SCOTTISH EXECUTIVE

Health Department

27 March 2007

Dear Colleague,

STRENGTHENING THE ROLE OF MANAGED CLINICAL NETWORKS

Delivering for Health noted that it was time to take stock of MCNs' role in the light of experience to date and the developments signalled in *Delivering for Health* itself. An undertaking was given that the Department would produce revised guidance aimed at strengthening MCNs' authority and increasing their influence over the way in which resources are allocated for services, particularly for service developments identified as a priority.

This HDL is the outcome of an extensive process of consultation, which was seen as consistent with the collaborative and pragmatic nature of the MCN concept. The main text of the HDL draws heavily on the many responses received, and on behalf of the Department we would like to thank all those who contributed to the process.

The attached guidance reiterates the core principles underpinning MCN development and covers issues such as integration of MCNs with other NHS bodies; leadership and management; patient and carer involvement; accreditation; and information technology.

The HDL also recognises that whole system change is beyond the capability of any single organisation, and therefore encourages the continuing development of Managed Care Networks.

The key message of this HDL is that the development of MCNs cannot take place in isolation. The support of the appropriate planning body, whether at local, regional or national level, must be sought at the earliest possible stage, so that the development of the Network can be fully integrated into relevant planning arrangements from the start.

MCNs' strengths lie in the promotion of consistency and quality of service throughout the care pathway, and the bringing of service user and provider views to the service planning process. In doing so, they help in the fundamental *Delivering for Health* aim of developing services which are truly person-centred, delivered locally wherever possible but specialised where need be. We must continue to work together to strengthen their role and increase their effectiveness.

Yours sincerely

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STRENGTHENING THE ROLE OF MANAGED CLINICAL NETWORKS

Introduction

1. A sequence of policy documents has emphasised the continuing importance of MCNs in implementing a number of key Executive policies:

- involving people in the future development of services, an essential element of truly person-centred services;
- helping achieve waiting times targets by streamlining the patient journey;
- improving quality of services through responding to the results of audit; and
- making the most effective use of existing resources, especially the workforce.

2. MCNs are an integral part of a systematic approach to service redesign, integration and improvement. They are also key to the development and implementation of the approaches to long term conditions set out in *Delivering for Health* as well as to the process of 'shifting the balance of care' away from the acute setting towards community-based services.

3. MCNs have a role in quality improvement and performance management, obtaining and negotiating agreement over clinical and other service issues, as well as acting as the planning forum for a Board around any particular disease area or topic.

4. MCNs can be described to some extent by their structures, but are best defined in terms of their stakeholders, their relationships and their external connections. MCNs have evolved differently across the country, to suit local circumstances. This is an essential part of the concept, and the guidance which follows is intended to acknowledge the need for autonomy in shaping MCNs in the way which best meets specific needs, within broad parameters which are not intended to be overly prescriptive. The majority of this guidance is aimed at local MCNs. Issues of significance to regional and national MCNs are set out in the Annex.

Managed Care Networks

5. Integration of services across the health and local authority sectors is one of the key aims of *Delivering for Health*, and the concept of 'Managed Care Networks' has an important role to play in achieving this aim. These MCNs are seen as a vehicle for providing an integrated approach along the continuum of care from community to acute care settings, within which shifts in the balance of care would be possible. The development of these MCNs needs to take place in the context of well established joint working policy, underpinned by the Community Care and Health (Scotland) Act 2002. *Partnership for Care* emphasised the concept of 'care networks' to help address the problems of service users as they move from one provider or partner organisation to the next.

6. The Joint Performance Information and Assessment Framework (JPIAF) provides a framework for evaluating key aspects of health and social care partnership working, and focuses on key outcomes and improvement targets. The development work on the new National Outcomes Framework will inform revised performance management arrangements during 2007. Managed Care Networks have a potential role in supporting delivery of key outcomes.

