

# WELSH HEALTH CIRCULAR



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## Clinical Networks

### Summary

Developing Clinical Networks to become “engines of improvement “ in delivery of specialist health services will be an important objective over the next few years as acute service reconfiguration matures across Wales as part of the Wanless reform agenda. This circular establishes a framework allowing a consistent approach without losing the benefit of diversity. Further discussion on future commissioning arrangements will take place during 2005/06 and this guidance may then need to be amended.

### Action

From 01.12.05 all Networks should:

- be founded on a written establishment agreement
- be registered with the Health and Social Care Department's Regional Offices
- be clinically driven
- be engaged by Trusts whenever they find difficulties in managing alone issues that the Network could help resolve
- have considered preparation of a work plan, and where appropriate have a development plan in place

In addition,

- Commissioners will be expected to draw on Networks' expertise when preparing needs assessments and in developing local strategies and commissioning plans
- all Assembly policy leads should by then have come to a view on the role of existing and potential Networks and agree with them both their current and future role.

### Background

1. Amongst its objectives *Improving Health in Wales* the Plan included the establishment of Clinical Networks, initially, for cancer and CHD. *The Review of Health and Social Care in Wales* advised by Sir Derek Wanless suggested that new mechanisms need to be created to ensure that the Assembly has the leverage to ensure effective and co-ordinated services are delivered by networks of partners.
2. Two major objectives of the Assembly Government are to reconfigure services and to ensure that services meet quality standards. Networks can potentially act as powerful change agents in achieving these, allowing rapid uptake of evidence for what should be done and how, without reference to the artificial constraints of organisational boundaries. A vital driver for change is well-informed commissioning. Networks can help provide and implement evidence, and used well can make a crucial contribution to commissioning decisions and to supporting practice change.

#### A. Types of network

3. A definition of a network might be *Linked groups of health professionals and organisations from primary, secondary and/or tertiary care, working in a co-ordinated manner, unconstrained by existing organisational boundaries, to ensure equitable provision of high quality clinically effective services*. They might also in certain cases include local authority representation.
4. In practice, networks will differ, depending on their purpose, and they will change their form as they gather confidence and gain or lose responsibilities. Some are very tightly

managed to ensure a consistent service through all providers – as for example with Cervical Screening Wales, which includes every Trust in Wales.

5. Commissioners will often need to work together to secure consistent access to high quality services and to drive service change. This is especially so if an individual commissioner is hard pressed to devote sufficient resources to elements of a large agenda or if several commissioners receive major elements of a complex service from one provider. Providers will often need to work together to ensure that service changes are well managed, that service components mesh together safely and effectively, and that they back each other up when pressure rise. In some cases, for instance where services contain several levels of service and face the need for rapid and significant change, networks might need to include both commissioners and providers.
6. Local Health Boards (LHBs) are the principal commissioners of secondary care services and are accountable for assessing the needs of their local population and securing suitable services to address them, in partnership with other agencies. Local commissioning derives its strength and its legitimacy from its local roots in the Local Health Board and Local Authority, and from those bodies acting in concert. Therefore any **commissioning network** must offer each LHB the potential over the longer term of securing better services and outcomes for its local population than it could achieve working alone.
7. Where appropriate, commissioner networks will include HCW - Health Commission Wales (Specialist Services) and local authorities. Networks will be expected to help resolve commissioning issues at the interface between secondary and tertiary care.
8. Commissioning networks will differ according to the service to be commissioned, and can change over time. Table 1 shows some of the potential variables; the status of any Network at any point in time might combine elements from different columns:

<b>Table 1</b>	Early stage	Developing stage	Advanced stage
<b>Funding</b>	The Network operates by negotiating with the partners	The Network controls elements of the commissioning budget e.g. an agreed quota from each partner or new investment funds	The Network has full control over the budget
<b>Leadership</b>	There is a rotating lead	One LHB takes the lead	A single senior management lead is in place
<b>Staffing</b>	Existing LHB staff are used	The lead LHB provides the staff	There are separately funded staff
<b>Strategic grip</b>	Changes are tactical, responding ad hoc to issues	Audit against standards provides hard evidence for change	Changes deliver an agreed long-term plan
<b>Authority</b>	Advisory, with issues raised with relevant commissioners	Commissioning strongly influenced by Network advice	The Network can radically change services
<b>Scope</b>	Only elements of a service are affected		The Network applies to a whole service
<b>Management control</b>	All changes require unanimity	Changes are according to a voting system	Networks take collective responsibility both for managing the network and for implementing decisions taken
<b>Quality control</b>	Identifying some standards		Accreditation of providers

