

East of England Clinical Networks and Clinical Senate

Annual Report 2015-16



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Medical Director's Introduction

It is a privilege to introduce the third annual report for the Strategic Clinical Networks and the Clinical Senate. This report summarises the achievements over the last twelve months from 1 April 2015 to 31 March 2016 and outlines our ambition for the next twelve months.

I have recently taken up the position of Medical Director for NHS England, Midlands and East (East) and had the opportunity to ask the question: 'So what do Strategic Clinical Networks and the Clinical Senate do and how do they make a difference?' This annual report is excellent for those of you asking the same question. The summary of the achievements over the last year demonstrate their benefits and the case studies go into more detail and bring to life their impact. The Strategic Clinical Networks and the Clinical Senate are now well-established and are delivering what they set out to do. They

continue to gather momentum and will play a crucial role in supporting the NHS to bring about improvements and transformational change over the next five years.

The review of the improvement functions – of which the Strategic Clinical Networks and Clinical Senate were part of – that support the NHS has completed. This slowed progress somewhat in 2015-16 but the newly named Clinical Networks and Clinical Senate are now in a stronger position to move forward, with their roles clearly defined and with more robust systems and processes in place.

Figure 1: Our priorities for 2015-16, Building the NHS of the Five Year Forward View, NHS England Business Plan 2015-16





Reading through this year's report I mapped our progress against the *Five Year Forward View* priorities. Our work in the last twelve months has supported all ten priorities (see Figure 1), as well as the clinical priorities outlined in the Five Year Forward View which are cancer, mental health, diabetes prevention, learning disabilities and maternity care. The Clinical Senate has played a key role in enabling whole system change, and there are also strong examples of patient and public participation.

The number of people with cancer is rising with a life time risk of one in two people getting a cancer and although outcomes are improving, two out of five cancers are preventable. Too many people are having their cancer diagnosed in the emergency department and there is more we can do to improve patient experience and provide care closer to people's homes. The Cancer Clinical Network has continued to provide local health systems with the data needed to both understand cancer within their population and the services needed to improve outcomes and reach national cancer treatment standards. The Network

promoted public health campaigns to enable earlier diagnosis and supported projects to see how effective it was to provide care for people with cancer closer to their homes. They have also supported research to look at how more people can benefit from earlier diagnosis.

Mental health is a national priority. One in four of us will suffer from a mental health problem in our lives and the cost to the economy is £105 billion, the cost of the entire NHS. New standards have been introduced to ensure patients are accessing treatment and support at an appropriate time. The Mental Health Clinical Network has worked with local health and care systems to develop services and implement new standards, including support for those having a mental health crisis, supporting women's mental health during their pregnancy and after birth, and for children and young people with mental health concerns. The Network has moved from merely identifying people with dementia to helping health and care systems improve support for patients and families once a diagnosis has been made.

The Cardiovascular Clinical Network has continued to monitor standards and develop services to ensure when we are most sick and vulnerable, for example when we have a stroke or heart attack we have access to appropriate care. Prevention and early identification are key and the Network has developed tools to support clinicians to identify atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate) and high blood pressure. And pilot sites have been identified to focus on diabetes prevention.

The Maternity, Children and Young People's Clinical Network has continued work to reduce ill health and death for mothers and their children, for example reducing stillbirths by ensuring babies are growing optimally and also focussing on risks that can be addressed such as smoking. Focus has now turned to implementing the *National Maternity Review, Better Births* recommendations. A toolkit for supporting providers and commissioners to ensure that children and young people receive good asthma care has been developed and the East of England co-ordinated this work nationally.

The Networks worked together on some cross cutting themes such as an e-learning package to support primary care professionals to look after people with asthma. This work undertaken by the Respiratory and Children's Networks is just about to be launched in some general practices in the East of England. The Respiratory Network has worked with the maternity group and the Mental Health Network to support people in high risk groups to stop smoking.

Patient experience and engagement is woven in to the work of the Clinical Networks and Clinical Senate. Work this year has included the production of guidance on how to involve vulnerable people and people from minority groups, projects which bring patients, carers and health professionals together to design services and training of young people to be health and well-being champions.

The Clinical Senate has completed a number of reviews which have included looking at ambitious

transformation plans across a large system to more focussed reviews of services. They have developed a process for peer review utilising the seven day service standards and produced guidance to support trusts in measuring standard eight, one of the ten clinical standards for seven day services which set standards for the ongoing review of some patients by a consultant.

Many of you are aware that local health and care economies have come together over the last few months as a single whole system which include clinical commissioning groups, provider organisations, local authorities and other stakeholders to develop sustainability and transformation plans (STPs) which outline their priorities for the next year and next five years. Clinical networks are optimally placed to support the STP areas to develop and implement their plans and the Clinical Senate to provide an independent review of the transformation proposals contained within them.

Moving forward NHS England will identify improvement priorities for their regional teams who will share these with the local health and care economies. Clinical Networks will support regional teams and local systems to develop and deliver their quality improvement priorities.

I would like to thank all staff in the Strategic Clinical Networks and Clinical Senate and stakeholders for their continued energy, passion and commitment, and for their resilience whilst NHS improvement services have been under review. I am confident that this time next year we will look back with even more pride on our achievements, as we maintain our focus on delivering quality improvement priorities and the sustainability and transformation plans across the East.



Alastair Lipp

Medical Director at NHS
England Midlands and East
(East)

June 2016

Who We Are and What We Do

Strategic clinical networks and clinical senates were established by NHS England in April 2013 to improve everyone's access to high quality care and to improve health outcomes. The networks and senates have strong clinical leadership and as such are well placed to influence and inform service change and whole system improvement across health and care.

The specific remit of strategic clinical networks is to bring together those who use, commission and provide services to improve outcomes for patients. Networks work across organisational boundaries to improve care for patients whose care is often provided by a number of organisations, using an integrated, whole system approach. Working in partnership, networks influence commissioning by:

- Highlighting and reducing unwarranted variation in health care
- Encouraging innovation in how services are provided now and in the future
- Providing clinical advice and leadership to support decision making and strategic planning.

In April 2013, NHS England mandated the following four strategic clinical networks as it is recognised that these areas would specifically benefit from whole system improvement:

- Cancer
- Cardiovascular disease
- Maternity, newborn, children and young people
- Mental health, dementia and neurological conditions

In the East of England we have also hosted a Respiratory Strategic Clinical Network.

Clinical senates have been established as a source of independent, impartial strategic clinical advice to commissioners and other stakeholders to assist them to make decisions about healthcare now and in the future for local populations.

The East of England Clinical Senate has a Senate Council and wider Clinical Assembly. Lead by an independently appointed chair, the Clinical Senate Council coordinates and manages Clinical Senate business. The Assembly has a membership of more than 200 people, drawn from a diverse range of health and care professionals.

Unique to the East of England is the Citizens' Senate. This is a 'connected and experienced group of people aiming to influence regional NHS strategy by presenting patient, carer and family perspectives'. The Citizens' Senate supports the work of the Strategic Clinical Networks and Clinical Senate.

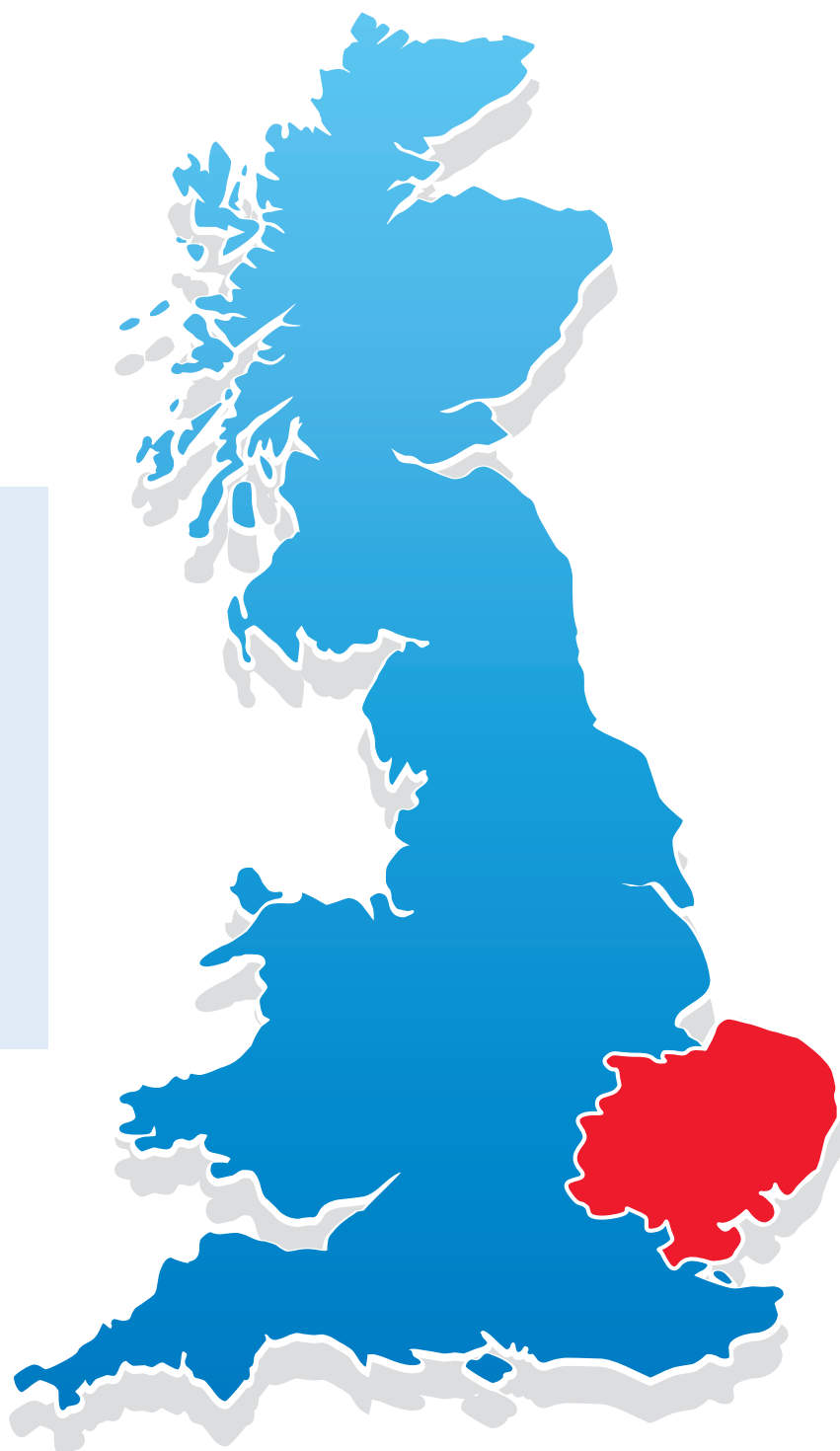
The East of England Strategic Clinical Networks and Senate cover a population of 6 million across the second largest regional area in England. This includes NHS England Midlands and East Region, 19 clinical commissioning groups, and a large number of primary, secondary and tertiary (specialist) care, voluntary sector and private providers.