7. MCNs should use Local Improvement Targets as a basis for their statement of service improvements. Single Shared Assessment offers a natural framework for the development of Managed Care Networks, as the concept and tools are already in place, developed to incorporate national common data standards and information-sharing requirements across health, housing and social work. The National Training Framework for Care Management is designed to underpin a streamlined approach to health and community care across local authority services, predominantly social work and housing, and NHS primary, secondary and acute care. The framework articulates the relationships between Single Shared Assessment across organisations and provides a means for ensuring that professionals understand their roles and responsibilities to ensuring that individuals receive the right inputs from the right professions at the right time.

8. While Managed Clinical Networks can reach across NHS systems at local, regional or national level, multi-agency Managed Care Networks are likely to operate best at local level, based on localities defined by local authority boundaries and/or CHPs, rather than NHS Board areas. However, examples are emerging of Managed Care Networks at regional level, such as the learning disability Network in South-East and Tayside.

9. In the rest of this HDL, the acronym 'MCN' is used to mean both 'Managed Clinical Network' and 'Managed Care Network', with references to 'Boards' being understood in the latter context as meaning Boards and their community planning partners.

Core Principles

10. The core principles of MCN development are re-stated here, with some modifications based on practical experience:

10.1 Each MCN must have clarity about its management arrangements, including the appointment of a person, usually known as the 'Lead Clinician' (or 'Lead Officer' if it is a multi-agency Network), who is recognised as having overall responsibility for the functioning of the Network. Each Network must also produce an annual report to the body or bodies to which it is accountable, and that annual report must also be available to the public.

10.2 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. This will usually be achieved by mapping the journey of care. The structure must indicate clearly the ways in which the Network relates to the planning function of the body or bodies to which it is accountable.

10.3 Each Network must have an annual work plan, setting out, with the agreement of those responsible for delivering services, the intended service improvements, and, where possible, quantifying the benefits to service users and their families.

10.4 Each Network must use a documented evidence base, such as SIGN Guidelines where these are available, and should draw on expansions of the evidence base arising through audit and relevant research and development. All the professionals who work in the Network must practice in accordance with the evidence base and the general principles governing Networks.

10.5 Each Network must be multi-disciplinary and multi-professional, in keeping with the nature of the Network. Multi-agency Networks will cover NHS and local authority/social

care services. There must be clarity about the role of each professional in the Network, particularly where new or extended roles are being developed to achieve the Network's aims.

10.6 Each Network should include representation by service users and the voluntary sector in its management arrangements, and must provide them with suitable support in discharging that function. Each Network should develop mechanisms for capturing service users' and carers' views, and have clear policies on improving access to services, the dissemination of information to service users and carers, and on the nature of that information.

10.7 Each Network must have a quality assurance programme which has been developed in accordance with the arrangements set out by NHS Quality Improvement Scotland. The social work Performance Improvement Framework (PIF) and developing work on joint inspection will be relevant to multi-agency Managed Care Networks.

10.8 Networks' educational and training potential should be used to the full, in particular through exchanges between those working in the community and primary care and those working in hospitals or specialist centres. All Networks should ensure that professionals involved in the Network are participating in appropriate appraisal systems which assess competence to carry out functions delivered on behalf of the Network, and that the participating clinicians are involved in a programme of continuous professional development.

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

Links with NHS Boards

11. For MCNs to be successful, strong links with NHS Boards' planning and operational service delivery, and with community planning, need to be in place. Responsibility for the delivery of services lies with Operational Management within NHS Boards. MCNs must therefore include Operational Managers/management teams in the Network, and work with them on the delivery of improvements in services.

12. Boards should agree with MCNs the service delivery and quality improvements for which they will be accountable, and the way in which these will be delivered through the local management arrangements. MCNs will be more likely to influence commissioning of and resource allocation to services where they can demonstrate the clinical evidence base, and also their ability to respond to the needs of patients and carers in a way which can be clinically audited.

13. For all of this to happen, it is essential that MCNs have explicit organisational arrangements with their local NHS Board or Boards. At local level, MCNs might be embedded in the organisation through hosting by the appropriate Division. This would ensure that accountability for the MCN was through a Divisional Director whose responsibilities included the specific objectives linked directly to the MCN's core purposes. Regional and national MCNs also need to cover such issues in their management structure and accountability arrangements.

