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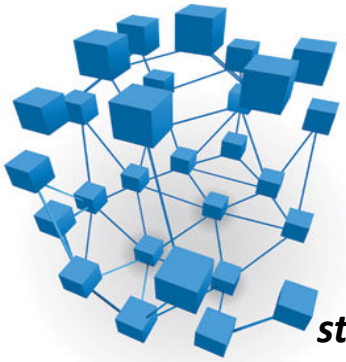

NET- RUN

strategic clinical networks and their contribution to the new NHS

A REPORT OF A SIMULATION BASED EVENT

Simulation Partners & Co-funded by:

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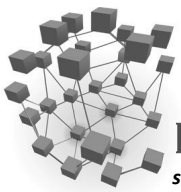
where medicine meets management



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Content

The simulation partners who co-funded this project had no editorial control into this report. The views expressed in this report do not necessarily reflect the views of Amgen, Bristol Myers Squibb, Janssen Cilag, MSD, Novartis or Roche.

Foreword

Strategic Clinical Networks (SCNs) will be a key part of the new commissioning landscape, supporting the new Commissioners – the NHS Commissioning Board and Clinical Commissioning Groups - in commissioning care that improves the quality of services and achieves better outcomes for patients with some of the country's most significant illnesses.

This ***Net-Run*** report has helpfully highlighted some of the questions about how the new Strategic Clinical Networks might operate in the context of the changes to the landscape of commissioning. We would like to thank all those who contributed to the ***Net-Run*** project. The single operating framework for SCNs has now been published and we have been able to take on board many of the issues raised in this report. There are other issues highlighted in ***Net-Run*** which remain 'work in progress' – such as the alignment of SCNs and their relationships with other new bodies such as the Academic Health Science Networks, the National Improvement Body and Local Education and Training Boards. The NHS Commissioning Board and the New NHS Improvement body have started work to set out national priorities for the SCNs. There will be some benefits too in national work around public and patient involvement, the specific functions of networks, the content of accountability agreements, the contribution of non-NHS partners and how SCNs can access the right data.

However, what was also clear from Net-Run is that much of the details about how these arrangements work in practice will need to be resolved locally by the Senate and Network Support Teams, the members of these different bodies working with local Commissioners – CCGs and the NHS CB - and through engagement with the wider clinical colleagues, taking care to maximise the opportunities for network alignment as the system evolves.

With the NHS firmly focused on delivering improved outcomes through clinically led organisations and putting patient and public interests at the heart of its work, SCNs and SNSTs are well placed to make a significant and sustained contribution.

Prof Sir Mike Richards
Director for Domain One
NHS Commissioning Board

Julie Wood
Commissioning Development Director
NHS Clinical Commissioners

Introduction

Extending clinical leadership in the NHS has been a central principle in the Government's reforms of the NHS. Strategic Clinical Networks (SCNs) and Clinical Senates have been identified as important mechanisms to support clinical leaders in delivering major improvements in quality and outcomes for patients.

Whilst the number and focus of SCNs and the geographical configurations of their Senate and Network Support Teams (SNSTs) have been confirmed, there remain questions about exactly how the arrangements will work in practice. We know that no matter how useful the previous clinical networks have been, there are a number of reasons why these 'old' working arrangements cannot be simply followed forward. In the first place, the commissioning 'landscape' has changed – with a larger role for Local Authorities through their Health & Wellbeing Boards (HWBs) and the new responsibilities for public health, with the advent of Clinical Commissioning Groups (CCGs) holding tremendous sway over what services are commissioned for local communities and with the creation of NHS Commissioning Board (NHS CB) commissioning some of the more specialised services on behalf of local communities. Moreover, the new SCNs – and their SNSTs – will also have to consider how they relate to the various new bodies that have an interest in improvement and innovation, including the Clinical Senates, Academic Health Science Networks and Local Education & Training Boards. Underpinning all these challenges are the rapid and continuous shifts in the pattern of needs and demands for care – especially in an economic downturn.

In some circumstances it might be acceptable to allow things to evolve gradually, making adjustment over time or having a 'shadow period' in which skills and experience can be developed. As SCNs will be responsible for improving the quality of services and for achieving better patient outcomes for the country's most significant illnesses, the risks incurred through such an evolutionary approach are potentially high. It was this recognition that led the NHS Commissioning Board (NHS CB) and NHS Clinical Commissioners – with the support of sponsors from the pharmaceutical industry[1] – to ask *Loop2* to design a behavioural simulation methodology to help test the SCN arrangements before they went 'live'. Medical Management Services provided the administrative support for the ***Net-Run*** programme. ***Net-Run*** was designed to help us learn about some of the potential risks and to highlight what different partners in the system to ensure the new arrangements are successful. This report summarises the key learning from the ***Net-Run*** – drawing on the thoughts of the participants immediately after the simulation, their reflections after they had returned to work and the comments from a 'Moderation Group' with whom we shared the initial findings. Appendices 1 and 2 provide a list of those who took part in these different stages of the ***Net-Run*** process.

Following an Executive Summary of the key messages, the report provides a brief overview of the proposals for SCNs and a description of the ***Net-Run*** project. The main body of the report covers these seven headline points in more detail outlining the issues and concerns that emerged from ***Net-Run*** followed by reflections on what actions need to be taken to address them. The final section concludes with some specific messages for SCNs, for SNSTs and for the NHS CB.

