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SCOTTISH EXECUTIVE

Health Department

Dear Colleague

PROMOTING THE DEVELOPMENT OF MANAGED CLINICAL NETWORKS IN NHSSCOTLAND

Summary

This HDL reiterates the Executive's commitment to the concept of Managed Clinical Networks, sets out their advantages, re-states the core principles governing their development, indicates the key areas which have been clarified by experience to date (quality assurance, clinical governance, funding and workforce arrangements in particular), draws attention to the pump-priming assistance available from the Department and gives details of key contacts and documents.

Action

Patients, those who provide services for patients, NHS Boards and their health planning partners should use the information provided to develop Managed Clinical Networks, where there is agreement that there are clear benefits to patients in doing so.

Yours sincerely

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Head of Department
and Chief Executive

DR E M ARMSTRONG
Chief Medical Officer

18 September 2002

Addresses

For action
Chief Executives, NHS Boards
Chief Executives, NHS Trusts
Medical Directors, NHS Trusts
Directors of Public Health, NHS Boards
Directors of Social Work
NHS Consultants
G Grade Nurses
Chairs, LHCCs
General Practitioners
Allied Health Professions
Voluntary Health Scotland

For information
Chief Executive, Clinical Standards Board for Scotland
Chief Executive, Common Services Agency
Chief Executive, Health Education Board for Scotland
Chief Executive, State Hospital
Chief Executive, NHS Education for Scotland
Chief Executive, Scottish Ambulance Service

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PROMOTING THE DEVELOPMENT OF MANAGED CLINICAL NETWORKS IN NHSSCOTLAND

Background

1. The concept of Managed Clinical Networks (MCNs) was first set out in the report of the Acute Services Review (June 1998). It was followed in February 1999 by Management Executive Letter (MEL) (1999)10, which defined Managed Clinical Networks as:

> 'linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, unconstrained by existing professional and Health Board boundaries, to ensure equitable provision of high quality clinically effective services throughout Scotland'.

2. The MEL set out the core principles which all developments seeking formal recognition as a Managed Clinical Network have to satisfy, and also indicated that demonstration projects were being set up to pilot the development of MCNs in vascular services and in neurology with particular reference to stroke. *Our National Health, a plan for action, a plan for change* (December 2000) highlighted the importance of developing MCNs for chronic conditions in particular. The potential for Managed Clinical Networks to play a key role in health care delivery also features prominently in the report of the CHD/Stroke Task Force (September 2001), in the Scottish Diabetes Framework (April 2002) and in *Future Practice*, the report on medical manpower (July 2002). A similar model for people with autism is advocated in *The Same as You?*, the review of learning disability services. HDL(2001)71 of 13 September 2001 sets out arrangements for MCNs for all cancers.

3. Since 1999, a great deal of effort has been, and continues to be, invested in the development of Managed Clinical Networks for a wide range of conditions and in different parts of the country. This is clear from, for example, the most recent annual reports from CMO's Specialty Advisers. However, awareness of the MCN concept remains patchy. In the light of the experience gained so far, the aims of this Health Department Letter are therefore:

- to re-state the Executive's commitment to Managed Clinical Networks, and its belief that Managed Clinical Networks are a key development that NHS Boards and NHS managers should consider implementing when planning quality services that span the traditional primary and secondary care boundaries;
- to re-iterate the core principles, with such clarification as seems necessary, based on experience to date;
- to make information available about the generic lessons on key issues which have been learned from MCN activity; and
- to provide information on the assistance which is available from the Department in taking forward MCN developments.

4. NHS Boards should now be planning their MCNs for CHD and stroke, since this will be the main message in the CHD/Stroke strategy due for publication shortly. They should also have embarked on planning diabetes MCNs, in line with the service development section of the Scottish Diabetes Framework.

5. A great deal of information has already been generated as a result of MCN activity, but it needs to be made more readily accessible. This HDL is intended to help point those developing an

MCN towards that information, in order to avoid duplication of effort. A list of key contacts and documents is set out in Appendix 1.

