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NHS England

Renal Clinical Network Specification

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Contents

Executive Summary

This specification sets out the scope for the work of the renal clinical networks commissioned across England and is designed to support networks with the production of their annual workplans, developed in conjunction with their commissioners.

Renal clinical networks support the delivery of the following priorities:

1. Promoting equity of access and reducing health inequalities
2. Quality of care, autonomy and wellbeing for those living with kidney disease,
3. Quality improvement, across the whole care pathway
4. Value in healthcare

The specification sets out clear expectations for the networks including key strategic and operational objectives and describes the required governance including lines of accountability, key stakeholders and interdependencies.

Finally, the specification provides key links to support documentation, key deliverables, performance data and indicators.

1. Clinical Networks

Specialised services Clinical Networks[1] are a vehicle for specialty level collaboration between patients, providers and commissioners. They should have a clear line of accountability to Integrated Care Boards (ICBs) and NHS England (NHSE) regional teams through a joint commissioning arrangement, to ensure local ownership, alignment and a local mandate.

To deliver service transformation, networks will:

- deliver robust specialty level provider collaboration across units/providers
- operate at place, system, multi system, region and national footprints, uniting and collaborating to deliver for populations

All networks have an important role in delivering the triple aim, supporting:

- better health and wellbeing of everyone,
- the quality of care for all patients, and
- the sustainable use of NHS resources

This specification sets out the appropriate scope for the work of Renal Networks. This will inform the development of the annual workplans developed in conjunction with the network's commissioners. No network will, or could, focus on all aspects of the scope described, at one

[1] While some specialised services Clinical Networks have previously been described as Operational Delivery Networks (ODNs), the range of activity undertaken is now significantly beyond that envisaged for ODNs, reaching into non-specialised services, and in some cases primary and community care and prevention. Some are jointly funded as part of national transformation programmes and have accountabilities outside as well as within specialised services. As a result, as a group they are now referred to as specialised services 'Clinical Networks'.

time. In describing the appropriate scope for networks, these specifications refer to the work of the network board and the network's members, supported by the network team.

Networks are not expected to assume the legitimate accountabilities and responsibilities of providers who are accountable for meeting the needs of the Service Specification. However, network responsibilities inevitably overlap with those of providers, because networks aim to improve the ways in which services are delivered operationally and shape how they develop and because providers are members of networks.

2. Renal Strategic Context

Moderate to severe chronic kidney disease (CKD stages 3-5) is present in 6% of the population and acute kidney injury (AKI) complicates over 300,000 admissions per year. Around 56,000 patients in England have advanced kidney disease requiring renal replacement therapy (RRT) (dialysis or transplantation) and this is growing at a rate of 3% per annum; predominantly these are kidney transplant recipients.

Pressures on the NHS such as increasing demand, an ageing population with complex health needs and workforce shortages have created an imperative to transform renal services in England. There is an impact on service users, staff experience, variation in service provision, inefficiencies and delays; renal clinical networks will have a role in delivering service transformation to address these challenges.

2.1 NHS Long Term Plan

The recommendations of the NHS Long Term Plan span the prevention, diagnosis and management of long-term condition services including renal which require a networked approach to development. The NHS Long Term Plan places an emphasis on virtual clinics and digital transformation within renal services which will improve the flow of care for patients and clinicians.

2.2 Getting it Right First Time (GIRFT)

The Renal Medicine GIRFT report recognised the strong track record of innovation in service delivery and improving the quality of patient care within the renal community. GIRFT also found evidence of unwanted and widespread variation in key patient outcomes and processes across renal centres and modalities of kidney care.

GIRFT considered that many of the more complex interventions which are part of the renal pathway require regional planning and co-operation and recommended the establishment of NHS-funded, regional renal networks.

2.3 Integrated Care Boards (ICBs)

Renal clinical networks will work across integrated care boards (ICBs), providing strategic oversight, planning direction for and co-ordination of local renal services including the design, guidance, and promotion of optimal renal care pathways. Renal networks may work across more than one ICB as necessary to ensure the inclusion of an entire patient pathway.