[1] *Our thanks to Amgen, to Bristol Myers Squibb, to Janssen Cilag , to MSD, to Novartis and to Roche for their sponsorship*

Executive Summary

Whilst the number and focus of SCNs and the geographical configuration of their Network Support Teams (SNSTs) have been confirmed, there remain questions about exactly how the arrangements will work in practice. The ***Net-Run*** programme, designed and facilitated by *Loop2* at the invitation of the NHS Commissioning Board and NHS Clinical Commissioners, was designed to help us learn about SCNs and their relationships with the other structures and processes in the reformed health and care system to highlight what different partners in the system might need to do to ensure the new arrangements are successful. This report summarises the key learning from the ***Net-Run*** simulation, participants' post-hoc reflections and the comments from a 'Moderation Group' with whom we shared the initial findings

The 'headline' conclusions are:

1. ***The function of SCNs*** – There is an urgent need for greater clarify about the function and '*unique selling points'* of SCNs, how they might operate differently to previous clinical networks and what good practice from these networks they will be expected to take forward. The NHS CB should set out what aspects of the SCNs work they expect to be mandatory and where there is scope for local discretion by SCNs and their Network Support Teams (SNSTs). Without this detail there is a significant risk that commissioners and providers as potential members of SCNs will not appreciate who the networks can add value to their organisations and may then not support their work.

2. ***Putting patients at the heart of their work –*** All parts of the new NHS system need to put patients at the centre of their activity: SCNs are no exception and in the way they work. Simply having patient representatives as SCN members will not be sufficient. Patients who have been involved in previous clinical networks are concerned that the new SCNs will not be sufficiently resources to undertake the same level of engagement. But it must be recognised that patient and public engagement is contested space. SNSTs and SCNs must focus on how they can add value to the involvement and engagement work that is undertaken by commissioners, providers, HealthWatch and by the other organisations that represent patient/service users.

3. ***Negotiating for a place in the innovation and improvement 'space'*** – There are now many organisations and networks that have a remit for improvement and innovation at national, regional and local levels. There is a risk that Clinical Senates, SCNs, Academic Health Science Networks (AHSNs) and Local Education & Training Boards (LETBs) will compete with each other for a legitimate role and for the time of their members. There are risks that there will be a conflict over priorities between these groups and agencies. There is also uncertainty about the role and level of support they can jointly and severally expect from the NHS Improvement Body. These organisations and networks need to find a complementary way of working so that they do not cut across each other and so their combined effort produces 'more than the sum of the parts'. While their relationships and interfaces need to be negotiated locally, the NHS CB could help 'fast track' this process by providing an 'illustrative map' of their respective contributions to achieving the NHS Outcomes Framework.

4. ***The responsibility of SCN members*** – The SNSTs will be at the centre of a 'network of networks' they are the 'organising hub' – but each SCN's success rests on the contribution of the clinical leaders that are its members and the organisations that they represent – it is the membership that is the network and *not* the Network Support Team.

5. ***Setting SCN priorities*** – A primary focus of SCNs has to be helping to deliver the NHS Outcomes Framework and other QIPP targets, but SCNs will not gain the full commitments of local leaders if they have no freedom to set their own local priorities and decide how they will be achieved: SCNs will atrophy if they are treated solely at a 'delivery arm' of the central NHS CB.

6. ***The SCN philosophy and way of working*** **–** SCNs must resist the temptation to focus only on the medical model of diagnosis and embrace both care and support. They need to have the whole person/pathway and the wider determinants of health as their focus. This has implications both for the choice of membership and the process for involving different stakeholders.

7. ***Taking an 'evidence based' approach*** **–** If the SCNs are to focus on improving outcomes they must be able to draw on an evidence/information base and analytical expertise in order to:

   a. identify the significant needs and variations in outcomes in the populations they serve in order to determine strategic priorities;

   b. assess the value of the current pattern of health and care investment and the outcomes produced from it;

   c. identify the scope for improving current services and;

   d. assessing the relative costs and benefits of alternative service delivery options.

   The NHS CB and their Local Area Teams can support SCNs by developing and defining suitable outcome and quality indicators and data sets, drawing up draft information sharing agreements between health and social care commissioners and providers and other bodies. LATs, SNSTs and SCN members need to think creatively about how they can deploy all the analytical capacity and capabilities of other Bodies, such as voluntary and community organisations and pharmaceutical companies.

The report concludes with some messages for different stakeholders about what they need to do to make SCNs a success.

The NHS CB – Having established the *Way Forward* guidance, the NHS CB needs to follow its descriptions about the form of SCNs with some clearer messages about the *function* and make *reassurances* about how patient voices will be placed at the centre of SCNs' work. The NHS CB must support LATs and SNSTs and *actively promote* the benefits of the new arrangements to CCGs and to HWBs. The accountability agreements with SNSTs must recognise that the success of SCNs is dependent on them being seen to be highly valued by and relevant to the needs to their members.

Senate & Network Support Teams – Once the members of SNSTs are appointed they must immediately begin mobilising support from the constituent organisations from which the SCN membership will be drawn, communicating clearly the potential benefits of SCNs and the expectations of its members and the organisations they represent. SCNs will be new bodies with management support coming from a small core team covering several networks. If they are to be seen to deliver innovation, quality and productivity improvements, SCNs and SNSTs will need to adopt new ways of working to make the best use of their combined skills and resources, drawing on additional support and capability from external sources such as voluntary organisations and pharmaceutical companies. For example; SNSTs should be looking at initiating cost cutting work streams that can benefit more than one clinical network. There are some integrated teams that are already supporting several clinical networks that have demonstrated how effective this can be in fast tracing development work and making best use of the skills and experience of the SNSTs.

CCGs and the providers of NHS Services – These organisations need to think about SCNs as one of the best ways to secure specific improvements in patient outcomes. For CCGs in particular, SCNs are a way of accessing peer support and expert clinical advice on those aspects of care that either might be too specialist to be undertaken within the CCG and/or where there are significant benefits to be gained from working at scale across a larger geographical area. Both CCGs and NHS service providers must resist the temptation to equate the success or potential benefits from SCNs with the amount of time that they get from their SNST. Those teams are there to support and facilitate: what will prove to be of greatest importance in delivering benefits to members is how much the members themselves are prepared to put in to their SCNs.