6. Experience suggests that developing an MCN requires at the outset a small team of people to drive the process forward. A project management approach has been shown to be particularly helpful. The project manager, who should be capable of assuming the role of Lead Clinician in due course, should ideally have a clinical background, management and project management skills, experience of a multidisciplinary environment and some experience of managing development programmes in the NHS.

The advantages of MCNs

7. While patients and their representatives, and many NHS staff, both clinical and management, are enthusiastic about MCN developments, it is essential that NHS managers are also aware of the advantages they can bring in the implementation of key Executive policies:

- Involving patients – as an integral part of MCN development. This is the most effective way of achieving the aim that a patient experiences co-ordinated care without becoming aware of professional and administrative boundaries;
- Helping achieve waiting times initiatives - by looking at services from the patient's perspective and ensuring that the care pathway is as smooth as possible, particularly across the transition from primary to secondary care and back again;
- Improving quality – through responding to the results of audit and the development of a formal Quality Assurance programme;
- Addressing workforce issues - through the development of innovative roles and new ways of working for health professionals, as recognised in the *Future Practice* report on the medical workforce and *Working for Health*, the action plan on workforce development.

8. It is clear that the development of a Managed Clinical Network brings together a range of people who would not normally come into contact with one another, and this in itself is a considerable advantage in terms of service planning.

Types of Network

9. As highlighted in MEL(1990)10, the main attractions of the MCN concept are its flexibility and pragmatism. Networks can relate to specific disease types or to a function, such as medical receiving. They can also operate across different geographical territories, for example:

- **Local**, equating to an NHS Board area;
- **Regional**, which should now be understood as relating to the arrangements being developed for regional planning, as set out in HDL(2002)10 and *Working for Health*, the action plan on workforce development; and
- **National**, where the disease or service is so rare or specialised that it would make sense to organise it on a Scotland-wide basis. Experience shows that a specific element of a service may be identified as suitable for this national MCN approach, with the bulk of the service continuing to be provided more locally.

10. Both the type and geographical range of each Network must be dictated by the best interests of the patients for whom the service is provided. Network development also needs to take account, however, of the practicalities involved in satisfying each of the core principles, and these should be the starting point for MCN planning.

Core Principles

11. The following core principles, which are in essence unchanged from MEL(1999)10, are re-stated with minor modifications based on the experience emerging from developing MCNs:

11.1 Each Network must have clarity about its management arrangements, including the appointment of a person who is recognised as having overall responsibility for the operation of the Network. The leadership responsibility might rest with a clinician, a clinical manager or some other person. Each Network should produce a written annual report to the NHS Board or Boards to which it relates, and that annual report must also be available to the public;

11.2 Each Network must have a defined structure which sets out the points at which the service is to be delivered, and the connections between them;

11.3 Each Network must have a clear statement of the specific clinical and service improvements which patients can expect as a result of the establishment of the Network;

11.4 Each Network must use a documented evidence base, such as SIGN guidelines where these are available, and must be committed to the expansion of the evidence base through appropriate research and development;

11.5 Each Network must be truly multi-disciplinary/multi-professional and there must be clarity about the role of each health professional in the Network, particularly where new or extended roles are being developed as part of the Network. Each Network should include patient representation in its management arrangements. The Executive's document *Patient Focus and Public Involvement* sets out the general approach to this subject;

11.6 Each Network must have a clear policy on the dissemination of information to patients, and the nature of that information;

11.7 All the health professionals who make up the Network must indicate their willingness to practice in accordance with the evidence base and with the general principles governing Networks;

11.8 An integral part of each Network must be a quality assurance programme acceptable to the Clinical Standards Board for Scotland (and subsequently to the new body responsible for quality and standards), which also has a role in ensuring consistency of standards and quality of treatment across all MCNs;

11.9 The educational and training potential for Networks should be used to the full, through exchanges between those working in the community and primary care and those working in hospitals or specialist centres. Networks' potential to contribute to the development of the Intermediate Specialist concept should also be kept in mind, and Networks should develop appropriate affiliations to universities, the Royal Colleges and NHS Education for Scotland;

11.10 All health professionals in the Network must participate actively in audit and in open review of results;

11.11 All Networks must include arrangements for the movement of staff in ways which improve patient access, and enable professional skills to be maintained. Each Network should have in place an appropriate programme of continuous professional development for every member of the Network, as well as a mechanism for ensuring the programme is being followed. Each Network must provide suitable support for the patients representatives involved in the management arrangements.

