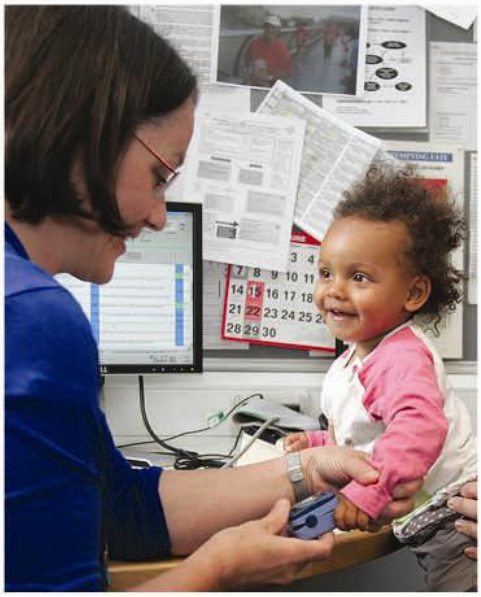
NHS
Commissioning Board

Clinical networks

Frequently asked questions



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Clinical networks

Frequently asked questions

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Frequently asked questions

1. **My profession / condition / patient group does not have a strategic clinical network, what happens now?**

   NHS Commissioning Board (NHS CB) strategic clinical networks are only one category of network in the new system.

   There is nothing to stop professional groups coming together to share best practice and support professional development. In addition clinical commissioning groups (CCGs) may wish to establish and maintain networks (such as urgent care networks) to support local priorities and ways of working, and providers may use a network model to enable the joint delivery of a service such as pathology.

   The strategic clinical network geographical support teams will be a source of expert advice for anyone wanting to establish a network. In addition, this support team will be able to provide some basic resource, such as a meeting room, to enable informal professional networks to flourish in the new system.

   We can expect the conditions and patient groups for which a strategic clinical network is prescribed will change over time in line with changing national priorities and as the improvement work of a specific network is concluded/mainstreamed.

2. **What is an operational delivery network and when will further information be available on these networks?**

   We need to ensure that an ongoing, long term operational network approach to pathway coordination is secured for burns care, critical care, neonatal care and trauma.

   It is crucial that we have a network model of pathway coordination for these patient groups and that these networks maintain the integrity of pathways, ensuring equity of access to provider resources, across wide geographical areas, together with consistency of treatment and outcomes.

   Further information will be shared shortly on the way forward for these networks.

3. **What problem are strategic clinical networks trying to solve in the new system?**

   Strategic clinical networks will provide a vehicle for improvement where a single organisation, team or solution cannot assure outcomes and value for money.

These networks will support whole system and combined improvement endeavors with a particular focus on helping commissioners to reduce unwarranted variation in service delivery and support innovation.

4. **The NHS Commissioning Board (NHS CB) has announced 27 local area teams, wouldn't it make more sense to have this number of networks too rather than move to a smaller number?**

   The number and size of each specific strategic clinical network should be based on patient flows and clinical relationships, for example there are currently 28 cardiac networks in the country and this number could remain the same in the new NHS system if it provides the optimum clinical configuration for an improvement initiative.

   However, it is neither affordable nor desirable for each strategic clinical network to have its own support team in the future. These support teams will be a resource for clinical senates too. The number of support teams therefore is based on the number of clinical senates agreed. In some instances it is expected that these teams will need to support more than one network for each prescribed condition/patient group (depending on pathways and clinical relationships) in their given geographical area.

   The defined geographies of each clinical senate has been developed to gain close alignment, and therefore promote close relationships, with other structures in the new system including academic health science networks (AHSNs) and local education and training boards (LETBs).

5. **There is reference to geographical alignment between structures but how will the activities of the AHSNs, clinical senates and strategic clinical networks inter-relate?**

   AHSNs, clinical senates and strategic clinical networks all have a role in supporting quality improvement and ultimately the achievement of patient and population health outcomes.

   Whilst the roles of these three structures differ in many ways they clearly have complementary agendas. In the first instance the focus has been on trying to align geographical boundaries, as it will be easier to develop and maintain effective partnerships between structures and member organisations if arrangements are consistent.

   It will be for local health communities to develop these structures to best effect, in line with local need and circumstances, recognising the potential for efficiency including possibly in support arrangements. Local health communities will also develop closer links between, the research, innovation, education and clinical communities; and ultimately to improved outcomes.

Effective strategic clinical networks will be embedded in the new system, linking with the full range of structures, not just AHSNs and clinical senates.

6. **Networks can only be effective if constituent organisations are actively engaged. During the engagement we heard the need a duty of cooperation, how will that be achieved?**

   Strategic clinical networks need add value for patients, professionals and constituent organisations. Constituent organisations will not be mandated to participate in strategic clinical network activity, however, it is expected that they will want to be actively engaged if the networks support them in achieving their aims and objectives.