Each of the strategic clinical networks has a clinical director, clinical lead, a manager and a small team of quality improvement leads who improve access to high quality care and improve health outcomes for people in the East of England.

Accountability for the East of England Strategic Clinical Networks and Clinical Senate in 2015-16 was through the Medical Director, NHS England Midlands and East (East).

NHS England, Midlands and East Region

- 6 million population
- 19 clinical commissioning groups
- 27 providers of health and care
- 11 local authorities
- 11 Healthwatch



Strategic Clinical Networks

'Our role as the East of England Strategic Clinical Networks is to connect people and organisations, to create an environment that enables change and innovation in order to improve people's health and wellbeing, so it is comparable with the best in the world.'

Cancer

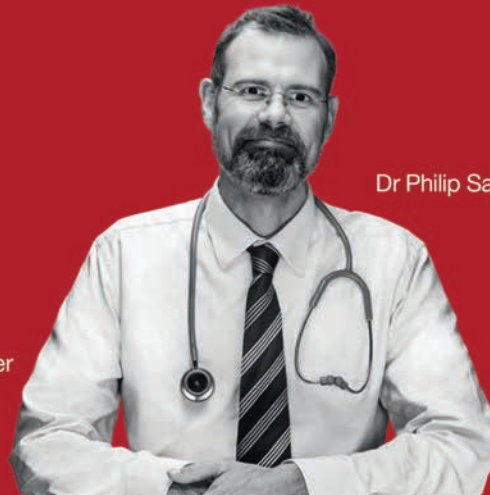
Major achievements in 2015-16

- Enabled clinicians and stakeholders to comment and act on variation and quality by continuing to provide a regular source of up to date information using data across the whole cancer patient journey for the East of England. This included producing and sharing cancer intelligence reports three times a year, twelve tumour site data reports twice a year, and GP practice-level data on cancer patients and how they access services, to all clinical commissioning groups and GP surgeries.
- Worked with commissioners to help return waiting times to target and better understand the breaches of cancer waiting times at nine key hospitals. This included undertaking clinical visits at seven hospitals, producing action notes for clinical commissioning groups and discussing the findings with NHS England's assurance teams. All trusts have action plans in place and the Network was an integral part of this process. This led to further work with the Trust Development Authority around capacity and demand modelling.
- Completed the Transforming Cancer Care in the Community Pilot across seven sites to test whether an out-of-hospital cancer care model can be cost effective and sustainable. Huntingdon was the most cost effective pilot which provided a return on investment of £5.90 for every £1 spent and improved patients' experience of the service; positive patient experience scores increased by 75% (23% to 98%). The pilot proved to be effective in certain areas which has led to clinical commissioning groups in Huntingdon, and Great Yarmouth and Waveney commissioning this model of care for a further year.
- Provided project management support and clinical advice to commissioners to enable them to reconfigure services to meet national guidance. In particular for patients using urology services (this specialty deals with the treatment of conditions involving the male and female urinary tract and male reproductive organs) and skin services in Essex.



Noticed blood in your pee? Tell your doctor straight away.

Blood in your pee could be an early sign of bladder or kidney cancer, even if it only happens once. Finding it early makes it more treatable.



Dr Philip Sawyer

NHS

**BE CLEAR
ON CANCER**

nhs.uk/bloodinpee

- Maintained the Network's cancer groups; provided support for 53 cancer meetings, including 17 pan East of England events. This included clinical advisory groups for 18 tumour sites and an East of England wide Cancer Patient Partnership Group. Each group has up to 35 clinicians who review their practice and their data around their cancer pathway. The pan East of England events enable up to 200 clinicians to share best practice and hear from eminent speakers, and more than 90% of attendees were satisfied with the days.
- Supported the national *Blood in Pee* campaign, which encourages people to tell their doctor if there is blood in their urine, even if it's just once. Provided local context and raised awareness of its potential impact amongst GPs and clinical teams.
- Recruited seven (six whole time equivalents) Cancer Research UK facilitators and a manager. These roles work with GP practices to strengthen awareness and understanding of cancer signs and symptoms to improve early diagnosis.
- Developed and distributed across the East of England a set of twelve standardised two week wait referral forms, conforming to National Institute of Health and Care Excellence (NICE) guidance published in June, on referrals for suspected cancer. They have been agreed by all 17 trusts and 19 clinical commissioning groups and are now being implemented.
- Delivered an award winning local research study called *Cancer Diagnosis in the Acute Setting* looking into why patients present as an emergency with their first diagnosis of lung or colorectal cancer rather than via other routes. Findings showed three key themes: a lack of both patient awareness of their symptoms and willingness to use health services, low rates of early presentation in 'at risk' groups such as the elderly or carers, and poor GP access to diagnostic tests for those patients with vague, non-specific symptoms who do not fulfil the two week wait referral criteria.
- Secured funding for a *Cancer Diagnosis in the Acute Setting Ovarian Research Study*. Designed the study and recruited Peterborough and Stamford Hospitals NHS Foundation Trust to lead this piece of research with Bruce Ramsay, Consultant in Obstetrics and Gynaecology, as Chief Investigator who will be responsible for the study's conduct and success. The study will look at what the contributing factors are for women who receive their first diagnosis of ovarian cancer via an emergency admission in the East of England.

Case studies

- Improving Cancer Diagnosis in the Acute Setting (page 29)
- Transforming Cancer Care in the Community (page 30)

Cardiovascular Disease

Major achievements in 2015-16

Stroke services:

- Stroke care remains variable across the East of England and in order to promote best practice the Network has worked with clinical commissioning groups and trusts to improve stroke care:
 - Following a regional review of stroke services in 2012, the Network has been working to implement the recommended service specification for hyper acute stroke units (these units bring experts and equipment under one roof to provide world-class treatment 24 hours a day, reducing death rates and long-term disability). Some trusts have been too small to implement the standards, and work to ensure all patients have access to a high quality hyper acute stroke unit has meant that The Princess Alexandra Hospital NHS Trust closed their unit. Patients now go to Broomfield Hospital in Chelmsford, the Lister Hospital in Stevenage, or Queen's Hospital in Romford for their hyper acute stroke care.
 - Encouraged James Paget University Hospitals NHS Foundation Trust and Norfolk and Norwich University Hospitals NHS Foundation Trust to work together on a pilot using telemedicine to cover ward rounds at weekends. The pilot will be evaluated and if successful other trusts might consider it.
 - Work to support more patients to be discharged early from hospital with additional care has steadily progressed with more clinical commissioning groups having services in place, coverage has risen from 72% to 83%.
 - Bedfordshire Clinical Commissioning Group are undertaking a pilot with the Stroke Association to review all stroke patients six months after their initial stroke to ensure their needs are being met in the long term.
- Updated the East of England's stroke divert and repatriation protocol. The protocol sets out procedures to ensure the safe and timely transfer and repatriation of patients between hospitals. The protocol now takes into account changes in the use of telemedicine and the review of hyper-acute stroke services across the region.
- Established a working group to look at mechanical thrombectomy (a procedure to quickly remove a blood clot from the brain for patients where clot busting drugs is not enough). The group, which has consultant members from stroke units and radiology departments across the region will review National Institute for Health and Care Excellence (NICE) guidance, discuss ways the service could be provided, from which centres and work with East of England Specialised Commissioning and East of England Ambulance Service NHS Trust to form a plan of action.
- Encouraged clinical commissioning groups to move to quarterly monitoring of stroke data, through the national Stroke Sentinel National Audit Project database, as the region-wide database was no longer capable of managing the amount of data. The Network has supported this through running a masterclass and bringing commissioners and providers together to understand what data is available and to agree measures for monthly reports.

Cardiac services:

- Undiagnosed or poorly managed atrial fibrillation (an abnormal heart rhythm) remains a major cause of strokes. The Network has developed and agreed an atrial fibrillation anticoagulant prescribing decision aid (to ensure patients with irregular heartbeats are given medicines to prevent blood clots) with supporting documents, through a clinical expert East of England Atrial Fibrillation Group. This will be distributed as



guidance to clinical commissioning groups and clinicians to improve prescribing and increase the uptake of oral anticoagulant in atrial fibrillation patients to aid the prevention of related strokes.

- The atrial fibrillation (an abnormal heart rhythm) project has been initiated in four clinical commissioning groups, this involves targeted educational support and use of the GRASP-AF tool. The tool captures and summarises individual patient and GP practice-level data for patients with atrial fibrillation, allowing GPs to review individual stroke risk and treatment.
- Developed an atrial fibrillation (an abnormal heart rhythm) educational slide set which will support the educational component of the atrial fibrillation project and can be adjusted to accommodate the demographics and data of the East of England clinical commissioning groups.
- Delivered the regional Primary Percutaneous Coronary Intervention (emergency coronary angioplasty, a non-surgical procedure used to treat heart attacks) audit meeting and revised the protocol to reflect current agreed safe practice against national guidance.
- Mapped and compared the Non-ST Elevated Acute Coronary Syndrome (acute chest

pain caused by narrowing of the coronary arteries) pathway in all hospital trusts in the East of England. Held an East of England wide meeting to demonstrate variations and possible inequity of access and timeliness of the services. This has highlighted the need for further work on seven day service access.