SCNs in the New Health & Care System: A Summary

Some of the participants in the simulation event had a must greater understanding of the SCN proposals than others. This differential will be replicated in the readers of this report and so here we set out a brief explanation of the proposals of the SCNs and the aspirations of their advocates.

'The Way Forward: strategic clinical networks' confirmed that the NHS Commissioning Board will establish a set of nationally authorised strategic clinical networks (SCNs) in the new system. These networks will work across the boundaries of commissioning and provision, as 'engines for change' in the modernised NHS, with a focus on quality improvement and improving outcomes for patients.

Initially there will be four SCNs whose work will be aligned to the outcomes set out in the NHS Outcomes Framework:

- *Cancer*
- *Cardiovascular (including cardiac, diabetes, stroke and renal disease)*
- *Mental Health, Dementia & Neurological Conditions*
- *Maternity & Children*

While the specific accountabilities of SCNs have yet to be determined, the values that the SCNs are expected to demonstrate in their operations are:

- *A clear sense of purpose;*
- *Clear accountability arrangements;*
- *A commitment to putting patients, clinicians and carers at the heart of decision making;*
- *An energised and proactive organisation offering leadership and direction;*
- *A focused and professional approach that is easy to do business with; Cancer*
- *An objective culture, using evidence to form the full range of its activities;*
- *Flexibility*
- *A commitment to working in partnership to achieve its goals*
- *An open and transparent approach:*

The network support teams for SCNs will be aligned to the 12 regional Clinical Senates and (broadly) with the new Academic Health Science Networks, with whom they are expected to work closely and collaboratively. SCNs and Clinical Senates will receive managerial support and clinical leadership from a single Senate and Network Support Team comprising a minimum of around 15 people, with more people supporting the larger senate areas. SNSTs will have further resources to either 'second' or 'buy in' additional clinical expertise as needed. The guidance to date includes that the SNSTs are expected to focus on:

- *Building and overseeing effective network arrangements;*
- *Providing leadership, project and programme management;*
- *Encouraging the use of the single change model to include adoption of innovation and spread of best practice*

The SNSTs will be based in one of the Local Area Teams (LATs) of the NHS Commissioning Board and will be able to draw on back office functions such as finance, HR and IT support from those offices. The SNST lead manager will be accountable to the LAT Medical Director. As well as support from the NHS Commissioning Board the SNSTs and SCNs are expected to draw on the resources and support provided by the NHS Improvement Body.

The *Net-Run* Project & the Simulation Design

At the heart of the ***Net-Run*** project was a *Loop2* behavioural simulation designed to help the participants experience and 'stress-test' the new SCN arrangements *before* they went live. While behavioural simulations cannot replicate all the intricacies of the real world, they can generate very accurate leaning about how systems behave in different circumstances and what can be done to improve their operation. This is because the simulation is a 'soft' process involving people representing all the key interests in the system and drawing on their experience, insights and judgements.

To provide participants with a shared and safe framework for discussion, the simulation was located in an imaginary place in England call *Middledale* serving a population of over three million people in the two counties of *Netshire* and *Ramshire* and the Metropolitan Borough of *Ramsdown*. The calendar was advanced to October 2013 when all the structural changes to NHS commissioning had been completed and SCNs were established.

The simulation participants were selected to represent the health and care organisations involved in the commissioning and delivery of services and support in *Middledale* as well as representatives from the NHS Commissioning Board.

While the *Middledale* SNST would typically service the four nationally designated SCNs and a Clinical Senate to simplify the number of interactions in the simulation, we focused on just two SCNs – *cancer,* as an example of a well established network and *mental health*, *dementia and neurological conditions* as an example of a recently initiated network. We had to make some assumptions about what the NHS CB would be expected SCNs to deliver and so we created 'mock' accountability agreements between the NHS CB and the two SCNs. These focused on clinical outcomes set out in the NHS Outcomes Framework and the performance requirements in the NHS CB mandate.

Our simulation participants were asked to address a set of hypothetical but realistic 'stories' designed to explore some of the key questions about how SCNs will work and how they would fit in with the new commissioning and service improvement landscape. Some of the issues that we explored were purposely designed to be of relevance to clinical networks beyond the two on which ***Net-Run*** focused.

It is important to recognise that this simulation was not a game played for its own sake and nor was it trying to predict the future. Its purpose was to stimulate shared understanding and learning about the dynamics of the new system.

To that end about half of the participants' time together brought them out of their simulation roles and had them working in mixed groups to pull together the learning points, identify the key areas of SCN implementation that need further attention and suggest some 'messages' for each of the stakeholders about how their behaviour can influence the success of the new arrangements.

In addition to the learning collected at this stage, we encouraged participants to share any further reflections they had *after* the event with the *Loop2* simulation designer. This represented the second stage of gathering the learning. The third stage was to share the initial ***Net-Run*** findings with a 'Moderation Group' comprising clinical network managers and clinicians, domain leads from the NHS Commissioning Board, voluntary organisation representatives and some people from health care trade associations – most of who had not been involved with the simulation itself. Their task was to review the learning from the event and place it within the wider operating context of the NHS. The sections which follow draw on these three opportunities to gather learning.

The Purpose of SCNs

Issues Raised

- The phrase *form should follow function* – originally coined by architects Louis Sullivan and Frank Lloyd Wright – has for many years been seen as an important principle in organisation design. While the NHS CB has set out details about the *form* of SCNs, as well as the geographical areas serviced by SNSTs and an indication of the values that should inform the workings of a SCN, it was felt that there is insufficient detail about the intended *purpose* of SCNs. This information is needed to inform the skills and qualities that will be required by SNST managers and directors and also to ensure that the SCNs are able to engage their members and partner organisations.

