 6 weeks for a spirometry test.





4 . Asthma

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.

The network focused on four objectives throughout 2024-25.

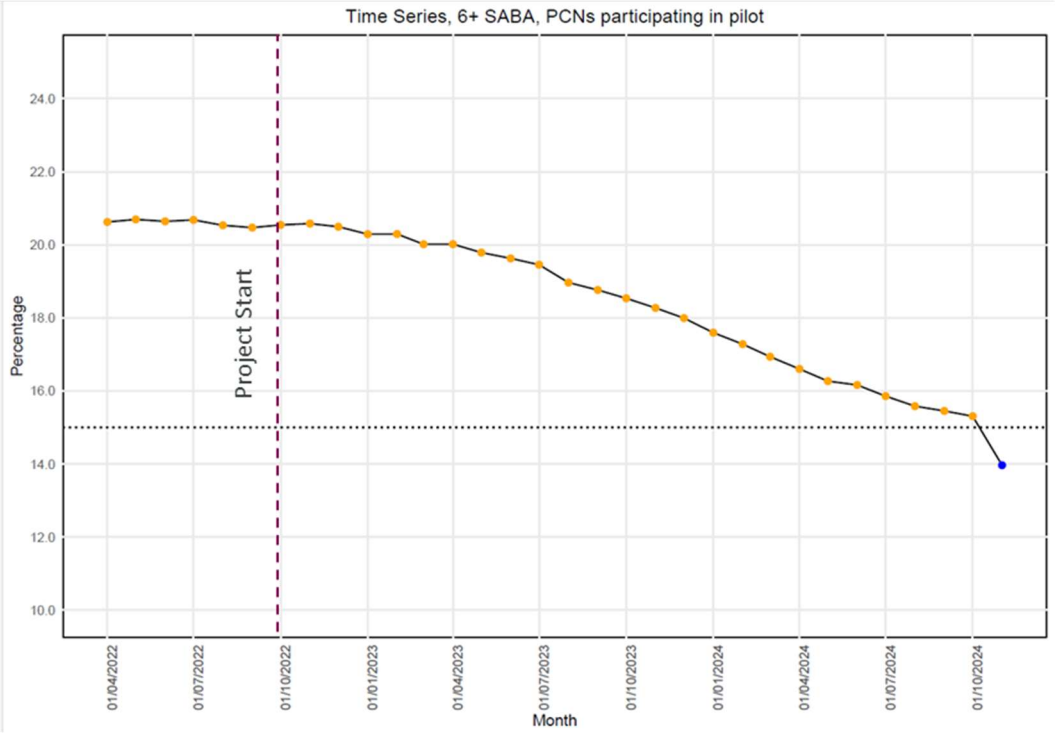
Objective 1: To review, consider and design adjustments to the asthma referral and patient pathways to secondary and tertiary care, supporting their implementation to ensure patients receive the best quality asthma care.

Environmental factors were agreed by the regional asthma steering group as a subject that the network should support systems with. A webinar on cold and mouldy homes was delivered in collaboration with the Children and Young People (CYP) transformation Programme, Public Health, and housing in April 2024, with positive feedback received from attendees. This led to the network establishing a Task and Finish group with CYP, Public Health and housing to take this area of work forward. The group has met regularly throughout 2024-25, with key progress made as follows:

- Developed and piloted a letter template for health colleagues to send to social housing to support patients to address problems with their homes, impacting on their asthma.
- Discussed the development of a toolkit for housing and health professionals. Which will include the above letter, another one for private landlords, along with of other useful contents such as key contacts and case studies. The exact content is to be determined by the group in early Q1 and developed over the next year, with outcomes shared in next year's report.

Objective 2: To work towards a minimal SABA prescribing ambition within the East of England.

The Network in collaboration with BLMK and SNEE ICBs delivered a quality improvement project to support patients to transition from short-acting beta agonists (SABA) inhalers to maintenance and reliever therapy (MART) where clinically appropriate, with sustained changes seen in 6+SABA prescribing in the PCNs that took part in the project:



The network is continuing to implement the key recommendations from the close of project report, which are:

1. To support interested parties as far as reasonably possible to implement SENTINEL Plus into their systems.

The network is part of an ICB project group, that is looking to reduce 6+SABA prescribing within their ICS. Lessons and outcomes of the regional project have been shared. Along with access to SENTINEL Plus, and advice on how best to utilise this resource tool. The network will continue to support this project in 2025-26.

2. Explore further QI projects to support regional uptake of the five core elements of SENTINEL Plus to work towards a minimal SABA prescribing ambition within the East of England.

A Partnership Development Group (PDG) was established in November 2024 to act as a forum between AstraZeneca UK, NHS East of England, ICBs, and Health Innovation East (HIE). One of purposes of the PDG is to enhance and accelerate programme benefits and outcomes across the health sector. Therefore, members of the PDG have met with the network to discuss the feasibility of delivering a SENTINEL Plus programme at Integrated Care System (ICS) level and have established a programme working group to co-design a systemwide SABA reduction Programme.

The key progress of this working group to date has been to develop a programme brief and to successfully engage an ICB to partner. The next steps for the group are to develop and implement a systemwide rollout plan.

3. Continue to review the project metrics and outcomes as part of the agenda of the network's Asthma Steering Group to ensure sustained change.

Regional data dashboards have been created this year, which include asthma prescribing indicators. These dashboards have been reviewed and discussed in various forums, including regional programme board, asthma steering group and meetings with individual ICBs. What we have seen in 6+ SABA prescribing is a continual downward trend with the regional average now below the 15% upper threshold for performance. There are multiple contributors to this regional improvement including:

- The availability of the MART regime on formularies
- Increased patient and clinician awareness of changing inhalers
- Launch of the November 2024 NICE/BTS/SIGN Asthma Guideline
- The impact of the regional SENTINEL Plus project

Regional Asthma Data Dashboard

Indicator	December 2023	November 2024	Regional Trend	Compared to national average
6 + SABA	18.2%	14.7%	↓	Lower (20.0%)
3 + SABA	39.4%	35.6%	↓	lower (40.3%)
2 + Prednisolone	43.0%	42.4%	↔	About the same (43.3%)

Whilst 6 + SABA prescribing will continued to be monitored. The key metrics for the asthma steering group in 2025-26 will be to reduce 3+ SABA and 2 + prednisolone prescribing. With a particular focus on 2+ prednisolone due to it currently remaining close to the national average.

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.

The network developed a regional Asthma Care and Medicines Optimisation Pathway Document - a resource for Health Care Professionals (HCPs) running asthma clinics for patients of all ages, whether in the community or in hospital. The document advises on pharmacotherapy, the asthma consultation, the identification of the high-risk patient, referral pathways, and signposting to resources.

The document follows the November 2024 BTS/NICE/SIGN guidelines and has been developed through engagement with key stakeholders at the regional Asthma Steering Group and the regional

Children and Young People's Asthma Network. It has also been reviewed by various stakeholder groups including those with an interest in respiratory medicine and was approved by the regional programme board in March. The latest version of this document is available on the NHS Futures Site.

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.

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 ICBs to participate in the programme and this project is due to go-live early in 2025-26.

5. 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 (LD). Following discussions with the regional Learning Disability Mortality Review (LeDeR) network and 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.

Objective 1: To support systems to make improvements to the LD annual health check.

A Task and Finish Group was established to design a series of three webinars on the following;

- 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 were delivered to primary care colleagues in 2024-25 and remain available on the NHS Futures Site.

The network also funded an ICB project which is working with a primary care network (PCN) to look at the existing annual health check template and amend accordingly to incorporate more respiratory questions. The ICB plans to assess the project in Q1 2025-26, and the network will capture the outcomes via a case study, that will be shared both regionally and nationally.

Objective 2: To support the reduction in the number of preventable pneumonia deaths.

The Respiratory Network has worked with the LeDeR Network to understand the themes from the ICB annual LeDeR annual reports and the responses to the RightCare toolkit self-assessment tool completed by local systems.

In follow up to the initial findings last year, The LeDeR network and an acute hospital undertook separate deep dives into their individual data, with the findings presented to the regional CAP steering group. These presentations did not lead to the development of further QI projects. However, a presentation from the regional dentistry team about the importance of good oral hygiene was incorporated into the webinars presented to primary care (see CAP objective 1).

Objective 3: To support the improvement in pneumonia 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. In 2024-25 the network worked with an ICB to try and improve their pneumococcal vaccination rates in vulnerable groups. The ICB plans to assess the project in Q1 2025-26, and the network will capture the outcomes via a case study, that will be shared both regionally and nationally.

6. Interstitial Lung Diseases (ILD)

It has been enormously valuable to work alongside the East of England Respiratory Clinical Network to adapt and implement the One-Voice-ILD pathway in the region. A strong emphasis on collaboration between the Network, clinical professionals, patients, and patient groups has led to solutions designed around patient need. The new Regional MDT will bring expert case closer to home for people living with ILD and will undoubtedly improve equity of access across the region.

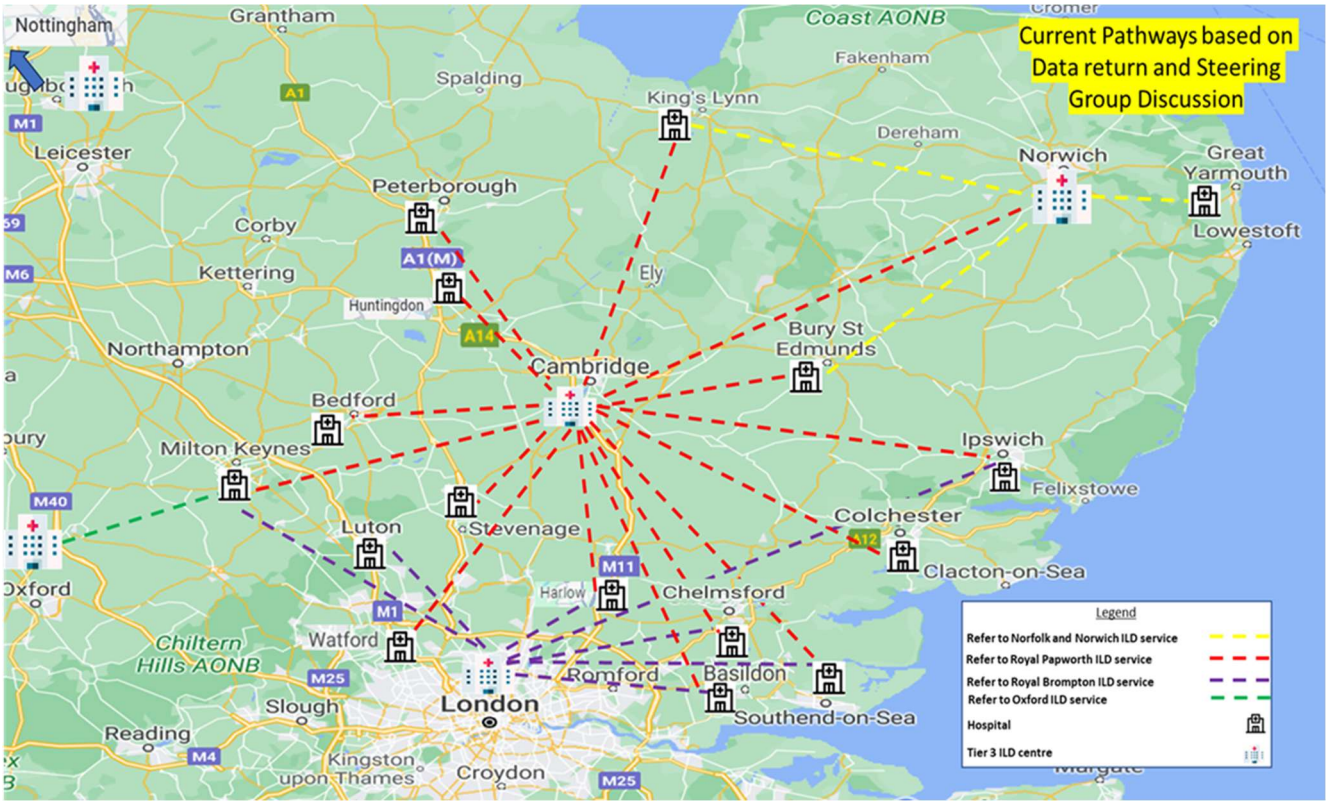
Bradley Price,
Director of Policy, Research and Involvement
Action for Pulmonary Fibrosis

Interstitial lung diseases (ILD) comprise a broad spectrum of conditions, all of which are characterised by inflammation or fibrosis of the alveolar wall with impairment of gas exchange. The commonest of these conditions are idiopathic pulmonary fibrosis (IPF), sarcoidosis and extrinsic allergic alveolitis (EAA). Together these conditions affect between 1,500 and 3,000 individuals in England each year.

