Strategic Clinical Networks - frequently asked questions (FAQ)

Frequently asked questions for staff who may be affected by the changes are available on the NHS Commissioning Board website:

http://www.commissioningboard.nhs.uk/resources/networks-senates/

Q. What are Strategic Clinical Networks?

Strategic Clinical Networks (SCNs) will bring together groups of health professionals to support commissioners to improve services for a particular condition in order to improve the quality of care and outcomes for patients.

The NHS CB has confirmed four initial SCN groupings which will operate throughout the country. These are:

- Cancer
- Cardiovascular
- Maternity and children
- Mental health, dementia and neurological conditions.

SCNs will be supported and funded through network support teams covering 12 defined geographical areas. The support teams will be hosted by the NHS Commissioning Board.

Q. What is the Single Operating Framework?

The Single Operating Framework outlines the establishment, development and function of SCNs and covers areas such as accountability and governance arrangements, models of the support teams and evaluation of network effectiveness.

The framework has been developed to promote consistency but also allows for local interpretation so health communities can develop their SCN structures in line with local needs and circumstances.

It is expected that the framework will be further developed by those appointed to the support teams.

Q. How were the initial four conditions/patient groups for SCNs decided?

The first SCNs were chosen using criteria developed with input from a broad range of stakeholders. Essentially, these are areas where:

- a large scale change is required across very complex pathways of care involving many professional groups and organisations and is the best approach to planning and delivering services; and

- a co-ordinated, combined improvement approach is needed to overcome certain healthcare challenges, which have not responded previously to other improvement efforts.

The detailed list of criteria can be found in *The Way Forward: Strategic Clinical Networks* document.

It's important to note that these are initial groupings and it is expected that as the work of a particular network is concluded or mainstreamed, there is potential to establish SCNs for other conditions and patient groups in line with local and national priorities.

Professionals will also be encouraged to establish informal networks to share knowledge and best practice.

Q. How will SCNs improve outcomes for patients?

SCNs will work across the whole NHS system to support commissioners to make improvements to services, resulting in improved outcomes for patients.

In particular, networks will work with commissioners to help them to reduce unwarranted variation in service delivery so services are streamlined and consistent.

They will also help commissioners to drive forward innovation so services are continually improving and becoming more efficient and effective.

Q. My profession / condition / patient group does not have a SCN, what happens now?

Where a particular profession/condition/patient group is not covered by one of the four initial SCN groupings, professionals will be encouraged to come together to share best practice and support professional development.

It is also expected that some Clinical Commissioning Groups (CCGs) will wish to establish and maintain networks to support local priorities and ways of

working e.g. urgent care networks. Likewise, providers may also wish to use a network model to enable the joint delivery of a service e.g. pathology.

The SCN geographical support teams will be a source of expert advice for anyone wanting to establish a network and they will be able to provide some basic resources, such as meeting rooms, to enable informal professional networks to develop in the new system.

It's important to remember that the initial SCN groupings will be expected to change over time in line with changing national priorities and as the improvement of a specific network is concluded or mainstreamed.

Q. Why can't individual SCNs have their own support teams?

It is neither affordable nor desirable for each SCN to have its own support team.

SCNs will be supported by network support teams covering 12 defined geographical areas. Shared support teams will ensure that the available resources are used to maximum effect. Some parts of the country are doing this already and are reporting that it works better and saves money.

Q. What is the difference between a SCN and a Clinical Senate?

SCNs, funded and hosted by the NHS CB, will be specific to a condition or patient group, for example, cardiovascular disease or maternity and children's services.

Clinical Senates will not be focused on a particular condition. Instead they will take a broader, strategic view of healthcare within a particular geographic area, for example providing a strategic overview of major service change. They will be non-statutory, advisory bodies with no executive authority or legal obligations and therefore they will need to work collaboratively with commissioning organisations.