11.12 There must be evidence that the potential for Networks to generate better value for money has been explored.

12. Managed Clinical Networks are dynamic systems, and their outputs evolve over time, but proposals must meet *all* of these core principles from the outset in order to be recognised as MCNs.

Key Areas which have been clarified

13. **Patient involvement**. The value of patient representation at all stages of MCN development – preliminary thinking, establishment, implementation and monitoring – has been clearly demonstrated.

14. **Social care**. The concept began as a medical model, but it is clear that has applicability beyond health. Its potential role in integrating health and social care should not be overlooked. This will apply particularly in relation to the holistic needs of individuals suffering from a chronic condition. References throughout the HDL to 'health professionals' should be understood as including social work and other professions appropriate to the type of MCN being developed.

15. **Service Planning**. MCNs need continuous management once established, and should be seen as an integral part of the local health plan and local health service delivery, not some disconnected or isolated development. MCNs are designed to foster organised collaboration, and should therefore provide a mechanism for patients and clinicians to be involved in disease-specific planning and strategic thinking with NHS Boards. There is no single way of achieving this, but some form of joint group which brings together representatives of the MCN with representatives of the NHS Board is likely to prove an effective mechanism. A key task for that group will be to develop and oversee the section of the local health plan dealing with the condition or service to which the Network relates.

16. **Quality Assurance programmes**. The experience of the Dumfries & Galloway cardiac services Managed Clinical Network has helped clarify thinking on the content of each Network's quality assurance programme. Details are set out in the protocol produced by the Clinical Standards Board for Scotland, which was circulated to all Boards and Trusts some time ago. It is included for convenience as Appendix 2. Prospective MCNs should make early contact with the Board (or its successor).

17. **Clinical governance** arrangements have also been clarified through the work of the Dumfries & Galloway MCN. Full details can be found on the Network's website (see Appendix 1 for address). They are summarised in Appendix 3.

18. **Funding arrangements**. MCNs will be providing services and using resources that cross boundaries between NHS organisations. It is therefore essential that financial accountability is clearly set out before a Network starts to function. In the case of *Local Networks*, existing organisations and their support systems will wish to retain and administer the resources involved in the services concerned. This enables existing systems of internal and external financial audit to operate. For *Regional Networks*, the financial arrangements should operate in line with the approaches set out in HDL(2002)10. For *National Networks*, modest funding has been provided through National Services Division to cover the costs of the additional administrative resources required to co-ordinate the Network in support of the lead clinician. Travel and some set-up costs have been supported. Administrative support may be required in both the host Trust of the national Network and in other centres throughout Scotland.

19. **Workforce arrangements**. Regional and national MCNs will require the deployment of professional staff across NHS Board boundaries. In developing and managing these MCNs, participating organisations should ensure that the workforce implications are considered from the outset and fully integrated into local and regional workforce planning, taking account of factors such as the European Working Time Regulations and the New Deal for Junior Doctors. NHS Boards

should address workforce aspects with their regional workforce co-ordinator, as outlined in *Working for Health.*

20. **Information Technology arrangements**. A key factor in the success of MCNs is the use of integrated clinical information systems that span traditional organisational barriers. This information technology can:

- Provide more accurate and timely information on the results of patient care and treatment in real time for the multi-disciplinary team;
- Connect patients with their carers for multiple purposes: health education, disease prevention, health promotion and disease management;
- Promote professional education and agreed clinical guideline implementation; and
- Facilitate the tracking of patients through the health care system for the purposes of audit and quality improvement according to criteria defined by SIGN and the Clinical Standards Board for Scotland.