2.4 Commissioning

The commissioning of care for patients with renal disease has been complex, with commissioning of advanced kidney disease and renal replacement therapy (dialysis and transplantation) by NHS England as a prescribed, specialised services but the majority of outpatient care and the transport for dialysis patients are commissioned by ICBs. In future ICBs will be increasingly involved in commissioning specialised services. For renal services this will initially involve renal dialysis and access for renal dialysis, with the commissioning of renal transplantation expected to follow in the future. More integrated commissioning will make it easier to deliver improvements along the whole patient pathway including earlier diagnosis and treatment, that can potentially prevent or delay the need for dialysis and transplant further downstream in the pathway.

Networks have a crucial role in the planning and co-ordination of care for patients with kidney disease to support ICBs in realising these benefits for patients.

2.5 Renal Services Transformation Programme

The Renal Services Transformation Programme (RSTP) has been established to support transformation of renal services across England to deliver better healthcare outcomes for kidney patients.

The programme advocates a system wide approach where commissioning and provision of renal services is more joined up across care settings and promotes a whole patient / whole pathway approach. This will enable ICBs to reshape the patient pathway with greater emphasis on prevention, early identification and treatment of renal disease. It will also make transplantation more accessible. The programme has five workstreams: Acute Kidney Injury, Chronic Kidney Disease, Dialysis, Transplant and Systems Working.

2.6 Transform Clinical Reference Group

Clinical Reference Groups (CRGs) have been established as the primary source of clinical advice to NHS England in support of the commissioning of specialised services. By working in partnership with key stakeholders, CRGs help drive improvements in the quality, equity, experience, efficiency, and outcomes of specialised services.

Transform CRGs are established where changes to the service is a major NHSE priority area: each Transform CRG is aligned to an approved national transformation programme.

3. Network Scope

3.1 Scope

Networks cover the whole adult renal pathway from prevention of kidney disease, primary to tertiary care and back into the community. This includes the following specialised services, as well as generalist and secondary care services:

- Services for acute kidney injury
- Preparation for and delivery of dialysis, whether in a renal centre or at home. This includes all dialysis services (including plasma exchange for patients with acute kidney injury). The service includes procedures relating to establishing renal access prior to dialysis.

- All kidney transplant-related care including all transplantation.

Specialised renal services are described in detail in the following Service Specifications:

- In Centre Haemodialysis (ICHD): Main and Satellite Units (A06/S/a)
- Haemodialysis to treat established renal failure performed in a patient's home (A06/S/b)
- Ex-vivo partial nephrectomy service (Adult) (A06/S(HSS)b
- Peritoneal Dialysis To Treat Established Renal Failure (A06/S/c)
- Renal Dialysis – Intermittent Haemodialysis and Plasma Exchange To Treat Acute Kidney Injury (A06/S/d)
- Assessment And Preparation For Renal Replacement Therapy (including establishing dialysis access) (A06/S/e)
- Specification for Haemodialysis Providers delivering only Dialysis Away from Base (DAFB) (A06/S/f)
- Encapsulating peritoneal sclerosis treatment service (Adult) (A07/S(HSS)a)
- Cystinosis diagnosis and co-ordination of management (all ages) (1640)
- Adult Kidney Transplant Service (16079/S)
- Atypical haemolytic uraemic syndrome (aHUS) (all ages) (170008/S)

Interdependencies for the specialised services elements of renal services are described in the Service Specifications listed above.

Not in Scope

Services for children with renal disease.