Q. What is an Operational Delivery Network (ODN) and when will further information be available on these networks?

Operational Delivery Networks will work to ensure there is equity of access to resources offered by providers across wide geographical areas, together with consistency of treatment and improved outcomes for patients.

As neonatal networks have a crucial role in co-ordinating patient pathways between providers over a wide geographical area, ensuring equity of access to treatment and outcomes, they fall into the category of ODNs.

ODNs will also secure the pathway coordination for burns care, critical care, neonatal care and trauma.

It will be important for SCNs and ODNs to work together to develop whole system pathways in areas such as maternity, neonatal, and children's care for the benefit of improved patient and population outcomes.

Further information about ODNs will be available in the near future.

Q. How will patients and the public be involved?

The contribution patients and the public have made to the current networks has been greatly valued. The NHS Commissioning Board (NHS CB) is committed to building on this in the new architecture and work has already been undertaken to understand their experiences and learn how we can best meet their needs in the future.

We intend to invite patients and the public to future workshops where their views will help to develop the plans for SCNs. We also plan to include network members, such as PPI group chairs or provider clinicians, in the interview process for the senior posts in the Senate and network support teams.

Q. How will SCNs work with Academic Health Science Networks (AHSNs) health and well being boards, local education and training bodies and Clinical Senates?

AHSNs, health and wellbeing boards, local education and training bodies Clinical Senates and SCNs all have a role in supporting quality improvement and helping to improve health outcomes for patients.

Whilst the roles of these organisations differ in many ways they clearly have complementary agendas and a shared vision to improve health outcomes for patients. 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. Local health communities will also need to develop closer links between the research, innovation, education and clinical communities.

Effective SCNs will be embedded in the new system, linking with the full range of structures, not just AHSNs and Clinical Senates.

Q. How will SCNs work with other NHS organisations?

It is expected that NHS organisations will want to play a full part in their SCNs to support them in achieving their aims and objectives. It will therefore be important for SCNs to demonstrate how they can add value for both patients and professionals.

One way in which CCGs will be able to demonstrate excellence in commissioning during the authorisation process will be to show active involvement in their SCN. NHS Commissioners will also 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.

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

Q. How will public health support SCNs?

Networks have benefited greatly from the expertise of public health consultants, public health observatories and quality observatories and it will be vital to retain this support for SCNs to build on the success of the current networks. SCNs will also need the expertise of colleagues from other support services such as financial analysis.

The proposed support team structure for the SCNs can be found in the Single Operating Framework.

Q. What is being done to ensure the safe transition of networks?
The essence of clinical networks is the web of relationships between individual clinicians. Clinicians are mostly unaffected by the changes in the NHS commissioning architecture, and will provide a key point of continuity through the transition process.

With regard to the 12 network support teams, all NHS Primary Care Trusts have developed comprehensive legacy documents, and network activities are included in these. In particular, it will be the role of the 12 Associate Directors who will lead the network support teams to ensure that the transition process is well managed on a local level. It is expected that the Associate Director posts will be advertised shortly and it is likely that many of the successful applicants will have existing network roles.

Q. How will funding be distributed between the SCNs? Will some of the current networks, such as cancer, have less resource in future?
£42m of national funding has been secured to support the activities of SCNs and Senates. The national allocation for each geographical area can be found in the Single Operating Framework.

Each of the SCN groupings will have clear terms of reference relating to outcome ambitions and the quality improvement needed. It will be for the local 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 some activities performed by current networks will need to be mainstreamed or concluded. However the constituent organisations may wish to allocate additional funding to support network activities.

Q. Does the national funding need to cover Operational Delivery Networks (ODNs) and Local Professional Networks as well?
No, the £42m national funding has been secured for SCNs and Senate activities. ODNs and Local Professional Networks will be funded / resourced via other mechanisms.