- Supported local audit meetings on heart failure, percutaneous coronary intervention (a non-surgical procedure to treat heart attacks), angiography (medical imaging to see arteries, veins and heart chambers) and cardiac devices services (to help control abnormal heart rhythms, such as a pacemaker), this enabled services to compare data and highlight variations in a timely way.
- Worked with the East of England Critical Care Operation Delivery Network to address the possibility of intubated (the placement of a flexible plastic tube into the windpipe) patients requiring a primary percutaneous coronary intervention (a procedure used to treat narrowed coronary arteries of the heart) not being accepted if there were no intensive therapy unit beds available in a heart attack centre. Options were taken to the Primary Percutaneous Coronary Intervention Expert Group and the policy was updated to ensure treatment of this small number of patients is not delayed and does not impact their health outcomes.

Vascular services:

- Worked with Public Health England to deliver a successful regional blood pressure workshop. It focused on improving prevention, identification and management of blood pressure, encouraging clinical commissioning group managers and primary and secondary care clinicians to identify gaps in current services and explore examples of good practice.

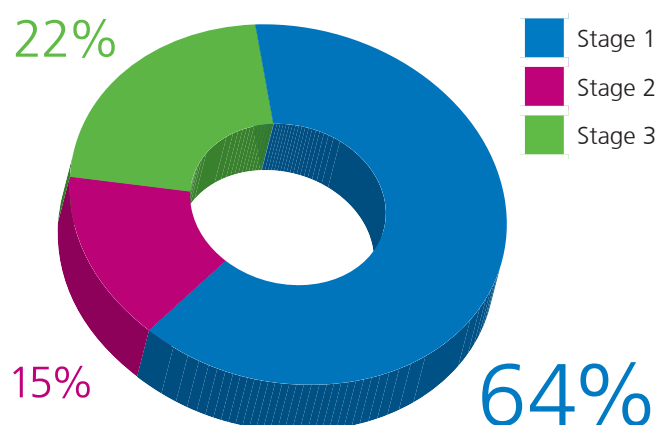
Renal services:

- In response to national concern about the mortality (death rate) and morbidity (being unhealthy) caused by acute kidney injury, the Network has supported all East of England NHS trusts to implement a NHS National Patient Safety Alert. The alert requires trusts to use a nationally approved algorithm (procedure) to generate e-alerts to highlight patients with, or in danger of developing acute kidney injury. It also requires all trusts to send data on the generated alerts to the UK Renal Registry. The Registry collects, analyses and reports on renal data and facilitates improvements in patient care. To support its implementation the Network shared information and tools developed by the national *Think Kidneys* campaign and has connected trusts and laboratories with the right technical people who can help with changes needed in laboratory information or IT systems in order to generate the e-alert to the agreed algorithm. Of 18 trusts in the region 14 are now using the new procedure, and four trusts are sending data. The Network is continuing its work with trusts to support implementation.
- Patients with mental health problems are often more at risk of acute kidney injury not being identified early. The Network has supported a national working group to develop guidelines which provide support to health and care professionals who are managing the care of patients at risk of, or with an acute kidney injury. The document is being piloted with some mental health professionals before being published nationally.

- Diabetic patients who spend several days a week on dialysis are at risk of missing out on vital podiatry (foot) care, putting them at risk of needing an amputation. The Network arranged a pilot project for staff at two dialysis units to have training to undertake diabetic foot checks. The training gave staff the skills to identify any areas of concern on the foot and to refer patients to podiatry experts for advice and care. Best practice from these projects will be shared through the diabetes networks.
- Established an East of England Renal Network; the membership (currently 61) consists mainly of clinicians. The Renal Network raised concerns about patient transport and supported the development of a patient transport survey. The survey was developed with an on-line facility that patients could complete on iPads whilst on dialysis. It is being piloted in the dialysis unit at East and North Hertfordshire NHS Trust and will be rolled out to other units if successful. The results will be used to support clinicians to negotiate more convenient transport for patients on dialysis.
- Established an East of England Acute Kidney Injury Network; the membership (currently 62) is made up of clinicians, pharmacists, bio-chemists and commissioners. As part of the start-up work the Network undertook a snapshot audit of patients with an acute kidney injury (see Figure 2). Twelve (of the 18) trusts took part.

Figure 2: Overview of audit by stage of injury

Twelve trusts by stage of acute kidney injury



Members of the Acute Injury Network felt that training and education could reduce the number of patients progressing on to stage two and three injuries. All trusts were asked to nominate three acute kidney injury champions – a nurse, a doctor and a pharmacist – and these champions were invited to a half day education and training event. During the event each trust presented their current acute kidney injury education and what they would like to improve. Trusts were given a good practice document to implement in their own trusts, and support and advice were offered to those trusts that needed more support.

Diabetes care:

The rapidly increasing incidence and the associated high morbidity (being unhealthy) and mortality (death rate) means that preventing diabetes and improving care of patients diagnosed with diabetes is a national priority.

- Providers were invited to bid for funds to support a new project to aid diabetes prevention. A panel assessed each bid against evaluation criteria and five projects were successful in securing funding. The two year projects will provide regular updates and will be evaluated at the end. In total the projects target over 1000 patients, with one project concentrating on patients from a south Asian background and another aimed at patients living with learning disabilities.
- The Network has established a number of advisory groups to bring together professionals and experts in each clinical area to review guidance, monitor variation and spread good practice. As part of this network of advisory groups, the Bedfordshire and Hertfordshire Diabetes Advisory Group were asked by the Bedfordshire and Hertfordshire Local Priorities Forum to review interim guidance for continuous glucose monitoring circulated by the East of England Professional Advisory Committee to ensure that the appropriate policies were established and adhered to across the area.
- Assessed the availability of psychological (relating to the mental and emotional state of

a person) services for diabetic patients across the region to show what is available and highlight gaps. The outcome was reported to each diabetes advisory group.

- North East Essex Diabetes Service undertook a comprehensive review of its multi-disciplinary team foot service. The Network was asked to facilitate the discussions, advise on information gathering and analyse data to show variation in clinic attendance. Several meetings took place to address clinic timings, issues with vascular cover and discuss contractual nuances between each of the providers within the service. A report has been written and options are being consulted on with a view to allow patients to be seen in the right place, at the right time, by the right clinician.
- As part of a national drive, the Network has actively encouraged GP practices across the East of England to take part in the National Diabetes Audit to collect data and drive improvement. Participation rates increased by 4% on the previous year.
- The Foot Care Network is beginning to share information, spread good practice and encourage cross boundary learning outside the formal group. A member has developed risk cards for patients which are given to patients by their GP so that they are aware of their own risk of developing a foot ulcer. These cards may be extended for use across the region if funding is available.

Case studies

- Managing Stroke Information (page 31)
- Continuous Glucose Monitoring (page 32)
- Primary Percutaneous Coronary Intervention (PPCI) – admission of intubated patients when there is no intensive therapy unit bed available at the heart attack centre (page 33)

Mental Health, Dementia and Neurological Conditions

Major achievements in 2015-16

Mental health:

- Designed and programme managed the *achieving a zero suicide ambition* programme across four sites in the East of England, covering a population of 2.5 million people. The programme received a positive evaluation from the independent charity, the Centre for Mental Health, and has been shared as a national good practice example. This improvement programme saves the lives of people participating in it.
- Supported commissioners and providers of health services across the region to prepare for the early intervention in psychosis (a severe mental disorder) access and waiting times standard. The standard requires that by 1 April 2016 more than 50% of people experiencing a first episode of psychosis will be treated with a National Institute for Health and Care Excellence (NICE) approved care package within two weeks of referral. The Network hosted three regional events; identified key issues and areas for improvement; provided opportunities to share solutions through hearing from national policy leads; showcased national and local best practice examples; and has worked across commissioning boundaries to support the successful introduction of the standard.
- Assured quality improvement aspects of clinical commissioning group liaison psychiatry (a medical field concerned with the diagnosis, treatment and prevention of mental health conditions) plans. Recruitment is underway for two clinical leads to support the introduction of anticipated new access and waiting time standards in liaison psychiatry across the region in 2016-17. Hosted and facilitated two events to improve the quality of psychological (relating to the mental and emotional state of a person) therapy services,

and supported commissioners and providers to understand their data, their services and how to make improvements.

- Successfully supported two clinical commissioning groups in the region to bid for additional funds, through the improving access to psychological therapy waiting times initiative to clear their waiting lists.
- Supported the region's crisis care concordat groups to deliver their plans (which change the way services involved in the care and support of people having a mental health crisis work together) through learning from national leads, sharing best practice and providing tailored support.

Child and adolescent mental health services:

- Provided quality improvement support to child and adolescent mental health services local transformational plan leads in the development of their plans. Of these, Essex and Norfolk have become national best practice examples.
- Member of the regional assurance panel which assured the five year child and adolescent mental health services local transformational plans. Commissioned specialist consultancy support to undertake a thematic review of the plans to ensure a clear focus for the Network's support in 2016-17.
- Started a four year regional programme to deliver the national child and adolescent mental health services specification. This will deliver significant changes in how services are delivered leading to marked improvements in the lives of children and young people with mental health concerns.
- Undertook a benchmarking and mapping exercise across the region, which has been well received, using the national report *Future in Mind: Children and Young People's Mental Wellbeing* recommendations.

- Planned and hosted a well-attended *Future in Mind* event. Future workshops are planned to show case areas of best practice, facilitate networking and to provide support for the delivery of local transformational plans.