- It was noted that there was a *danger of competition* for clinician time. While many clinicians in provider organisations will have had some experience of working in clinical or professional networks, the representatives of CCGs are less likely to have direct experience of working in this way. If they are GPs they will have multiple and potentially conflicting demands on their time spent delivering primary care – as clinical leads, perhaps also members of the CCG governing body and/or involvement in local partnerships such as HWBs or 'collaborative commissioning' arrangements. Unless the function of SCNs is both clear and relevant to the CCG's ability to deliver on its Accountability Agreement with the NHS CB then there are risks that SCNs will not be considered relevant by CCGs and their member practices.

- A further concern, as the cliché goes, was the risk of *throwing out the baby with the bathwater*. As SCNs replace some of the previous clinical networks there are natural concerns that some of the valued aspects of current clinical networks and the skills of the teams that supported them will be lost.

- Some participants felt that there needed to be more clarity about where the role of quality assuring providers role will sit within the new NHS. The Francis Report when published may need to be considered with regard to this.

- While the value and importance of the new network of mental health, dementia and neurological conditions was recognised *the sheer breadth of the issues* that need to be addressed were felt to be a challenge to a single network, even though there are some interesting synergies and similarities between these conditions. There was a strong view from some that three sub-networks would be an inevitable development. The SCN and the SNST will have to work hard at the outset to devise ways of supporting all three clinical components.

- The guidance from the NHS CB is clear that because of geography there may need to be more than one network set up for each four SCN care areas all serviced by SNSTs. There were concerns that the size and capacity of SNSTs presents some constraints to this in practice – their efforts and capacity will be diluted the larger the number of networks they have to service. The large geographical areas covered by SCNs present two risks – the time taken to travel across the patch to attend network meetings and the SCN's ability to reflect the variations in clinical needs, existing patterns of care and other local circumstances.

Future Considerations & Actions

- SCNs will serve both commissioners' and providers' interests. There will be times when their work might be tilted more to the needs of one of these parties than the others'. For example: SCNs might be delivering specific advice to commissioners about future investment and/or facilitating peer learning and support about a specific aspect of service delivery. SCNs and their SNSTs should maintain a *flexible approach to balancing interests* but continually assess the degree to which the network is serving the needs of all its members.

- SCNs are intentionally strategic but their impact will be less if they try to spread their interests too thinly. If they are to *go for maximum effect* SCNs should focus 'inch wide and mile deep' rather than 'mile wide and inch deep'.
- In being selective about their purpose and priorities SCNs should establish a set of *principles to guide decisions* about when programme support from the SNST should cease and the work either becomes the responsibility of individual commissioners or providers or is handed over to alternative bodies, such as HWBs or provider networks.
- Established clinical networks, such as those for cancer and cardiac care, will need to consider how they migrate the current arrangements to the new SCNs. Network directors and their teams, if they have already done so, should aim to *build on the legacy´* and capture what has/has not worked well and what aspects of the current functions are most valued by commissioners and providers. The NHS CB should look at ways of disseminating some of the best practice and learning points nationally.
- Net-Run participants and commentators were clear that although details about SCN functions can be worked out by the new SNSTs and networks, some further clarify from the NHS CB about *mandate and desirable functions* would help to frame and short circuit these negotiations and reduce the risk of SCNs losing support amongst local clinicians because of a lack of local focus. The NHS CB should consider whether any further arrangements for the quality assurance are needed in the new NHS, over and above the responsibilities of commissioners.
- SCNs will not be performing a single function – there will be a range of things that they can and should be depending on, the circumstances and needs of their members and the requirements of the NHS CB. There will equally be some functions that SCNs should not undertake. Clarity about the 'don't do's' would be as helpful as pointers about the 'must do's and may do's'.

The table below while not necessarily comprehensive or definitive provides an illustration of SCN functions, based on comments made during the ***Net-Run*** Project.

Table 1: Suggested Functions for Strategic Clinical Networks

Essential	Desirable	To be avoided
Agreeing a work plan and priorities that enables network members to meet those elements of the NHS Outcomes Framework that present the greatest challenges and which would benefit from a collective approach or which cannot be resolved by individual commissioners, providers or health systems. Generating ideas and identifying best practice about how to improve the value from health investment, including new ways of delivering care and options for disinvestment.	Facilitation of relationships between clinicians in different sectors and leaders in other bodies that can have a role in health determinants, rehabilitation and re-ablement. Generation of additional funding for the SNST to extend its work in support of network members. Facilitating the capacity of health and care providers to undertake service improvement e.g. through design of change tools/templates.	Performance monitoring of providers in relation to quality standards. Detailed service quality improvement work for individual providers. Quality assurance of providers – this is a valuable activity but could be undertaken elsewhere in the system. Primary research on patient opinions.

Essential	Desirable	To be avoided
Facilitating the co-ordination of commissioning by different commissioners (e.g. NHS CB, LAs, CCGs) in order to secure the delivery of integrated pathways. The development of clinical standards or protocols for those aspects of care not covered by NICE guidance. Providing advice to commissioners about priorities that they have identified e.g. about areas for investment/disinvestment. Leading/providing programme management to service redesign across the network area where there is no other coordinating body appropriate to lead this work. Mobilising, co-ordinating and facilitating the development of service improvement skills within and across the networks. Undertaking generic service redesign work that can benefit multiple disease entities. Developing draft service specifications e.g. for those aspects of care that might be too specialist to be part of CCGs' work programmes and yet not so specialist that they fall within the remit of specialist commissioners Establishing consensus amongst network members about how to align incentives and leverage whole system solutions to network priorities.	Facilitating the capacity of Trusts to undertake meaningful patient engagement around network priorities e.g. by promoting awareness of different engagement methods and how they can be applied. Facilitating sharing of experiences across the network. Meta-analysis of different sources of information in relation to SCN agreed priorities e.g. on patient opinion and experience. The development of commissioning support tools e.g**.** service specifications that can be adapted to local need without major duplication of effort or economic modelling tools to enable commissioners to see move from current outcome models to best practice.	Decisions about future investment – these are the responsibilities of commissioners and providers.