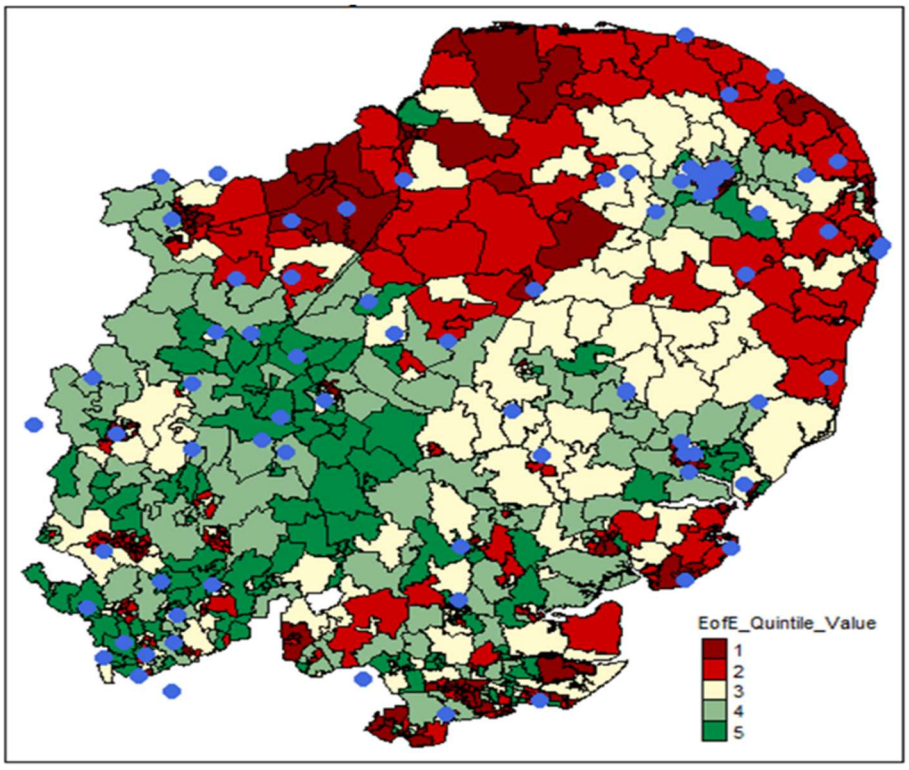
The network organised a face-to-face event in March 2024 with ILD clinicians from across the region. Based upon the outcomes of this event and initial conversations with key stakeholders, the network established an ILD Steering group for 2024-25 with its initial objective being to ensure that patients have fair and equitable access to treatment by supporting the development of ILD services.

A mapping exercise was completed to understand current journey times and costs from referring hospitals to specialist centres for patients. The exercise identified average travel times of one hour

by car and two hours by public transport. People living within higher deprivation areas typically experienced longer and more costly travel times to specialist centres.



This mapping exercise was followed up with a patient survey that was shared on behalf of the network via local ILD clinics and Action for Pulmonary Fibrosis. The survey received a total of one hundred and six responses with good geographical, deprivation, age and gender variation.



The survey responses along with the results from the mapping exercise were used to help scope a QI project that the network could deliver to make improvements ILD care. One outcome of this scoping exercise, was the collaborative working of the network, Royal Papworth Hospital and Health Innovation East to establish a virtual regional MDT meeting for clinicians to review ILD patients with regional specialists. Funding to enable the project was secured through Health Innovation East's Health Care Inequalities programme (InHIP) for 12 MDTs (1 per month) with the first MDT being held in November 2024.

The outcomes seen to date have been extremely positive:

East of England regional ILD MDT data after 5 MDT's

Metric	Outcomes
Number Patients reviewed at regional MDT Minimum target 72 patients – Stretch target 96 patients	61/96
% of patients able to stay under the care of their local service, preventing unnecessary travel	39%
% of patients discussed who have had a change or confirmed diagnosis	77%
% of patients have had alterations to their medical treatment plan	64%
% of patients have been identified as appropriate for antifibrotic therapy.	38%

Next year the network will be supporting the development of regional commissioning standards and shared care agreements for ILD services. As well as continuing to deliver the regional MDT project, with a view of making it a sustainable model.

7. Long COVID

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 December 2023, commissioning guidelines for Post COVID services were published, which included responsibilities for regions. These guidelines were discussed at the regional programme board, where it was agreed that the network would provide the proposed level of support to systems. This support would be delivered through the existing structures, of the individual quarterly ICB

meetings and the Long COVID steering group. It was also agreed that this support would be provided until March 2025, whereupon the network would close its Long COVID workstream.

The sole objective for the Long Covid workstream for 2024/25 was to support the transition of post-COVID services to ICBs. 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 was that the region was not seeing any significant increase in referrals or patient activity. As well as activity trends showing that in general there was a decrease in waiting lists.

To support with the transition of Long COVID services, the network met regularly with ICBs to discuss their plans. As of March 2025, all ICBs had plans in place or were finalising their plans for business as usual services, with three main models emerging for Post COVID services. The first is looking to combine the service with other services such as ME and Chronic Fatigue, the second is a primary care based model and the third is to continue as a standalone service.

As agreed at the regional programme board, from April 2025 the regional Long COVID steering group will close with the work moving to business as usual at the ICBs.

Challenges

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

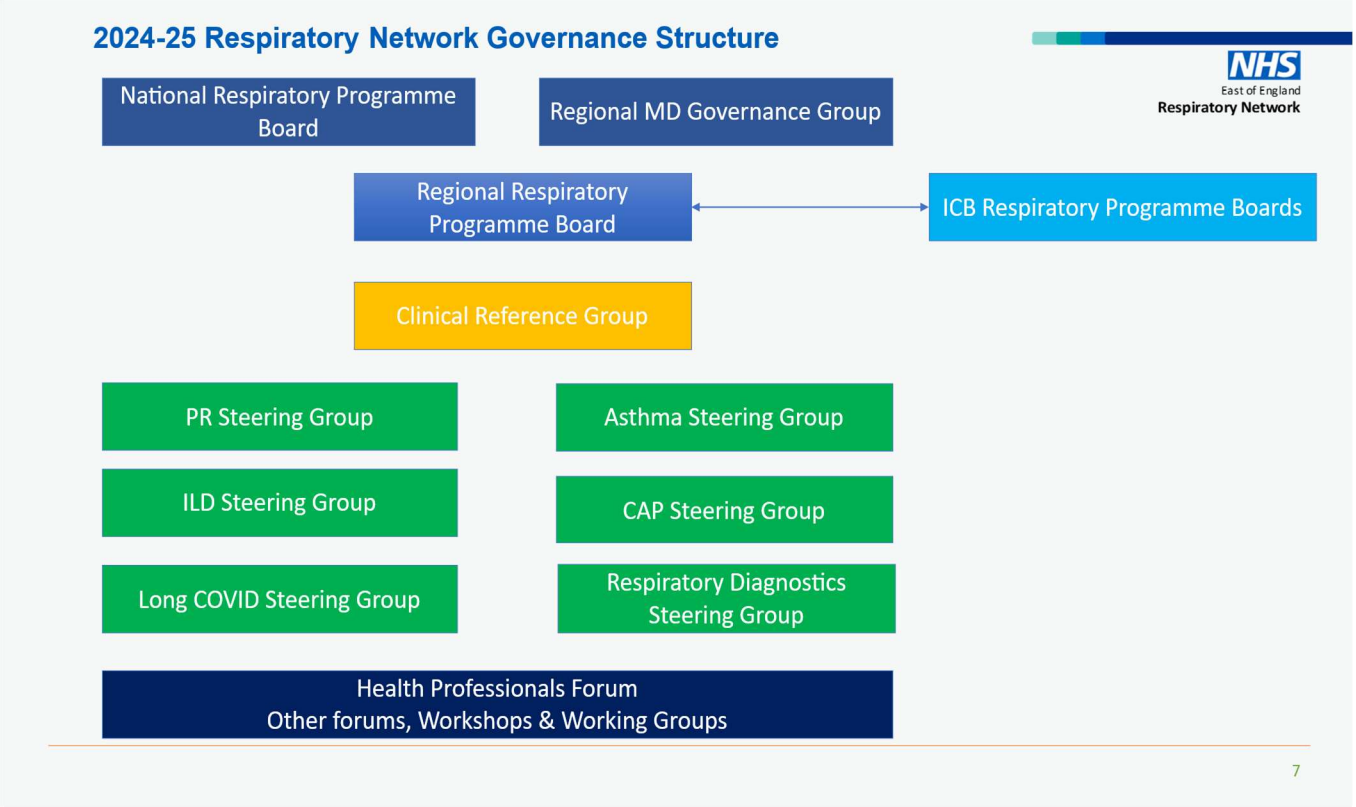
Data: The network has made significant progress in terms of data to inform plans and demonstrate outcomes. However, challenges remain in some areas with meaningful spirometry data remaining a significant challenge for the network to adequately identify capacity, demand and activity issues across the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

2024-25 Network Governance

Existing steering groups were developed and strengthened. Stakeholder engagement with systems and partners remained strong throughout 2024-25 with support forums for initiatives such as integrated care workshops, ARCU peer reviews and winter planning.



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

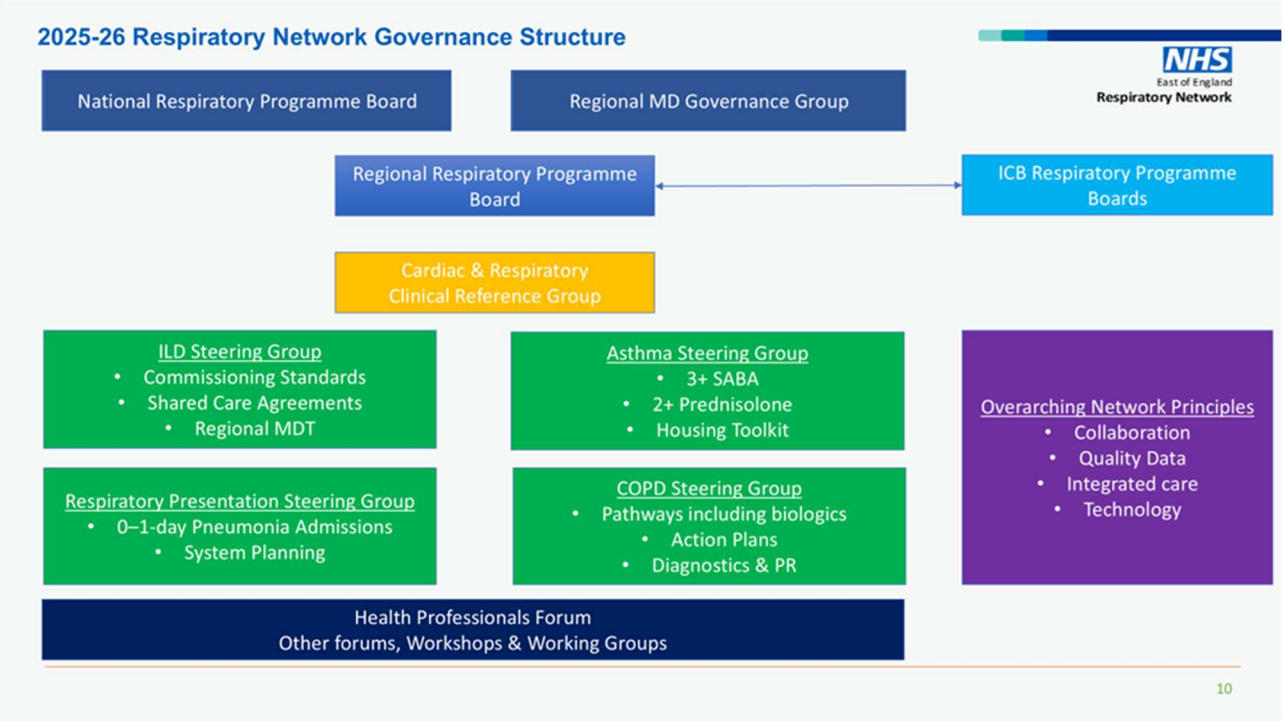
Funding Allocation Description	Amount
Network substantive staffing	£145,089
PMO support costs	£80,742
Clinical Leads	£42,006
Patient/carer representatives	£327

Targeted funding for specific projects (out to systems)

Funding Allocation Description	Amount
Spirometry Training	£100,000
Spirometry QI Project	£79,000

Areas of Focus for 2025/26

A network Priority Setting Workshop was held in January 2025, with programme and clinical representation from ICBs. The workshop's agenda was to review the current network structure, and priorities for 2025-26. Taking into consideration how best to support the implementation of the new 10-year health plan, other national/regional priorities and network capacity. This has led to the approval of a revised governance structure for 2025-26; including a new joint cardiac and respiratory CRG, four steering groups being closed (PR, Diagnostics, CAP & Long COVID) and the establishment of two new steering groups (COPD and Respiratory Presentations).



