Health Innovation East

Project Review Report

The Innovation for Healthcare Inequalities Programme Wave 2 Project

East of England Interstitial Lung Diseases (ILD) Virtual Regional Multi-Disciplinary Team Pilot

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Part of the Health Innovation Network
Local change, national impact
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Contents

Executive summary:

Lung conditions are an area of huge inequality, with the biggest impact falling on the poorest communities in the UK[1]. Interstitial lung diseases (ILD) affect between 1,500 and 3,000 individuals in England annually, with patients receiving treatment and care in local and specialised hospital settings. Nationally services for ILD patients were identified as needing development[2] to address current challenges in ensuring equitable and timely access to care and supporting alignment with optimal integrated care pathways.

This project was an opportunity to test an innovative approach to shared care for ILD patients in the East of England. Through the establishment of a digital regional multi-disciplinary team (MDT), the project enhanced multi-disciplinary working across care settings, reduced the travel burden for patients, supported more timely diagnosis and increased access to specialist treatments and medicines as required. We worked closely with the East of England Respiratory Clinical Network and colleagues at the Royal Papworth Hospital and from the region to fund, mobilise and assess the impact of the project and support the case for change, to enable the network to secure sustainable longer-term funding for the project – from pilot to practice.

Background to InHIP Wave 1 and Wave 2 programmes and our approach

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

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

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

The specific innovations, technologies and medicines supported across the second wave included:

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

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

[1] https://www.asthmaandlung.org.uk/sites/default/files/2023-03/Research_Superpower_report.pdf
[2] One Voice ILD Integrated Care Pathway Action for Pulmonary Fibrosis April 2024

approach for Wave 2, increasing the number of projects from four to seven across a wider range of clinical and geographical areas including delivering our first regional project with local ICB based projects. We reduced the total investment envelope by 50% and delivering the same level of impact. This was based on our approach of building on local assets and partnerships, and through scaling activities we understand to be effective. All six projects Wave 2 projects are now complete with one project to be finalised by the summer 2026.

Our approach to evaluation has also developed over the lifespan of the programme. The four initial projects included formal impact evaluations, available from the ICS project teams, and the Health Innovation Network published a national Impact Report in December 2024. Wave 2 has taken a proportionate approach to reviewing project learnings, outcomes and impact, scaled to reflect the budget distributed and partner capacity.

Each project has completed a Project Review Report - drafted with all delivery partners to focus on real world examples of how targeted interventions and innovations have improved healthcare access, experience and outcomes for communities facing the greatest health inequalities.

Background to scope of the project and partners

ILD comprises a broad spectrum of conditions, all of which are characterised by inflammation or fibrosis of the alveolar wall with impairment of gas exchange. The commonest of these conditions are idiopathic pulmonary fibrosis (IPF), sarcoidosis and extrinsic allergic alveolitis (EAA). Together these conditions affect between 1,500 and 3,000 individuals in England each year. A national taskforce called One Voice ILD supported by Action for Pulmonary Fibrosis have published a report that sets out a transformative vision for the way in which ILD services should be organised across the UK using an integrated pathway approach. Current ILD commissioning models are not fit for purpose and with increasing demand, are not sufficient to ensure those eligible for treatment can receive it or services can tackle the growing inequalities of care. Patient experience can be variable, as shown by quotes from people with lived experience of ILD.

"It's an awful thing to say but I wish it was cancer. There would be more support if I had cancer."	**"I waited months to be seen, meanwhile my condition was deteriorating."**	**"The treatment and frequency of appointments, scans etc, seems to be a postcode lottery."**

The full development of the optimal integrated care pathways into practice at scale will take time, with estimates from the report suggesting between five to ten years. To support the transformation needed in services locally, the East of England Respiratory Clinical Network set up a dedicated ILD steering group as part of the 2024/25 and 2025/26 business and work plan to help address the development needed. The aim of the steering group was to ensure that patients have fair and equal access to treatment by supporting the development of ILD services.