Negotiating a Space for Innovation, Improvement & System Integration

The Issues

- *Competition for innovation and improvement.* Not only is there potential for confusion about their respective functions, there is also a risk that Clinical Senates, SCNs, AHSNs and LETBs will compete with each other for priorities and for the time of their members. Participants indicated that there was effectively a 'market' for their time and commitment – unless they were mandated to attend they would be likely to choose the network(s) that they felt would best suit their personal interests and requirements or those of the organisation that they represent.
- A further area of ambiguity for SCNs is the area of *system integration'* where some AHSNs and HWBs may lay claim to a role in this area.
- There was uncertainty about what SCNs can expect in terms of the *support from the NHS Improvement Body* as this is a relatively new organisation that is having to make tough decisions about how best to use a lower level of resources than that available to its predecessor organisations.
- SCNs may find there are other networks working in their field, including clinical and non-clinical networks and partnerships with other sectors. A recent mapping exercise in London identified at least 40 different professional and inter-organisational networks that related to mental health alone. It will be important therefore to SCNs to *network with other networks.*

Future Considerations & Actions

- CCGs representatives need to recognise that they are a conduit between SCNs and the HWBs of which they are members. SCN representatives from CCGs must ensure that they maintain clear lines of communication between these important co-ordinating bodies.
- There needs to be clarity about the respective roles of the various local bodies with a remit in innovation and improvement. LATs and SNSTs should *facilitate local agreements* between SCNs, the AHSNs, LETBs and Clinical Senate about how they will work together in a way that is complementary rather than duplicatory.
- Net-Run illustrated if the respective functions, contributions and priorities of SCNs and AHSNs, for example, can be aligned they can be 'more than the sum of the parts' and help to deliver fast and sustainable service transformations. While the details of these relationships and interfaces have been worked out locally, some of the areas that SCNs and AHSNs could helpfully discuss might include their respective roles in:
    - *Identifying priorities for innovation/improvement*
    - *Establishing evidence to support improvement*
    - *Identifying innovations and assessing their relative costs and benefits for commissioners and providers*
    - *Supporting the rapid diffusion of innovation*
    - *Research to evaluate the effectiveness of different approaches to service deliver*
    - *System integration*

The Responsibility of SCN Members

The Issues

- ***Net-Run*** highlighted the *danger of equating SNSTs and SCNs* because the SNSTs are the visible hub for a number of networks. It has to be remembered that the SNSTs sit 'under' the networks supporting them and that it is the members themselves that 'are' the network.
- There needs to be greater clarify about the *status of independent sector providers* in SCNs. While there was a consensus that SCN's members should include patients and representatives of voluntary and community organisations, there was less agreement about whether independent sector providers should be included in the networks and how best they would be represented. AHSN representatives were far less equivocal – for them the inclusion of private providers of NHS funded services was seen as a desirable way of bringing in innovation and fresh thinking.
- SCNs are intended to be clinically-led but NHS Trust consultants were unsure about how their time would be funded. Trusts are taking an increasingly tough line on consultants' job plans. The amount of time available for supporting professional activities such as attending clinical networks or representing the Trusts on AHSNs or Senates, in some organisations, is just 1.5 sessions a week. With other demands on their time for teaching, research and continuing professional development *consultants may find it increasingly difficult to prioritise participation in SCNs* without additional sessions being granted by the Trust or funding being made available from the SCN.

Future Considerations & Actions

- While the style and support of the SNSTs is important and valuable, the larger share of SCNs' success will rest on the *contribution of the clinical leaders´* that are its members and the organisations that they represent.
- There will be an onus on the network members and the organisations they represent to play a significant part in making the networks effective by such things as leading work streams or providing mutual peer support. It is essential that *CCGs and Trusts 'own' the SCN agenda* and fully understand the benefits of participation if they are to allow their clinicians to commit their time to clinical network business.
- SNSTs will have some resource to support clinical engagement and other activities but they will need to think carefully about the best way of resourcing clinical leadership. SNSTs need to fund the *most productive balance* between funding clinicians to attend meetings and using funds to take forward specific elements of the work programme.
- The expectations of members and how they *hold each other to account* for their respective contributions is something that should be made explicit in the network governance arrangements right from the outset.

Establishing SCN Priorities

The Issues

- The NHS CB has not yet spelled out its performance requirements of SCNs but ***Net-Run*** participants were clear that if SCNs were used or seen to be used simply as a *tool for delivering the NHS CB mandate* they will lose the support of their clinical and organisational members.
- The NHS Outcomes Framework provides a common focus for commissioners, providers and those that oversee their performance: indeed the *focus on outcomes* is something that most SCNs are likely to support. But if the Accountability Agreement for SCNs is very prescriptive about which outcome targets must be met (to the exclusion of others) and prescriptive about how SCNs should go about achieving those targets, there is a risk that SCN members will feel that the network is not addressing the needs and priorities that are of greatest importance to patients and clinicians locally. Given the comments made earlier about the pressure of scarce clinical time and the competition for the attention of clinical leaders, the net effect of this would be that SCNs lose the support of their members.
- A similar concern was raised about priorities set by the SCNs themselves – give the large geographical areas that SCNs may cover there are questions about the *degree of variation that can be handled within SCNs* e.g. about how specific outcome targets might be achieved across the network's different communities or the pace of change.