1. Overarching Network Principles:
Key Principle 1: To enhance the support the network can provide to ICBs 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, pharmaceutical partners and other networks.
Key Principle 3: Throughout 2025-26 to have provided support and guidance as required across the East of England.

2. Interstitial Lung Diseases (ILD):
Key Objective 1: To ensure that patients have fair and equal access to treatment by supporting the development of ILD services.
Key Objective 2: Further development of the regional MDT with a view of making it a sustainable model.

3. Asthma:
Key Objective 1: Support patients to receive the best quality asthma care.
Key Objective 2: To work towards a minimal SABA prescribing ambition by reducing 3+ SABA prescribing to a regional average of 30%.
Key objective 3: Encourage optimal use of oral steroids through the reduction of 2+ prednisolone to a regional average of 15%.
Key objective 4: To support the accelerated access for severe asthma patients to timely and appropriate expert care and treatment.

4. Respiratory Presentations:
Key Objective 1: Reduce 0–1-day hospital admissions.
Key Objective 2: Development of system wide plans for respiratory that consider, a) Pro-active detection of high-risk patients. b) Effective use of alternative treatment pathways e.g. PIFU & Virtual Wards.

5. Chronic Obstructive Pulmonary Diseases (COPD):
Key Objective 1: Develop integrated COPD pathways with ICBs from prevention to end of life care.
Key Objective 2: Patients have improved access to diagnostic services by waiting no longer than six-weeks for a spirometry test.
Key Objective 3: Patients continue to have access to high quality PR services by reducing the regional average for waiting to start PR to 90 days.

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

Nino Lumonsgod (July 2024 – Jan 2025)
Renal Network Manager

Helena Baxter
Head of CVD, Respiratory, Diabetes and Renal Networks, East of England

Gail Murray
Commissioning Manager, East of England Specialised Commissioning

Vacant
Nursing Lead

Harwinder Singh
Network Administrator

Dr Vivian Yiu
Acute Kidney Injury Lead

Dr Poorva Jain
Chronic Kidney Disease Lead

Dr Dominic Summers
Transplant Lead

Dr Michael Fawzy
Dialysis Lead

Dr Gowrie Balasubramanian
Systems Working Lead

Olivia Kanka
High Cost Drugs and Medicines Optimisation Lead

Rachel Jones
ENKID Clinical Lead

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)
    - 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 renal providers in region and 2 out of region renal providers. The region has 1 transplant centre (Cambridge University Hospital Trust) and is supported by neighbouring transplant centres in London and Oxford. Post transplant care is managed by 6 of the 7 renal providers

Network performance and achievements

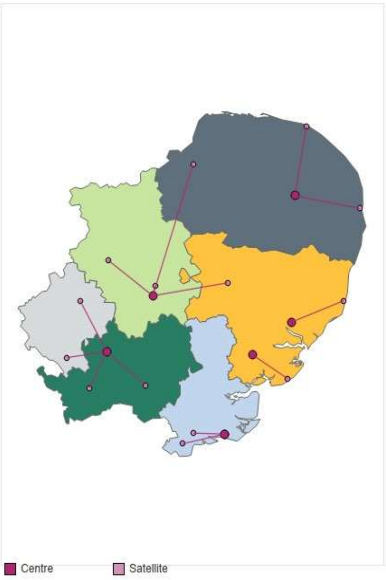
Dialysis - Centres and satellites

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.

The Network has made significant progress in 2024-25 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. However, some delays were encountered by vacancies in key roles affecting some of the workstreams.

Work commenced in 2023/24, such as the Patient Reported Experience Measure (PREM) was continued in 2024/25, with regional participants encouraged to undertake quality improvement initiatives from the results.

"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

Renal Network workstreams

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

The network supported the ENKID programme and secured the continued 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.

This programme is now embedded in the East of England and is in it's second year. It operates independently of the renal network.

2. High-cost Drugs and Medicine Optimisation (Pharmacy)

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 established a pharmacy steering group in 2023, which has excellent engagement across the region. The group, which meets on a regular monthly basis, 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. In 2024-25, three new renal pharmacists within the region have been added to this group to ensure that all renal units in EOE are represented and to ensure equity of care to all renal patients across the region.

The network recruited a High Cost Drugs and Medicines Optimisation lead in October 2023, which has been continued through 2024/25 and now extended to March 2026. Key achievements include:

- Establishing Green Formulary status for dapagliflozin, empagliflozin and finerenone for all ICBs across the region.
- Sharing implementation plans/guidelines for drugs including avacopan, voclosporin, roxadustat, targeted-release budesonide (Kinpeygo) and vadadustat.
- Supporting delays in implementation of ICB-funded medication to ensure equity of access across the region.
- Writing the CKD pathway for primary care in conjunction with GPs, which has now been shared across all ICBs in the region.
- Designing and completing a survey for the ENKID MDT to understand how the MDT is being used and attended, as well as local access to specialist MDTs within the region. This has helped to aid decisions regarding at which trusts blueteq forms should be switched on. Next steps will be to use the data from ENKID meetings on the electronic system Epic at CUH to postcode map prescribing and identify variation in prescribing of high cost drugs. This data can be used to drive education and resource where needed.
- Establishing a collaborative approach to issues and risks such as medication shortages.
- Regional tacrolimus brand switch from Advagraf to cheaper brands - either Daliport or Envarsus, which will be a huge cost saving to the NHS. NHSE have agreed to fund payment per patient successful switch to enable trusts resource this switch appropriately. All trusts in the region have the brand on their formulary, have commenced new patients on the new brand and are ready to initiate the switch programme in 2025/26.

3. Acute kidney Injury (AKI)

The AKI workstream has been focused on raising awareness, education and reducing incidence of AKI specifically involving virtual wards. Discharge processes and audit tools.

Awareness and identification of risk of AKI in healthcare professionals led to a letter to the regional post-graduate medical schools requesting for AKI to be included in junior doctor induction training and made available to all members of the multi-professional health care teams. An audit tool was developed it focus on the number of patients being flagged with AKI on admission with a plan for junior doctors to complete this audit for their own Trusts later in the year.

The steering group linked with the EoE Cardiac Network to share best practice and promote 'sick day rules' to help reduce the risk of AKI in heart failure patients. They also promoted the use of warning cards for patients if they are prescribed certain medications for the first time. The longer term aim is to engage pharmacists and primary care across the region with this patient education material. One ICB (SNEE) has already launched this with through their pharmacies.

- The workstream engaged in activities for the AKI Awareness Week in September. This included;
- Social media campaigns
- Developing education materials, such as AKI and fluid management in care homes
- Promoting wider awareness through other regional networks, particularly cardiac and diabetes
- Identifying and targeting high risk groups

West Suffolk Hospital also developed an electronic alert on their Patient Administration System for patients with AKI stages 1-3+. The alert directs doctors to relevant templates and assessments, such as blood tests, urine tests and ultrasound which can be used to initiate a care plan. This alert system has been shared with Mid and South Essex Trust and the wider network.

In September, a webinar was held on AKI aimed at primary care, community teams, care home teams and secondary care to learn more about how to identify patients at risk of, diagnose and manage patients with, AKI. This included the 'sick day' guidance and importance of fluid balance.

The AKI education workstream for UK Kidney Association was co-led by Karen Nagalingam (East of England) and Dr Lynne Sykes (North West) and involved a national multi-disciplinary group who worked on developing resources. This included input from various clinical leads across the country including Dr Vivien Yiu (AKI education lead for East of England). In April 2025 Acute Kidney Injury: The essentials https://education.ukkidney.org/courses was published as a free e-learning package designed to give clinical staff an introduction to acute kidney injury and is accessible through the UKKA website.

4. Chronic Kidney disease (CKD)

Chronic Kidney Disease affects between 6-10% of the population and is key area for focusing prevention and early intervention to prevent progression to end stage renal disease.

Supported by the CVD Prevention Clinical Advisory Group in the region, webinars and meetings with ICB prevention leads have taken place to highlight the need for CKD interventions. In the latter part of the year, the renal network began to work collaboratively with pharma companies to support the agreed principles improving;

- Identification and coding of patients with CKD
- Risk stratification
- Early intervention and management of CVD risk factors to reduce progression of the disease

Alongside this is the need for better patients information and primary/community care education and more integrated working with secondary care providers to support patients outside the acute care setting. It was agreed that the LUCID project run in Leicestershire and Rutland in conjunction with Astra Zeneca would be promoted in the region commencing in 2025/26.

Initial data gathered from the UK Kidney Research CKD calculator estimates for CKD prevalence and CVD Prevent prevalence of East of England registered patients with CKD stages 3a-5 suggests a considerable gap in case finding.

ICB	All stages CKD	Predicted CKD 3a-5	CVDP registered 3a-5 (Sept 24)	Gap
C&P	90,700	40,815	28,025	12,790
BLMK	87,540	39,393	25,760	13,633
HWE	150,850	67,882	46,850	21,032
MSE	133,170	59,926	44,220	15,706
N&W	129,160	58,122	45,975	12,147
SNEE	149,320	67,194	49,395	17,799

Some areas, such as N&W and SNEE have a high proportion of patients over 50 years old and therefore the prevalence of CKD may be higher than estimated.

In March 2025, a new steering group was formed from the renal network, CVD Prevention network, Health Innovation East and Astra Zeneca to develop the plan for the coming year. The objectives for this group are to;

- Increase casefinding
- Improve the management of unmet need in cardiovascular risks, eg hypertension and high cholesterol
- Increase appropriate use of SGLT2 inhibitors in high risk patients
- Adopt the LUCID programme across the region.

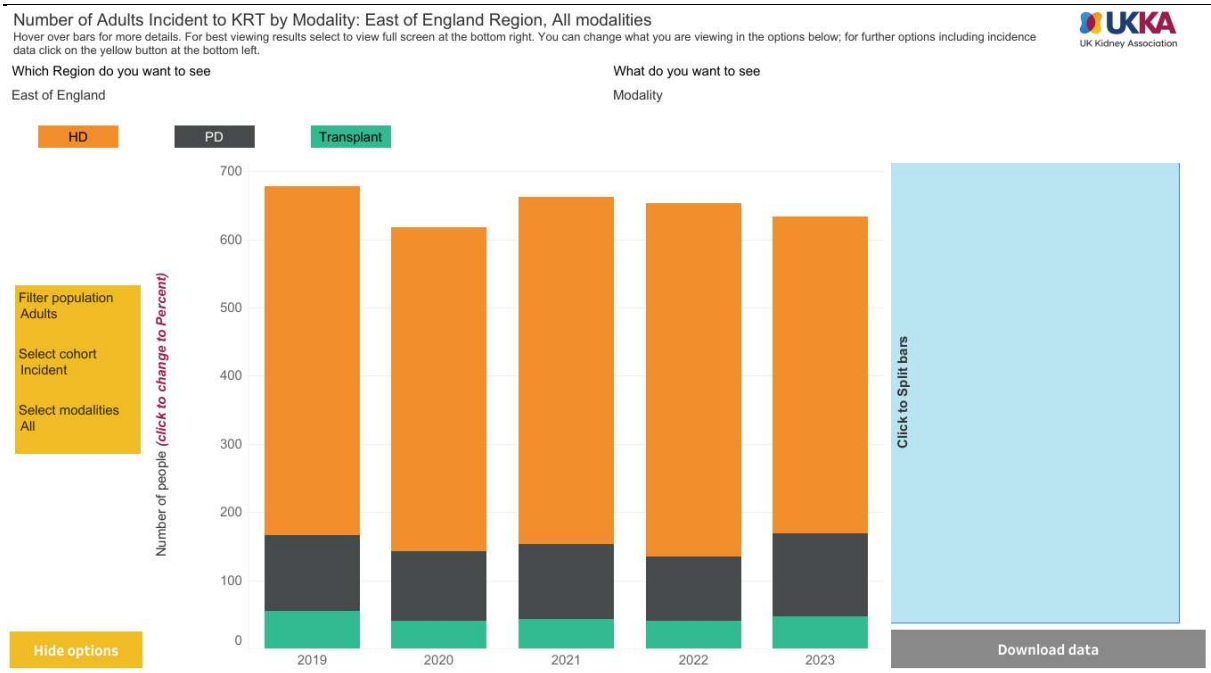
5. Dialysis

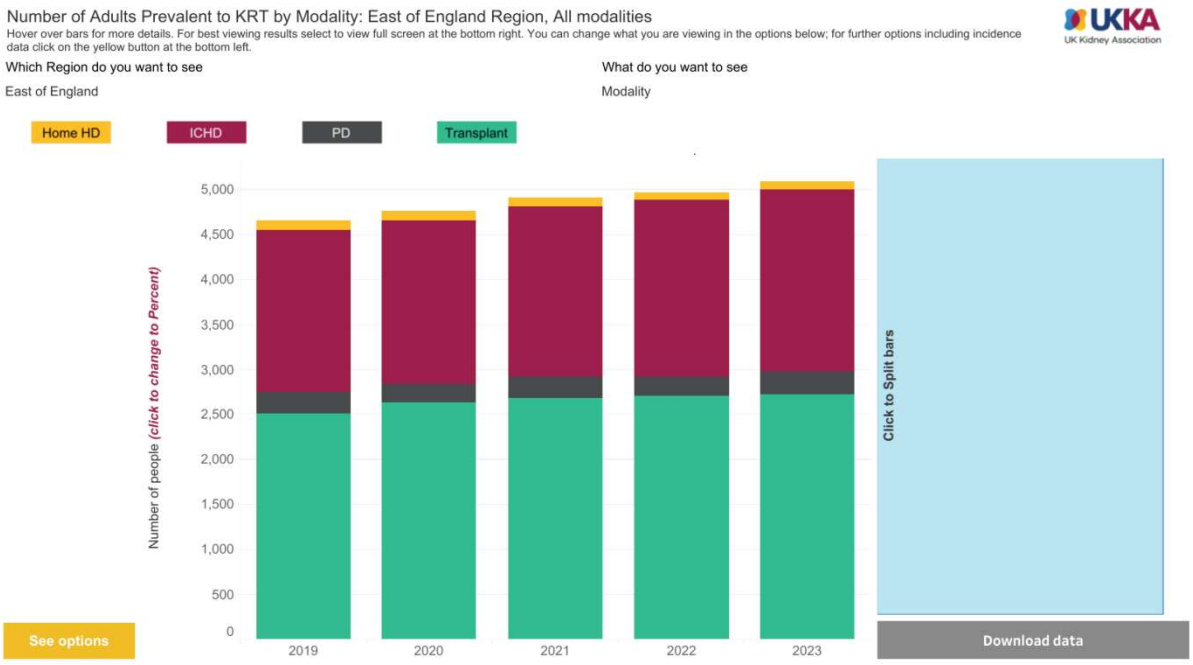
There has been an increasing need for people needing renal replacement therapy in the East of England.