Care for children and young people between 0 and 16 years will often be within children's services, but arrangements vary for young people over 16 years. Each network should work with the relevant paediatric renal providers within their network footprint to agree a policy on developmentally appropriate care arrangements for children and young people 16-18 (and beyond 18 years where this is appropriate, for example those with learning disabilities) cared for outside a specific child or young person's service. The network should also have an agreed transition protocol which includes these issues, in line with NICE guidance 'Transition from children's to adults' services for young people using health or social care services'[2]

3.2 Population Covered

All providers of renal services in England will be required to be part of one of eight renal clinical networks which cover the country and are coterminous with NHSE regions. Every network must include at least one tertiary centre. The networks are:

NORTH EAST AND YORKSHIRE
North East and Cumbria
Yorkshire and Humber

NORTH WEST
North West

MIDLANDS
Midlands

[2] Guideline NG43 Transition from children's to adults' services for young people using health or social care services, NICE, 2016 available here: https://www.nice.org.uk/guidance/ng43

EAST OF ENGLAND
East of England

LONDON
London

SOUTH EAST
South East

SOUTH WEST
South West

Wales and Scotland: While some residents of Wales and Scotland receive their care in England, hospitals in these countries are not part of these networks.

Networks in England will work with colleagues in Scotland and Wales to offer mutual aid as appropriate at times of service pressure.

Crown Dependencies: Residents of the Channel Islands and the Isle of Man receive their care in England and for this reason hospitals in these territories are also part of these networks.

Northern Ireland: While some residents of Northern Ireland receive their care in England, hospitals in Northern Ireland are not part of these networks.

4. Network Aims and Objectives

4.1 Network Vision and Aims

The aim of renal clinical networks is to improve the quality and equity of care and outcomes for renal patients in their catchment population, with the following priorities:

- Supporting restoration and recovery of renal services
- Promoting equity of access and reducing health inequalities
- Increasing the autonomy and wellbeing for those living with kidney disease
- Improving the quality of care, including outcomes and patient experience, across the whole care pathway
- Collaboration within the network and sharing learning between networks
- Value in healthcare

4.2 Network Objectives

Described below are the network's objectives, both short term operational and longer term strategic, that assist in meeting the overall vision and aims, are which are both achievable and measurable:

- To restore referrals for treatment to pre-pandemic levels
- To reduce patient waits to pre-pandemic levels
- To reduce variation across the care pathway by developing, agreeing and implementing standardised pathways of care
- To improve equity of access and outcome for everyone with kidney disease within the network catchment population
- To identify health inequalities and develop plans to address these inequalities
- To improve quality of care, autonomy and wellbeing for everyone living with kidney disease within the network catchment population

- To ensure that the available health resource is used effectively and efficiently, providing best value for every health pound.

4.3 Network Functions

Transformation: *the network's role in planning sustainable services that meet the needs of all patients*

- Regularly review network configuration, capacity and compliance with standards, advising and agreeing a plan with commissioners to assure sustainable services that meet the needs of all patients
- Improve equity of access for planned and unplanned care and swift escalation pathways.
- Work in partnership with ICBs to develop a strategic approach to improving renal care and pathways, developing a Whole Person / Whole Pathway approach to patient centred commissioning.
- Apply improvement and redesign methodologies to all aspects of the network's work to deliver ongoing quality and service improvement.
- Undertake systematic clinical audits and ensure shared learning across the network.
- Adopt a network agreed research strategy including access and participation in clinical trials.
- Participate in national, regional, and local research and audit across all clinical disciplines and share findings.
- Support the early and systematic adoption of innovation and research across the network.
- Horizon scan for innovation and improvements

Service delivery: *the network's role in planning and managing capacity and demand*

- Support pandemic restoration and recovery planning and delivery
- Develop, agree and implement common referral, care and transfer pathways and other policies, protocols, and procedures across the network, to reduce variation in service delivery, with an initial focus on:
    - Acute Kidney Injury (AKI)
    - Chronic Kidney Disease (CKD) and the prevention of progression
    - Renal Replacement Therapy (RRT) including dialysis and home therapies
    - Transplantation
- Work with interdependent specialties to establish effective pathways to support timely care for renal patients e.g. vascular interventional radiology to support vascular access and cardiology to support timely transplant work up
- Undertake capacity planning and activity monitoring to ensure service capacity matches demand requirements, identifying and resolving gaps and blockages in services with an initial focus on access to transplantation and vascular access.
- Manage crisis where this arises, within the network's boundaries and with other networks where appropriate, ensuring continuity of care via mutual aid.
- Identify and offer network wide solutions where capacity and demand are not in equilibrium, with oversight across the pathways of care and providers.
- Optimise the timeliness of care through, for example, joint waiting lists and priority management.