14. Fundamental to the success of an MCN is the absolute agreement by the head of the different parts of the organisation - NHS Board, Operating Division and CHP - that the MCN will be an appropriate focus for work in that area of care. An MCN adds value by offering a

service user and carer view of priorities across the whole system, rather than the view of any specific operational part of the organisation. Aligning individual MCNs to a relevant strategic change programme as a way of delivering service improvement could be helpful.

15. Board Chief Executives will obviously continue to be accountable for issues such as clinical governance, waiting times guarantees, delivery of clinical standards and quality improvement work and the use of resources, delivered through Clinical Directorates and Community Health Partnerships. MCNs nevertheless have an important influencing role to play, for example through development of referral pathways, treatment protocols, clinical audit and the provision of good quality, consistent information to service users and their carers.

16. MCNs should be fully involved in the prioritisation process for services in their area. Prioritisation is a two-way process, with the MCN brokering clinical/service user and carer input to the Board on priorities, and the Board representatives explaining to the clinical and lay members the wider policy context of Scottish Executive and Board priorities and the public health of the Board's population.

17. NHS Boards or Regional Planning Groups (RPG) which have recognised an MCN should use the Network to advise on service gaps and areas for service improvement, as well as including the MCN in service and workforce planning exercises commissioned by the Board or RPG. The Board or Region might also commission MCNs to carry out work on its behalf, for example advising on service standards and access to services.

Relationship with CHPs

18. CHPs are accountable for the planning and delivery of all primary and community based services for their area, with a full range of delegated functions and resources to enable them to deliver their objectives. CHPs do this by working in partnership with a wide range of professionals and by involving service users and their carers in planning and decision-making. CHPs also play a key role in delivering health improvement and in strategic planning and service redesign by supporting the integration of primary and specialist services. It is therefore clear that MCNs can help CHPs to achieve their objectives, especially in relation to the management of long term conditions. CHPs have responsibility for the health of the community as a whole, whereas most MCNs are focused on the health of the individuals with specific clinical condition(s) within that community.

19. The MCN should ensure that the CHPs covered by its geographical area are fully involved in its working arrangements, bearing in mind that in some Boards one CHP may have a lead role on behalf of the others for planning and delivery of some specific aspect of services across the whole Board area.

20. MCN involvement with each CHP in its area is essential, and should be flexible and adaptable to meet the needs of the population within the CHP. The Network will advise and support the CHP in delivering relevant services.

21. Health improvement is an obvious area in which CHPs and MCNs share a common agenda. Many MCNs (notably CHD and Stroke) are already acting as vehicles for implementation of Boards' health improvement strategies in specific patient groups. CHPs are ideally placed to implement these strategies fully at population level. This kind of

approach will help to achieve a much more joined up 'Health Improving NHS' approach to health improvement.

Leadership

22. MCN Lead Clinicians (who do not need to be doctors) should be supported in their role from the very start by the local Board, to enable them to become effective leaders of change. As senior managers, they should receive relevant official documents and be able to devote adequate time to reading non-clinical material. The Lead Clinician for any MCN needs a clear induction process, to ensure he or she is fully aware of how the NHS operates locally, regionally and nationally. Training in finance should be provided by the Board where necessary.

23. Leadership of an MCN is a distinctive role which benefits from a democratic, consensual style and a willingness to take on board the views of all the interests represented within the Network. MCN Lead Clinicians require a number of skills, including clinical authority, and an ability to lead a multidisciplinary team and to work across boundaries. Above all they need to focus on listening to and responding to the needs and views of service users and their carers and the voluntary sector. In this way, they can demonstrate an independence from sector or site loyalties, which in turn promotes a spirit of trust within the MCN.

24. Lead Clinicians should ideally be in post for a fixed term, so that the role can be refreshed regularly. At the time of appointment an agreement should therefore be drawn up with service managers in relation to return to full clinical duties.

25. Where the Lead Clinician is a consultant, his or her Job Plan should recognise the time devoted to leading the Network by allocating specific PAs to the role. The Lead Clinician's performance appraisal should be undertaken by the relevant professional lead in the Board concerned. Where the Lead Clinician is a GP or senior primary care clinician, appropriate remuneration will be required to backfill for the time dedicated to the role. Appraisal in these cases should also be by the relevant professional lead in the Board.