Dementia:

- The Network has provided a range of quality improvement support which has led to sustained clinical commissioning group activity and innovative thinking to progress towards the achievement of the 67% dementia diagnosis rate. This has led to clinical commissioning groups in the region significantly increasing their diagnosis rates to an average of 62% in February 2016.
- Provided individual tailored support and advice on a 4-6 weekly basis to all 19 clinical commissioning groups in the region through parity of esteem calls (where mental health and physical health are treated equally) with NHS England Midland and East colleagues and clinical commissioning groups.
- Designed and programme managed the Primary Care Mental Health and Dementia Supported Delivery Programme, which gave financial, clinical, quality improvement and programme management support to four dementia and two primary care mental health projects. These best practice examples were show cased at a regional event organised and hosted by the Network.
- The Network launched its Well Pathway for Dementia Supported Delivery Programme. This will give financial, clinical and programme management support to eight sites to work on transformational projects which underpin the living well and supporting well pillars of the Well Pathway for Dementia. This National Institute for Health and Care Excellence (NICE) pathway can help ensure that appropriate care is provided at the right time to enable people to continue to live well with dementia.
- Designed and hosted a regional dementia conference with key note speaker Professor Alistair Burns providing support to clinical commissioning groups around diagnosis and moving forward into the well pathway for

dementia. The event showcased regional examples of best practice and a new data tool from Public Health England which provides clinical commissioning groups and local authorities with data and information to support planning and providing services locally.

- Supported the Regional Parity of Esteem Board for NHS England Midlands and East and the Parity of Esteem (East) meetings which looked more broadly at what support the region required to progress the parity of esteem (where mental and physical health are treated equally) agenda.

Neurological conditions:

- Developed two eLearning modules to better support adults with epilepsy in primary care.
- Produced three epilepsy guidelines to support the management of adults with epilepsy.
- Provided clinical and quality improvement support to clinical commissioning groups within the region that were looking to transform their neurology services.

Co-production:

- Coordinated a range of co-production initiatives across the region – this work sees service providers and service users or citizens, work together to create a decision or a service which works for them all. The Network provided programme management support and procured expertise from the National Development Team for Inclusion to support three in depth projects and three action learning sets to co-produce a range of services.

Case studies

- Dementia diagnosis (page 34)
- The zero suicide programme (page 35)
- Co-production programme (page 37)

Maternity, Newborn, Children and Young People

Major achievements in 2015-16

Maternity and newborn:

- As part of our regional programme to reduce stillbirths and improve outcomes in maternal and child health, the Network:
 - supported the ongoing implementation of gestational related optimum weight (GROW) software in 15 out of 17 trusts in the region. Held a well-attended growth assessment protocol training and support event for regional GROW, maternity and obstetric leads in conjunction with the Perinatal Institute to promote the ongoing implementation of the software within the region.
 - developed a new workstream to reduce smoking in pregnancy. Held a regional event for commissioners, clinicians, managers and stop smoking services in partnership with Public Health which was well attended. This facilitated the development of plans for each locality in the region to reduce smoking at the time of delivery rates by at least 10% over the next year. This has been reinforced with targeted visits and support to commissioners from the Network and Public Health.
- Engaged the family nurse partnership leads in all localities, through the Family Health and Experience Forum, to develop and agree a standard process for booking teenage pregnancies to promote best practice outcomes for teenage parents in the East of England.
- Established and launched a new East of England forum to lead on the improvement of perinatal (the period throughout pregnancy and up to a year after birth) mental health. Linking with the Family Health and Experience Forum and Child and Adolescent Mental Health Services Forum this group works

with key stakeholders to lead on quality improvement for women and families who experience perinatal mental health issues. It includes all aspects of care from prevention and early diagnosis, treatment of mild and moderate conditions, as well as more severe conditions like psychosis and inpatient care. Also, held a Perinatal Mental Health Round Table Event in partnership with NHS England, for senior leaders in Norfolk, Suffolk and Cambridgeshire to discuss investment in mother and baby unit capacity in the region.

- Developed regional guidelines to standardise the quality of care for women requesting an elective (planned) caesarean section. The guidelines on caesarean section and sepsis (blood poisoning) will be implemented in 2016-17.
- Development of a regional plan for implementing the recommendations from the *National Maternity Review* published in February 2016: *Better births – Improving outcomes of maternity services in England* is underway. Also, working with the National Clinical Director for Maternity to support the development of a national maternity dashboard.

Children and young people:

- Hosted the National Paediatric Asthma Collaborative led by the Network's clinical lead Dr Richard Iles. This year the collaborative, which champions and leads on quality improvement for children's asthma, has included eight (of the twelve) networks nationally as well as NHS England, Asthma UK, Primary Care Respiratory Society and the British Thoracic Society. Achievements this year include the:
 - launch of a quality improvement toolkit for children's asthma on www.respiratoryfutures.org

- development of an innovative national e-learning education programme for children's and adult asthma in partnership with Health Education England and Education for Health. Working with four clinical commissioning groups in the East of England to support the implementation and evaluation of the programme in 2016-17 before it is launched nationally.
- development of a specialist payment framework (CQUIN – commissioning for quality and innovation) and best practice tariff for children's asthma.
- completion and sharing of documents including the *London Asthma Standards* and the *Greater Manchester, Lancashire and South Cumbria Primary Care Asthma Standards*. These documents share best practice and are useful tools to support the implementation of national guidance.
- Supported the development of a regional model of networked care for children's rheumatology (diagnosis and treatment of rheumatic diseases such as arthritis and autoimmune diseases). Facilitated two engagement events to get the views of children, young people and parents on the proposed model of care. Worked with East of England Specialised Commissioning to support the development of action plans from regional centres to implement the new model of care in 2016-17.
- Undertook a regional audit of all 17 acute trusts in the region against the standards of care for children's surgery and anaesthesia. The audit report was developed and shared with acute trusts in the region to enable them to benchmark their service regionally and develop local action plans.
- Completed a regional audit of all 17 acute trusts in the region against key standards of emergency and urgent care, shared best practice on new models of emergency and urgent care and high volume pathways to support commissioning for children and young people.
- Held two events for regional children and young people and, maternity health

commissioners. This was an opportunity for commissioners and clinicians to come together for education, discussion and support with a focus on the high quality commissioning of maternity, newborn, children and young people's services in the East of England.

Young health ambassadors:

- Re-launched the Young Health Ambassador's Forum following a review of its membership and function. There has been excellent engagement from most localities in the East of England with a huge amount of engagement work completed – getting the views of children and young people from across the region and feeding these in to local workstreams and national forums.
- Commissioned and delivered co-production training over two sessions to maternity, newborn, children and young people leads to promote the engagement of children, young people and families, recognising them as experts by experience and as equal partners driving improvements in the quality of care.
- Commissioned and delivered the *Royal Society of Public Health Young Health Champions Training* as an innovative 'train the trainer' model to eight members of the Young Health Ambassador's Forum to spread and cascade the delivery of this programme to schools and youth groups in the region.
- Hosted and successfully ran an all-day event to mark Children's Takeover Day.
- Represented the East of England at the National Children and Young People Patient Experience Event run by NHS England and the Patient Experience Network.
- Continued to represent the voice of children and young people at Citizens' Senate.

Case studies

- National Paediatric Asthma Collaborative (page 39)
- Young Health Ambassadors (page 40)

Respiratory

Major achievements in 2015-16

- Worked with a number of clinical commissioning groups (in particular West Norfolk and Luton) to develop local respiratory networks where key stakeholders collectively plan to commission and provide high quality and cost-effective care to people with respiratory problems. This has resulted in more efficient care, additional pulmonary rehabilitation (a programme of exercise, education and support to help patients learn to breathe and improve their physical condition) places, commissioning of new respiratory services, and improved awareness, understanding and adoption of best practice.
- Pulmonary rehabilitation is one of the most effective treatments for people with chronic lung problems. This programme of exercise,

education and support should be offered annually to everyone who experiences breathlessness as a result of chronic lung disease. There is however a national shortage of pulmonary rehabilitation capacity and a variation in care provision which the Network set out to address. It provided leadership to the regional pulmonary rehabilitation group, shared best practice with local providers, collected comparable data, developed and shared reports with commissioners and providers and made recommendations for change. This resulted in a 3.3% increase in regional pulmonary rehabilitation capacity, allowing an extra 216 patients to benefit from pulmonary rehabilitation; a 3% increase in people completing pulmonary rehabilitation; and more sharing and adoption of best practice.





- When people with chronic lung disease fall ill they may require emergency oxygen which needs to be carefully prescribed and administered otherwise it can make the problem worse. The Network adapted and tested a new model of care called '6-Min Cycle' to simplify emergency oxygen prescribing for ambulance staff, and in collaboration with East of England Ambulance Service NHS Trust, developed guidance for use in primary care so that staff administer emergency oxygen appropriately. Following the successful pilot, the '6-Min Cycle' will be rolled out across the region. In other areas this has provided safer care, reduced the need for patients to go to hospital and the need for emergency treatment.

- Smoking rates amongst people with mental health issues are significantly higher than the general population and they often have higher levels of addiction. Evidence tells us that people with mental health issues who stop smoking feel better and live longer, but that common misconceptions, longstanding attitudes and staff prejudices limit access to stop smoking support. The Network collaborated with Public Health England to increase stop smoking training for mental health staff and improve referral rates to stop smoking services. This led to a 129% increase in staff training and a 27% improvement in regional referral rates.
- The Network wanted to improve the use of respiratory care bundles across hospitals in the region. Care bundles use sets of evidence-based practices in a structured way to reduce variation in care and improve patient outcomes. The Network audited the use of respiratory care bundles across the region, developed and shared reports with recommendations to key stakeholders and supported various localities with their implementation. This increased the use of respiratory care bundles, with two additional trusts using the COPD (chronic obstructive pulmonary disease) discharge care bundles and a further two trusts exploring the use of an asthma care bundle.
- A key finding of *Why asthma still kills, The National Review of Asthma Deaths, 2014* was the absence of regular primary care asthma reviews in the year before death in 43% of patients who died of asthma. The report recommended that pharmacists could support improvements in care by completing high quality asthma medicine use reviews, these are structured reviews, undertaken by pharmacists to improve medicine adherence. The Network supported six pharmacists and their associated practices to undertake high quality asthma medicine use reviews using the SIMPLE asthma platform, an evidence based tool. The Network provided training on the platform as well as an update on asthma management and device training. The results of this pilot will be analysed,

however the Network is confident it will result in more high-quality asthma medicine use reviews being undertaken and improve communication between pharmacists and general practice.

