

From the Director of Secondary Care

For Action:

Chairs of DBS Area Programme Boards

For Information:

Members of the Regional DBS Steering Group
Chief Executives of Health & Social Services Trusts

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Dear Colleague

MANAGED CLINICAL NETWORKS: THE WAY FORWARD

The regional conference on Managed Clinical Networks on 10 March 2005 affirmed the Department's strong commitment to Managed Clinical Networks as a key tool in implementing the *Developing Better Services* agenda across Northern Ireland. At this conference we announced our intention to designate two flagship MCNs per Area Programme Board with some central funding input. The appendices to this letter set out both the process for designation of these flagship Managed Clinical Networks and a framework for their operation.

As you will see, the designation process involves three stages: firstly, designation as a 'flagship MCN under development'; secondly, the developmental phase of the MCN and finally its designation as a 'fully fledged flagship MCN'. The guidance in **Appendix 1** provides details of how the designation process should be managed.

Appendix 2 sets out the framework for the operation of a Managed Clinical Network. This framework covers the management, quality assurance, standards, communications and clinical and social care governance elements of the MCN. Adherence in full to this framework will be a requirement of all centrally funded flagship MCNs, and should generally be used as a template for the development of all MCNs.

On foot of this letter you are requested to begin the designation process either within your own Area Programme Board (APB) area or in collaboration with other Area Programme Boards as appropriate. Two 'flagship MCNs under development' should be identified by each Area Programme Board and their proposal documents sent to the Department for approval by 30 September 2005. Flagship MCNs may be within a single Board area or across two or more Board areas. The process thereafter is set out in the guidance below, but it is the aim of the Department that each APB should have two fully fledged flagship MCNs in operation by 30 September 2006. APBs are asked to take the necessary steps now to ensure achievement of this goal.

May I take this opportunity to once again commend Managed Clinical Networks as a key tool in the implementation of the *Developing Better Services* vision across Northern Ireland. I look forward to receiving your proposal documents for the selected Managed Clinical Networks by 30 September 2005. You are asked to send these in the first instance to Elaine Twinem, Room 1, Annex 1, Castle Buildings, Stormont Estate, Belfast, BT4 3SQ.

Yours sincerely

A handwritten signature in black ink that reads "Dean Sull.". The signature is written in a cursive style with a long horizontal stroke extending to the right.

DEAN SULLIVAN
Director of Secondary Care

PROCESS FOR DESIGNATION OF FLAGSHIP MANAGED CLINICAL NETWORKS

1. Each Area Programme Board is asked to take forward a designation process which will see the identification and development of flagship Managed Clinical Networks (MCNs) across Northern Ireland. The details of this process are set out in the guidance below and in tabular format at Annex 1a.
2. The designation process for a flagship MCN runs over three stages (as per Annex 1a) which may be defined as follows:
Step 1: Designation as a ‘flagship MCN under development’
Step 2: Development of the MCN
Step 3: Designation as a ‘fully fledged flagship MCN’

Step 1: Designation as a ‘flagship MCN under development’

3. Area Programme Boards should work with Boards and Trusts to identify service areas which could be usefully developed as an MCN. The principal driver behind the decision to develop an MCN must always be service users’ need; improved service users’ care must always be the principal output. In addition, in the context of identifying MCNs suitable for central funding, Area Programme Boards should seek as far as possible to put forward those MCNs that are likely to offer the greatest opportunity for wider ‘learning’ within the HPSS. **To this end, MCNs that cut across primary, community and secondary care sectors and different professional groupings will be particularly welcome.**
4. Once potential service areas for MCN development have been identified, those wishing to be considered as a flagship MCN under development will be required to provide their relevant Area Programme Board with a proposal document. Participating Trusts will be expected to support individual clinicians in the production of this proposal document which should include the following details:
 - Timeline/Gantt Chart for the development of the MCN as a fully fledged network;
 - Details of how service users/public representation will be included in the management structure of the MCN;
 - Statement of the clinical and service improvements which service users may expect as a result of the MCN service;