In 2023, in the East of England

1. There were more than 5000 people who required kidney replacement therapy; more than 50% with a functioning renal transplant, but only 14.5% of dialysis patients doing a home based therapy
2. 634 people started kidney replacement therapy in 2023, with the largest proportion starting with haemodialysis (73%) and least with a pre-emptive transplant (7.4%)

The number of patients on home dialysis is still low compared to the national target of 20%, which puts increased pressure on in-centre dialysis units, where there is need for increased workforce and capital estates resource.





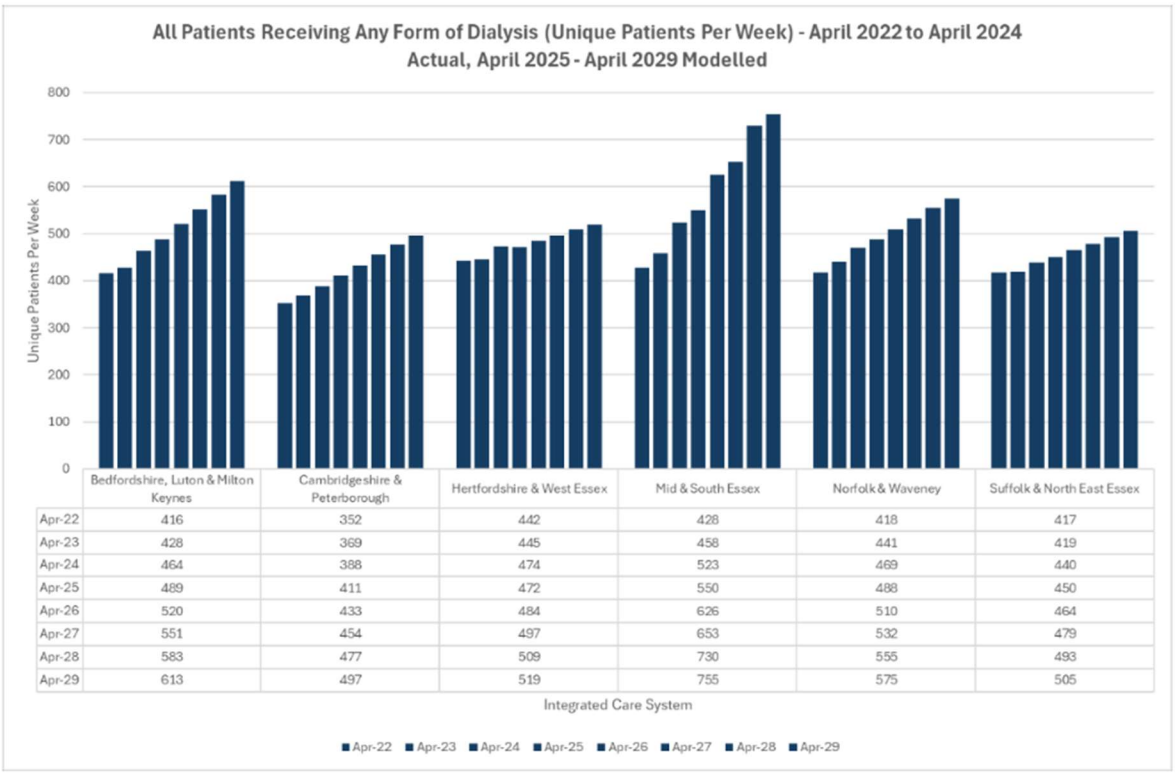
Data Source: UKKA Data Portal

The network has established demand and capacity model, to

1. Predict dialysis growth in the region with more real time data compared to the UKKA data portal
2. Support right sizing of in-centre dialysis units and aim for patients to be managed as close to home as possible
3. Support resource management for home based therapies
4. Develop a strategic model of renal care for the region

The 3 strands of this modelling uses current data submissions (updated monthly) from renal providers to the commissioners to predict dialysis needs for the next 5 years

1. Capacity needs for dialysis for the next 5 years
    a. Current dialysis patient growth is 5% per annum in the EOE with some ICBs growth as high as 8%
2. Using the Dialysis Occupancy Measure (DOM) – a national tool developed by the London Kidney Network – to report estates and staffed capacity for in-centre dialysis units
    a. 65% of units are above the 90% threshold for estates operational capacity
    b. 67% of renal providers are using inpatient wards, home therapy areas and acute dialysis units to dialyse chronic dialysis patients, to mitigate lack of estate capacity
    c. The staffed capacity usage for the EOE is 101.4% (over capacity)
3. Predict population based geographical needs for dialysis (currently in progress)



	Bedfordshire, Luton & Milton Keynes	Cambridgeshire & Peterborough	Hertfordshire & West Essex	Mid & South Essex	Norfolk & Waveney	Suffolk & North East Essex
Apr-22	416	352	442	428	418	417
Apr-23	428	369	445	458	441	419
Apr-24	464	388	474	523	469	440
Apr-25	489	411	472	550	488	450
Apr-26	520	433	484	626	510	464
Apr-27	551	454	497	653	532	479
Apr-28	583	477	509	730	555	493
Apr-29	613	497	519	755	575	505

Source: NHS Digital Patient Level Contract Monitoring Dataset (Analysis), East of England Cardiovascular & Respiratory Disease Network (Analysis)

Fig .Growing need for dialysis in the EOE ICBs

ESTATES CAPACITY

Month	Max Estates Capacity (stations x6)	Actual no PATIENTS in month	Patients as a % of Max Estates Capacity
Apr-24	2,586	2,347	90.8%
May-24	2,586	2,367	91.5%
Jun-24	2,586	2,380	92.0%
Jul-24	2,586	2,377	91.9%
Aug-24	2,586	2,396	92.7%
Sep-24	2,586	2,416	93.4%
Oct-24	2,586	2,438	94.3%
Nov-24	2,586	2,425	93.8%
Dec-24	2,586	2,444	94.5%
Jan-25	2,586	2,446	94.6%
Feb-25	2,586	2,465	95.3%
Mar-25	2,586	2,467	95.4%

Predicted Model

STAFFED CAPACITY (overestimates as 2x/week not factored)

Month	Max Staffed Capacity (including 2 sessions extra capacity)	Actual no PATIENTS in month	Patients as a % of Max Staffed Capacity (inc 2 sessions)
Apr-24	2,392	2,347	98.1%
May-24	2,396	2,367	98.8%
Jun-24	2,396	2,380	99.3%
Jul-24	2,396	2,377	99.2%
Aug-24	2,396	2,396	100.0%
Sep-24	2,384	2,416	101.3%
Oct-24	2,408	2,438	101.2%
Nov-24	2,428	2,425	99.9%
Dec-24	2,432	2,444	100.5%
Jan-25	2,432	2,446	100.6%
Feb-25	2,432	2,465	101.4%
Mar-25	2,432	2,467	101.4%

Predicted Model

Month	% of patients on 2 sessions a week
Apr-24	15.6%
May-24	32.4%
Jun-24	12.9%
Jul-24	13.8%
Aug-24	13.3%
Sep-24	13.4%
Oct-24	13.5%
Nov-24	0.0%
Dec-24	0.0%
Jan-25	0.0%
Feb-25	0.0%
Mar-25	0.0%

STAFFED SESSIONS CAPACITY (underestimates as 2x/week not factored)

Month	Total number of sessions deliverable in month	Actual no SESSIONS in month	Sessions as a % of Deliverable Sessions
Apr-24	31,096	28,107	90.4%
May-24	31,148	29,238	93.9%
Jun-24	29,921	27,294	91.2%
Jul-24	32,375	29,551	91.3%
Aug-24	32,375	29,638	91.5%
Sep-24	29,834	27,576	92.4%
Oct-24	32,470	29,866	92.0%
Nov-24	31,564	0	0
Dec-24	31,616	0	0
Jan-25	32,863	0	0
Feb-25	29,184	0	0
Mar-25	31,616	0	0

Fig .Dialysis Occupancy Measure for the EOE indicating operational pressures for capital estates and workforce

LKN London Kidney Network

Summary

NHS

Region: **East of England**

Overall

6 Trusts
20 Locations reported on

20 Chronic funded locations
(4 other locations activity reported as part of main unit, contributed to overall data are escalation capacity or ward based**)**

Estates Capacity

6 Trusts
20 Locations reported on

67% (4 of 6 Trusts) operating above **90%** Kidney DOM threshold

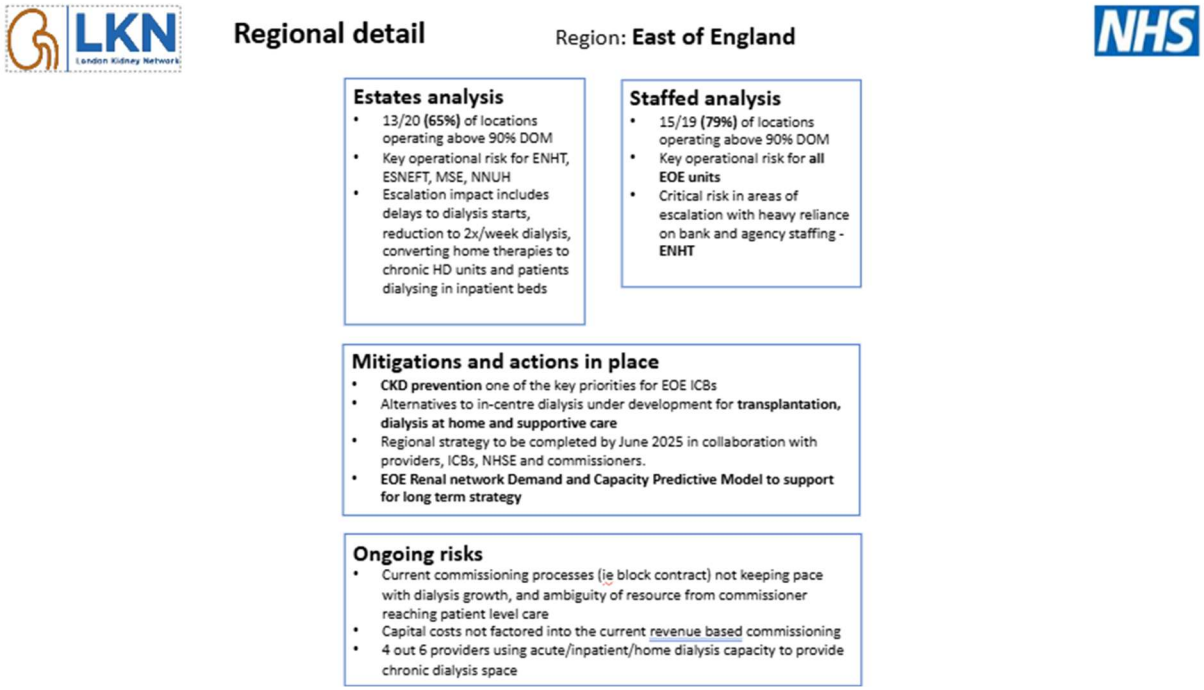
65% (13 of 20 Locations) operating above **90%** Kidney DOM threshold

Staffed Capacity

5 Trusts
19 Locations reported on

100% (5 of 5 Trusts) operating above **90%** Kidney DOM threshold

79% (15 of 19 Locations) operating above **90%** Kidney DOM threshold



6. 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 network wide collaboration.