- Medicine use reviews are structured reviews, undertaken by pharmacists to improve medicine adherence. This is an advanced service within the pharmacy contract and pharmacists receive payments for their activity, however the quality of this service varies. The Network, with Reading University, developed a questionnaire to measure the quality of asthma medicine use reviews, and this was tested alongside the introduction of the SIMPLE asthma platform. The questionnaire will soon be available for wider use and will reduce variation and improve care.
- Asthma is one of the top three reasons for emergency admissions to hospital and up to 75% of these admissions are avoidable. Local audits have shown that primary care professionals do not feel confident in their management of asthma. To improve this the Network developed an online education resource, called 'e-Asthma', for healthcare professionals who are not asthma specialists and come into contact with children or adults with asthma. Three clinical commissioning groups will implement the resource in GP practices, and are aiming for at least 60 GPs and 120 practice nurses to complete a short pre-course evaluation, the adult and children's training modules, a post-course evaluation, and a further evaluation after three months. This evaluation will be used to inform the national communications strategy when the resource is launched across England later in 2016.
- The Network has worked with clinical commissioning groups to help them develop and implement improvement plans in primary respiratory care to tackle avoidable emergency hospital admissions. Plans suitable for each clinical commissioning group were developed and a risk assessment was undertaken using GP clinical systems to provide

information about patients in the practice with COPD (chronic obstructive pulmonary disease) and asthma. This supported clinical commissioning groups to produce a respiratory service relevant to their needs. In addition, the Network has encouraged clinical commissioning groups to meet and discuss how best to design a service which met the needs of their patients, was deliverable within the constraints of everyday general practice and financial limitations. Four clinical commissioning groups are using this work, as part of a local improvement plan, to support improvements in primary respiratory care and reduce avoidable emergency admissions.

- Involving patients in shaping local healthcare has long been recognised as important. Many clinical commissioning groups run local respiratory networks, and patient involvement with these networks offers many benefits. Recognising this, the Network wanted to ensure all local respiratory networks received appropriate patient representation, and that these patients felt able to make contributions, network and share experiences. With the British Lung Foundation the Network mapped local networks and their patient representation throughout the region, and now most local respiratory networks have patient representation. The Network also ran a series of events to enable patient representatives to become competent local leaders and have held two regional events to bring patient representatives together.

Case studies

- Increasing Patient Access to Pulmonary Rehabilitation (page 42)
- Smoking and Mental Health Project (page 43)

Citizens' Senate

The Citizens' Senate is a *'Connected and experienced group of people aiming to influence regional NHS strategy by presenting patient, carer and family perspectives'*.

There are 25 active members, all connected to patient groups such as Healthwatch and clinical commissioning or GP partnership groups. The Citizens' Senate is supported by the East of England Strategic Clinical Networks and Clinical Senate, as part of a commitment to public participation.

Its main achievements have been to raise the profile of the public voice and participation, to ensure a flow of information via patient groups, and to support and share best practice and innovation.

This has been done through networking and regional meetings, where members have learned about a number of exciting projects which have improved the experiences of patients. These have included medical innovations and community projects to support healthier lives, such as the *Parish Nurse* project in Cambridgeshire and the *Connect Well* social prescribing project in Essex. Members have shared the success and learnings from these projects back in their own areas to share best practice and support change.

In addition, members have supported the Eastern Academic Health Science Network Patient Safety Collaborative, by conducting a region-wide survey of frail and elderly people. Each member surveyed three individuals about their health and care needs, and findings have been fed back to inform the project development.

Members have been in demand across the region and elsewhere for the vital contribution they make in providing expert patient and carer perspectives across an ever-changing healthcare landscape. The Citizens' Senate was recognised at *The Commissioning Show 2015* where it was lauded as one of the achievements of Strategic Clinical Networks.

We have developed guidance for partners wishing to work with us, which can be found on our website www.eoescn.nhs.uk/citizens-senate. The site also hosts information such as our governance structure and how to get involved.



Clinical Senate

'The East of England Clinical Senate brings together health and social care professionals and patients to provide independent, sound, thoughtful clinical advice and leadership to support strategic service change that improves patient outcomes and the population's health.'

Clinical Senate

Clinical senates provide independent, strategic clinical advice and guidance to commissioners and other stakeholders within a geographical area to help them make the right decisions about healthcare for the populations they represent. Generally, clinical senates do this through clinical review panels that bring together a group of senior clinicians and patient and public representatives. The review panel looks at the case for change, the proposals and supporting evidence for change to provide advice through recommendations.

Clinical review panels are usually held face to face and include some time with representatives from the commissioning organisation who are able to answer the panel's questions. Clinical review panel members are drawn from our Clinical Senate Council and Assembly which includes patient and public representatives, and will often include clinical experts from across England.

Major achievements in 2015-16

- Clinical Senate Council was asked to review a number of proposals and undertook clinical review panels that ranged from looking at large scale transformational change proposals across a large geographical area to a very specialised single service covering the East of England. Reports from two of the independent clinical review panels are now available on the Clinical Senate website www.eoesenate.nhs.uk/senate-advice/publications-and-advice-provided/. Reports from other clinical review panels will be published by respective commissioners as the proposals develop.
- Clinical Senate Council was keen to support health economies across the region in assessing their readiness for seven day services. After discussion with the medical directors of acute hospital trusts in the East of England early in 2015, the Clinical Senate Council agreed to undertake a project

on standard eight, one of the ten clinical standards for seven day services. Standard eight sets standards for the on-going review of some patients by a consultant, and the medical directors felt this was one of the more difficult standards to measure and achieve.

Clinical Senate Council in conjunction with Public Health England established a working group to develop approaches to assessing and sharing practice, refining toolkits, and a system for peer review for this standard. Three acute trusts supported the project and hosted site visits for the team to discover how hospitals may be addressing the standard differently. Those hospitals were Papworth Hospital, Southend University Hospital and Queen Elizabeth Hospital King's Lynn, NHS foundation trusts. The findings of the project and final report can be found here: www.eoesenate.nhs.uk/events/news/seven-days-service-standard-8/

- Clinical Senate Council is in discussion with the Regional Medical Directors Forum to establish another working group looking at the provision of and access to interventional radiology services across the East of England. Again, this will be in partnership with Public Health England.
- In October, Clinical Senate was delighted to have Dr Rachel Addicott, Senior Research Fellow at The King's Fund, attend a meeting of the Council to talk about new models of care and integrated care. Members of Clinical Senate Assembly attended this well received presentation and discussion.

Financial Summary

The East of England Strategic Clinical Networks and Clinical Senate are funded by NHS England with a total budget in 2015-16 of £3,184,031. This included a running cost budget of £458,831 and a programme budget of £2,725,200.

In addition, the Strategic Clinical Networks received £245,500 in year to support new work in mental health, and £18,000 sponsorship for Cancer Network clinical groups.

The table below shows the budget and expenditure across the East of England Strategic Clinical Networks and Clinical Senate in 2015-16, and the position at year end. Individual Network budgets are set at the beginning of the year and are reallocated accordingly throughout the year in response to their detailed operational plans.

Running Costs	Budget (£)	Actual (£)
Clinical Senate	458,831	84,091
Strategic Clinical Networks		387,699
GRAND TOTAL		471,790

Programme Costs	Budget (£)	Actual (£)
Corporate costs	282,624	232,362
Strategic Clinical Networks:		
Maternity, Newborn, Children and Young People	504,422	281,431
Cancer	644,631	755,256
Cardiovascular Disease	483,034	394,541
Mental Health, Dementia and Neurology	559,900	802,060
Respiratory	250,589	207,584
Network Programme Costs	2,725,200	2,673,234
GRAND TOTAL	3,184,031	3,145,024

Plans for Next Year

In October 2014 the NHS *Five Year Forward View* was published which set out a new shared vision for the future of the NHS based around new models of care. Local health and care systems are taking this forward through the development of five-year sustainability and transformation plans (STPs).

In the last year or so NHS England has also reviewed the improvement support it provides to the health system to improve services for patients. As a result, in 2016-17 the Clinical Senate will continue to provide independent, impartial strategic clinical advice to commissioners and other stakeholders to assist them to make decisions about healthcare now and in the future, for example in relation to service change arising from sustainability and transformation plans.

Strategic Clinical Networks have been renamed Clinical Networks and their focus going forward will be on enabling improvement in the following clinical areas which are central to delivering the NHS *Five Year Forward View* and local sustainability and transformation plans – mental health and dementia, cancer, diabetes and maternity.

Mental health and dementia

The Clinical Network will support the local health system to implement NHS England's *Five Year Forward View* for mental health focusing in 2016-17 on:

- improving mental health care for women during pregnancy and the first year after birth
- expanding access to high quality mental health care for children and young people
- improving adult mental health through:
 - introducing and embedding new national targets to improve the early detection and treatment of people with a first episode of psychosis (a severe mental disorder)
 - increasing access to psychological therapies (talking therapies) for people with common mental health problems;



integrating new services with physical healthcare

- improving the availability of and access to mental health liaison teams in acute hospitals.
- continuing to support the achievement of the national dementia diagnosis ambition
- working with the health and care system to improve care for people with dementia.