- Outline of the structure of the proposed MCN, including the points at which the service is to be delivered, and the connections between these points;
 - Outline of the planned subgroups which will underpin the development of the MCN;
 - Job descriptions for key staff members of the MCN including the Project lead (i.e. the clinician who will lead the development phase prior to the appointment of the lead clinician for the operational MCN);
 - Communication strategy.
5. On the basis of the proposals received, the Area Programme Board should select two MCNs for development. The details of these two MCNs, including the proposal documents, should be submitted to the Department for approval. These should be sent in the first instance to Elaine Twinem, Room 1, Annex 1, Castle Buildings, Stormont Estate, Belfast, BT4 3SQ by 30 September 2005. If the Department is in agreement, these two MCNs will be designated as ‘flagship MCNs under development’ and some central funding will then be released to fund the developmental stage.

Step 2: Development of the MCN

6. The structure of the developmental phase of the MCN is set out at Annex 1a. This phase, which begins with the production of a project initiation document, normally lasts around one year leading up to the formal launch of the MCN as a fully-fledged network. During this time, the MCN must work to fully satisfy the criteria set down in the attached framework document for Managed Clinical Networks in relation to its management structure, quality assurance programme, clinical and social care governance and communications arrangements.
7. Prior to its launch as a fully-fledged Managed Clinical Network, the MCN must provide both its relevant Area Programme Board and the Department with a written report setting out how it meets the requirements of the framework document which is set out in Appendix 2.

Step 3: Designation as a fully fledged MCN

8. Providing that this written report is judged to satisfy the criteria of the framework document, the Department and the Area Programme Board will jointly agree to launch the MCN as a fully-fledged Managed Clinical Network. Central funding will continue for a year following the launch of the MCN, at which stage a review of its effectiveness – in the form of an annual report in the format set out in the framework document – must be conducted before further funding is committed.

Steps in Designation Process	MCN: Key Development Areas¹
Step 1	Identify service areas which may be developed as MCNs
	Produce proposal document as outlined above and submit to Area Programme Board
	Secure agreement from Area Programme Board for further development of the MCNs
	Submit selected MCNs to Department together with proposal documents for approval and official designation as an ‘MCN under development’
Step 2	Produce Project Initiation Document
	Identify the key clinicians in the area
	Secure administrative/secretarial support and a base or office
	Secure the involvement of a project team
	Appoint a project leader and project manager
	Hold first meeting of project team to: <ul style="list-style-type: none"> • Agree development plan and timetable • Discuss use of allocated budget and identify any potential shortfall • Agree numbers and remit of working groups • Discuss possible membership of working groups • Identify obstacles to progress and key clinical issues on which to focus in development • Agree responsibilities
	Establish working groups and: <ul style="list-style-type: none"> • Agree work programme and working methods for each • Agree timetable and key outcomes • Undertake development work
	Arrange regular project team meetings to: <ul style="list-style-type: none"> • Review, co-ordinate and guide • Consider working groups’ progress • Produce regular newsletters

¹ Based on the guidance of: Baker, C “Managed Clinical Networks: A Guide to Implementation” (Pfizer: 2002)

	<p>Hold open meetings to consult on and refine:</p> <ul style="list-style-type: none"> • Quality assurance programme and agreed standards • Care pathways and protocols • Any core documents, eg: referral and discharge documents
	Finalise quality assurance programme and agreed standards
	Appoint lead clinician (not necessarily the same as project leader) and ratify transfer of project manager and support staff to MCN
	Produce written report to Area Programme Board and the Department setting out how the MCN meets requirements of the framework document
	Obtain agreement from Area Programme Board and Department to launch MCN as a fully fledged Managed Clinical Network
Step 3	Launch of MCN