9. **Provider networks** operate beyond the boundaries of individual Trusts (often at an all-Wales level). Provider networks draw their authority from the combined expertise that

they wield and their ability to improve services on the ground. The management element of the network may lie with the providers themselves, or be provided by the commissioner, as is the case with the Paediatric Intensive Care Network. Because provider networks will acquire a greater understanding of the needs and circumstances of the service they provide, Commissioners will be expected to draw on their expertise when preparing needs assessments and developing local strategies and commissioning plans. At present provider Networks include those for Genetic Services, Breast and Cervical Cytology Services, Paediatric Intensive Care and Renal Services in South Wales.

10. Provider networks will differ according to the service, and can change over time. Table 2 shows some of the potential variables; the status of any Network at any point in time might combine elements from different columns:

<b>Table 2</b>	Early stage	Developing stage	Advanced stage
<b>Funding</b>	The Network operates by negotiating with the partners	The Network manages elements of the budget e.g. an agreed quota from each partner	The Network has full control over the budget
<b>Leadership</b>	There is a rotating lead	One provider takes the lead	A single senior management lead is in place
<b>Staffing</b>	Existing staff are used	The lead provides the staff	There are separately funded staff
<b>Operational mode</b>	There is ad hoc management of issues		There are agreed protocols for managing issues
<b>Strategic grip</b>	Changes are tactical		Changes deliver an agreed long-term plan
<b>Scope</b>	Only elements of a service are affected		The Network applies to a whole service
<b>Management control</b>	All changes require unanimity		Changes are according to a voting system

11. **Combined commissioning and provider networks** can bring together both the power of commissioning and the opportunities providers have to remould service from the base. They need to pay heed to the issues raised in paragraphs 3-10 above; their evolution will combine elements from tables 1 and 2. There are combined commissioner and provider networks for Cancer and Cardiac Services.

## **B. Network Essentials**

12. Networks need a clear objective, should wherever possible help tackle priority issues and must have clear accountability arrangements. Therefore, their purpose and operating rules, and the responsibilities of those composing the Network, of whatever type it is, must be written down and agreed, to ensure that it is properly managed.
13. Networks might be created in response to a decision by the Assembly, or might emerge from decisions at local level. All Networks create mutual responsibilities. The partners agree to work together and cede some level of independent working, to ensure the population they serve receives the greatest benefit from available resources. In addition, Networks operate across and outside the normal managerial relationships, which are there to ensure coherence and accountability. To avoid confusion, free-riding and loss of control, there must be clarity and certainty in the way that Networks operate, especially in the following areas:

### a. clarity about aims and objectives

14. Networks should aim to co-ordinate the use of available resources to ensure equitable access to and the delivery of good quality and effective care; their function is to support

the clinical process to achieve the best outcomes for patients. In doing so they should consider:

- a. *The service to the user* - looking at care from the patient's view; analysing the care pathway, and intervening as early and as effectively as possible; reducing health inequalities and maximising equity of access; applying relevant standards of care; defining the contribution to be made by each of the Network's members – clearly the most direct way of securing the views of patients and carers is to ask them and from an early stage their contribution to the development the Network should be considered, and this should be reviewed as appropriate
- b. *Resource use* - using all resources effectively, and searching out options for improvement in their use; setting priorities for change and development; using opportunities to influence decisions and processes for resource allocation minimising bureaucracy, simplifying decision-making and ensuring timely action.
- c. *The results* - maximising the impact of every intervention opportunity; measuring clinical outcomes and the extent to which health care and support needs of patients and their families/cares are met; auditing across the network compliance with standards and care pathways
- d. *Network development* - fostering a culture of collaboration, partnership, teamwork and learning.