- Identify and manage cross-boundary and border issues and patient flows with neighbouring networks, NHS regions, Wales and Scotland, the Isle of Man and Channel Islands as appropriate.

***Resources:** the network's role in stewardship of resources across whole pathway and minimising unwarranted variation*

- Develop an approach to clinical stewardship of resources across whole pathway
- Standardise drugs, devices etc. for best value, using collaborative purchasing arrangements to achieve the best price.
- Reduce unwarranted variation in pathways and processes that lead to inefficiencies.
- Support consistent, network-wide implementation of digital healthcare approaches that offer greater efficiency e.g. remote patient monitoring.
- Support consistent, network-wide implementation of new approaches to outpatient care e.g. phone/video OP clinics, patient-initiated follow-up.
- Improve effectiveness and appropriateness of use of high-cost treatments and consumables.
- Work with other related networks, flexing use of resources to find efficiencies, target resources for best effect and share insight and experience.
- Advise on improvements across the whole pathway that reduce demand by supporting prevention, earlier intervention and avoiding escalation.

***Workforce:** the network's role in ensuring flexible, skilled, resilient staffing*

- Assess future workforce needs for provision of renal services across the network taking into account projected demand.
- Support providers to develop and implement innovative and extended roles for non-medical staff groups, through training and development and network wide policies and procedures.
- Assess training needs for the network (including baseline skills audit and network maturity assessment) and networked services.
- Develop and agree a network training plan that meets the needs of the network both in the delivery of care and in the functioning of the network.
- Agree with commissioners and providers how the planned training will be resourced and delivered.
- Monitor delivery and assess the effectiveness of the agreed training.
- Enable the movement of staff through the implementation of a staff passport.
- Promote workforce resilience through:
    - mutual aid agreements;
    - health and wellbeing support for staff.

***Quality:** the network's role in improving quality, safety, experience & outcomes*

- Create a culture of ongoing service improvement, ensuring best practice models are embedded and contribute to improved quality performance
- Reduce variations in care access, outcomes and experience.
- Improve overall patient experience through whole system improvements to renal care across specified geographical areas and ensure future sustainability and viability of services.
- Establish and maintain systems for the collection, analysis and reporting of key indicators of outcomes, quality of care and patient experience and ensure data is submitted as required.

- Run regular clinical forums to review outcomes across the network.
- Ensure that the whole patient pathway is focused on the holistic needs of the patient.
- Develop an active patient engagement strategy, involve patients in their care of and use patient feedback to monitor and improve services.
- Undertake comparative benchmarking, monitoring and audit across the network with an initial focus on infection rates and psychosocial health.
- Produce an annual network annual report.
- Manage risks to the delivery of the network's annual work programme.
- Identify service issues and risks and ensure they are managed through regional and system quality structures following agreed escalation processes. Providers or commissioners may ask networks to facilitate the response to risks, but providers and commissioners remain accountable for their services' risks.
- Ensure the provision of high-quality information for patients, families, staff and commissioners, standardised across the network.

Collaboration: *the network's role in promoting working together across organisations at local, system and national level*

- Engage with all relevant partners to foster a culture of collaboration and promote the development of provider collaborations across the network with a view to improving care pathways.
- Link network clinical leadership with system, regional and national clinical leadership cadres to support a collaborative approach and shared aims.
- Share best practice with other renal networks across the country.
- Share best practice relating to the delivery of network functions, particularly within the local system.
- Identify opportunities for shared solutions and resources.
- Enable and empower collaboration via agreements with clear roles/delegation.
- Actively participate in and support the national network of networks and participate in national audits.
- Engage with the national Renal Service Transformation Programme (RSTP) and the Clinical Reference Group (CRG) to build future specifications and standards from the identification of the characteristics of excellent care and engage with future national accreditation.