   The geographical support teams will have a significant role in supporting the development of coherent and effective network arrangements; this will include fostering a culture of collaboration and engagement for quality improvement.

   One way that clinical commissioning groups will be able to demonstrate excellence in commissioning at their annual assessment (linked to the authorisation process) will be through active involvement in strategic clinical networks. In addition, NHS commissioners will have the opportunity to assure that CQUIN and other payments they make as part of NHS contracts go to providers whose clinicians are actively engaged and services are delivered in line with network recommendations/programmes of improvement.

7. **How will the funding be distributed between the prescribed strategic clinical networks? Will some of the current networks, such as cancer, have less resource in future?**

   National funding has been secured to support the activities of strategic clinical networks and senates. This funding is slightly more than the national monies currently spent on networks however there will be more prescribed clinical networks from 2013.

   Each of the strategic clinical networks groupings will have clear terms of reference relating to outcome ambitions and quality improvement needed. It will be for the local communities (the network support teams and their constituent organisations) to determine how their resource is allocated to support the work that needs to be undertaken. This may mean that some activities that are performed by current networks need to be mainstreamed or concluded; alternatively the constituent organisations may wish to allocate additional funding to support network activities.

8. **What are the implications of these changes for network staff?**

From a clinical perspective, each geographical support service will have a part-time clinical director overseeing all the prescribed strategic clinical networks.

These posts will be recruited to in the near future and then it will be for the clinical directors, together with their senate and network director, to determine the number of clinical leads/sessions needed for their strategic clinical networks and to appoint to these posts. Current network clinical leads will be in a good position to apply for these posts.

From a management perspective, each geographical support service will have a core number of essential posts, which will include: a senate and network director; assistant network directors; quality improvement/network managers; a personal assistant; a network assistant and an administration and support officer.

9. **How will the workforce changes be progressed?**

The NHS CB has developed a people transition policy to guide the way posts are filled in the NHS CB. Key aims of this policy are to make the transition as smooth as possible, to ensure that arrangements are open and fair, and to minimise redundancies. The precise arrangements for filling the network posts in the NHS CB will be determined in consultation with current employers and trade unions. Broadly speaking, if there is a transfer of functions, job matching will be undertaken to compare existing posts with posts in the NHS CB. If there is a one-to-one match, individuals will be slotted-in to posts in the NHS CB. If more than one individual is matched to a post in the NHS CB then a competitive process will be required. If there are no job matches, or if there is no transfer of function then posts will be made available for ring-fenced competition.

10. **What is the single operating model that is referred to?**

A single operating model is being developed to promote consistency and reduce unwarranted variation in network effectiveness. However, within this model there will be opportunity for some adaptation to local circumstances.

The model will cover a range of things including frameworks for the core support team; network development; evaluation of network effectiveness; accountability and governance arrangements.

The next steps will include the establishment of a programme group, in late September 2012, comprising the clinical directors and senate/network directors who will be able to contribute to the further shaping of this operating model before it is finalised.

11. **How do the strategic clinical networks fit with one domain of the NHS Outcomes Framework in particular maternity has been aligned to Domain 3, which focuses on 'Recovery from Injury and Illness,' what is the rationale for this?**

    Strategic clinical networks will support commissioners with their core purpose of quality improvement and the achievement of outcome ambitions for patients in the new system. Organising the work of the strategic clinical networks to Domains 1-3 of the NHS Outcomes Framework maintains alignment with outcomes and creates a sense of common purpose. Domain 4-5, patient safety and experience, will be embedded in the work of all the strategic clinical networks.

    Aligning maternity and children to Domain 3 is not meant to imply a medical model of childbirth for example, rather it has been agreed that this strategic clinical network grouping best fits this Domain which focuses on episodic care.

12. **How do you envisage public health supporting strategic clinical networks moving forward?**

    Current networks have benefited greatly from expertise derived from public health consultants; public health observatories and quality observatories. It will be important for strategic clinical networks to have access to such expertise as well as a range of other supporting services such as financial analysis.

    Work is currently progressing with the NHS Commissioning Board to agree this support for strategic clinical networks and further information will be available in the Single Operating Framework which is being developed for the geographical support teams.

13. **If there are only 12 clinical senate geographical patches, does this mean there will only be 12 strategic clinical networks for any of the prescribed conditions such as cancer in the future?**

    No. Twelve geographical areas have been identified by the NHS CB. Each of these areas will have a support team providing clinical and managerial input to strategic clinical network activities. In some instances, it is expected that these teams will need to support more than one network for each prescribed condition/patient group (depending on pathways and clinical relationships) in their given geographical area. For example, if there is a focus on a rare cancer, there might be only one network in a geographical area. However, where the focus is on a more common cancer there might be a need for more than one network in an area. It will be for local health communities to determine the number and size of networks, based on patient flows and clinical relationships, and to deploy their resources appropriately.

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