NHS Commissioning Board

DEVELOPING OPERATIONAL DELIVERY NETWORKS

THE WAY FORWARD

December 2012

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FOREWORD

Clinical networks are an NHS success story. Combining the experience of clinicians, the input of patients and the organisational vision of NHS staff they have supported and improved the way we deliver care to patients in distinct areas, delivering true integration across primary, secondary and often tertiary care.

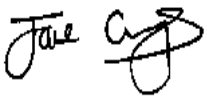
In July 2012 we published *The Way Forward: Strategic Clinical Networks*; we are now delighted to announce the next step in this process: *Developing Operational Delivery Networks: The Way Forward.*

Operational Delivery Networks (ODNs) cover areas such as neonatal intensive care, adult critical care, burns and trauma and are focused on coordinating patient pathways between providers over a wide area to ensure access to specialist support. ODNs will need to work closely with Strategic Clinical Networks, commissioners, providers and patients.

Since July we have held a number of stakeholder events to explore how this model should develop and comments from these events have fed into this document. This document sets out the steps that need to be taken to transition current delivery networks into the new system and ensure that local clinicians continue to come together to improve care for patients.

The next stage is for regional specialised commissioning teams to agree with local providers who should host each ODN moving forward, and then commence consultation with staff about transfer to the new body, in line with the nationally determined service specification. CQUIN payments are confirmed as the source of transitional funding although over time the costs of these networks will be included in tariff.

This is a great opportunity to improve outcomes for patients across the country for some complex and specialist areas of care. Through the development of a national specification for ODN and implementation through these ODNS, patients will see the benefits of consistent standards of care and the use of the very latest evidence and technology to improve their lives.



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INTRODUCTION

1. The NHS Commissioning Board (NHS CB) has recognised that clinical networks are an NHS success story and have been responsible for some significant and sustained improvements in the quality of patient care and the outcomes of their treatment.

2. *The Way Forward: Strategic Clinical Networks (July 2012)* outlined the range and role of clinical networks in the new health system. There will be a range of networks performing different functions which include:
   - a small number of Strategic Clinical Networks (SCNs) that are established and supported by the NHS Commissioning Board (NHS CB) to advise commissioners, support strategic change projects and improve outcomes
   - Operational Delivery Networks (ODNs) that are focused on coordinating patient pathways between providers over a wide area to ensure access to specialist resources and expertise.

3. This paper sets out the way forward for Operational Delivery Networks.

CONTEXT

4. The NHS CB prescribed networks will be called Strategic Clinical Networks (SCNs). SCNs will bring primary, secondary and tertiary care clinicians together, with partners from social care, the third sector and patients to define evidence based best practice pathways, which are implemented and assured through network relationships with commissioners and providers. SCNs will operate as 'engines' for change across complex systems of care maintaining and / or improving quality and outcomes.

5. ODNs will be determined by clinical need as agreed between providers and commissioners.

6. Success factors for ODNs will be:
   - Improved access and egress to/from services at the right time
   - Improved operating consistency
   - Improved outcomes
   - Increased productivity

CURRENT SITUATION

7. Existing provider delivery networks with national coverage are:
   - Critical care – adult
   - Critical care - neonatal
   - Burns
   - Major trauma

8. The intention of this paper is to ensure safe transfer of existing provider delivery networks so operational capacity is not lost during transition to the new system in 2013/14. In addition to those networks listed above with national coverage, there may be a small number of other existing delivery networks requiring transitional support. These will be determined on a case by case basis by the regional specialised commissioning teams of the NHS CB.

   There is an acknowledged case for the development of additional ODNs, but this is outside the scope of this paper. Areas for early consideration by specialised commissioners will include: Adult Congenital Heart Disease, Paediatric Congenital Cardiac Surgery and Paediatric Neuroscience. Some of these already exist in developing form in some parts of the country.

9. Variable funding mechanisms are currently in place with no agreed standard. Some operational networks receive funding from commissioning organisations, the Department of Health (DH) through the financial 'bundle' allocated to SHAs, and some from acute trusts.

10. Based on 2011/12 data, over £8.5m is currently being spent on provider delivery networks. From this fund, just under £4m is spent on the running costs of adult critical care networks and £3m on neonatal networks. Funding for the majority of trauma networks at that time was being negotiated for 2012/13.

11. There is known disparity in individual network funding levels arising from historical arrangements. To take critical care as an example, the lowest funding received by a network is £84K and the highest being £621K.

12. In *The Way Forward: Strategic Clinical Networks* (July 12), the NHS CB recognised the vital importance of these delivery focused networks and committed to describe how they would be maintained both in transition and over the longer term. It also confirmed that it is not the direct responsibility of the NHS CB to support the running costs of ODNs. Therefore there needs to be consideration of the ways of retaining critical parts of these networks to maintain collaborative working between providers.

PROPOSAL

13. ODNs will be established across England within the 12 geographical areas of the Clinical Senates. For 12/13 these will be based on existing geography. Over time it is anticipated that the number of similar networks within a Senate area will reduce to ensure optimal collaboration and effective use of resources. Each network will be aligned to a named Senate.