21. With the SCI developments, web-based clinical information technology can now cross traditional NHS organisational boundaries. For example, SCI-DC is a nationally funded development that will support MCN development for diabetes throughout NHS Scotland (see appendix). Other SCI initiatives include SCI-clinical for cardiovascular disease and developments that will underpin cancer developments. It is critical that the information technology requirements of any MCN proposal are addressed early in the planning process, building upon expertise and resource already available within NHSScotland, where appropriate.

22. **Evaluation arrangements**. The work in Lanarkshire on the evaluation of the national demonstration Managed Clinical Networks has shown that the key features in relation to evaluation of MCNs are: measuring change in clinical outcomes; measuring patients' experience before the introduction and after the establishment of the MCN; and qualitative research on the organisational developmental aspects of the MCN.

Recognition of Networks

23. Those wishing to establish an MCN at local level must seek the formal approval of their NHS Board. The revised Performance Assessment Framework will be used to monitor local and regional MCN developments, especially in priorities such as CHD, stroke, diabetes and chronic conditions. Those wishing to establish an MCN at regional level must seek the formal approval of the relevant regional planning group.

24. Where a proposal is being developed for a national MCN, it is essential that it should be discussed with the National Services Division of the Common Services Agency and SEHD's National Workforce Committee at an early stage.

Assistance available from the Department

25. The Department has limited funds available to foster the development of Managed Clinical Networks. These were originally earmarked to assist the evaluation of MCNs, but experience has shown that critical elements in successful MCN development are the ability to free up the time of the lead clinician to allow that individual to pursue the larger agenda and the provision of dedicated project management. The Department has therefore decided that the funding should be made available to assist with infrastructure costs, for example the appointment of a Network Manager or administrator, perhaps coupled with IT and secretarial underpinning and resource. In most cases, these are expected to be of the order of £40-50,000 a year, since the Network Manager post will be

graded at around A&C6. In making such an appointment, it is recognised that the set-up period is likely to be around 1-2 years, and that an appointment for that duration is more likely to attract the necessary calibre of staff. These funds are not available for service development, such as the appointment of new healthcare professionals, which remains the responsibility of 'parent' NHS Boards.

26. As more and more MCNs are developed and become operational, NHS Boards may well wish to consider the efficacy of aligning Network Managers with their planning capability, as a generic resource providing administrative support for all MCNs in their area. This cadre of staff would then be able, collectively, to provide the Network manager functions needed by each Network.