26. Primary care clinicians are generalists, and necessarily will be part of a number of MCNs. There is no need for them to be particularly aware of this, but the Lead Clinician should ensure that the MCN has a significant role in helping to continue the process of shifting the balance of care, for example by developing protocols and care pathways, or organising focused directed educational meetings and training events. MCNs offer a golden opportunity for a primary care voice in priority-setting and planning at Board level to ensure balanced development of services.

Management

27. The role of the Network Manager should be focussed on ensuring that the Network functions effectively and will achieve tangible progress in developing equitable, high quality, clinically effective services. The Network Manager's role needs ongoing support and recognition, particularly once the Network has moved beyond the developmental phase.

28. MCN management must be used as effectively as possible. Many NHS Boards are already acting on the fact that resources for the following activities can usefully be shared

across MCNs: some generic aspects of patient partnership work, for example training for service user and carer representatives and staff in Patient Focus and Public Involvement (PFPI); and communications, including the upkeep of websites and ensuring that information is provided in a format which takes account of individual needs and abilities.

29. Most MCNs will establish a Steering Group at the outset, with members nominated by each relevant 'constituency'. Those members need to understand that they are there not as individuals, but rather as a representative of that constituency, with an important role to promote two-way communication.

Patient and Carer Involvement

30. Each MCN needs to have a clear strategy for involving service users and their carers. There should be an agreed minimum number of service users and carers actively engaged with each MCN, with meetings organised at times and in ways which facilitate the involvement of all relevant groups. There should be support for travel, and agendas and papers should be circulated well in advance so that all can approach the meeting well-informed and with a sense of involvement.

31. Service user representatives should also have a link to a wider group for advice. Training and development must be offered to lay people to enable them to participate effectively in the work of the Network. There is a particular role here for voluntary sector organisations, which can provide training both in relation to the NHS and to the particular condition to which the Network relates. There should be a service user induction programme, and identified service user training needs should be addressed. Each Network should consider setting up a Patient Focus and Public Involvement sub-group to ensure that a PFPI approach is integral to all MCN business and structures. In taking this forward, MCNs should look to each NHS Board's PFPI Director for support.

32. MCNs should consider how best to use CHPs' Public Partnership Fora as a source of 'lay' input to MCNs. Joint Future Partnerships should be explored as a further source of 'lay' participants within MCNs, given that they are also required to engage effectively with local communities.

Accreditation

33. In light of experience and following consultation with network managers and lead clinicians, both the Department and NHS Quality Improvement Scotland (NHSQIS) are aware of concerns about the administrative burden which has been placed on MCNs by the arrangements for completion of the Quality Assurance Framework. As a result, NHSQIS has radically revised its accreditation arrangements. In essence, local MCNs are now expected to seek accreditation from their NHS Board at an appropriate stage in their development and NHSQIS will work with Boards to ensure a consistent approach. This process will also help to achieve the aim of developing closer working links between MCNs and Boards. Regional and national MCNs will continue to be accredited by NHSQIS and details of both these processes can be found on the NHSQIS website.

Information Technology

34. The development of local, dispersed MCN databases must be avoided since these will not be linked to other systems and are resource intensive. The development of the generic clinical system (GCS) is the preferred way ahead and there are good examples of MCNs at local, regional and national level working with those responsible for GCS to develop MCN databases.

35. MCNs will actively promote local development of the e-health strategy as it applies to their service by:

- contributing to the development of data standards by the National Clinical Dataset Development Programme (NCDDP) and ensuring progress towards compliance with these standards locally;

- using Board level data and IT systems and the reports from national databases to monitor the quality of care locally and identify opportunities for improvement;

- using their unique role in crossing the boundary between primary and secondary care, to develop improved referral guidelines and structured discharge documentation integrated with IT developments. Sharing data with local authorities is a further integration which can be fostered by the work of the MCN;

- using web-based information for the benefit of patients, carers and public, as well as using web-based workspaces to support their own Network activities.