Population health: *the network's role in assessing need, reducing inequalities in health, access, experience and outcomes*

- Working with ICBs:
    - understand the needs of the population for renal services
    - reshape the pathway with greater emphasis on prevention and early identification and treatment of renal disease
- Review service delivery across network against need and identify gaps and variation in services – gaps in overall provision, quality, geographical distribution - and deliver improvements to network services to address these issues.
- Develop specific proposals which mitigate inequalities for the vulnerable groups identified.

4.4 Annual workplan

The RSTP and Transform CRG will advise on national objectives and principles and the networks will be responsible for operational delivery.

The network board will agree an annual workplan with its commissioners (system and regional). This will reflect national, regional and local priorities taking account of the resources available to support delivery. The workplan will describe its expected deliverables and benefits.

The network board will publish an annual report detailing its activities, accounts and delivery against the agreed annual plan.

5. Governance

5.1 Accountability

Hosting

The network will be hosted by a named organisation within the network geography.

Accountability and responsibility

Network footprints reflect patient flows, provider scale and catchments so will often cut across commissioner boundaries (ICB and regional). Governance arrangements must provide clear accountability to commissioners at system level (with links to all relevant ICBs) and region as appropriate for both network delivery and commissioning responsibilities. Local arrangements to achieve this should be clearly documented within the network's terms of reference.

Networks will be responsible to ICBs for the management of local pathways and delivery of locally agreed targets. This should be set out in memoranda of understanding between ICBs, providers and the network.

The network will be accountable to the regional team of NHSE via the appropriate board within the Region including any multi-ICB decision bodies established.

Network plans and deliverables should be agreed with all ICBs within the network's geography and signed off by the region. Networks will be expected to provide regular reports and have regular reviews with their commissioners.

The network's authority to act on behalf of its commissioners and members will be set out clearly within the network memorandum of understanding and where necessary clarified within the agreed annual plan.

All renal networks are expected to actively engage with and have accountability to, the national RSTP and Transform CRG. Appropriate reporting and participation will be expected.

5.2 Network governance and architecture

Members and stakeholders

Networks must be established with appropriate patient, clinical, improvement and operational leadership reflecting the whole patient pathway and a network's population.

Clinical representation should cover the whole multi-disciplinary team and pathway of care and include wider professional representation including nursing and allied health professions. It should include at least one representative from a tertiary provider of renal services.

The network should develop an approach to working with patients and families that ensures patient views inform its whole work programme and to support optimal service provision for patients. Patients and third sector organisations will be core stakeholders within the networks.

Networks will align to ICB(s) as appropriate to care pathways; potentially spanning several ICB areas and relationships will need to form accordingly.

Networks will have strong relationships with and draw membership from local Primary Care Networks (PCNs), to enable meaningful engagement with primary care, across the network footprint.

Renal networks will include all providers who deliver renal services across the entire pathway of care including providers of:

- Prevention
- Primary care
- Diagnostics
- Community services
- Ambulance & Transport Providers
- Secondary care
- Tertiary care

The Board

The board should meet on a regular basis and operate under the oversight of a suitable chair with agreed terms of reference.

The chair will be an appropriately experienced, impartial leader who is credible across the whole network and will be appointed through a fair and open process.

- The chair should not be the network clinical lead, and ideally should not have the same main employer as the Network Clinical Lead in order to mitigate the risk of (real or perceived) conflicts of interest.
- They could be a board member or senior clinician from one of the provider organisations in the network (ideally not the host, to underpin the collective nature of these arrangements) or a patient representative where a suitable candidate is available.

5.3 Risk Management and risk sharing

Networks do not manage risk independently but within a system of national, regional and system level arrangements. Networks support risk identification, assessment, mitigation and may facilitate any agreed response.