Managed Clinical Network Contacts

- ***Neurology with particular reference to stroke***:
  Dr Anne Hendry (Chair), Consultant in Geriatric Medicine, Wishaw General Hospital, Lanarkshire
  Tel: 01698 361100; Fax: 01698 376671; e-mail: Anne.Hendry@laht.scot.nhs.uk
  Dr Keith Muir, Consultant Neurologist, Institute of Neurological Sciences, Southern General Hospital, Glasgow.
  Tel: 0141-201 2494; Fax: 0141-201 2510; E-mail: K.Muir@clinmed.gla.ac.uk
- ***Vascular Services***:
  Mr Hector Campbell, Clinical Director in Surgery, Wishaw General Hospital, Lanarkshire
  Tel: 01698 3667135; Fax: 01698 366136; E-mail: Hector.Campbell@laht.scot.nhs.uk
- ***Cleft Lip & Palate***:
  Trudie McDonald, Cleftsis Office, Room 4, Admin. Block, Perth Royal Infirmary
  Tel: 01738 473319; Fax: 01738 473538: E-mail: Trudi.McDonald@tuht.scot.nhs.uk
- ***Coronary Heart Disease*** (Dumfries & Galloway):
  Dr Chris D Baker Lead Clinician, Ashley Webster, Network Administrator,
  MCN Office, 1st Floor, Crichton Hall, Glencaple Road, Dumfries. DG1 4TG.
  Tel: 01387 244312; Fax 01387 244063;
  E-mail cbaker@dg-primarycare.scot.nhs.uk Awebster@dg-primarycare.scot.nhs.uk
  Website - www.show.scot.nhs.uk/mcn
- ***Stroke*** (NHS Highland):
  Ms Susan Eddie, Chair, Highland Stroke Steering Group, General Manager, Medical Director, Highland Acute Hospitals Trust, Raigmore Hospital, Inverness
  Tel: 01463 704000; Fax: 01463 711322; E-mail: Susan.Eddie@haht.scot.nhs.uk
- ***Diabetes***: Tayside:
  Karen Hunter, Managed Clinical Network Manager, NHS Tayside,
  karen.hunter@tuht.scot.nhs.uk,
  David Cline, Secretary to Scottish Diabetes Group, David.Cline@scotland.gsi.gov.uk
  Dr Andrew Morris, Chairman of Scottish Diabetes Group, a.d.morris@dundee.ac.uk
  Websites: www.diabetes-healthnet.dundee.ac.uk
  www.show.scot.nhs.uk/crag/topics/diabetes/main.htm
- ***Palliative care***:
  Professor John Welsh, Chair, West of Scotland Palliative Care MCN, Department of Palliative Medicine, Beatson Oncology Centre, Western Infirmary, Glasgow
  Tel: 0141-211 2411; Fax: 0141-211 6307; E-mail: j.welsh@beatson.gla.ac.uk
  Mr David Dalglish, Adviser, Borders Palliative Care MCN, Head of Pharmacy, Borders Primary Care Trust, Melrose
  Tel: 01896 825579; Fax: 01896 828298; E-mail: david.dalglish@borders.scot.nhs.uk
  Website: www.in-touch.org.uk
- ***Epilepsy***:
  Hilary Mounfield, Chief Executive, Epilepsy Action Scotland, 48 Govan Road,
  Glasgow G51 1JL Tel: 0141-427 4911; Fax: 0141-419 1709;
  E-mail: enquiries@epilepsyscotland.org.uk
- ***Multiple Sclerosis***:
  Mark Hazelwood, Director, Multiple Sclerosis Society Scotland, Rural Centre, Hallyards Road, Ingliston, Midlothian EH28 8NZ
  Tel: 0131-472 4106; Fax: 0131-472 4099; E-mail: admin@mssocietyscotland.org.uk

Ms Norma McIndoe, Lead Clinician & MS Specialist Nurse, Forth Valley MS MCN, Stirling Royal Infirmary
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Key papers

- Methodology for Evaluation of Vascular MCN (available from Vascular MCN contact);
- Lanarkshire Vascular MCN Newsletter, June 2002;
- 'Managed Clinical Networks: A Review; and a proposal for a pilot MCN for MS in Scotland' (available from MS Society Scotland)
- BMJ Editorial: 'Clinical Networks: Advantages include flexibility, strength, sped and focus on clinical issues', BMJ Vol 324, 12 January 2002, p63
- Managed Clinical Networks (Department of Health, London, September 2000)
- *What are Managed Clinical Networks?* and *Managed Clinical Networks: a guide to implementation* (Hayward Medical Publishing) (in press: a copy will be given to everyone registering for the Department's national conference on MCNs, to be held on Tuesday 12 November at Murrayfield Stadium Conference Centre, Edinburgh.)

Clinical Standards Board for Scotland Protocol for Managed Clinical Network Quality Assurance Frameworks

1. Under the terms of MEL(1999)10 all managed clinical networks are to have quality assurance frameworks that have been approved by the Clinical Standards Board for Scotland. This protocol provides guidance as to how the Board will carry out this responsibility, and is designed to assist prospective networks in developing their quality assurance framework.

2. There are two key components of a quality assurance framework:
   - a set of standards
   - agreed arrangements by which performance against the standards will be audited and monitored, and action taken to implement any recommendations that are agreed in response to the findings.

3. This protocol is consistent with and summarises the relevant sections of the Board's Quality Assurance and Accreditation Manual.