Cancer

The Clinical Network will support the local health system to take forward the recommendations of the national cancer taskforce report focusing in 2016-17 on:

- ensuring a sustainable return to the cancer 62 day waiting times target
- diagnosing cancer earlier to improve survival and reduce the number of premature deaths from cancer
- improving cancer outcomes by establishing cancer alliances which will bring together commissioners and those who provide care
- developing new ways of commissioning lung cancer services to improve detection, early diagnosis and treatment
- ensuring effective patient and public involvement in cancer networks and cancer alliances going forward.

Diabetes

The Clinical Network will support the local health system to improve outcomes for diabetes:

- reducing the risk of people developing diabetes through supporting the delivery of the national diabetes prevention programme
- enabling delivery and evaluation of local diabetes prevention projects aimed at hard to reach groups
- providing clinical advice and support to clinical commissioning groups identified as having poorer outcomes for people with diabetes



- providing specialist clinical advice and leadership for cardiac, stroke and vascular services as required by local urgent and emergency care networks.

Maternity

The Clinical Network will support the local implementation of the national *Better Births* report focusing in 2016-17 on:

- developing clinical networks to implement the *Better Births* transformation programme
- improving outcomes and facilitating a culture of learning by working with local maternity systems
- reducing stillbirth rates through implementing the *Saving Babies Lives Care Bundle* which addresses variation by bringing together the best available evidence and practice
- improving data capture to enable benchmarking and improve quality and outcomes.

Strategic Clinical Networks' Case Studies

Cancer

- Improving Cancer Diagnosis in the Acute Setting **29**
- Transforming Cancer Care in the Community **30**

Cardiovascular Disease

- Managing Stroke Information **31**
- Continuous Glucose Monitoring **32**
- Primary Percutaneous Coronary Intervention (PPCI) – admission of intubated patients when there is no intensive therapy unit bed available at the heart attack centre **33**

Mental Health, Dementia and Neurological Conditions

- Dementia diagnosis **34**
- The zero suicide programme **35**
- Co-production programme **37**

Maternity, Newborn, Children and Young People

- National Paediatric Asthma Collaborative **39**
- Young Health Ambassadors **40**

Respiratory

- Increasing Patient Access to Pulmonary Rehabilitation Programmes **42**
- Smoking and Mental Health Project **43**

CASE STUDY

Improving Cancer Diagnosis in the Acute Setting

Overview

To discover why up to 40% of lung and 26% of colon cancer patients in the East of England are diagnosed via urgent and emergency care, rather than through primary care. Diagnosis as an emergency is associated with poorer survival. Having mapped patient, clinical and organisational issues, the project issued specific learning to support earlier diagnosis.

Strategy

Colon and lung cancer patients who were diagnosed as an emergency were identified at 14 East of England trusts over a nine-month period (March to November 2014). Patients were surveyed and medical records were reviewed to understand events leading to diagnosis.

Findings showed three key themes: a lack of both patient awareness of their symptoms and willingness to use health services, low rates of early presentation in 'at risk' groups such as the elderly or carers, and poor GP access to diagnostic tests for those patients with vague, non-specific symptoms who do not fulfil the two week wait referral criteria.

Outcome

As a result, the project shared specific learning points with all GP practices in the East of England and have set up three multi diagnostic centres to pilot easier GP access to diagnostic tests to exclude cancer. Our overall aim is to develop the shortest and safest route to cancer diagnosis particularly for patients with non-specific, vague symptoms.



CASE STUDY

Transforming Cancer Care in the Community

Overview

A pilot programme seeking to move support and treatment for appropriate cancer patients into the community and away from hospital. The aims are to improve patients' experience of care and reduce the need for expensive hospital care.

Strategy

Seven pilot projects were set up across the East of England in partnership with Macmillan Cancer Support. The projects involved 16 nurses and seven support staff working to provide more personalised care to cancer patients in their own home or other community setting. This included home chemotherapy and assessment, fast track to hospital where required, late-effects clinics and a range of wellbeing services.

The pilots were positively received by patients and evaluated well against criteria in the National Cancer Patient Experience Survey with positive

patient experience scores increasing by 75% (23% to 98%). In addition, full evaluation of the project was undertaken by the University of East Anglia, which revealed an impact on the number of hospital admissions and a potential return on investment of £5.90 for every £1 spent. This would provide an annual saving of £547,267 for the most productive pilot.

Outcome

The pilot proved to be effective in certain areas which has led to the clinical commissioning groups in Huntingdon, and Great Yarmouth and Waveney commissioning this model of care for a further year.

The programme was announced overall winner of the prestigious national Quality in Care Oncology Awards in 2014 and pilots also won many local awards including Health Education East of England Leaders Award and Norfolk Community Project Award.



CASE STUDY

Managing Stroke Information

Overview

The majority of trusts and clinical commissioning groups used a region-wide database for managing stroke information. During 2014-15 it became apparent that this database was no longer capable of managing the amount of data. Trusts were also being asked to upload the same data onto the national Stroke Sentinel National Audit Project database for national benchmarking.

The difference between the two systems was that clinical commissioning groups received monthly data from the trusts via the region-wide database, however the quarterly stroke sentinel national audit project data was only received quarterly. Clinical commissioning groups had been monitoring information for their stroke patients on a monthly basis and had been reluctant to move to quarterly data.

Strategy

The Network was asked to encourage the clinical commissioning groups to use the quarterly data provided by the stroke sentinel national audit project.

The Network arranged for the Royal College of Physicians Stroke Sentinel National Audit Project leads, who manage the database, to provide a masterclass to stroke unit staff, clinical commissioning group information leads and community providers to ensure that they understood the system and what information is both required and reported on a quarterly basis. The Royal College of Physicians also worked with each clinical commissioning group in individual workshops to help them understand what information can be downloaded outside the normal quarterly reporting to enable them to make best use of the database.

Over 75 delegates from across the region, including representatives from eleven clinical commissioning groups, eleven acute trusts and eight community providers attended.

Outcome

Clinical commissioning groups are working with providers to understand what data is available. A working group has been established between providers in one area to agree the measures for the monthly reports, with a view to limiting ad hoc reporting, and encouraging clinical commissioning groups to benchmark using the quarterly stroke sentinel national audit project data.



CASE STUDY

Continuous Glucose Monitoring

Overview

The Network has established a number of advisory groups to bring together professionals and experts in each clinical area to review guidance, monitor variation and spread good practice. As part of this network of advisory groups, the Bedfordshire and Hertfordshire Diabetes Advisory Group were asked by the Bedfordshire and Hertfordshire Local Priorities Forum to review interim guidance for continuous glucose monitoring circulated by the East of England Professional Advisory Committee to ensure that the appropriate policies were established and adhered to across the area.

Strategy

The Priorities Forum directly approached Bedfordshire and Hertfordshire Diabetes Advisory Group for feedback on the interim guidance regarding continuous glucose monitoring. However, subsequently the National Institute for Health and Care Excellence (NICE) updated their adult and paediatric (children's) diabetes guidelines which included new information relating to continuous glucose monitoring.

The Advisory Group set up a sub-group to review and compare the Priorities Forum and NICE guidance. The group included representatives from acute providers across Bedfordshire and Hertfordshire, adult and paediatric specialists, consultants and Cardiovascular Network leads.

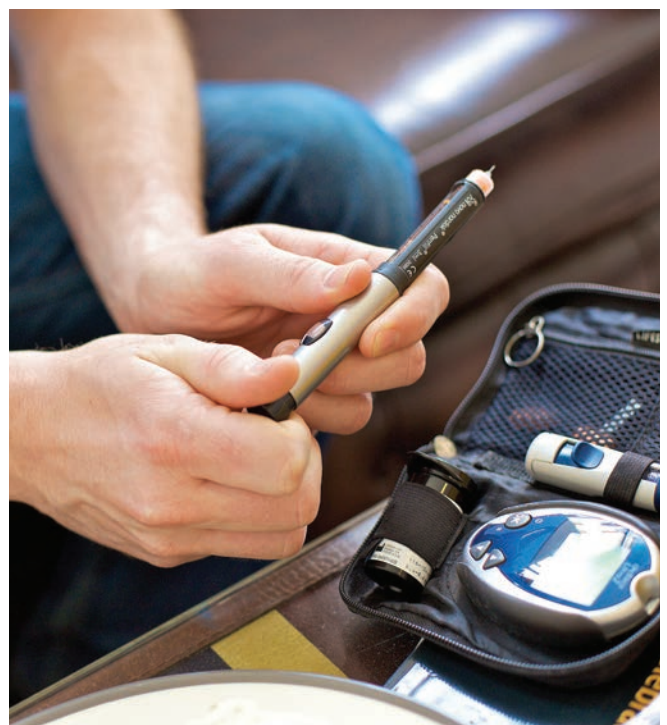
The Priorities Forum guidance only included adult provision, however the Chair requested paediatric specialist nursing representation within the sub-group so that continuous glucose monitoring for children could be addressed at the same time.

Outcome

The NICE guidance was more comprehensive than the guidelines the Priorities Forum had asked to be reviewed. Both the adult and paediatric NICE guidance addressed the issue of continuous glucose monitoring in real time and retrospectively.

The group's clinical advice to the Priorities Forum was to use the NICE guidance. However, it was noted that this guidance did not address some key issues around moving from paediatric treatment in to adult care, or advice to commissioners on how to address the issue of patients who no longer meet the strict NICE guidance criteria that must be met in order to access NHS funded treatment.

Recommendations on these points will be made later this year for use across Bedfordshire and Hertfordshire, and across the East of England if needed.