Q. Will the new structure result in additional costs to providers?
An underlying principle of the new arrangements is that clinicians will be given greater opportunity to make decisions and lead changes. We expect providers will want to support their clinicians to be involved in the new arrangements as

it will enable them to improve outcomes for patients in a cost effective and coordinated way.

Although the funding will reduce for Cancer Networks, there will be more national funding overall, covering the four priority areas. In the past national funds have been supplemented by local funds as these teams have been considered so essential to improving care. We anticipate this will continue.

Funding arrangements for ODNs have not yet been confirmed.

Q. How will SCNs be held to account?

SCNs are non-statutory organisations. However, an annual accountability agreement, agreed with the host LAT Medical Director, will be put in place to hold SCNs to account.

An annual work plan, informed by national improvement priorities identified by the national domain leads across all five areas of the national Outcomes Framework, will be included alongside local priorities.

We will continue to look at how we develop this to ensure robust lines of accountability are in place.

Q. Why has it taken so long to clarify arrangements for networks?

Whilst the overall NHS CB structure was being finalised it was not possible to confirm the position of networks. Now the high level structures of the NHS CB have been published, the final details of networks and Senates have been finalised.

Q. If there are only 12 Clinical Senate geographical patches, does this mean there will only be 12 SCNs for any of the prescribed conditions such as cancer in the future?

No, 12 geographical areas have been identified by the NHS CB. Each of these areas will have a support team providing clinical and managerial input to SCN 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.

Q. What if network boundaries do not align to the proposed clinical senate boundaries?

There will be local agreement between NHS CB Local Area Teams (NHS CB LATs) about who the host LAT is for a given network, based on patient flows and clinical relationships. For example, staff in a network which spans two regions could be given the opportunity to opt for inclusion in the pool for redeployment for part of the Senate support team in a different geographical area.

An example of this is the three counties cancer networks, where one of the counties, Gloucestershire, is in the South region and the other two are in the Midlands and East region. Staff could be given the opportunity to be part of the pool for the West Midlands Senate support team as this may best align to existing clinical flows.

Q. There isn't a designated nursing post in the network structure. How will SCNs access nursing advice in the future?

SCNs are clinically led organisations and we expect that nurses from all parts of the network, including local providers will want to play key roles.

The Clinical Senate will be a multi-professional body and support the development of broader clinical networks, including a wide range of clinical professionals across all parts of the system.

Networks will also have access to the full matrix of NHS CB support, including the national and local nursing teams.

Q. The NHS Commissioning Board (NHS CB) has announced 27 local area teams; would 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 SCN 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 SCN to have its own support team in the future. These support teams will be a resource for Clinical Senates too therefore the number of support teams is based on the number of Clinical Senates. 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 geographical area.

The defined geographies of each Clinical Senate have been developed to gain close alignment, and therefore promote close relationships, with other organisations including Academic Health Science Networks (AHSNs) and Local Education and Training Boards (LETBs).

Q. Isn't this simply a budget cut, dressed up as creating more networks?

No, the centre will be using the investment more efficiently as administrative support for the clinical networks will be streamlined. It is also expected that local CCGs may invest further in networks that are of particular importance to their locality.

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

Each geographical support service will have a part-time clinical director(s) overseeing all the prescribed SCNs. 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 associate directors, to determine the number of clinical leads/sessions needed for their SCN and to appoint to these posts. Clearly the experience and knowledge of current network clinical leads will not want to be lost so it is expected that many will apply for these posts.

Each geographical support service will have a core number of essential posts, which will include: a senate and network associate director, network

managers, quality improvement leads, a personal assistant, a network assistant and an administration and support officer.

Further information can be found in the Single Operating Framework.

Q. How do the SCNs 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?

SCNs will support commissioners with their core purpose of quality improvement and the achievement of outcome ambitions for patients. Organising the work of the SCNs 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 SCNs.

Aligning maternity and children to Domain 3 is not meant to imply a medical model of childbirth, rather it has been agreed that this SCN grouping best fits this domain as it focuses on episodic care.