Key stakeholders included:

- Patients
- Regional ILD specialist consultants and clinicians from The Royal Papworth Hospital
- Secondary care consultants and clinicians from the region
- Health Innovation East / UCL Partners
- Integrated Care Board (ICB) colleagues
- East of England Respiratory Clinical Network and ILD Steering Group.
- NHS England Specialist Commissioning

Delivery and key findings

To understand the picture further, the network undertook a mapping exercise to show potential travel times and costs to the closest specialist centres for patients within the East of England. This found average travel times to the Royal Papworth Hospital of one hour by car, and two hours by public transport. For people living within higher

deprivation areas journeys to specialist centres were typically longer and more costly, meaning on occasion the appointments were declined by patients, see appendix 2a for a detailed breakdown. This data was supplemented by patient survey shared on behalf of the network via local ILD clinics and Action for Pulmonary Fibrosis. The survey received a total of one hundred and six responses with good geographical, deprivation, age and gender variation achieved, and the responses confirmed the findings of the mapping survey.

One solution identified was to introduce a dedicated regional MDT for local clinicians to discuss patient cases with regional ILD specialists, potentially reducing travel time and costs for patients and enabling access to specialist care more efficiently and consistently for clinicians. A project was set up to deliver twelve MDT meetings to assess the concept and provide evidence from a real-world setting. In Spring 2024, it was agreed the pilot would be eligible for local Wave 2 InHIP funding as it met the criteria of improving access to the innovative medicine Nintedanib, an antifibrotic medicine used for the treatment of patients with progressive fibrosing ILD and on the national programme as an eligible innovative medicine that required increased access. This project could support that ambition while providing an improved pathway of care for patients across the region, particularly those living with suspected or confirmed ILD in more deprived areas.

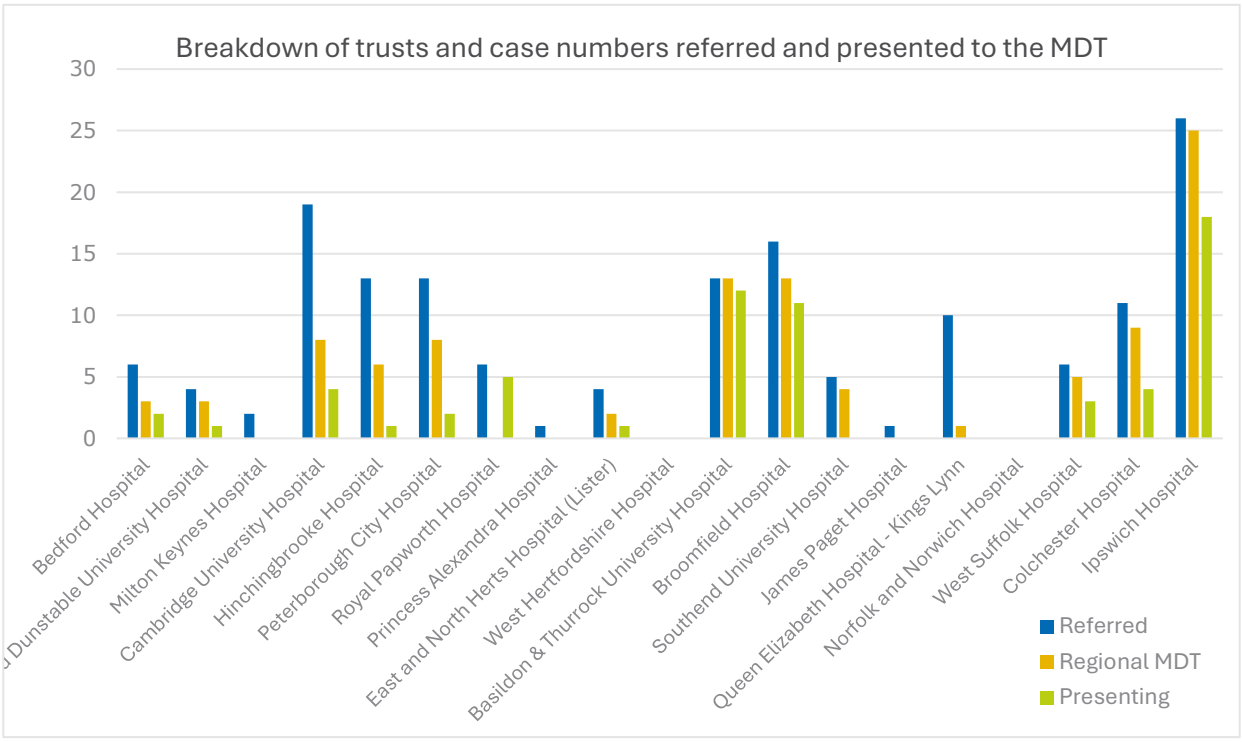
The scoping of the agreement phasing took approximately 3 months with the project delivered over a 12-month period from September 2024 to October 2025. The delivery approach was based on quality improvement principles supported by an improvement project team made up from colleagues from the Network and Health Innovation East, and funding of £17,500 for the host site the Royal Papworth Hospital to cover clinical time and administrative support. Localised governance arrangements were put in place to support oversight and risk management for the project via the Respiratory Programme Board, the Network and Health Innovation East. The logic model, project plan and KPIs were co-developed to ensure data requirements were aligned and joint impact and outcomes measures could be shared as appropriate. Joint reporting structures were also established to provide a proportionate level of reporting and to support system wide clinical engagement. This was particularly relevant to ensure access to and buy in from local respiratory consultants to maximise the MDT offer.