CASE STUDY

Primary Percutaneous Coronary Intervention – admission of intubated patients when there is no intensive therapy unit bed available at the heart attack centre

Overview

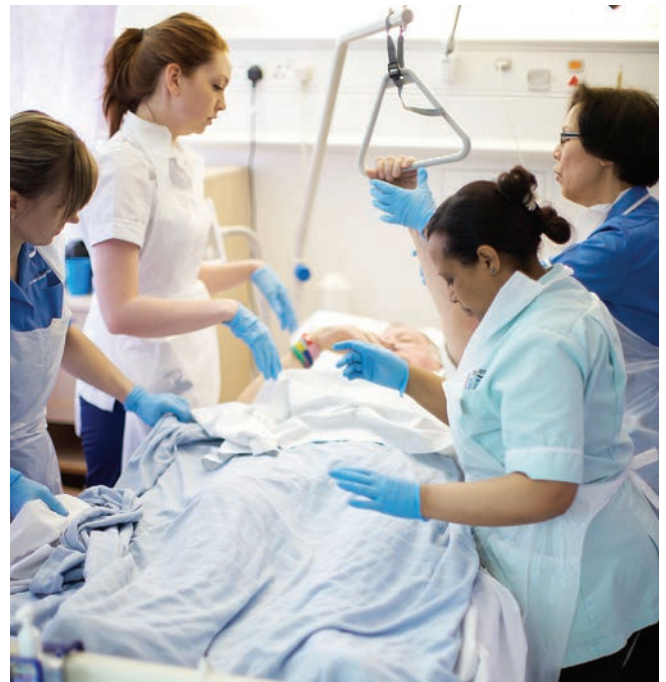
The East of England Critical Care Operation Delivery Network asked to collaborate with the Cardiovascular Network to address the possibility of intubated (the placement of a flexible plastic tube into the windpipe) patients requiring a primary percutaneous coronary intervention (a procedure used to treat narrowed coronary arteries of the heart) not being accepted if there were no intensive therapy unit beds available in a heart attack centre. Although this affected a small number of patients, it would lead to delays in treatment and impact health outcomes for these patients.

Strategy

A series of teleconferences were held between the Critical Care Network, the East of England Ambulance Service NHS Trust, heart attack centre leads and Network leads to identify best practice. Two options were discussed, to:

- treat patients and then transfer them to a centre which has a free intensive therapy bed – which is not current practice
- secure another primary percutaneous coronary intervention specialist centre which has a free intensive therapy bed – the ambulance service would be informed of lack of capacity and redirected to an alternative centre.

The options were taken to the Primary Percutaneous Coronary Intervention Expert Group for final discussion, where both the East of England Ambulance Service NHS Trust and the Critical Care Network were represented. The Cardiovascular Network Clinical Lead underlined latest guidance that intubated patients should have the same access to care as non-intubated patients, and the Critical Care Network shared



their current policy on the approach to a similar issue in emergency neurosurgery.

Outcome

The Primary Percutaneous Coronary Intervention Expert Group agreed that all eligible patients should be taken to the nearest primary percutaneous coronary intervention centre. If the centre has no intensive therapy unit beds then it is the responsibility of the centre to locate an intensive therapy unit bed following the primary percutaneous coronary intervention.

Where possible if the patient requires respiratory support (intubation), the centre should be contacted and informed in advance of the requirement for an intensive therapy unit bed. The *East of England Primary Percutaneous Coronary Intervention Policy* was updated to include this agreement.

CASE STUDY

Dementia diagnosis

Overview

In 2013, NHS England set a national ambition that two thirds of people living with dementia would have a formal diagnosis and access to appropriate support by 2015. Despite a huge amount of effort the ambition was not reached nationally or in the East of England with diagnosis rates in the East of England increasing from an average of 47.5% in August 2014 to 55.7% in March 2015. NHS England extended the ambition to March 2016 and emphasised the importance of the diagnosis and access to appropriate post diagnosis support.

Strategy

The Network responded to the challenge and implemented a range of interventions to improve dementia diagnosis across the region, these included:

- Reviewed and provided tailored feedback on the dementia recovery and dementia improvement plans for all 19 clinical commissioning groups in the East of England and provided clinical and quality improvement support over the year.
- Provided dedicated support to North East Essex and South Norfolk clinical commissioning groups, including being actively involved in work streams and revision of the dementia pathway.
- Provided support and guidance through a webinar: *Dementia Diagnosis – Learning from Corby Clinical Commissioning Group*. The webinar used examples, which could be replicated, of how Corby Clinical Commissioning Group had increased their diagnosis rate.
- Provided support and guidance for clinical commissioning groups by hosting a number of webinars. A webinar: *Improving Your Memory Assessment Service* shared three best practice models of this service with



practical examples which could be replicated. A webinar: *Dementia Diagnosis in Care Homes – Learning from South Essex* covered a programme which effectively diagnosed people with dementia who were residing in care homes. The best practice has now been replicated across the East of England.

- Supported the planning and design of Norwich Clinical Commissioning Group's Dementia Event. Professor Alistair Burns focussed on how to improve engagement with primary care and identified possible solutions to challenges in achieving the 67% dementia diagnosis target in Norwich.

Outcome

The Network has provided quality improvement support which has led to sustained activity and innovative thinking by clinical commissioning groups in the region. It has also ensured significant progress towards the achievement of the 67% diagnosis rate; as of February 2016 the diagnosis rates were from 55.4 to 69.8% with the majority of clinical commissioning groups averaging 62%. The six most challenged clinical commissioning groups in the East of England increased their diagnosis rates from 55.4% to 61.9% with the majority of the six averaging 60% by February 2016.

CASE STUDY

The zero suicide programme



Overview

The majority of people who take their own lives are not in contact with specialist mental health providers at the time of their death. The aim of the programme set up by the Network in 2013 was to develop services particularly for those people not in touch with services, focus on how to engage and energise community support, and to achieve zero suicides in the areas concerned.

The programme aimed to replicate the vision of the work of Dr Ed Coffey, from Behavioural Health Services in Detroit where a zero suicide ambition was set and an approach built on other mental health recovery developments in the United States.

Strategy

Four clinical commissioning groups (Mid Essex, Hertfordshire, Bedfordshire, and Cambridgeshire and Peterborough) ran projects to improve outcomes for individuals and their carers. The projects used partnership working and the local community to address gaps in services or the transition between them, whilst also demonstrating a commitment to engage 'hard to reach' patient groups and patients from ethnic minorities.

Each project worked with their local communities, involving coroners, librarians, gym staff, housing association staff, publicans, social care assistants, paramedics, faith groups, Football Association staff, clinical commissioning group employees, private security staff and the British Transport Police.

Projects were expected to contribute to:

- reducing risk of suicide and self-harm
- improved outcomes
- rapid access to evidence-based treatment
- improved quality and experience of depression care
- increased efficiency of services
- easing the access to services for patients and referrers.

Projects revealed considerable unmet need in different parts of their communities, of which statutory services were largely unaware. Each project was given resources and the space to develop their approaches and engage with a broad range of stakeholders to develop and deliver a mix of creative and innovative ways to reach people.

All sites developed a web and social media presence, linking with local services so people could access services directly if needed.

The projects included a diverse range of interventions, including the development of local 'brands' for the programme, signing up to a 'stop suicide' pledge or building on existing voluntary sector services. One site asked their local newspapers to help signpost people to services after any articles on suicides, while others have begun to think that a broad wellbeing focus may be more effective.

One of the most exciting and common areas of work across all sites was the delivery of training, a mix of general awareness and understanding, and applying suicide prevention and intervention skills. Training was provided to a broad range of people from NHS and voluntary sector staff to British Transport Police, pub landlords, library staff and the public.

Outcome

- Given the capacity, with a clear and shared vision and a challenging objective, local groups can develop and deliver creative and effective local approaches to suicide reduction.
- Partnership between community groups, voluntary organisations and statutory sectors can unlock previously unrecognised value in social capital and local knowledge.
- Integrating services with web and social media communication can be a core part of the programme, and offers more than simple information sharing.
- There is significant need for more training which needs to be built into core professional training and continuing professional development for all staff working in the NHS, the police, local authorities and other service providers, and delivered on a multi-disciplinary basis.
- Coroners can be partners in suicide reduction and should be commissioned to regularly carry out suicide audits.
- Research and timely, accurate and reliable data are essential to evaluate the effectiveness of programmes such as these.
- Effective projects needed passion, and also capacity in terms of money, people, and commitment from other services.

CASE STUDY

Co-production programme

Overview

The Network was keen to investigate different approaches in bringing people with lived experience and their carers into the centre of service redesign. The Network used co-production to do this, which is a way of thinking and working where patients and carers are equal partners with healthcare providers, and they work together to improve health services, strategies or programmes of work.

Strategy

In 2014, the Network bought the services of the National Development Team for Inclusion, a not for-profit organisation which promotes inclusion and equality for people who are at risk of exclusion and who need support to lead a full life. The Team have extensive experience of leading co-production projects with a range of providers, including in health and social care.

The programme had two elements, an in-depth programme which supported three clinical commissioning groups to work with patients, carers and families as equal partners on large-scale service improvement in mental health or long-term conditions. The projects received funding from the Network and specialist support from the National Development Team for Inclusion. The projects selected were:

- Putting people diagnosed with progressive neurological disease at the centre of service redesign. The aim of East and North Hertfordshire Clinical Commissioning Group's project was to develop service principles and models to support the commissioning of local services.
- To provide support for people living with dementia and their carers in Luton. Luton Clinical Commissioning Group's project is a finalist in the Patient Experience Network Awards in the Team of the Year category 2016.





- Community Asset Modelling for Mental Health. The aim of South Norfolk Clinical Commissioning Group's project was to identify local resources in a community (libraries, gyms, health centres and specialist mental health interventions) that can offer support to a person in mental distress and help them live better with their mental health problem. The approach involves helping service users and professional staff become more aware of how these resources can help and encouraging their use.

The programme also supported the development of action learning sets, which are dedicated days for teams to work together on their projects and support others with theirs through a process of listening, reflection, questions and actions. Three teams met five times over 2015, and the projects and teams selected were:

- Development of an integrated mental health care strategy – Ipswich, East Suffolk, and West Suffolk clinical commissioning groups and Suffolk County Council.
- Improving annual health checks for people with a learning disability in Thurrock – Thurrock Clinical Commissioning Group, experts by experience, and a local social enterprise company.
- Development of a rare neurological disease pathway – Luton Clinical Commissioning Group, Motor Neurone Disease Association, Progressive Supranuclear Palsy Association and a local hospice.