Future Considerations & Actions

- While the primary focus of SCNs must be in helping to deliver the NHS Outcomes Framework if they are to gain the commitment of clinical leaders, the NHS CB must design an Accountability Agreement that balances the contribution of networks to the national mandate and some freedom and flexibility to agree their own priorities and decide how they will be achieved: SCNs will atrophy if they are treated solely as a 'delivery arm' of the central NHS CB or even the Local Area Team.
- SNSTs/SCNs should accept that there will be *variations in investment and in the models of care* across SCNs and use this as opportunities to help members assess the relative benefits of different approaches to delivering outcomes.

The SCN Philosophy & Way of Working

The Issues

- There is a risk that the name 'clinical' might be interpreted as meaning medical, both in what the networks choose to focus upon and in the selection of their members. Yet for cancer and for mental health, dementia and neurological conditions (and potentially for the other clinical networks as well) patient needs go much wider than the diagnosis and medical treatment of the condition. *Long term conditions need a more holistic approach.*

- The capacity of the SNSTs compared with the scale of support for earlier clinical networks has been given a good deal of coverage in the trade and more recently the national press. The guidance to date indicates that the support teams are expected to focus on:

    - *building and overseeing effective network arrangements;*
    - *providing leadership, project and programme management;*
    - *encouraging the use of the single change model to include adoption of innovation and spread of best practice*

- For ***Net-Run*** participants a missing ingredient in this list was the essential *facilitation, coaching and diplomacy skills* that network support staff have brought to making service change happen. SNSTs can act as honest brokers, mediating between commissioners and providers and between central and local players where tensions arise.

- These SNST functions will make an important contribution to the success of SCNs but there are concerns that the new teams will be unable to undertake the same level of service improvement work as that performed by the people that supported that previous cancer, stroke and cardiac networks. Service improvement and clinical quality are clearly the responsibilities of provider organisations: but while some are able to undertake exemplary work others expressed concern about whether their organisation would have the right skills, capacity or resources to fill the gap left by the previous clinical network improvement leads.

- There is a long tradition of working through clinical networks for cancer but this way of working is less well established for the new networks such as mental health, dementia and neurological conditions. Each has its own set of challenges. For cancer and cardiac services, they are about shifting to a new way of working and establishing how some of the *'legacy' initiatives should be handled* with the more limited capacity of the SNST. For the new mental health, dementia and neurological conditions network, there is the challenge of a broad spectrum services and conditions its covers, *the early task of securing the interest and commitment of its clinical and other members and then establishing trust and building relationships* between them.

Future Considerations & Actions

- SCNs must resist the temptation to focus only on the medical model of diagnosis and treatment and focus on the care and *support of the whole person/ pathway* and the wider determinants of health. This has implications both for the choice of membership and the process of involving different stakeholders.

- While SNSTs may not have the capacity to support improvement work in individual organisations, they do have an important role in *mobilising, co-ordinating and facilitating the development of service improvement skills* to support the achievement of SCNs priorities. The NHS Improvement Body should both establish and provide early communication about how it can support this work.

- In setting the accountability agreement for the mental health, dementia neurological conditions network the NHS CB should bear in mind the importance of '*organisation development'* work. These SCNs will need time, for example, to agree common philosophy or vision about what good outcomes look for the people with those conditions.

Putting Patients at the Heart of SCN Work

The Issues

- The mantra *'no decision about me without me'* is beginning to be 'hard wired' into the way that NHS commissioners and providers operate so it was not surprising that the way SCNs engage the public and patients in their work was highlighted as both a concern and an opportunity.
- Patient representatives with experience of the current cancer clinical networks has significant concerns that SNSTs and SCNs might not be able to support the type of detailed patient engagement and co-design work that they have experienced in the old network arrangements, particularly if there were no dedicated patient engagement facilitators in the SNST. However, it must also be recognised that like innovation and improvement, patient and public engagement is becoming a contested space: the new HealthWatch organisations, for example, are joining commissioners and providers that also have responsibilities for engaging patients in their work. SCNs and the SNST need to exploit these new developments and not replicate them.

Future Considerations & Actions

- The NHS CB and the SNSTs once appointed must provide reassurance to patients and patient representatives about how their voice and contributions will contribute to SCNs: having a patient representative on each SCN is unlikely, in itself, to be a sufficient demonstration that patients are at the heart of SCN business. This reassurance is important both for those clinical conditions which already have active patient involvement in strategic clinical networks and for the newer networks.
- SCNs should set out how they intend to add value to the public and patient engagement initiatives in the fields and geographical areas that they cover. Some suggestions included:
  - *Undertaking meta-analysis of existing evidence on patient views and preferences.*
  - *Bringing together representatives from the different HealthWatch organisations in the SCN area to keep them informed about the SCN programme and agree how they can support the SCN's agenda.*
  - *Ensuring there are opportunities for patients to be involved in all aspects of the SCN's work programme, resisting the temptation to make assumptions about what 'they would be interested in'.*
  - *Helping commissioners and providers to understand the different opportunities, tools and techniques for involving patients and the public in local service improvement initiatives.*
  - *Facilitating sharing of patient/service user involvement practice across the network.*
  - *Training for expert patients interested in taking part in network activities.*

Taking an Evidence Based Approach

The Issues

- ***Net-Run*** participants stressed how important it was to have a strong evidence base to inform their work. SCNs will need evidence in order to:

  a. identify the significant needs and variations in outcomes in the populations they serve in order to determine strategic priorities;

  b. assess the value of the current pattern of health and care investment and outcomes produced from it;

  c. identify the scope for improving current services and;

  d. assess the relative costs and benefits of alternative service delivery options.

- While some felt that the SNSTs should be able to offer informatics and analytical skills, the prevailing view was that given the many demands on their time, SNSTs should be *drawing on the evidence marshalled by others* e.g. the Joint Strategic Needs Assessment and mobilising the analytical capacity in the system to support the SCN. The potential contribution of CCGs' Commissioning Support Services was highlighted.