14. Outcomes and outputs of the ODNs will be included in commissioning service specifications, commencing in 2013/14 contracts for the existing networks. Over time there will be a move from specification in contracts into tariff structures through identification in reference costs.

15. Subject to finalisation of national 2013/14 commissioning guidance, transitional funding will be via specialised services CQUIN payments. An amount will be held back from all relevant specialised commissioning provider contracts and paid to the lead provider to cover the costs of running the network, aligned to specific quality improvements for which the host can reasonably be held to account. Some adult critical care is not commissioned by specialised commissioners and these providers will not have CQUIN payments retained in the same way. The arrangements will ensure that *all* critical care is delivered through an ODN environment, supported through specialised commissioning funds. This is a pragmatic transitional arrangement until the national tariff aligns.

16. There will need to be close collaboration between ODNs and other parts of the system, notably SCNs, academic health science networks, senates and Health Education England. The new improvement body will provide support in improvement techniques and training.

17. Within the new national model for clinical networks, ODNs will focus on operational delivery. Strategy will be set nationally. ODNs will ensure outcomes and quality standards are improved and evidence based, networked patient pathways are agreed. They will focus on an operational role, supporting the activity of Provider Trusts in service delivery, improvement and delivery of a commissioned pathway, with a key focus on the quality and equity of access to service provision. This will allow for more local determination, innovation and efficiency across the pathway. ODNs support the delivery of 'Right Care' principles by incentivising a system to manage the right patient in the right place.

18. Commissioners will clearly define pathway standards through a service specification, articulating the requirement for a networked provision of services, and delivered through the contract delivery mechanism. For NHS CB directly commissioned services, these specifications will be nationally developed for consistency. This will determine that patients will receive the same standard of

care and treatment regardless of which hospital they are admitted to through a consistent approach to the application of national service standards and networked pathways. The ODN will provide an environment where clinicians work together to 'do once' where possible, to share best practice and promote best quality care to continually improve services.

19. ODNs will deliver a whole system work programme for a service across a defined geographical area and within a specific area of care. They will align and work with established and evolving NHS organisations such as Senates and Clinical Reference Groups (CRGs). The ODN model will be reviewed and developed through the regional specialised commissioning bodies, coordinated through national 'Programmes of Care' as the delivery mechanism of the four regions, linked to CRGs, then out into the networks with delivery of the aligned pathways through the provider landscape. To improve joined up working to achieve better outcomes and service access, ODNs will collaborate with regional level Programme of Care (commissioning) leads, as well as commissioning quality teams and the leads for national outcomes.

OPERATING PRINCIPLES

20. These are the national operating principles on which the ODNs should be founded:

- The network will be hosted by an agreed lead provider within the geographical area
- The chair will be an appropriately experienced leader
- There will be a clear link to the relevant national CRG, supporting the development of national contracting products, quality monitoring tools, and involvement in developing clinical innovations
- The networks will work across a range of services in accordance with the specification drafted for that pathway.

FUNDING MECHANISMS

21. There is a clinically compelling case for retaining this way of working in the new NHS architecture. The long term plan is for this to be included in tariff as reference costs catch up with the costs of service development.

22. CQUIN will be used as a source of transitional funding for a one year period to allow time to include it in tariff mechanisms for associated specialised services. (This is subject to final confirmation within the NHS CB 2013/14 commissioning intentions).

23. NHS CB Area Teams (ATs) that have a specialised commissioning function will negotiate the actual financial amount with the host provider for a given network and include expectations in the contract. Each relevant service specification will state the requirement for providers to have networked pathways through an ODN approach and the quality outputs associated with the CQUIN payment.

24. Commissioners and clinicians will work in an integrated way at local and national level to determine the outcome priorities for the year and how they will be monitored. It will be essential to use the wealth of experience in current network teams to inform this.

25. We anticipate that ODNs could function if each NHS CB AT retained c0.1% of the total i.e. 2.5% CQUIN budget for relevant specialised commissioning areas for payment to host provider trusts for ODNs. However given the variation highlighted above, there will need to be some changes to ensure national consistency of approach.

ACCOUNTABILITY

26. The ODN will be hosted by a provider organisation, likely but not necessarily to be a tertiary centre. The Chair will be an appropriately experienced leader, unlikely to be employed by the host, to underpin the collective nature of these arrangements. As part of the NHS drive to increase opportunities for clinicians in leadership roles, it is anticipated that clinicians will wish to hold the chair role. The individual will need to be credible across the whole network and evidence alignment to the needs of the network.

27. A governance framework underpinning the network will be fundamental for both provider and commissioner assurance. This will encompass a governance structure including clear terms of reference and mechanisms for identifying, managing and escalating risks. This will need careful consideration by members to ensure that the network is effective and not seen to be dominated by one part.