In October 2024 at the East of England Renal Network day, data about referral patterns for transplantation across the region was presented to delegates, alongside the draft referral guidelines. It is expected that the referral guidelines will help increase the number of patients listed (and transplanted) pre-dialysis and reduce inequity across the region, as well as providing audit standards to assess referral patterns in future.

Repatriation data (patients returning to their local units following transplantation) was analysed during the New Year of 2025 and presented at the Transplant Education Symposium in April 2025. These data demonstrated widespread disparities in access to local transplant services following transplantation. In collaboration with the Pharmacy leads, Dailiport has begun to be rolled out across the region, with all new transplant recipients in Cambridge receiving Dailiport. The research programme to improve evaluation of patients prior to transplant listing has received funding and is awaiting a formal ethical review prior to starting.

The network facilitated and organised a regional Transplant Education Symposium in April 2025 with around 90 attendees from full wider multidisciplinary team. The education day included a presentation of the repatriation data, along with a wider discussion with attendees about developing an improved pathway for returning care more locally. The feedback from the attendees was excellent with an average response of 4.56/5 for the quality of the talks.

Quotes from the education day

‘That there is so much interesting work and research going on, and plenty of ideas and scope to enhance the day to day work.’

‘Some inspirational and some practical information’

'Got us all together to discuss stuff that we wouldn't usually have time for. Great to hear about colleagues work and research. Essential for group.'

'Good venue and opportunities to network and receive relevant updates'

Plans for next year:

- Set up transplant steering group to meet regularly and facilitate referral pathways
- Introduce pathway for returning patients to base centre.
- Set up Transplant Symposium March 2026
- Start research programme into recipient evaluation across renal network.
- Explore and develop obesity management programmes for potential transplant recipients.

7. 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.

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.

Whilst most patients preferred to use hospital transport for their dialysis, the delays at either end of the journey were identified as a cause for concern in patient experience. Feedback from PREMS has suggested that this has become progressively worse since 2021 with poor communication, co-ordination and timeliness.

The group conducted a deep dive into one system's transport delays and an East of England Transport Framework was developed. It recommends that each ICB should appoint a designated dialysis transport SRO, with the region committing to a 60 min tolerance for delays for drop off and pick up times, although reporting of this metric is inconsistent. Locally, several providers have instigated regular meetings between the hospital transport service leads, Patient Transport Services (PTS) and the dialysis units to discuss and resolve local issues.

The group continued to work with national colleagues to implement the reimbursement scheme for patients who use their own transport but recognised that this may not be a universally financially viable option.

8. Sharing Best Practice

The network held a variety of face-to-face events and webinars during 2024/25

Face to face events:

- East of England Renal Network Day, 27th November 2024

- Renal Workshop, 23rd January 2025

Webinars:

- Acute Kidney Injury Webinar, 16th September 2024
- Chronic Kidney Disease Webinar 1st October 2024

9. Quality Improvement Projects.

A number of quality improvement projects were funded by the network following expressions of interest. These included;

Development of a cloud-based electronic referral portal linking the trust and renal electronic patient record – this project has now been implemented successfully and the Trust is now getting the majority of referrals via the portal.

Embedding Patient Activation in Advanced Kidney Care Clinics – this project has been delayed by approximately 6 months but is expected to deliver within 2025/26.

Development of a Renal Simulation Programme – the team have now completed 4 simulation days and have another 4 planned for the rest of the year. Feedback has been very positive and the lead consultant will be presenting to the local patient board meeting. The educational simulation sessions were designed with patient involvement using co-production methodology.

Structured Weight Management Clinic – 10 patients have completed the programme with 80% of them losing weight by attending the structured weight management clinic. Besides weight loss, positive outcomes for patients included;

- One patient no longer requiring insulin due to their healthier diet and reduction in carbohydrate intake
- One patient had much improved mobility and was no longer reliant on taxis for short distances
- One patient was activated on the transplant list having achieved the weight loss required
- Two patients will have achieved the weight loss required for transplant once they become eligible for listing.

Patient feedback was very positive with all respondents saying they felt more confident in knowing how to lose weight safely and having the additional support from the programme. The dietitians are keen to incorporate this programme into the main service as a result of the project.

Kidney Beam – Kidney Beam is a kidney-specific exercise and lifestyle management app that was funded for the whole of the East of England region. All sites were included and were encouraged to

have Kidney Beam champions in their units. In total, 251 patients signed up and 70 activated their accounts. Requirements for on-going Kidney Beam applications are being discussed with units and with ICBs.

Integrated CKD Nurse Specialist – The CKD Outreach programme was developed to achieve much more than increased capacity and care nearer to home. They establish secure connections with primary care providing post-graduate training, opening up lines of communication facilitating not only optimal prescribing to prevent progression of CKD, but also supporting all aspects of management of patients with kidney disease including diagnosis and appropriate triage of referrals. The funding awarded by EoE Renal Network has allowed employment of a CKD Outreach Nurse to support this programme. ESNEFT has provided matched funding to make this a 2 year appointment.

This nurse started work on 1.3.25. The work has initially focused on establishing clinics in two practices. The first two clinics have taken place in one practice with monthly clinics now scheduled. The first clinic in the second practice will take place in June

Key Challenges

Vacancies

There were a number of vacancies in crucial roles within the network during 2024/25. The Programme Manager post was vacant and then filled temporarily until January 2025 when further recruitment was required. The Nurse Lead post was vacant for most of the year despite attempts to recruit. This was filled in January, but had a major impact on the progress of the nursing workstream.

Delegation of renal services to the ICB

Renal dialysis was delegated from Specialised Commissioning to the East of England ICBs in April 2024. This delegation led to changes within the ICBs and new governance arrangements for delegated services. Engagement from ICBs improved throughout the year and identifying key stakeholders continues to be critical to the functioning of the network.

Network Governance

The network is governed by the CVDR clinical networks team in the Medical Directorate with input to the Joint Commissioning Committee for Specialised Commissioning. The CVDR network and Specialised Commissioning teams continue to work closely together.

The network programme board meets quarterly to review network progress against the work plan, review any risks and steer strategy. The Renal Operational Delivery Network meets monthly to identify any operational progress, challenges and risks not covered by the overall Renal Network priorities.

Areas of Focus for 2025/26

1.The programme plan for 2025/6 has reduced in the number of workstreams it intends to develop. This is a direct result of the capacity and demand modelling conducted for renal dialysis and the dialysis occupancy measure which identifies a considerable level of risk in dialysis capacity over the next 5 years. The programme has been aligned to prioritise those areas which will have the greatest impact on reducing the demand for dialysis in future years.

2. Chronic Kidney Disease – appropriate treatment and management of early CKD can delay or prevent end stage kidney failure requiring renal replacement therapy. The focus of this workstream in 2025/26 will be;

- Identification and coding of patients with CKD stages 3a-5
- Risk stratification
- Early and appropriate intervention, including the optimisation of cardiovascular risk factors.
- Education for Primary Care and patients
- Virtual MDT

3. Dialysis –

- Further refinement of capacity and demand and dialysis occupancy measure
- Right sizing current capacity and provision with the New Hospitals Programme
- Increasing home dialysis to a target of 20%
- Shared decision-making

4. Transplant – this workstream will focus on improving pre-emptive transplantation, including;

Improving optimisation and listing of patients for transplant and managing transplants closer to home

5. High Cost Drugs and Medicines Optimisation – continuing to support collaborative working across the region, supporting professional development and ensuring equal access to high cost drugs.

6. Nursing – focus on workforce for home haemodialysis and peritoneal dialysis, transplant education and the transition of young adults on haemodialysis from paediatric to adult services.

7. Health Equity – ensuring all workstreams and projects are viewed through a health equity lens, ensuring equal access to all services regardless of ethnicity, deprivation, and health literacy.

8. Development of a renal dashboard reflecting metrics from GIRFT and RSTP.

Network Budget

The Renal Network is funded through Specialised Commissioning on a recurrent basis with additional funding provided for the ENKID workstream. The renal network is externally hosted by East and North Hertfordshire NHS Trust.

The renal network received a budget of £212,747 for 2024/25.

1. **Network staffing:**

Funding Allocation Description	Amount
Network staffing	£91,171
Clinical leads	£38,638
Hosting Fee	£12,000

Network staffing costs were lower than expected this year due to a number of vacancies across the year in key posts. A surplus of £68,000 was generated, £55,000 of which was allocated to one of the ICBs who were not awarded quality improvement project funding in the previous year. Norfolk and Waveney will be running a project to identify, code and risk stratify patients with chronic kidney disease for delivery in 2025/26.

6. Diabetes Clinical Network

Diabetes Clinical Network

At the East of England Diabetes Clinical Network, our vision is to enhance the quality of life and health outcomes for people living with diabetes, as well as those at risk of developing type 2 diabetes. We do this by supporting clinicians, healthcare providers, and commissioners in delivering high-quality diabetes prevention and care. Our focus includes reducing inequalities of access to optimal care, eliminating unwarranted variation in care pathways and promoting the sharing of best practice. This is driven by regional support for local initiatives and alignment with national programmes.

The Network continues to build strong partnerships with all six Integrated Care Systems (ICS) across the region, as well as with key stakeholders such as Diabetes UK.

Throughout 2024/25, ICS and primary care business planning assurance processes have been underway to guide the use of national funding. These efforts have prioritised key areas including supporting ICBs in delivering the Hybrid Closed – Loop 5-year implementation strategy, improvements in the achievement of the eight care processes, the promotion of diabetes prevention, support for Type 2 Diabetes Remission, and the expansion of the Type 2 Diabetes in the Young Programme.

Network priorities for 2024/25

Priorities were similar to those in 2023/24, built on the Long-Term Plan, but with new national priorities for people with diabetes. ICSs were provided with funding to support the national programmes through baseline funding and service development funding (SDF)

Priorities for use of national programme funding in 2024/25:

1. Increase primary care referrals to the NHS Diabetes Prevention Programme across all ICBs *(LTP).*
2. Increase and support uptake of primary care referrals to the NHS Type 2 Diabetes Remission (T2DR) programme.
3. Support people with diabetes (aged 18-39) to access nationally commissioned Type 2 Diabetes in the Young (T2Day) programme.
4. 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. 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 purpose of the Adult Network was to identify and recommend sites for Transition and Young Adult pilot programmes, with continued support provided throughout implementation.
9. Type 1 Disordered Eating (T1DE) pilots – awarded summer 2022 with ongoing monitoring and support.
10. Increase the delivery of the Diabetes 8 Key Care Processes and achievement of 3 Treatment Targets.

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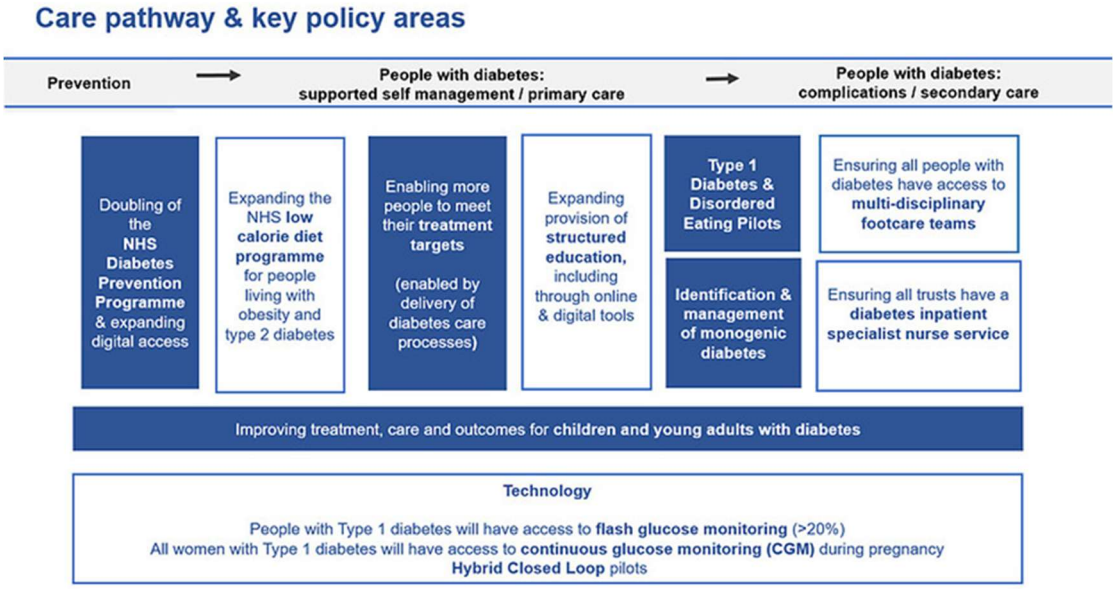
11. Diabetic Footcare – Re-establishing a Footcare network for all individuals involved in diabetic foot care and growing membership.
12. GIRFT – establishing a Self-Administration of Insulin (SAMI) working group and supporting development of a regional workshop related to Improving the Perioperative Pathway for patients with Diabetes



Network Team

Dr Rob Sherwin
Senior Responsible Officer

Professor Gerry Rayman
Secondary Care - Clinical Lead

Dr Chirag Bakhai
Primary Care - Clinical Lead

Kirsty Goddard
Quality Improvement Programme Manager (until December 2024)

Helena Baxter
Interim Programme Manager (from December 2024)

Abbie Bardell
Quality Improvement Project Officer

Amanda Harrington
Business Support Officer

As a key member of the East of England Transformation Board and Clinical Network, and in collaboration with the NHSE Quality Improvement team, we have developed initiatives to enhance patient experience across the region. Diabetes UK has worked productively with East of England NHS England on several projects, including the regional Footcare Network, which aims to reduce foot ulcerations and amputations and improve annual foot check uptake. The CVD network launched a gold, silver, and bronze standard of footcare at the second foot network forum in June.