Desired benefits of the project

- To reduce health inequalities by reducing the significant geographic variation in accessing care for ILD.
- To enable better joined-up care and services to be delivered to patients in a more integrated way.
- To improve wait times for patients to be discussed as part of an ILD MDT.
- To improve patient waiting times to treatments such as antifibrotic drugs.
- To improve clinician confidence to diagnose specific ILD conditions.
- To provide an access portal of education to the wider region from a specialist centre.

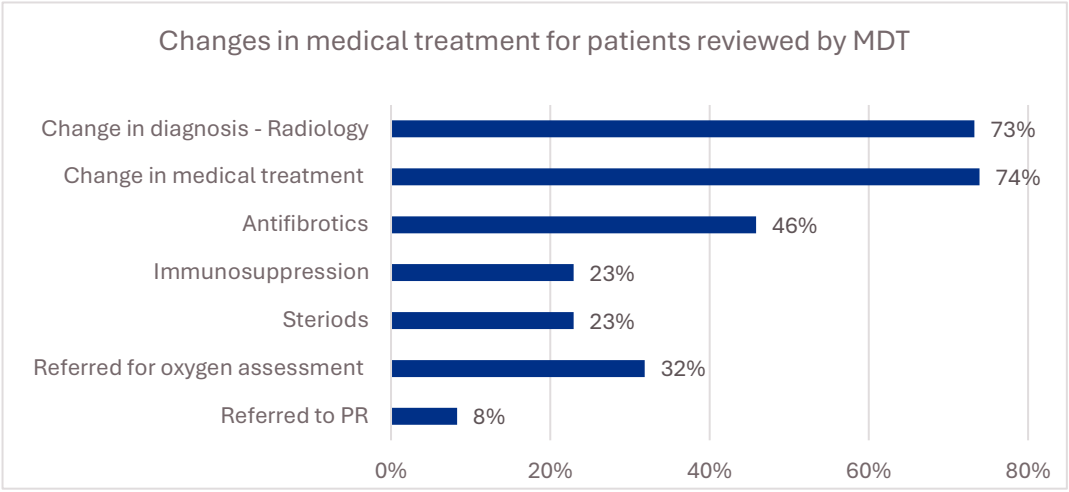
The project concluded in October 2025; a total of **157** patients were discussed through the Regional MDT in twelve months. At the end of the project 64% of referrals discussed during the pilot period were identified as Regional MDT referrals and 41% of cases discussed were presented by the referring consultant; with a particular increase in attendance at the Regional MDT seen after the mid-point review held in April 2025.