The projects and sites chosen were selected from a number of applicants by a Co-Production Steering Group panel, which included equal numbers of patients and carers, and professionals. This steering group continued to oversee the in depth support through quarterly meetings.

Outcome

All projects were evaluated by the National Development Team for Inclusion to measure the impact of co-production as a method of working. The final report will be available in spring 2016. However the quotes below, from the people involved in the projects, give an insight into the impact of this way of working.

"In my head I thought it was patient engagement wrapped up in a different name – it's not. The badges and roles have gone... everyone brings their own skill set."

"It's taken a couple of months for me to get used to the idea that the Council actually listen to me and want to hear my voice. It feels genuine; I feel part of the team."

"I can't imagine ever trying to do another service change without involving members of the public ever again – to do so would be a nonsense... It must be used to make changes."

"...everyone has evolved, the preconceptions have gone out of the window, our eyes have been opened to a new way of working."

CASE STUDY

National Paediatric Asthma Collaborative

Overview

The East of England Strategic Clinical Network is the lead for the National Paediatric (Children's) Asthma Collaborative. Established in June 2014, the collaborative brings together professionals from across NHS England, strategic clinical networks, clinical leads, academic health science networks, respiratory networks, professional bodies and voluntary sector organisations who all have responsibility for improving outcomes for children and young people with asthma.

Strategy

The Collaborative was established to deliver the following, to:

- reduce the national level of avoidable deaths for children and young people with asthma
- reduce the national level of avoidable hospital admissions for children and young people with asthma
- reduce medication errors and inappropriate prescribing



- increase the national adoption of asthma plans. An asthma plan includes all the information patients need to manage their asthma well, significantly reducing their risk of having an asthma attack.
- increase the national adoption of asthma care pathways to ensure patients have access to best practice standards of care.

Outcome

The Collaborative's programme of work is designed to deliver measurable outcomes and significant progress has been made in the following areas:

- Partnership working and patient and family engagement in the design of services
- Improving asthma education for professionals, clinicians, children and their families so they can effectively control their own asthma
- Development of national information for asthma care for health professionals to give consistent messages to families which are in line with best practice guidance
- Creation of a model service specification for primary, secondary and tertiary (specialist) asthma care, and other support to enable services to be commissioned in line with best practice guidance
- Progress on developing a primary care data proforma for GPs and nurses to use in consultations with asthma patients to ensure the review meets best practice standards
- Development of prescribing surveillance in primary care to ensure patients are correctly prescribed asthma drugs
- Sharing of agreed films and apps to support good inhaler technique
- Launch of our website in partnership with Respiratory Futures.

CASE STUDY

Young Health Ambassadors

Overview

The Young Health Ambassador's Forum is a group of young people from across the East of England whose role is to engage with children and young people to get their feedback and views on health services. The Network feeds this back to commissioners and forums leading on improving the quality of services for children and young people.

The Network works with young people in the Forum involving them as 'experts by experience' in health care so that all changes and service developments directly meet their needs and address their specific issues.

Strategy

The East of England Young Health Ambassador's Forum represent the views of thousands of children and young people from across the region. They feed back to the Network key issues affecting young people today, and invariably these include mental health awareness, access and support; primary care access; and communication issues between professionals and young people.

In November, Young Health Ambassador Alex Burroughes, hosted the first Children's Takeover



Day in Cambridge. Children's Takeover Day is a chance for young people to get involved with organisations and see how they function and operate. It is also a chance for them to give their opinions and share their views with the aim of affecting changes in that organisation.

Eleven young people aged 16-21 attended the event and met a wide variety of healthcare professionals. They had the chance to talk to them about a wide range of issues including how the NHS engages with children and young people, what the Network's priority areas are, finance and communication.

As part of the day, healthcare professionals had to explain their role to a young person within two minutes, similar to speed-dating. This exercise was undertaken to inform young people about the different roles involved in the NHS and to enable the professional taking part in the exercise to feel more comfortable talking to young people.

Outcome

Young people set the challenge to health professionals on the day to make sure that young people's comments were considered and, where appropriate, acted upon. The seven challenges were:



1

Mental Health

Young people frequently report feeling stressed or anxious, and say that mental health is a big concern for them. They want to be educated about mental health and how to cope – what are you doing around mental health?

2

Communication

The way that professionals communicate with young people is often brought up as an issue. How can you improve your communication with young people? (Take a look at www.mefirst.org.uk)

3

Healthcare Information

Doesn't always mean paper – young people may prefer to find information online, so signposting is key. How do you provide your information?

4

Primary Care

Access to appointments can be difficult. Some young people say they would prefer a school nurse in schools, or having a clinic run at the school. Could you do more in schools?

5

Peer Support

Young people want more support in schools and are likely to ask each other for advice – what are you doing to inform/educate young people? (Take a look at Royal Society of Public Health's *'Youth Health Champions Training'*)

6

LGBT+

What support is in your area for young LGBT+?

7

Co-production

Everything done/made for young people should be produced with young people i.e. in partnership. Could you do this? Do you know who your local youth groups are?

The video can be found at <https://www.youtube.com/watch?v=Fq-h0LZNKeA&feature=youtu.be>

CASE STUDY

Increasing Patient Access to Pulmonary Rehabilitation Programmes

Overview

Pulmonary rehabilitation should be offered to all suitable people with Chronic Obstructive Pulmonary Disease (COPD) and other chronic respiratory conditions. Many pulmonary rehabilitation providers frequently struggle to receive sufficient referrals to maximise the programme capacity. The Respiratory Network assessed the extent current capacity is used and compared this for all pulmonary rehabilitation providers across the region. This was fed back to all providers and commissioners with some recommendations to increase the availability of pulmonary rehabilitation to patients.

Strategy

A regional Pulmonary Rehabilitation Network was formed to enable improvements through sharing of best practice, peer support and the collection of meaningful data. A data set was agreed and between 2013-14 and 2015-16 quarterly data was collected from all East of England providers of pulmonary rehabilitation. Amongst other data, the number of available pulmonary rehabilitation places and the number of people starting pulmonary rehabilitation was collected for each locality.



Outcome

Regional pulmonary rehabilitation capacity increased by 216 places (3.3%) between 2013-14 and 2015-16. During the year 4,706 people started pulmonary rehabilitation, utilising 73% of regional capacity. Regional capacity remained the same in 2014-15 compared to 2013-14, with uptake between sites varying from 49% to 148%. Patients completing pulmonary rehabilitation increased from 62% in 2013-14 to 65% in 2014-15.

The Pulmonary Rehabilitation Network supported providers and commissioners to review their services and referral rates. Following this the Network provided every clinical commissioning group with a report to inform them of their situation compared to the rest of the region with some bespoke suggestions on how to improve their services locally.



CASE STUDY

Smoking and Mental Health Project

Overview

The Network collaborated with Public Health England during 2015-2016 to encourage people with mental health conditions in the region to stop smoking. Smoking kills and reducing smoking rates will reduce the number of deaths associated with respiratory illness. Smoking prevalence is high in people with mental health problems as well as people working in mental health services.

Strategy

This was a collaborative programme between the Network and Public Health England which sought to improve links with local authority tobacco alliance leads.

The aim of the project was to encourage people with mental health conditions to stop smoking. The intended outcome was to increase referrals from mental health services to stop smoking services and to increase the number of smoking cessation trained staff in mental health services.

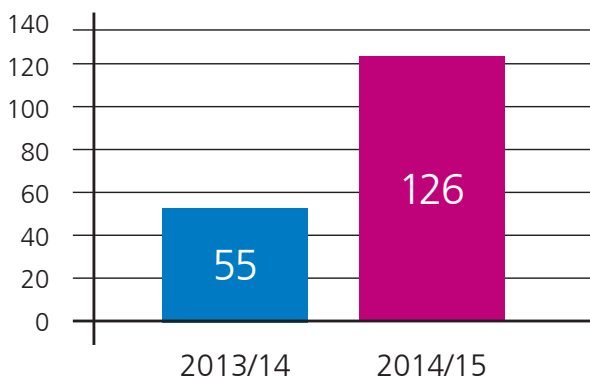
Mental health smoking cessation referral rates and the number of smoking cessation trained staff in mental health services were initially benchmarked, and a subsequent audit was undertaken with key stakeholders.

A regional event was held to share the findings of the audit and best practice to improve outcomes. Three local action groups across the region were created to progress the local issues identified during the event, to map patient pathways, identify potential barriers to improvement, and to agree ambitions. These groups consisted of mental health commissioners, local authorities, mental health providers and stop smoking service providers. The action groups were supported by the Network and Public Health England.

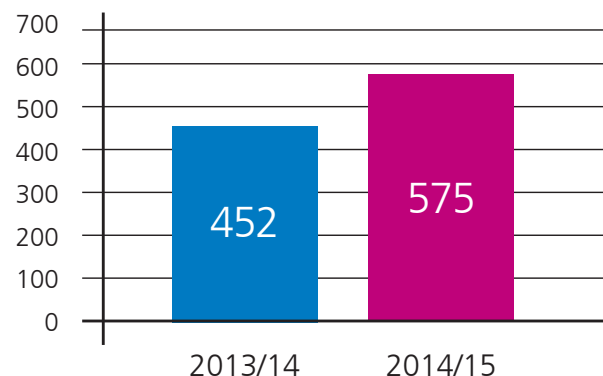
Outcome

The programme facilitated improved engagement between local mental health services and stop smoking service providers. The graphs (below) show an increase in smoking cessation trained mental health staff and an increase in referral rates to stop smoking services.

Number of mental health staff who have undertaken smoking cessation training



Number of referrals from mental health staff to stop smoking services



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