The Midlands & East Diabetes UK region introduced patient-friendly leaflets detailing the 8 NICE care processes for type 1 and type 2 diabetes. These leaflets, available for free from the Diabetes UK online shop, empower patients with knowledge of expected care and include a checklist, personal plan section, and a QR code for an online survey. Over 41,000 leaflets have been distributed with positive feedback, including use in Desmond structured education programmes.

Supported by the CVD network and a PCN, a health bus in North East Essex provided point-of-care testing for approximately 100 patients, checking HbA1c, lipids, and blood pressure, and signposting to local prevention and remission programmes and Talking Therapies. We also adapted and promoted a preconception leaflet across Mid and South Essex ICB, translating it into multiple languages.

Planning is underway for an East of England regional conference on February 26, 2026, focusing on improving the delivery of the 8 Care Processes and enhancing footcare outcomes in primary care. Midlands & East Diabetes UK looks forward to collaborating with the CVD network to improve care delivery and patient health outcomes in the coming year.

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

DIABETES UK
KNOW DIABETES. FIGHT DIABETES.

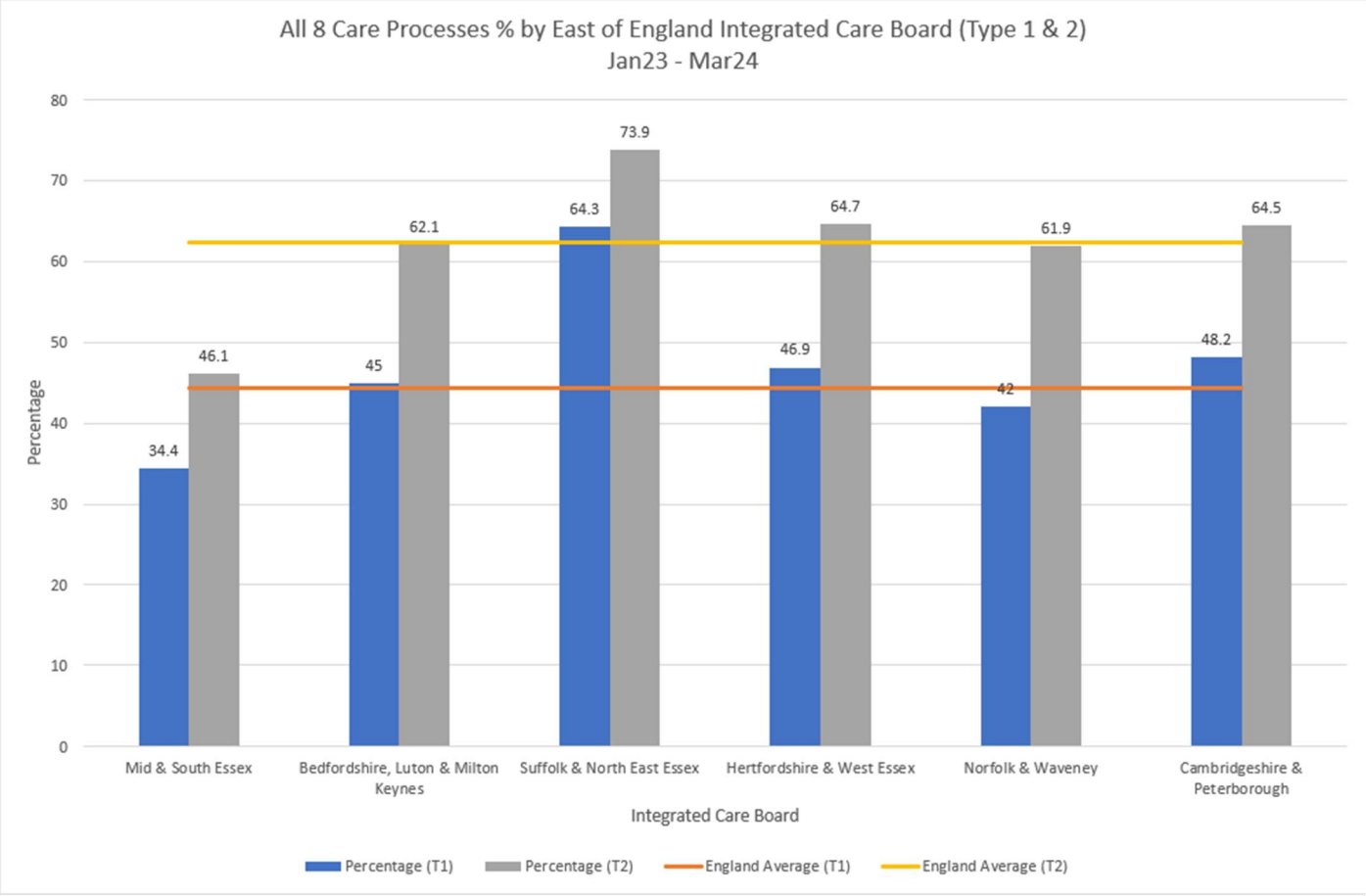
Network Performance and Achievements

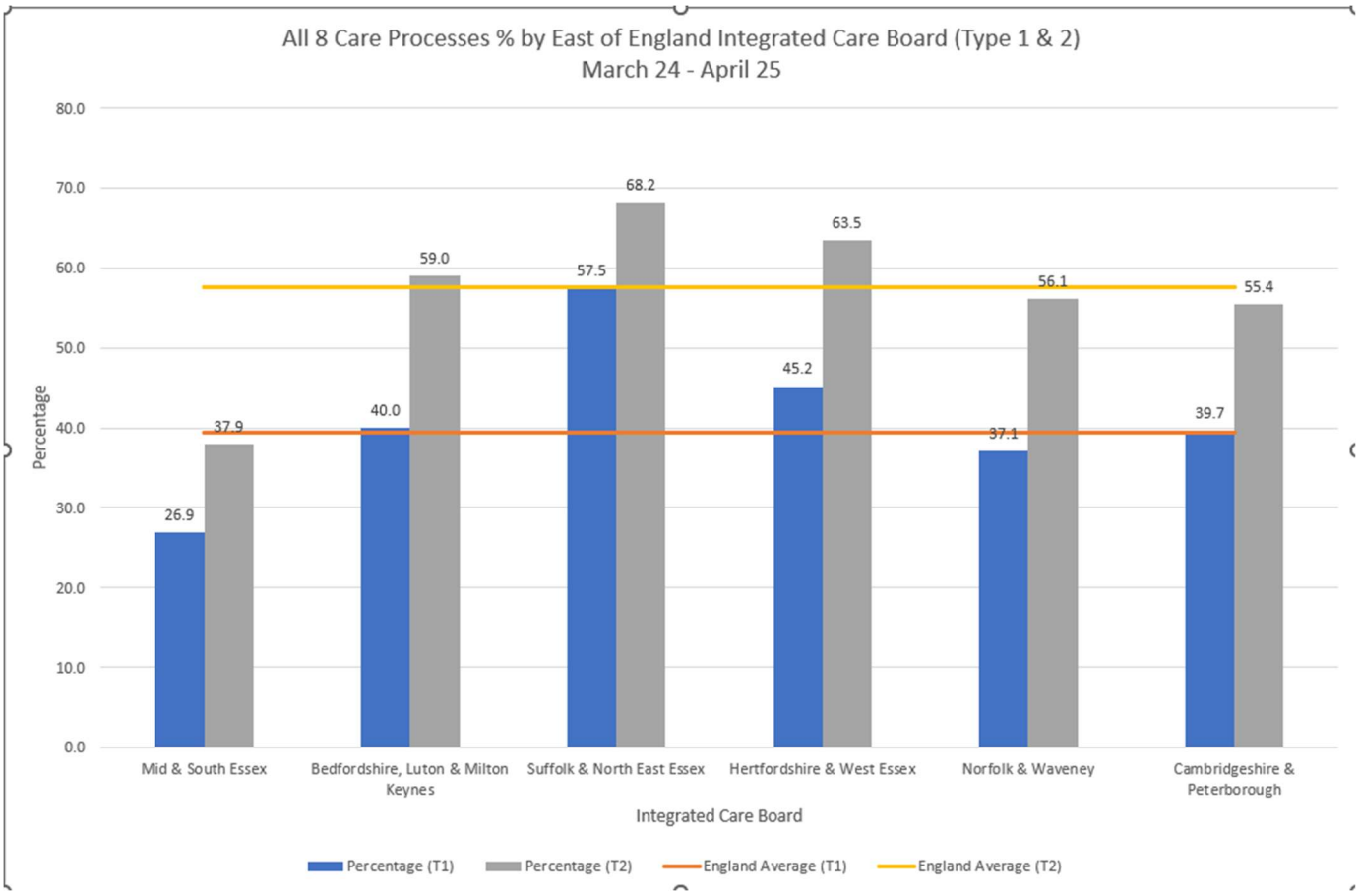
1. Using diabetes data in planning, monitoring and evaluation

The use of diabetes data in planning, monitoring, and evaluation has strengthened decision-making within Integrated Care Boards (ICBs), ensuring that resources are directed where they are most needed. By promoting relevant data in meetings, there has been a noticeable shift in ICB thinking. While National Diabetes Audit (NDA) data is important for strategic planning, local ICB dashboards - providing real-time, PCN-specific insights, are now prioritised to address pockets of health inequalities and deprivation. All 6 ICBs are using their own local data dashboards to evaluate ongoing projects, such as the 8 Care Processes, ensuring that decisions are more responsive to local needs and disparities.

2. Increasing provision of 'routine' care processes

We have enhanced the delivery of 'routine' care processes, with a strong emphasis on reducing variation and addressing inequalities. All ICBs have demonstrated significant improvements in care process outcomes (see data charts below for comparison).