- For some disease conditions there is *not yet an agreed set of outcome or quality indicators.* In some cases it was suggested that there is relevant data that is routinely collected that may be of value to SCNs but it needs interpretation to turn it into useable information. This is work that is best undertaken nationally.

- There were some concerns that where SCNs are putting together advice for commissioners based on available evidence, that commissioners may receive contradictory advice from other sources. This *situation can be avoided* if commissioners are clear about their expectations of the various bodies from which they will draw their commissioning support.

Future Considerations & Actions

- The *NHS CB Central and LATs can support SCNs* by developing and defining suitable outcome and quality indicators and data sets, facilitating information sharing agreements between health care commissioners, providers and other organisations and illustrating how analytical capacity in the system can be used to best effect for SCN business.

- CCGs and other commissioners should look at opportunities to use their own 'in-house' and external commissioning support arrangements to *support the work* of the SCNs/ LATs should also look at how the whole capacity of the LAT can be used to support and supplement SNSTs and SCNs.

- *SCNs should consider working with the Pharmaceutical Industr*y: many pharma companies have and will be able to provide good and informatics, analytical skills, national and local data in presentable and understandable formats and have a long history of supporting the previous cancer and cardiac networks.

- One of the key roles for SCNs is providing advice to commissioners. SCN members have a responsibility *to be explicit about their requirements* e.g. the format in which the advice should be presented so that the advice is as useful as possible.

Concluding Messages

Net-Run took place at a very early stage in the development of the new SCN arrangements. It has highlighted some of the areas of uncertainty which now need to be addressed nationally by the NHS CB, the NHS Improvement Body and locally by LATs and the new SNSTs. Three overriding concerns have been highlighted. The first is about how the SCNs fit in with the new commissioning structures and the new arrangements for innovation and system integration. The second concern is about how best to deploy the available resources in the SNST, especially balancing the contribution of clinicians and other members of the SCN with those of patients and the wider public. The third concern is the degree to which SCNs will have freedom to set their own priorities, drawing on local evidence of needs and variations in quality and outcomes or have their agenda pre-determined by the NHS CB mandate.

In the last session of ***Net-Run*** we asked mixed groups to talk about what they thought were the key messages for the key stakeholders that will influence the contribution that Strategic Clinical Networks will make to quality, productivity and patient satisfaction.

The NHS CB: Having published the *Way Forward* guidance the NHS CB needs to follow its descriptions about the *form* of SCNs with some clearer messages about their *function* and provide *reassurances* about how patient voices will be placed at the centre of SCNs' work. The NHS CB must support LATs and SNSTs and *actively promote* the benefits of the new arrangements to CCGs and to HWBs. The accountability agreements with SNSTs must recognise that the success of SCNs is dependent on them being seen to be highly valued by and relevant to the needs of their members.

Network Support Teams: Once the members of SNSTs are appointed they must immediately begin mobilising support from the constituent organisations from which the SCN membership will be drawn, communicating clearly the potential benefits of SCNs but also the expectations of its members and the organisations they represent. SNSTs are also in a strong position to identify common themes that will be of interest and benefit to more than one clinical network – if they are to prove their worth as hubs they must promote that wider transfer of learning. The experience of integrated teams that are already supporting several clinical networks has demonstrated how effective this can be in fast tracking development work and making best use of the skills and experience of the SNST.

CCGs and the providers of NHS Services: These organisations need to think about SCNs as one of the best ways to secure specific improvements in patient outcomes. For CCGs in particular, SCNs are a way of accessing peer support and expert clinical advice on those aspects of care that either might be too specialist to be undertaken within the CCG and/or where there are significant benefits to be gained from working at scale across a larger geographical area. Both CCGs and NHS service providers must resist the temptation to equate the success or potential benefits from SCNs with the amount of time that they get from their SNST. Those teams are there to support and facilitate: what will prove to be of greatest importance in delivering benefits to members is how much the members themselves are prepared to put in to their SCNs.

'The NHS CB should, under the wider UK Strategy for Health Innovation and Life Sciences and in the spirit of the 'Innovation Health & Wealth Review' conducted by Sir Ian Carruthers, hold a scoping meeting, with the six industry partners who supported this simulation and discuss how the Pharma Industry can effectively work in partnership with the SCNs and SNSTs. For example:

- *Supporting legacy programmes*
- *Relationship Management*
- *Cross cutting topics as well as disease specific initiatives*
- *Patient Participation*
- *Analytical Support*
- *Health economic analysis to support advice to commissioners*

Appendix 1: *Net-Run* Participants

Name	Position	Organisation
Linda Agnew	Director of Corporate Development	Bridgwater Community H/C NHS Trust
Tracy Allen	Chief Executive	Derbyshire County PCT
Mark Angus	Assistance Chief Executive – Specialist Surgery & Surgery, Executive Lead for Cancer Services	Mid Essex Hospitals
Robin Armstrong	Clinical Cancer Lead	County Durham CCG
Manik Arora	GP Exec Lead for Long Term Conditions	Nottingham City CCG
Clive Bowman	Medical Director	BUPA Care Services Division
John Brewin	Medical Director	Lincolnshire Partnership NHS Foundation Trust
Andy Buck	Chief Executive	NHS South Yorkshire and Bassetlaw
John Burn	Professor of Clinical Genetics	Institute of Genetic Medicine, Newcastle University
Phil Crossley	Interim Director of Services	NHS South Yorkshire and Bassetlaw
Richard Cullen	North Trent Cancer Network Primary Care Lead	Commissioning Executive Rotherham CCG
Julia Das	Policy Manager (Commissioning)	NHS Confederation
John De Pury	NHS Confederation Research Networks	NHS Confederation
Caroline Dollery	GP Lead for IAPT	Mid Essex CCG
Sue Dutch	Programme Manager for Quality & Safety Assurance	NHS London Medical Directorate
Rob George	Palliative Care Lead	St Thomas's Hospital London
Ian Golton	Director, Stroke Improvement Programme	NHS Improvement
Sylke Grootoonk	Head of Services	InHealth
Tony Halsall	Associate Director & Former FT CEO	NHS Confederation
Donna Hawkes	Director of Quality & Clinical Effectiveness	Midlands & East Specialised Commissioning Group
Rezina Hakim	Policy & Campaigns Officer, Mental Health Services	MIND
Brenda Hennessy	Director of Patient Experience & Public Engagement	Cambridge University Hospitals Foundation Trust
Mike Hobday	Director of Policy & Research	Macmillan Cancer Support
Sally Hughes	Head of Service Development & Change	MS Society
Elizabeth Hunt	Associate Director of Operations for Cancer	Cambridge University Hospitals Foundation Trust
Julia Jessop	Service Development Lead	North Trent Cancer Network