There was good regional engagement from referring consultants and hospitals with over two thirds of all regional trusts (13/19 local trusts) referring patients to the service. Those sites with low or no referrals such as Milton Keynes and West Hertfordshire Hospitals were identified as having existing referral pathways into other tier 3 centres such as The Royal Brompton Hospital, or for The Norfolk and Norwich Hospital, into an existing internal tier 3 service



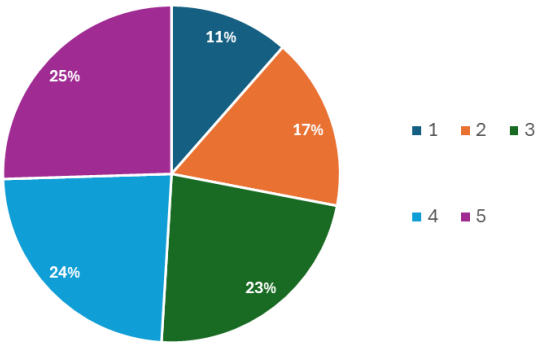
There were positive outcomes in medical treatment plans for patients, with 73% of patients having a change or confirmation of diagnosis following specialist radiology review. This facilitated 74% of patients having a change in medical treatment and 41% of patients being identified as suitable for antifibrotics as shown in the image below.

Whilst the increasing access to innovative medicines was one of the main ambitions of the InHIP programme, the project team were pleased to see changes in many aspects of care for patients demonstrated by the project. This included onwards referrals into locally provided services such as pulmonary rehabilitation or home oxygen, demonstrating the project also supported the integration of care and care provided closer to home, enabled by access to specialist support, advice and guidance.



Deprivation data was gathered to assess if a reduction in health inequalities was met. There were no specific requirements in the referral process for the patient to live in a specific deprivation quintile -based on the Index of Multiple Deprivation (IMD) - and the final deprivation outcomes are shown below. These are in keeping with the deprivation proportion seen in the East of England. This supports the idea that no health inequalities were inadvertently created from the project, and that equal access to specialist review for all patients, regardless of

deprivation was achieved.



Deprivation Score	Patients	Percentage
IMD 1	18	11%
IMD 2	26	17%
IMD 3	36	23%
IMD 4	37	24%
IMD 5	40	25%
Total 1-5	157	

FIGURE ONE - DEPRIVATION SCORES FOR PATIENTS REVIEWED BY MDT

The outcome of each patient encounter was gathered during the project to identify if the patient could receive their treatment at their local ILD centre or required an appointment at the tertiary centre. 29% of patients were identified as being able to continue with a new medical treatment plan following specialist MDT discussion at their local hospital. In the category of patients requiring tertiary follow up, (71% of patients) there was a clinical indication that this level of care was required. However, it should also be noted that patients who were attending for tertiary follow up and identified as suitable for antifibrotics it was clinical confidence with antifibrotic prescribing and the infrastructure for drug monitoring which was a significant contributing factor that prohibited local follow up.

Impact and benefits

The project promoted care closer to home and reduced health inequalities by reducing the significant geographic variation in accessing different elements of care for ILD. The project was delivered on time and in budget with the following key metrics achieved:

- 157 patient cases discussed against the original target of 96 – a 63.5% increase on the original estimate.
- 29% of patients had changes in medical treatment that could be delivered closer to home, preventing unnecessary journeys, travel costs and time. This also allowed service capacity to be repurposed for patients who required specialist review, creating efficiencies for the specialist hospital service.
- 28% of patients discussed lived in the 1-2 deprivation quintiles.
- Thirteen of our nineteen regional hospitals referred cases to the regional MDT.
- Eleven of our nineteen regional hospitals presented cases at the regional MDT.

Reflection and learnings

Overall, the project has positive outcomes with care delivered closer to home and showing benefit for patients and the region. There are several reflection and learning points below that emerged from risks or challenges encountered during the project. These risks and challenges were mitigated to ensure the project was delivered to plan.

Clinical capacity in radiology: Radiology support for the MDT was scoped at 2 PAs per MDT, totalling 24 PAs over the planned 12 meetings. The availability of specialist radiologists was initially limited due to workforce constraints at the host site. As this role provides critical clinical input, particularly for diagnosis decisions, the risk was mitigated in two separate ways. Firstly, radiology teams in other tier 3 services were approached to provide support to the regional MDT if required. Secondly, the risk was escalated to the management and operations team at Royal Papworth Hospital who completed a brief review of contracts and clinical duties within the wider radiology team to identify capacity to support the project.