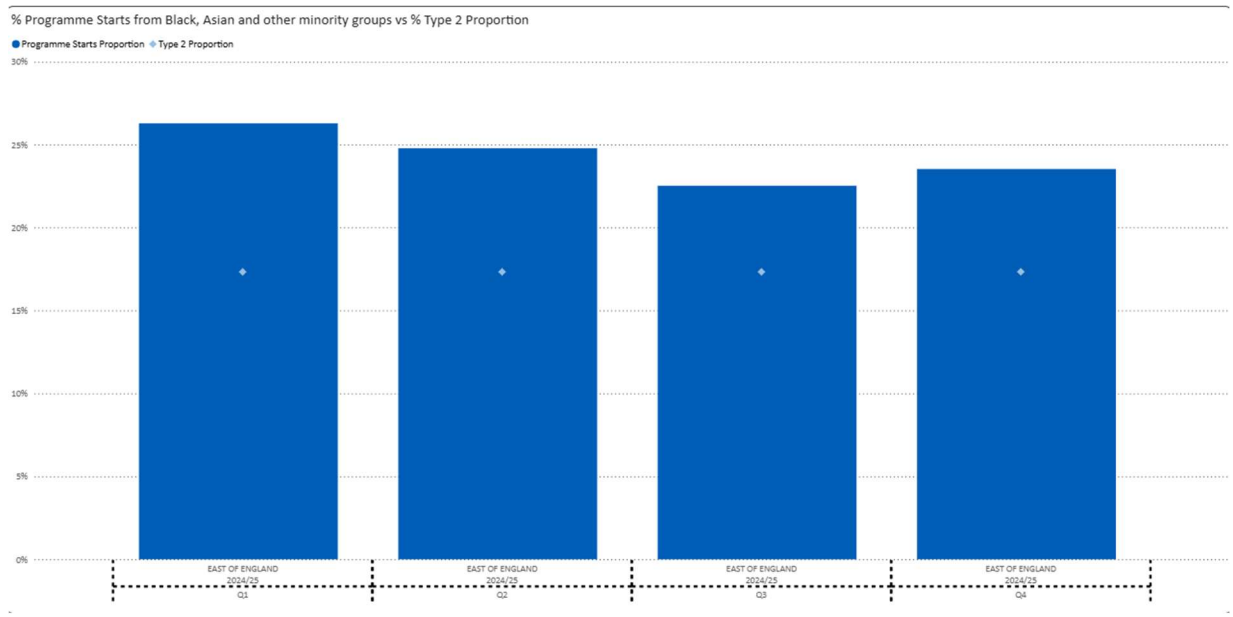


Data Source: The National Diabetes Audit

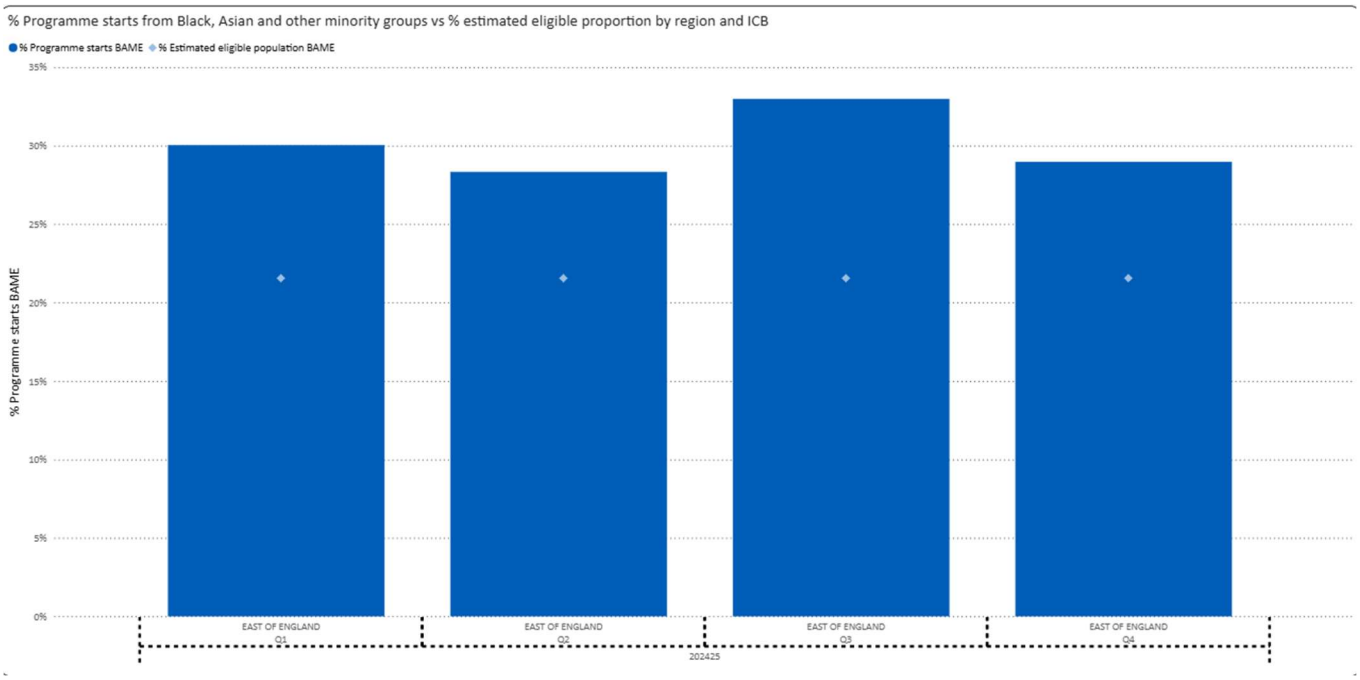
3. **Increasing referrals and uptake to the Diabetes Prevention (DPP) and Type 2 Diabetes Remission (T2DR) Programmes with a focus on reducing inequalities**

Overall, referrals and first attendance to the Diabetes Prevention Programme (DPP) in the East of England more than doubled between Q4 in 2023/24 and Q4 2024/25. Inequalities are being actively addressed at a local level. The data (graph 1) below shows a steady increase in the percentage of DDP programme starts in 2024/25 from Black, Asian, and other minority groups over the year. Furthermore, the T2DR data (graph 2) in 2024/25 shows that the % Programme starts exceeds the % Estimated eligible population, reflecting effective outreach and engagement efforts.

*Data Source: The NHSE Diabetes Prevention Programme Dashboard
Graph 1:



Graph 2:



Systems are actively collaborating with providers to boost referral uptake, with a strong focus on tackling inequalities related to deprivation and underserved groups. Targeted efforts include:

- ✓ 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 (all ICBs)
- ✓ Those from Black and South Asian communities

- ✓ Inequality due to deprivation (all ICBs)
- ✓ Reducing inequality success from N&W highlighted nationally, engagement at Royal Norfolk Show in June 2024 saw a significant uptake in referral numbers onto the DPP and T2DR programmes

Another key achievement comes from Hertfordshire and West Essex ICB, which has launched a patient webinar series covering key topics such as the Diabetes Prevention Programme (DPP), Type 2 Diabetes Remission (T2DR), the 8 care processes and the emotional wellbeing aspects of diabetes. To reach a diverse patient population, the webinars are scheduled at various times throughout the day.

Referrals to, and uptake of, the Type 2 Diabetes Remission Programme (T2DR) have increased across the region. Building on the pilot phase, which initially involved BLMK and MSE, the programme is now available to eligible individuals nationwide and all six ICBs in the region are actively delivering the initiative.

	Started Programme	**Indicative profile and date** TDR: Total Diet, Replacement phase	**Type 2 Remission TDR starts as of April 2025** *(rounded at source)*
BLMK	June 2023	500 TDR starts by June 2025	1000
MSE	Feb 2024	500 TDR starts by Feb 2026	400
C&P	September 2023	500 TDR starts by September 2025	400
HWE	April 2024	500 TDR starts by April 2026	300
N&W	April 2024	500 TDR starts by April 2026	300
SNEE	April 2024	500 TDR starts by April 2026	100

*Data Source: The NHS England Type 2 Diabetes Remission Dashboard

4. **Type 2 Diabetes in the Young (T2DAY)**

All ICBs in England are encouraged 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 with generally poorer long term outcomes.
All ICBs were funded through the national team for this programme, with the aims and intended outcomes;

1.) To deliver 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 extend into 2025, with ongoing collaboration with primary care providers and systems to ensure the service's sustainability in the future. 5 ICBs in the East took part in the initiative, and evaluation is taking place nationally.
Funding is being used to pay for reviews with a bonus payment on outcomes.
5. Technology in Diabetes

5. Hybrid Closed Loop (HCL) – 'Artificial Pancreas'

HCL technologies are the next technical advancement linking continuous glucose monitoring (CGM) and insulin pump technology, sometimes referred to as an 'artificial pancreas.'

NICE approved Hybrid Closed Loop technology policies were in place in all six ICBs by December 2023, with a mobilisation fund allocated to ICBs nationally to support HCL planning and national diabetes audit (NDA) baseline returns. This equated to £60,000 allocated to each ICB in December 2023. The NHS England 5-year implementation strategy was published in January 2024, with an initial focus on the following populations during the early stages of implementation:

- Children and Young People
- Those who are pregnant or planning pregnancy

The strategy makes clear:

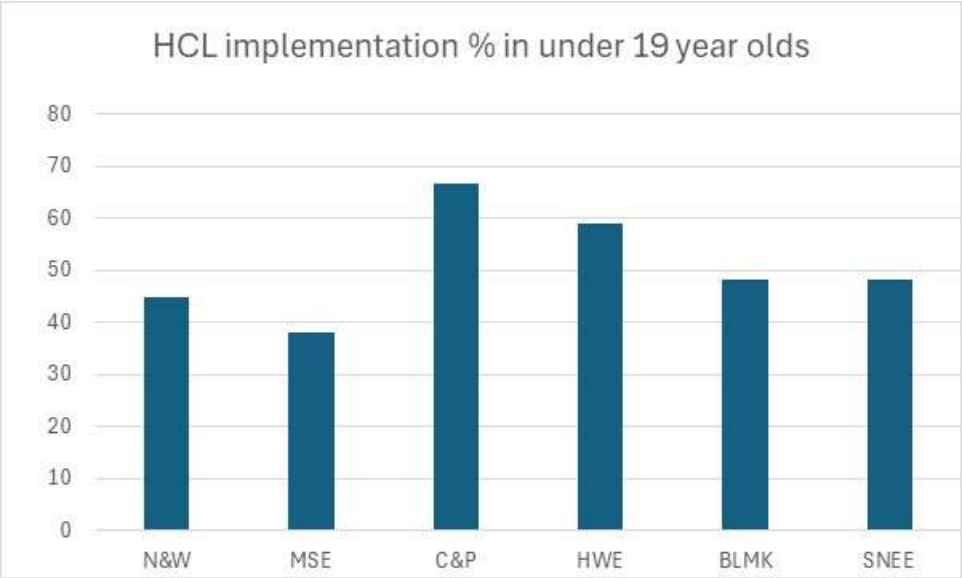
Phased Implementation: NICE and NHS England have agreed to a five-year phased rollout for Hybrid Closed Loop (HCL) systems, instead of the standard 90-day funding mandate. This extended timeline allows for the development of essential workforce skills within specialist adult diabetes services.
HCL Reimbursement Fund: The implementation plan includes a commitment to cover 75% of the additional costs incurred by ICBs in meeting the requirements of the NICE Technology Appraisal (TA).
National Audit Data: NHS Trusts prescribing HCL must submit quarterly data to the National Diabetes Audit, National Paediatric Diabetes Audit, and National Diabetes in Pregnancy Audit. These submissions are required to receive retrospective, activity-based payments from the HCL Reimbursement Fund.

A one-off (non-recurrent) allocation was made to ICBs in September 2024 to cover the costs of switching pregnant people with type 1 diabetes who were already benefitting from insulin pump therapy prior to 1 April 2024, to insulin pumps that are compatible with a pregnancy specific HCL system. Switches are only required for people using insulin pumps that are not compatible with a pregnancy specific HCL system.

Eight HCL combinations are available of ICBs and Trusts in line with the NHS England Supply Chain Procurement Framework.

The network supported all six ICBs across the East of England in delivering the HCL NICE Technology Appraisal (TA). This includes hosting quarterly regional HCL meetings with ICB HCL Leads and providers to share best practice, facilitate discussion, and escalate any queries to the National Diabetes Team.

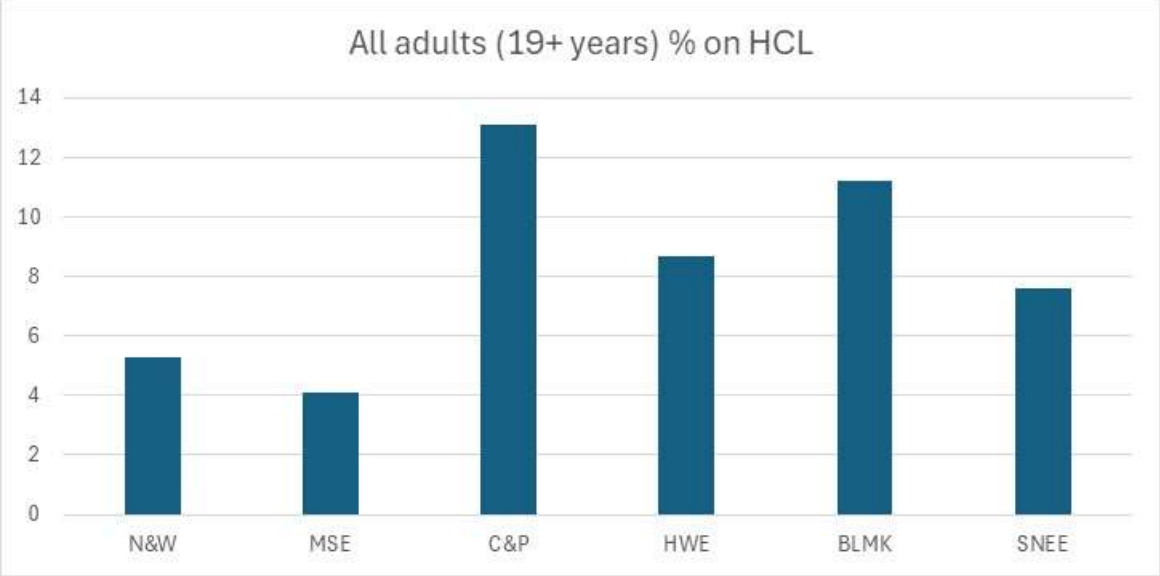
Over the course of the year, the ICBs have worked hard on delivery of the first year of the implementation plan, with a focus on children and young people.