    Some model arrangements are being developed and commissioners will review this aspect carefully during the transition. The host provider will be responsible for ensuring that the Network Board is accountable to the organisations represented on its board. In addition, the standard contract that the NHS CB has with both the hub and the spokes will require all to operate within the protocols and procedures agreed by the Network Board.

28. The AT commissioners would expect to receive an annual account of network activities and achievements to demonstrate improvements towards the NHS Outcomes Framework, to support the achievement of the CQUIN payment.

HR

29. The individual existing networks are not employing bodies in their own right and are all hosted with formal arrangements in place. Local circumstances will need to be taken into account.

30. A set of HR FAQs will be developed to ensure national consistency in key areas, underpinned by the principles set out in the national People Transition Policy.

31. It is expected that providers will want to make best use of existing talent and experience to ensure continuity of delivery.

32. The working assumption is that TUPE applies i.e. the ODN network function is transferring with the associated staff. There will need to be local agreement about the detail of the function transferring and the associated staff.

33. Specialised commissioners will lead local discussions to agree the host provider, the contract specification and to coordinate communication of these discussions with sender organisations, future host providers and the wider networks of providers.

34. The sender organisation, i.e. existing employer, will be responsible for determining the local applicability of TUPE arrangements, communicating with existing staff and managing formal consultation where appropriate as well as managing the transfer of staff.

35. Where the sender is not a PCT, the HR team of the local PCT will provide advice on the People Transition Policy.

36. National timescales apply which means PCT/SHA staff need to know their destination by 31 December 2012 so they will know that they are part of the team associated with the transferring function. Given that contracts will not be agreed with providers until February/March 2013, this will require cooperation between providers and commissioners to retain the skills and talents of staff.

37. It may be appropriate for staff to continue to provide input to the network through a service level agreement or secondment to the host provider. Such arrangements have worked well in the past, particularly for clinical staff who provide a sessional contribution.

38. Staff currently employed by PCTs and SHAs will have the opportunity to apply for posts in the Strategic Clinical Network and Senate Support teams, in line with the People Transition Policy. This is until such point as they are defined as being in a team associated with a function that is transferring.

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COMMUNICATIONS AND ENGAGEMENT

39. A detailed communication and engagement plan will be drafted to ensure key stakeholders are informed of the establishment of ODNs and the requirements that need to be put in place by 1st April 2013.

40. Communications will be published via the NHS CB website.

NEXT STEPS

41. These are as follows:

- Publication of *Developing ODNs: The Way Forward* (this document)
- Development of communication and engagement plan by NHS CB communications team, to be supported by local teams
- Arrangements for management of risk during transition led by local senders, working with specialised commissioners
- Local negotiation between specialised commissioning teams and providers, initially about host provider and then in relation to specification and TUPE arrangements
- Development of national products to support local arrangements i.e. model governance arrangements and model specification.

APPENDIX A

PURPOSE OF OPERATIONAL DELIVERY NETWORKS

ODNs will respond to need through national, regional and local determination, depending on the identified challenge, for example, a local critical care bed crisis or a large scale mass incident.

An ODN will:

- Ensure effective clinical flows through the provider system through clinical collaboration for networked provision of services
- Take a whole system, collaborative provision approach to ensure the delivery of safe and effective services across the patient pathway, adding value for all its stakeholders
- Improve cross-organisational, multi-professional clinical engagement to improve pathways of care
- Enable the development of consistent provider guidance and improved service standards, ensuring a consistent patient and family experience
- Focus on quality and effectiveness through the facilitation of comparative benchmarking and auditing of services, with implementation of required improvements
- Fulfill a key role in assuring providers and commissioners of all aspects of quality as well as coordinating provider resources to secure the best outcomes for patients across wide geographical areas
- Support capacity planning and activity monitoring with collaborative forecasting of demand, and matching of demand and supply

The benefits of this will be improved outcomes, productivity and increasing efficiency through:

- Stronger collaborative networked provision of services
- Maintained and/or improved patient outcomes and quality of care and, where appropriate, standardisation of care.
- New approaches associated with new hosts
- Increased opportunities for risk sharing between providers
- Opportunities to more accurately cost out the pathways of care and the utilisation of resources more efficiently
- Sharing the benefit of QIPP opportunities
- Opportunity to move to a ‘prime contracting focus’ i.e. a single contract for a pathway of care over several providers, though this has not yet been agreed
- More effective utilisation of contract levers for commissioners
- Increased speed of adoption of innovation
- Rapid learning and development
- Improved system resilience, including major incident planning

Members of ODNs will work collaboratively to share learning, experiences, knowledge, skills and best practice for the benefit of all within that specialist environment. The ODN will need to function based on a ‘compact’ between all parties which defines professional behaviour. To promote providers to do a good job, a network competency assessment would allow qualification to establish an inter-provider contract model.

The outcomes and indicators in the NHS Outcomes Framework were chosen with a view to measuring the outcomes resulting from treatment activity for which the NHS is largely responsible. Providers will be held to account for delivering improved outcomes. Providers will be supported by ODNs in achieving their critical contribution to the indicators within the NHS Outcomes Framework.