b. clarity about accountability and performance management

15. Network governance arrangements must be clear. There may need to be a Network Board, with sufficiently senior representation (clinical or other) from each LHB and/or Trust to support decisions and follow-through. The role, responsibility, time commitment, accountability and subsequent communication requirements for each network participant must be determined at the outset and described in the establishment agreement. Any support staff for each network should be formally employed by a host LHB or Trust, which will be financially accountable for the resources levied from each stakeholder organisation to fund the support costs. There may be grounds for a national board to provide an overview, as for example where there are separate Networks in each Region, as with cancer, or where a number of Networks have a shared interest, as with Children and Young People's Specialised Services.
16. Each Network should institute its own formal performance management process, and the Regional Office should oversee this.

c. clarity about clinical accountability and clinical governance

17. Chief Executives of LHBs and NHS Trusts cannot pass their legal responsibility for clinical governance to the Clinical Network. However, Networks will need to develop a framework for dealing with clinical governance issues, including clear protocols for reporting clinical governance issues to the relevant Chief Executive (or nominated clinical governance lead). Individual health care professionals have the responsibility of conforming to the guidance of their individual registration authorities in the way that they conduct network business.
18. Networks will likely develop over time. Some have now reached the point where they can accredit providers and effectively mould services. Where Networks wish to secure additional responsibilities, they should in the first instance raise the matter with the relevant Assembly policy lead.

**C. Formal Requirements**

19. If designed and run well, Networks can strengthen the roles of commissioners and providers, and of both. They also offer an opportunity for stronger clinical leadership of service change. While differences are natural and welcome, all Networks must contribute strongly to service objectives. Therefore the Assembly expects Networks to be much

more assertive in improving standards and driving service change, and in particular will require that from 01.12.05:

- a. All Networks will have a formal establishment agreement clarifying their purpose, objectives, membership (with their accountability), support requirements and performance management arrangements. The Annex to this paper contains a checklist of issues to be covered by such an agreement.
- b. All Networks will be registered with the Health and Social Care Department's Regional Offices, which will monitor the operation and development of Networks to ensure that they function effectively and are adequately involved in the planning and commissioning processes within their regions. Network Chairs should be appointed after agreement with the relevant Regional Director.
- c. Networks will be clinically driven.
- d. Commissioners will be expected to draw on Networks' expertise when preparing needs assessments and in developing local strategies and commissioning plans.
- e. Trusts will involve relevant Networks whenever they find difficulties in managing issues alone.
- f. All Networks will have formally considered preparation of a work plan with clear criteria by which to measure progress and achievements against objectives. Where appropriate they should have or be preparing a development plan covering a number of years as agreed centrally. This plan must reflect existing resources, including workforce, and changes needed within the network in order to achieve the requirements set at a national and local level in terms of service standards, care quality and other appropriate criteria.
- g. Drawing on this paper, all Assembly policy leads, working as appropriate with Health Professionals from the Office of the Chief Medical Officer, nominated Service Directors, and Regional Directors, should consider the role of existing and potential Networks in relation to planning, commissioning and performance improvement and agree with them both their current status and their possible future development role.

## The Network Establishment Agreement

As set out in paragraph 19a, each Network should have a formal agreement governing its working. This should cover most or all of the following:

- ✓ Service area covered
- ✓ Participating organisations
- ✓ Purpose of the network
- ✓ Principles on which the network is based
- ✓ Date by which a work plan is expected
- ✓ Clarity about the role of constituent bodies
- ✓ Name of the Chair and time commitment expected
- ✓ Those who need to be on the Network Board in order to achieve these, clearly specifying their role, responsibility, time commitment, constituency and authority to commit their organisation
- ✓ The role of the Network in the context of overall service commissioning e.g. what part of service commissioning the Network will aim to influence and how this might link to primary care contracting
- ✓ Role and responsibilities of the various network members - how are they expected to discharge their role, e.g. to whom do they need to communicate what
- ✓ How other bodies who have an interest in the network will be involved/communicated with
- ✓ How the participation of service users and carers is to be achieved
- ✓ How the network is to be managed e.g., frequency of meetings, quoracy
- ✓ What support does the network require (costed)
- ✓ The "host" of the network (if required)
- ✓ Clearly expressed expectations/requirements such as:
  - shared and understood "terms of engagement"
  - a communication strategy
  - a work plan to monitor its own internal performance and that of its members
  - protocols for service delivery
  - standards – are they mandatory or advisory
- ✓ In-year objectives
- ✓ Relationship with other bodies – for example the National Public Health Service, which can be a source of evidence and advice on both service issues and network management.