Data source: National Diabetes Audit

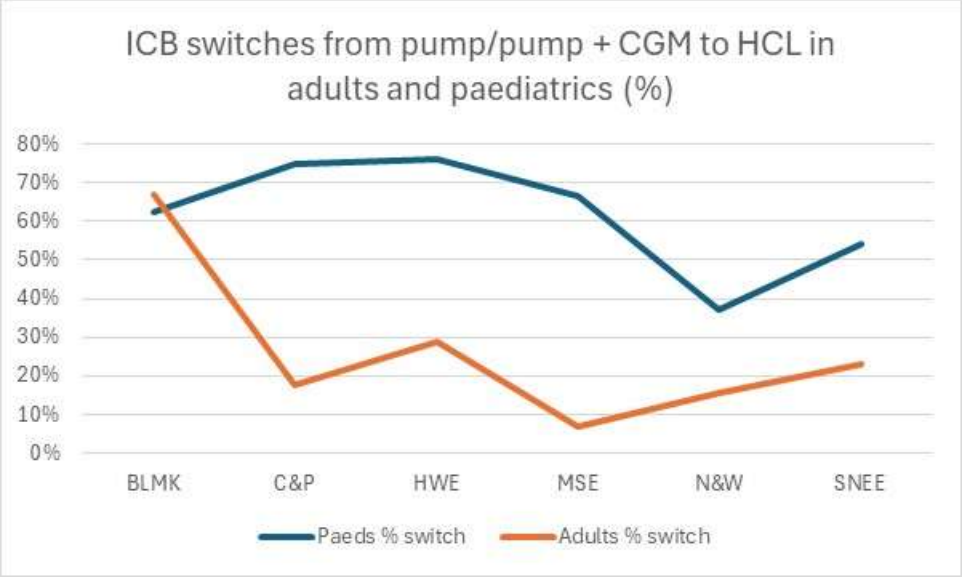
Across the East of England, 50.9% of children and young people (under 19 years) are now using hybrid closed loop systems, although there is variation between systems, ranging from 38% in Mid and South Essex to 66.7% in Cambridgeshire and Peterborough. There is an additional 1950 children across the region to meet 100% coverage.
The use of hybrid closed loop in pregnancy is known to reduce complications in both mother and baby. While the pregnancy data has not yet been published, we expect it to be available in the coming months.

It is estimated that approximately 60% of the adult Type 1 diabetes population will meet the criteria for hybrid closed loop systems. Although the initial focus in the 5 year implementation is to prioritise children and pregnancy, higher risk adults have also been started on HCL where appropriate and many patients have switched from pump + continuous glucose monitoring (CGM) or flash glucose monitoring (FGM) to HCL systems



There is an estimated population of 18,738 adults in the East of England who will meet the NICE criteria for hybrid closed loop. At the end of Q4 2024/25, 13.3% of adult patients were using HCL, with a remaining 16,228 patients to be assessed and offered HCL over the next 4 years.

Many patients were already on insulin pumps or insulin pumps plus continuous glucose monitoring. All children and many adults would benefit from upgrading to a hybrid closed loop system, and this work has been undertaken across the ICBs to a greater or lesser extent at minimal cost.



6. Other highlights:

- **Type 1 Disordered Eating Pilot:** In 2022/23, the network managed the regional expression of interest process, with Norfolk and Norwich successfully securing funding for the pilot. Due to challenges with staff recruitment and securing appropriate clinic space, the pilot transitioned to virtual delivery, causing the go-live date to be delayed until November 2023 for an 18-month

programme. The network continues to provide ongoing support and assurance, including regular reporting to the national diabetes team. In addition, we are assisting Norfolk and Norwich in developing an internal business case to ensure the service can continue beyond the current funding period, which is scheduled to end in March 2026. An evaluation of the project's impacts and outcomes is being conducted at the national level, with the final report expected to be published in Q3 2025/26.

- **Children and Young Adult Pilots:** In 2022/23, the network led the regional expression of interest process for the Children and Young Adults (CYA) pilots, resulting in successful funding awards for Ipswich and Norfolk and Norwich. Both sites have since developed strong services, with improvements reported in patient engagement, wellbeing, HbA1c levels, and Did Not Attend (DNA) rates. The network continues to provide support and assurance through regular site engagement, national reporting, and assistance with the development of internal business cases to help secure continuity of the services beyond the current funding period, which is due to end in March 2026. An evaluation of the project's impacts and outcomes is being conducted at the national level, with the final report expected to be published in Q3 2025/26.

- **Self-Administration of Insulin (S.A.M.I) Working Group:** A working group was established in partnership with GIRFT and the region's Trusts to develop and promote a local policy on self-administration of insulin. Enabling patients to take a more active role in managing their care during hospital stays has been shown to improve both patient experience and clinical/safety outcomes. As part of this work, an exclusion criterion was developed to ensure patient safety, outlining specific circumstances where self-administration may not be appropriate, such as those admitted with poor glycaemic control or risk of self-harm. The checklist was piloted with five selected Trusts in the region to evaluate its effectiveness and support broader implementation. Shared learning from the pilot is regularly discussed at our working group meetings.

- **Secondary Care Forum:** A Secondary Care Forum was established to focus on secondary care pathways and GIRFT recommendations, including 7-day working, DEKODE, self-administration of insulin (S.A.M.I), and emergency surgery.

- **IP3D Workshop:** In June 2024, a workshop was held in collaboration with GIRFT to support the implementation of the IP3D Programme across regional Trusts. The event featured an overview of the programme, highlighted the role of the Perioperative Diabetes Specialist Nurse, and offered pilot sites the chance to share their experiences. Attendees also explored resources available for local adaptation.

- **Footcare Conference:** In April 2024, a conference and launch event was held to support the reinstatement of the footcare network in the East of England. The event was well attended by professionals involved in diabetic footcare in various capacities. It focused on key topics such as the National Diabetes Foot Audit (NDFA), vascular assessment and limb salvage, and the treatment of diabetic foot disease in orthopaedics. The conference highlighted areas in diabetic footcare that require attention and improvement to enhance clinical pathways and patient care.

- **Strong NHSE relationships with all ICBs:** Facilitating the discussion and resolution of common issues and promoting the sharing of best practices. The network supports ICBs by organising one-on-one support visits to review achievements and challenges. It also encourages the use of both local and national data, with many ICBs developing diabetes databases to track progress and reduce variation by learning from past initiatives and comparing outcomes.

Sharing Best Practice

A significant highlight for the Network was hosting a 'Footcare' Conference in collaboration with Diabetes UK in April 2024, attended by over 60 clinicians and commissioners, with representation from all ICBs. Following the successful launch of our Secondary Care Forum in December 2023, we now hold regular footcare forums with face-to-face meetings every six months.
Additionally, we liaise with other regions in England to share ideas and best practice

Other key highlights include:

- Hertfordshire and West Essex, who launched a patient webinar series covering key topics such as the Diabetes Prevention Programme (DPP), Type 2 Diabetes Remission (T2DR), the 8 care processes and the emotional wellbeing aspects of diabetes.

- Cambridgeshire and Peterborough successfully partnered with an independent provider, Minuteful Kidney, to use SMS messaging for patient engagement. This initiative has helped increase uptake of the urine albumin (uACR) test (one of the eight care processes) particularly among individuals who do not have a recorded uACR test in the past 6 to 12 months on a GP Clinical System.

- Norfolk and Waveney for their outreach engagement at the Royal Norfolk Show in June 2024, driving a significant increase in programme referrals for both DPP and T2DR.

Key Challenges

- Restructures in the Integrated Care Systems/Boards resulted in a loss of momentum in some areas of work for 2024/25. This has led to capacity challenges within some ICBs, with a few operating without a dedicated diabetes leads.

- 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 25/26

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

3. Encouraging each ICB to set its own challenging targets for improving 8 CP and 3 Treatment Targets

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

5. Bringing a focus to improving Footcare Pathways via the Footcare Network by:
   - Developing an East of England Footcare Quality Standards and piloting with sites to determine current footcare provision at provider level
   - Strengthen engagement ICB Commissioners to collaboratively develop objectives that drive improvements in footcare standards
   - Host a Primary Care Education Event in partnership with Diabetes UK (DUK) to enhance engagement and collaboration with Primary Care professionals.

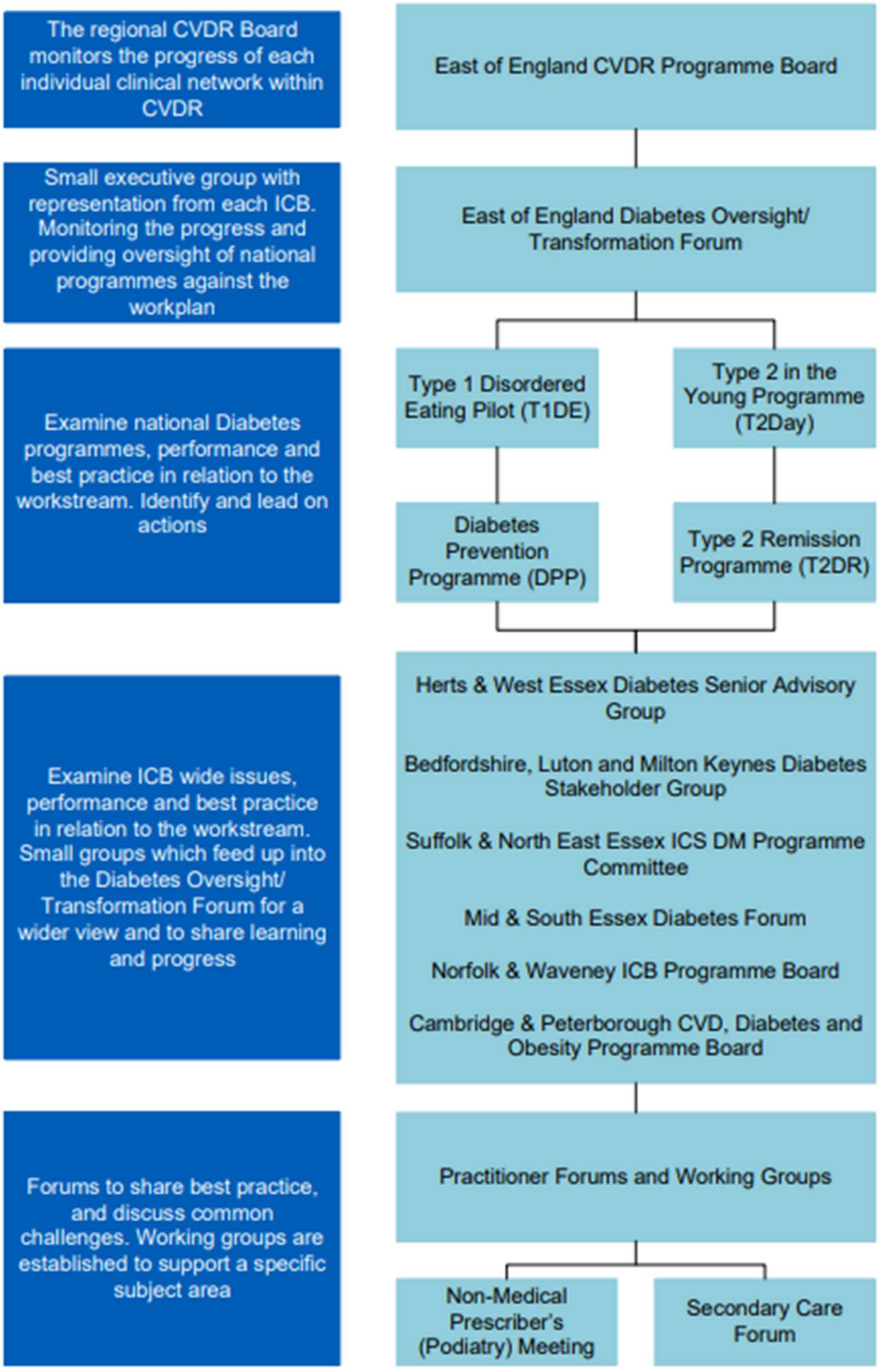
6. Improving the uptake of technology for Type 1 diabetes - continuous glucose monitoring, increasing the number of insulin pumps for patients meeting the criteria and reviewing uptake to Hybrid Closed Loop systems in line with NICE Guidance via NDA data.

7. – Encouraging Trust participation in S.A.M.I and
8. Collaborating with GIRFT to establish an Outpatients Working Group.

Network Governance

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	£115,123
PMO costs	£80,742
Clinical Leads	£34,254

Network costs were lower this year as vacancies were carried over into the new financial year of 2025/26

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

Funding Allocation Description	Amount
T1DE	£65,000

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. Funding for hybrid closed loop has been allocated to each system for reimbursement from the national team following submission of data.

To find out more about the work of the East of England CVD-R, 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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For general enquiries, please find the below email addresses for each clinical network:

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Integrated Stroke Delivery Networks:
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Respiratory Clinical Networks:
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Renal Clinical Network
enh-tr.eoerenalnetwork@nhs.net

Diabetes Clinical Network:
england.eoediabetescn@nhs.net