Standards

4. The standards developed for the services provided by the network should:
   - focus on clinical issues but not to the exclusion of non-clinical factors that affect the quality of care;
   - be written in simple language;
   - be based on evidence (recognising that levels and types of evidence will vary);
   - take explicit account of other recognised standards and guidelines where available; (drawing upon existing CSBS standards as appropriate)
   - be clear and measurable;
   - focus on improving the outcomes of care and treatment provided for patients;
   - be published and widely available;
   - be regularly reviewed and revised to make sure that they remain relevant and up to date;
   - be related to patients' journeys through different parts of NHSScotland;
   - be "achievable but stretching".

5. The standards should be set out in a format which comprises:
   - a standard statement explaining the level of performance to be achieved;
   - a rationale providing the reasons why the standard is considered to be important;
   - criteria, stating exactly what must be achieved for the standard to be reached.

An example is provided in the Quality Assurance and Accreditation Manual and on the CSBS Website.

6. The process by which standards are developed is crucially important. Each managed clinical network will be expected to show that it has adopted an open and inclusive process involving all the healthcare professions and sectors responsible for providing the network's services and patients and carers in the development of the standards and that they have been subject to a process of extensive consultation.

Audit and Monitoring

7. Managed clinical networks will be expected to demonstrate that arrangements are in place:

- to collect data required to monitor performance in all parts of the network against the standards;
- to conduct regular audit of performance (including obtaining patient feedback);
- to take action in response to the findings of such audit and monitoring.

This is necessary for the ongoing work of the network and will facilitate periodic review by other bodies including the Clinical Standards Board.

Submission

8. Each managed clinical network should submit to the Board a draft of its quality assurance framework including the standards and the audit/ monitoring arrangements. In order to consider this document the Board will also require a short scoping outline of the network and of the services it will provide.

Review

9. The Board's approval of the quality assurance framework will last for 3 years at which point the network will be asked to submit a revised framework demonstrating that:

- the standards remain relevant and up-to-date
- the framework is being used in all parts of the network for systematic audit and monitoring
- action has been taken to implement agreed findings of audit and monitoring

10. In addition to reviewing the quality assurance framework every 3 years, the Board will review the performance of the network periodically as part of its rolling programme of reviews of all clinical services.

Clinical Governance Arrangements

1. The Network will have agreed standards with the Clinical Standards Board for Scotland or its successor organisation. If there is a problem relating to a clinician working in the Network, the lead clinician or manager will need to involve the appropriate employing organisation and its clinical governance procedures and structures. Disciplinary or contractual issues will fall out naturally, and Chief Executives retain responsibility for their employees.

2. The Chief Executives and Clinical Governance Committees of participating organisations will need to accept and clarify responsibility for clinical and managerial issues that may arise at the interface between professions and organisations. A protocol should be drawn up to cover these interface issues, including the following key points:

- Where a critical or significant event occurs within the service provided by the Network, the lead clinician for the Network will undertake a critical event analysis. A formal report will be produced and placed before the Clinical Governance Committee of all the participating organisations. Similarly, where there is a suggestion of a failure of systems, the lead clinician and Network manager will conduct an investigation and report to the Clinical Governance Committees;
- Where a critical event occurs that involves the lead clinician, the investigation and analysis should be undertaken by the Medical Director of the Trust which employs the lead clinician;
- Where the Clinical Governance Committees require remedial action to be taken as a result of considering a report, the Chairmen of the Committees should agree which Trust will take the lead in addressing issues which arise at the interface between professions or organisations. The lead Trust will receive support and co-operation from all the organisations involved in the Network;
- Professional heads in each participating organisation will provide support to the Network manager and lead clinician in addressing professional issues at the interface between clinical groups;
- Quality issues arising in the patient journey from primary care to secondary care should normally be assumed to be the responsibility of the Primary Care Trust;
- Quality issues arising in the patient journey from secondary care to primary care should normally be assumed to be the responsibility of the Acute Trust;
- Comparable arrangements will need to be agreed with any providers of tertiary services.