Consultant engagement: Engagement from acute trusts and specialist consultants from across the East of England was a risk during the project. The original funding envelope did not include any costs for the presenting consultants at

the MDTs, therefore attendance and engagement were undertaken in their own time or around other clinical duties. Promotion of the Regional MDT was via the ILD steering group and email correspondence with the principle ILD contact identified at each acute trust. This was critical to develop interest and feedback progress and momentum. The key benefits of regional ILD specialist discussion were regularly shared for continued positive promotion. To promote ease of access to the regional MDT it was established that diary holds for consultants with the referral form(see appendix 2G) would be beneficial. Due to data sharing agreement restrictions, a regular MS teams invite capturing the mailing list for all ILD consultants in the region was not possible. Within the diary hold the contact details for the administration contacts and the process to access the regional MDT were clarified.

Administration and data collection: It was identified during the planning stage of this project that the regional MDT required good administrative support and robust data collection for reporting purposes. It was agreed that the project team from the network would gather the data during the pilot period.However, to be more sustainable, the Royal Papworth Hospital should undertake the administrative processes for the MDT. The data collection parameters were agreed at the project initiation stage, via the funding agreement and also agreed in person. The approach was for the MDT coordinator to follow the same administrative requirements as the local MDT but with the additional requirements to ensure that outside consultants had the appropriate MS Teams link, information and understood their timeslot within the MDT. After two regional MDT's the project lead met with the administrative and consultant team to discuss the practicalities of the MDT. The following recommendations were made to ensure that the MDT ran effectively:

- MS teams link and agenda to be shared with joining consultants and project lead the Friday prior to the MDT.
- Joining consultants to be prioritised on the agenda unless a specific time slot requested.
- Outcomes to be emailed to project lead for robust data collection.

Following this meeting the administrative running of the MDT was effective and risks mitigated. This was re-reviewed and discussed at the mid-point review to support sustainability. However, some key areas for improvement were identified and these were discussed with Royal Papworth Hospital and at the ILD steering group to ensure appropriate next steps were taken. The key areas included:

- Increase in consultant attendance and engagement
- Streamlining administrative processes
- Long-term sustainability of the Regional MDT

A mid-point review was undertaken in April 2025 to monitor project performance and identify areas for improvement. The initial outcomes of the project were positive. The project lead identified the regional areas with both good and poor engagement. Targeted work was undertaken with acute trusts that had not attended or referred to the regional MDT. The common themes for lack of attendance were:

- Timing of the MDT clashing with clinical or personal duties
- Lack of funding
- Referring to tertiary centres out of region

Whilst proof of concept in the benefits and outcomes of the Regional ILD MDT project has been identified, there needs to be acknowledgment of the further work required to promote regional development in ILD care and care closer to home.

Conclusion – *250 words max*

The outcomes identified above enabled the East of England Respiratory Network to work collaboratively with specialised commissioning, and recurrent funding has been allocated to Royal Papworth Hospital to ensure long-term provision for the Regional MDT. This will be a vital tool for further developments in ILD care in the East of England and supports education for clinicians across the region. The pilot project is now closed, with the acknowledgement that the project has fully delivered its intended benefits and objectives.

References and Background - Assets to Share

Appendix 1 – Logic Model	
Appendix 2a – ILD Mapping Exercise	ILD mapping exercise - Final version.pdf
Appendix 2b – Project Brief	Regional ILD MDT Quality Improvement
Appendix 2c – Regional MDT Project Measures	Measures INHIP Wave 2 - ILD .pdf
Appendix 2d Data Collection Template	ILD Regional MDT Data Collection Templ
Appendix 2e – Data Sharing Agreement	RPH Information Sharing and Processir
Appendix 2f – Quarterly Reporting	Regional MDT overview.pptx
Appendix 2g – Regional MDT Referral Form	Generic ILD referral v2 (003).pdf

Job Roles and MDT breakdown approximately £1.25k per PA

- Consultant Radiologist x 2 PAs per MDT = 24 PAs per 12 MDTs
- Consultant Chest Physician x 1PA = 12 PAs per 12 MDTs
- Registrar x 1 0.5 PA = 6 PAs per 12 MDTs
- Consultant Rheumatologist x 1 0.5 PA = 6 PAs per 12 MDTs
- Pathologist 1 per quarter = 4PAs
- MDT Co-ordinator

Appendix 3 – Acknowledgement and References