36. As with all NHS IT developments, MCNs' arrangements should recognise the requirements which local Joint Futures partners, including CHPs, have to work towards shared information stores for Single Shared Assessment and Child Protection. Relevant social care and housing electronic intelligence must be accessible through the Network. The Department is fully aware that there remain a number of outstanding questions in relation to the governance of health information, and steps are being taken to establish a National Health Information Governance Board. Part of its remit will be to provide definitive guidance in a transparent way designed to reassure both service users and professionals

MCNs: Delivering the Future

37. Truly holistic care recognises the wider determinants of health and the whole system approach required to improve health and maintain well-being. MCNs are consistent with the fundamental principles of public service reform:

- personalised / user focus;
- quality and innovation;
- efficiency and productivity;
- integration;
- accountability.

38. Networks of the future will increasingly be multi-agency collaborations, (recognising the increasing inter-dependency of partner organisations) involved in delivery of personalised services to meet complex needs and rising public expectations. The further development of

MCNs will be a key tool to deliver the future transformational change required in NHSScotland at local, regional and national level.

39. Whole system change across complicated health and care organisations is unlikely to be achieved through refining traditional hierarchical structures in isolation. Local planning partners and RPGs therefore need to maximise the potential for MCNs to improve service quality and performance management throughout the patient pathway, by using them as planning fora in the relevant disease area or topic. Crucially, they also need to ensure that MCNs are fully integrated into local or regional operational and management structures if their potential to help deliver modern, sustainable services is to be realised.

Annex

Regional and National MCNs

Regional MCNs

1. The aim of all Regional Networks is to clarify and support the development of patient pathways across Board areas when the service cannot be provided in one Board area alone. They are therefore focused on common protocols, training and audit.

2. Generally, the arrangements which are being put in place by the 3 Regional Planning Groups relate to the assessment of applications to become a regional MCN to ensure that there is clarity about the benefits to be gained through the development of the Network, as well as clarity about the management and clinical lead arrangements, and any costs involved.

3. There is also an important role for inter-regional MCNs. These may cover 2 or more regions, and in some cases which would not meet the criteria for designation as a national MCN, may need a Scotland-wide scope through a co-ordinated approach by all 3 Regional Planning Groups.

4. It is important to emphasise, particularly in the regional and national contexts, that MCNs should not be viewed as a means of filling a funding gap in existing services. However, they **can** exert influence through their integration into regional planning processes and through their role as vehicles for developing an evidence base to support quality improvement and service developments.

5. Each MCN must have clarity about its accountability and governance arrangements, and differentiate between governance, accountability, performance management and accreditation. The core principles set out in paragraph 10 of the main HDL apply to regional MCNs.

National MCNs

6. There is a need to distinguish between a national service and a national Managed Clinical Network, both of which are funded through the National Services Division of NHS National Services Scotland. A national service will usually be provided from one site and will be low volume / high cost. A national MCN on the other hand will apply to a specialised service which is provided on a number of different sites where issues such as ensuring uniformity of standards, or equity of access across the country need to be addressed.

7. The core principles set out in paragraph 10 of this HDL apply to national MCNs in the same way as they do to any other MCN.

8. Detailed guidance on the process of applying for recognition as a national MCN is available from the National Services Division of NHS National Services Scotland. Where the application meets the criteria for designation, and is approved by Board Chief Executives and the Minister for Health & Community Care, top-sliced funding is available to meet the cost of providing administrative and IT support for the Network.

9. Recognition of the role of the Lead Clinician of a *national* MCN raises a particular issue. In keeping with the general guidance on Lead Clinicians, the time commitment involved in performing this role needs to be reflected in the clinician's job plan. It is anomalous, however, that the cost associated with this time commitment should fall on a local Board, when the role is a national one. The costs associated with back-filling the Lead Clinician post, in line with the commitment of time required to discharge it properly, should therefore be included in the applications submitted for recognition as a national MCN.

10. The generic clinical system (GCS) is the vehicle within the e-health strategy that meets the information needs of MCNs. The application for recognition as a national MCN should therefore include the resources needed to support the implementation of GCS in the Network. NSD has developed a standard approach to the funding of the databases of national MCNs.