Name	Position	Organisation
Annabel Johnston	Interim Commissioning Services Director	North Yorkshire & The Humber Commissioning Support Unit
Mary Keenan	Medical Director	Oxfordshire Clinical Commissioning Group
Ian Lacy	GP Executive Member	Lincolnshire West CCG
Rebecca Larder	Director	East Midlands Cardiovascular Network
David Levy	Medical Director	United Lincolnshire Hospitals NHS Trust
David Makin	Patient Representative	Macmillan Cancer Support
Denise McLellan	Chief Executive	Birmingham & Solihull NHS Cluster
Martin McShane	Director for Domain Two – Medical Directorate	NHS Commissioning Board
Karen Metcalf	Network Director	Pan Birmingham Cancer Network
Peter Miller	Associate Medical Director	NHS Midlands & East
Stuart Moore	Director of Planning & Strategy	The Walton Centre NHS Foundation Trust
Julie Oldroyd	Patient Representative	Macmillan Cancer Support
Louise Patten	Chief Executive	United Commissioning, Buckinghamshire
Alison Railton	Public Affairs Manager	Motor Neurone Disease Society
Mike Richards	Director for Domain One – Medical Directorate	NHS Commissioning Board
David Sharp	Chief Executive	Derbyshire PCT Cluster
Kathryn Smith	Operations Director	Alzheimer's Society
Geraldine Strathdee	Associate Medical Director, Mental Health	NHS London
Nicola Strother-Smith	National Director	NHS Diabetes & Kidney Care
David Thomas	Director of Quality & Governance	St Andrews Healthcare
Luke Twelves	Cancer Lead	Cambridgeshire CCG
Jan Vaughan	Director of Clinical Networks	Cheshire & Merseyside Clinical Networks
Hilary Walker	Director	NW & NC London Cardiovascular & Stroke Network
Anna Walker-Holliday	Senior Commissioning Specialist (Network & Long Term Conditions)	North Yorkshire & The Humber Commissioning Support Unit
Arlene Wilkie	Chief Executive	Neurological Alliance
Michael Wilson	Programme Director	NHS London
Julie Wood	National Director Clinical Commissioning & Commissioning Development Director	NHS Alliance& NHS Clinical Commissioners
Peter Wozencroft	Associate Director of Strategy	Nottingham University Hospitals NHS Trusts
Angela Young	Network Director	Cardiac & Stroke Network – Birmingham & Solihull

Appendix 2: *Net-Run* Moderation Group

Name	Position	Organisation
Andy Buck	Chief Executive	NHS South Yorkshire and Bassetlaw
Mike Durkin	Director for Patient Safety – Nursing Directorate	NHS Commissioning Board
Steve Field	Deputy National Medical Director (Health Inequalities)	NHS Commissioning Board
Richard Gleave	Director of Patient Experience – Nursing Directorate	NHS Commissioning Board
Ian Golton	Director, Stroke Improvement Programme	NHS Improvement
Julian Hartley	Chief Executive	NHS Improvement Body
Angela Helleur	Deputy Medical Director	NHS London
Karen Helliwell	Director Commissioning PCT Cluster Director of Commissioning	NHS Commissioning Boards Birmingham, Solihull & The Black Country
Alistair Henderson	Chief Executive	Academy of Medical Royal Colleges
Nikki Hill	Deputy Director Communications	The Stroke Association
Damian Jenkinson	Interim National Clinical Director for Stroke	Department of Health
Gareth Llewellyn	Chair – Service & Standards Committee	Association of British Neurologists
Beverley Matthews	Director	NHS Kidney Care
John McIvor	Chief Executive	NHS Lincolnshire
Andy McMeeking	Associate Director	National Cancer Action Team
Margaret McQuade	North East Network Manager	NHS Kidney Care & Liver Care
Martin McShane	Director for Domain Two – Medical Directorate	NHS Commissioning Board
Federico Moscogiuri	Director	ARMA
Jan Norman	Director of Nursing	NHS Milton Keynes & Northampton
David Paynton	Joint Clinical Lead	RCGP
Jane Povey	Engagement Director, Commissioning Development	Department of Health
Steve Powell	Chief Executive	SignHealth
Jane Ratcliffe	Director of Networks	NHS GM
John Stewart	Quality Framework Director	NHS Commissioning Board
Peter Swinyard	Chairman	Family Doctors Association
Trish Thompson	Director of Operations & Planning	Leics & Lincs LAT/PCT
Elizabeth Wade	Head of Commissioning Policy & Membership	NHS Confederation
Stuart Ward	Medical Director	Wessex
Jo Webber	Deputy Policy Director	NHS Confederation

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strategic clinical networks and their contribution to the new NHS

A REPORT OF A SIMULATION BASED EVENT

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