Specific local risk management arrangements and governance processes should be managed locally through MOUs/ SOPs etc which are clear and signed off. Escalation processes for risks within a system should be clear and explicit, with any quality concerns escalated through agreed systems and regional processes.

5.4 Interdependent Relationships

Networks will need to collaborate within and between each other, as well as with other networks at place, system, regional and national level.

Key interdependencies with other networks include:

- Vascular Surgery
- Cardiac
- Diabetes
- Stroke
- Paediatric renal services

6. Resources

Network funding provided to the host is ring-fenced for the network programme of work.

Each network should have a team to support its work that provides clinical leadership, management and administrative support. Networks should also have arrangements for analytical and business intelligence support. Commissioners must ensure as part of the annual planning process that the scale of resource made available to networks is sufficient to support the agreed programme of work. The capacity of the network to deliver its programme of work does not reside solely in the network team but also in the support of all network members including its commissioners.

As part of the annual planning process, commissioners must ensure that:

- the scale of resource made available to networks is sufficient to support the agreed programme of work
- networks have access to the data they need and the analytical capacity and capability to turn this into actionable improvement programmes

Roles such as administration, network management and analytical support may be appropriately combined across networks, with further opportunities to increase the value from these investments, share learning across networks and improve the sustainability of networks through the provision of a pool of staff to support specialised services Clinical Networks across a region.

7. Deliverables, Service Indicators & Outcomes

Indicators and metrics of network performance come from three principal sources:

1. Generic indicators of a well set up, well-functioning network
    - There is an appropriate network management team in post with the skills to deliver the specification
    - The network board meets at least three times per year, is quorate, and minutes, actions and risks are recorded
    - As appropriate to the network spec, there are regular network specialist Multi-Disciplinary Team (MDT) meetings (or equivalent)
    - There are IT facilities in place that enable communication across the network, supporting image transfer and remote participation in the MDT.
    - There is an annual workplan agreed with the network's commissioners

- There is an agreed plan for PPV engagement
- There is an analysis of the service needs of the population served by the network, a gap analysis, and a plan, agreed with the network's commissioners to meet those needs
- There are network agreed patient pathways, procedures, and protocols
- There is an analysis of workforce requirements and a plan, agreed with network members to meet these requirements
- There are arrangements (for example passporting) that enable workforce flexibility between providers within the network.
- There is an analysis of training needs, and an annual network training plan agreed with network members
- There is an analysis of the networks data and information needs and a plan, agreed with network members to meet these requirements
- There is a network agreed research strategy including access and participation in clinical trials
- The annual workplan includes at least one quality improvement initiative
- An annual report is produced, summarising the work of the network and its outcomes. The report includes a financial statement
- The network participates in the national network of networks

2. Nationally agreed indicators and outcomes for all networks of this specialty, for example as defined by a national transformation programme, or included in the service specification and delegated to network leadership.

All in year deliverables, alongside service indicators & outcome data can be found at:
https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-a/renal-services/

NHS Futures Page: Renal Service Transformation Programme –
https://future.nhs.uk/RSTP/groupHome

3. The network's individual locally agreed annual workplan, which should build in metrics and indicators for each element.

The network board will agree an annual workplan with its commissioners which will include the expected in year deliverables along with the indicators that will demonstrate effective network operation.

8. Further support and information

Renal services service specifications available at:

https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-a/a06/

All references and support will be made available via NHS Futures page:

Renal Service Transformation Programme – Future NHS Collaboration Platform

Renal Medicine National Specialty Report, GIRFT, 2021 available here:

https://future.nhs.uk/connect.ti/GIRFTNational/view?objectId=112161669

The full suite of materials covering what clinical networks do, commissioning of specialised services clinical networks and the clinical networks operating model together with model materials for use by networks and their commissioners can be found on the Future NHS website here:
https://future.nhs.uk/NationalSpecialisedCommissioning/view?objectID=34094320

Access requires membership of the site and permission to access the workspace. This is straightforward for all NHS employees.