FRAMEWORK FOR MANAGED CLINICAL NETWORKS

Policy Context

1. The DHSSPS's 'Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005-2025' identifies the need to create responsive and integrated health and social care services for Northern Ireland. It cites the creation of teams, networks and pathways which cross boundaries as key to the fulfilment of this strategy. This is in line with the *Developing Better Services (DBS)* agenda which sets out a vision for a future health service for Northern Ireland, one which offers high quality, safe services, accessible for all and provided by well trained, motivated staff in modern settings.
2. In order to fulfil this vision for the future we need to make the fullest use of all our resources. Managed Clinical Networks (MCNs) offer a way of doing this which builds on existing services and draws them together in networks of care which are service user focused and locally responsive. The basic concepts of MCNs are of partnership and service integration. They may be defined as 'linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, unconstrained by existing professional and health board boundaries, to ensure equitable provision of high quality, clinically effective services'.²

Principles underpinning the development of MCNs

3. The very flexibility of the MCN format necessitates strict adherence to a set of core principles in order to ensure a quality-controlled service for service users. Whilst each MCN will be a product of local circumstances and relationships, this appendix sets out the core principles which should underpin the operation of all MCNs. These principles cover the following key areas:
 - Management arrangements
 - Standards and targets
 - Quality assurance programme
 - Clinical and social care governance arrangements
 - Communication

² Baker CD, Lorimer AR. *BMJ* 2000; 321:1152-3

Management arrangements

4. The “managed” element of the MCN is of crucial importance to the success of MCNs. In essence, this is the defining component of the MCN which differentiates it from other, informal, networks between clinicians.
5. Each MCN must have a defined structure which sets out the points at which the service is to be delivered and the connections between these points. A service mapping exercise can be usefully conducted as a means of defining the services and connections within the MCN.
6. Each MCN requires a lead clinician, a network manager and appropriate administrative support. It must also include representation from service users’ organisations in its management arrangements. The views and experiences of service users should be sought in relation to planning, delivery, evaluation and review of services.
7. An effective lead clinician is key to the success of the MCN. While the size and complexity of the MCN may vary, the lead clinician will normally contribute one to two sessions per week and should have credibility in all parts of the local system.
8. A network manager with a clinical background should also be appointed to work approximately two days per week on the MCN. The network manager, normally at Grade 7 level, will take responsibility for managing finance and infrastructure in the MCN.
9. The MCN also requires appropriate administrative support – normally a full time administrator/secretary at Grade 3 level.
10. In addition to the above formal measures, it may also be useful to establish a multi-disciplinary forum for clinicians. This will foster the collaborative practices which are core to the successful operation of the MCN and will also provide a useful forum to raise matters of concern and to discuss the development of clinical issues and techniques.

Standards and Targets

11. Each MCN must set out clear standards and targets against which its effectiveness may be measured. Whilst the particulars of these standards and targets will be locally defined, they should seek to mesh with the overarching principles set out in section 2 of the draft document

'Best Practice, Best Care: The Quality Standards for Health & Social Care' (full details of this section are attached here at Annex 2a). These draft principles state that user experience, safety and effectiveness, structures and processes and service improvement should be at the heart of the development of standards. MCNs are asked to keep these tenets in view while setting down their standards and targets. In addition, each MCN should specifically aim to:

- Improve care in a way which enables and supports people to achieve their potential in health and social well-being;
- Set out specific standards for key points on the service user's journey. These should clearly define what should happen in terms of care and treatment at any point in his/her journey through the system;
- Detail disease specific standards. Appropriate reference should be made to any published standards issued by the DHSSPS, including those issued or endorsed by the Standards and Guidelines unit;
- Be based on evidence (recognising that levels and types of evidence will vary);
- Be SMART (specific, measurable, agreed, realistic and time bound);
- Be published and widely available;
- Be regularly reviewed and revised to make sure that they remain relevant;
- Demonstrate service user involvement within the management structure of the MCN and in the development of appropriate information materials;
- Detail clinical and social care governance structures and processes of the participating Trusts including how these will interface with the MCN and its services and arrangements for corrective action in the event of a critical incident;
- Set out equipment levels and safety standards for each part of the MCN. Systems should be in place to ensure the safety of service users, carers and staff in all aspects of health and social care delivery across the MCN;
- Provide information on staff training and continual professional development arrangements. Staff in the MCN should be fully supported, regularly supervised and adequately trained to provide safe and effective services;
- Highlight arrangements for public information and the provision of annual reports. Structures and processes should be in place for the adequate review of service and care delivery within the MCN;
- Detail policies and procedures which will encourage continuous quality improvement;
- Demonstrate that due regard has been given to promoting equality of opportunity for the nine statutory equality groups specified in the statutory equality obligations (Section 75 of the Northern Ireland Act 1998).

12. Managed Clinical Networks must have a written Quality Assurance Programme in place. This programme must be agreed by all members participating in the MCN, the relevant Area Programme Board, the *DBS* Regional Steering Group and the Department. It should be signed off before the official launch of the network.
13. Arrangements should be in place to collect data to monitor performance in all parts of the network. This should include activity details outlining numbers of patients treated, admission dates, diagnoses, outcomes and any critical incidents.
14. MCNs should also be in a position to evaluate performance in relation to the disease specific standards outlined under the standards section. These should be consistent within each area of the MCN and should cover each part of the network (primary, secondary and community). MCNs should be able to demonstrate how they are meeting these standards.
15. Service user satisfaction feedback must also be sought on a regular basis as part of the quality assurance process. Service users should be encouraged to provide a narrative of their journey within the network as a means of evaluating its impact on service users' experience of their health and social care.
16. Self-assessment by those participating members of the MCN should also be included as a means of determining the effect on service provision from a clinician's standpoint.
17. The above information should be collated by each MCN in the form of an annual report. The report should be provided to each participating member of the MCN, the relevant Area Programme Board, the *Developing Better Services* Regional Steering Group and to the Department. It should contain the following elements:
 - Executive summary/brief outline of work and progress;
 - Details of services provided in the MCN including where and by whom;
 - Activity report as per point 13 above;
 - Evaluation of performance against disease specific standards as per point 14 above;
 - Service user satisfaction feedback as per point 15 above;
 - Clinician self-assessment as per point 16 above;
 - Details of improved outcomes for service users;
 - Impact on workforce numbers and skill-mix;
 - Workforce development needs, including Continuing Professional Development;

- Details of the MCN's financial status;
 - Information on the MCN's clinical and social care governance arrangements;
 - Details of any critical incidents or problems encountered together with an explanation of corrective action taken in this regard.
18. In addition to the formal Quality Assurance Programme, the Network Manager and the Lead Clinician should report regularly to their relevant Area Programme Board and to the lead provider Trust (i.e. that of the lead clinician). These bodies should be kept up to date with any issues arising within the MCN and should maintain oversight of management and performance.

Clinical and Social Care Governance

19. The establishment of a Managed Clinical Network as the preferred means of service delivery does not remove or dilute the statutory governance requirements placed on Boards or Trusts. MCNs work across traditional structural boundaries and therefore require careful management particularly at the interfaces between its various organisational components. The structures for managing health and social care professionals and clinical processes within the MCN must be clearly set out within the Quality Assurance Programme.
20. Each MCN should draw up a protocol to cover critical incidents, particularly interface issues³, including the following key points:
- If there is a problem relating to a healthcare professional working in the MCN, the lead clinician or manager will need to involve the appropriate employing organisation and its clinical and social care governance procedures and structures;
 - In the event of a critical incident, the lead clinician will follow the appropriate processes already in place in HPSS organisations for reporting, investigating, managing and reviewing an adverse event, including learning, sharing of knowledge to ensure prevention of recurrence in the future;
 - Where a critical event occurs that involves the lead clinician, the investigation and analysis should be undertaken by the Medical Director of the Trust which employs the lead clinician;
 - Where remedial action is required, the Chairmen of the Clinical and Social Care Governance Committees should agree which Trust will take the lead in addressing the issues which arise at the interface between professions or organisations. The lead Trust will receive support and co-operation from all the organisations involved in the MCN;

³ NHS Circular: HDL(2002)69

- The management team within the MCN should ensure that there is a system in place to collate and analyse all adverse events occurring within the scope of the network; and that there is formal reflection, review and feedback by all participants;
- Clinical and Social Care audit should be an integral component of all MCNs.

Communication

21. The recently published draft standards ‘Best Practice, Best Care’ have suggested criteria for open and effective communication. These are included here at Annex 2b and can be usefully applied to MCNs.
22. In addition to these general good practice guidelines in relation to communication, each MCN should also seek to comply with the following:
 - At the outset, it will be of primary importance that the support of those commissioning the MCN and those who will be working within it, is sought and fostered. This should be done through face-to-face contact as much as possible;
 - Service users should be involved from the outset in order to ensure that the focus remains on patient care rather than on organisational structures and boundaries. Service users should be fully involved in the development of materials for the MCN – particularly service user information leaflets. They should also play a formal role in the management structure of the MCN;
 - Once the network is established, frequent communication between the network manager, lead clinician and the various parts of the network must be maintained, with the network manager and lead clinician visiting MCN participants on a regular basis to support the cohesive functioning of the MCN;
 - They should also liaise with service users and seek their input in the form of narratives of their experiences within the MCN and through service users satisfaction surveys;
 - The MCN project team should include individuals who will be able to act as information conduits – both to service users and to medical staff. They should be encouraged to fulfil this role pro-actively;
 - The internet can be a powerful resource for communication. Service mapping, service users’ journeys, newsletters and resources can all be usefully posted on line so as to maximise access to both clinicians and non-clinicians.

Annex 2a

Extract from Best Practice, Best Care Section 2: Values and Principles Underpinning Service Delivery

The following overarching principles are fundamental to the development of these standards:

USER EXPERIENCE	<p>The views and experiences of service users, carers, staff and local communities are taken into account in the planning, delivery, evaluation and review of services.</p> <p>Service users and carers, where appropriate, are involved in, and informed about, decisions made on every occasion they seek access to or receive services during their journey of care.</p>
SAFETY AND EFFECTIVENESS	<p>Systems are in place to ensure that the safety of service users, carers and staff underpins all aspects of health and social care delivery. In some circumstances, the imperative to protect children and vulnerable adults may take precedence over the specific wish of the service user.</p> <p>Quality systems are in place to enable staff to play a full and active role in providing effective and efficient health and social care services for all who use these services.</p> <p>Staff in the HPSS are fully supported, regularly supervised and adequately trained, both personally and professionally, to provide safe and effective health and social care services.</p>
STRUCTURES AND PROCESSES	<p>Information is used appropriately to optimise benefit in all sectors of health and social care.</p> <p>Structures and processes are in place for the adequate review of service and care delivery.</p>
SERVICE IMPROVEMENT	<p>Policies and procedures are in place to encourage and enable continuous quality improvement.</p>

Extract from Best Practice, Best Care: Section 7: Theme 4 – Open and effective communication

Criteria

An organisation communicating openly and effectively should have:

- An effective information and communication strategy, appropriate to the needs of the public, service users and carers, and the size, functions and complexity of the organisation;
- Up to date information and information technology systems and processes in place to meet its aims and objectives;
- Systems and processes in place to ensure that urgent communications, safety alerts and notices, standards and good practice guidance are made available in a timely manner to relevant staff and partner organisations and that these are monitored to ensure effectiveness;
- Clear communication principles for staff and service users, which include:
 - Openness and honesty;
 - Use of appropriate language and methods of communication;
 - Sensitivity and understanding;
 - Effective listening; and
 - Provision of feedback;
- Effective records management policies and procedures covering access and the completion, use, storage, retrieval and safe disposal of records, which it monitors to assure compliance and takes account of Freedom of Information legislation;
- Procedures for protection of service user and carer information which include the timely sharing of information with other professionals, teams and partner organisations as appropriate, to ensure safe and effective provision of care, treatment and services;
- Effective and efficient procedures for obtaining valid consent to examination, treatment and/or care;
- An effective complaints and representation procedure and feedback arrangements, which is made available to service users, carers, and staff and which is used to inform and improve care, treatment and service delivery;
- A range of published up-to-date information about services, conditions, treatment, care and support options available, and how to access them both on and out of service hours, which are subject to regular audit and review;
- Active participation of service users and carers and the wider public in the development and audit of communication and information management systems and processes.

