Applications for designation as a national managed clinical or diagnostic network - guidance for applicants

1. Introduction

The National Specialist Services Committee (NSSC) considers applications from managed clinical and diagnostic networks if they cover the whole of Scotland. Applications for national diagnostic networks also need to have the support of the SGHSCD Diagnostics Steering Group.

Funding for the administrative costs of national networks comes from top-slicing NHS Boards' general allocations (as is the case with mainstream national services).

The process for approval for new national managed clinical networks (NMCNs) and national managed diagnostic networks (NMDNs) from April 2013 onwards is:

1. Consideration of application for NMDN by the SGHSCD Diagnostics Steering Group.

2. Consideration of an application for either NMCN or NMDN by NSSC against the criteria below. Annex A gives a guide to the NSSC approvals process and its timetable.

3. Formal consideration of the funding sought (in the case of applications that meet the NSSC criteria) by NHS Boards and a decision on what funds will be made available (this may be none or only a part of total if shared resourcing with other networks is possible).

4. Consideration and final approval (or rejection) by Scottish Government Health and Social Care Directorates (SGHSCD) of those applications that both fit NSSC criteria and have the agreement of NHS Boards to support the administrative costs of the network.

5. Once agreed for designation, the network will be expected to agree a quality assurance framework; progress against this will be used to assess the effectiveness of the network.

6. Networks are designated in the first instance for five years only. A full review of the achievements of the network in improving patient care will be undertaken within this timeframe to inform a decision by NHS Boards on any continuing central funding. Performance in achieving objectives is assessed annually and networks that are shown to have had little or no impact on patient care after 5 years will be recommended for de-designation. It is possible also for a network to achieve its objectives in less than 5 years and require no further funding.

Submissions which are approved by other bodies for short term funding (eg SGHSCD, NHS HIS, Scottish Cancer Group, Diagnostics Steering Group) will still need to be approved through the process outlined in this paper to attract long term NHS Board funding.
2. **Principles of managed clinical networks**


The prime focus of networks is to:
- Produce benefits for patients through improvements in services
- Establish the evidence base for interventions/elements of care
- Develop appropriate evidence-based standards and agree these with NHS HIS
- Use their experiences to develop protocols and to share good practice
- Perform clinical audit to support improving patient care
- Apply protocols and support local clinicians across wide geographical areas to offer care locally to patients within national protocols
- Subsequently re-audit to assess the impact on patient care
- Assist clinicians in gathering information about their performance
- Produce an annual report.

Networks are virtual entities designed to drive upwards the standards of patient care through integration of services and collaboration. It is this concept that is the essence of a managed clinical network, hence the funding allocated nationally to National Managed Clinical and Diagnostic Networks (NMCNs and NMDNs) reflects the funding needed to assist clinicians and other partners in setting up and running the network:

- Appropriate administrative support to organise meetings, newsletters and the annual report
- Support for audit through the national Clinical Audit System
- Backfill for lead clinicians
- Travel expenses.

Funding levels will also reflect the need to ensure flexibility in administrative support so that staff can move from one network to another, or contribute to the support of more than one network at national or regional level.

Networks themselves do not employ staff or contribute to the costs of clinical services, although it is necessary for a lead clinician to be appointed part time, usually for a temporary period of around two years on rotation, to chair meetings of an executive group, whose main purpose is to steer the Network, to develop clinical protocols and review results of audit. In line with HDL(2007)21, the costs of providing backfill for lead clinicians is included within national funding.

**Please note that lead clinician backfill is available only for network administration and not for any care delivered within the network** (e.g. attendance at MDTs as part of the network’s approach to managing patient care).

Networks also have a role in teaching and research in that they are an excellent opportunity for clinicians to share experience and pass on good practice.
3. **Aspects of service to be considered by NSSC**

The aim of NSSC is to ensure that the highest possible standard of care that can be delivered within available resources is available to all residents of Scotland requiring treatment or investigation of a specialised nature, or for an uncommon condition. This is true of both designated services, NMDNs and NMCNs.

Applicants are expected to address all the aspects of service highlighted and are encouraged to include any appropriate additional information. Where applicable, supporting evidence from published literature should be provided. All criteria are considered as interdependent factors and not in isolation.

NMCN and NMDN applications should include a supporting statement from an NHS Board Chief Executive. The supporting Board is responsible for ensuring that all information required is included. National Services Division (NSD) can advise on potential resources within existing network offices to support additional networks.

*Any gaps in providing the information detailed below will prevent bids from being considered until all required elements are complete.*

3.1 **Network description**

Each NMCN and NMDN must have a defined structure which sets out the points at which the service is to be delivered and the connections between them. Networks applying for national designation must be multi-disciplinary and/or multi-professional and require collaboration across Scotland to generate a critical mass of expertise and ensure equitable access and treatment.

**Patients, or voluntary organisations representing the interests of patients, must be involved in the running of the network.** Participation from other partners (e.g. local government, especially health, social work and education representatives) is strongly encouraged.

It is expected of a national network that only a small number of centres (or a similarly limited number of clinicians in a single centre) will deliver the more complex aspects of the service and that the key aspects of service are specialist in nature.

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<tr>
<th>Areas for consideration</th>
<th>Information to be provided by applicants</th>
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<tbody>
<tr>
<td>Incidence/prevalence</td>
<td>Full details of the current Scottish incidence/prevalence. (Where the network covers newly-established clinical services, any projections should be supported by the experience of current UK/international centres.)</td>
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<tr>
<td>Estimate of likely need for services within the network</td>
<td>Numbers expected to be treated by participants within the network in the first year and the current and likely future referral patterns.</td>
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<tr>
<td>Nature and pattern of service</td>
<td>Detail of the elements of service provided at primary and secondary levels which will be linked to the specialist services provided by the network, and a full list of all proposed organisations/clinical groups which will take part.</td>
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<tr>
<td>Impact on equality and diversity</td>
<td>To what extent will the service address current health or other inequalities? Applicants must, as a minimum, be able to demonstrate that services will provide equity of both care and access to all residents of Scotland.</td>
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3.2 Clinical effectiveness of service

Applicants must be able to demonstrate an existing evidence base for the service to be covered by the proposed network and provide a clear statement of the clinical benefits to be gained from the network.

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<td>Clinical benefit of existing treatment</td>
<td>In addition to a summary of the current literature, this should include recommendations and/or guidance issued by the Scottish Intercollegiate Guidelines Network (SIGN), NHS HIS, the National Institute of Clinical Effectiveness (NICE), the Cochrane Library and other appropriate professional bodies.</td>
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<tr>
<td>Improvements in clinical effectiveness sought by network</td>
<td>Applicants should provide demonstrable, specific, clinical and service improvement targets which will be delivered through the network.</td>
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<td>Applicants should also detail any added health effect to be gained from collaboration across levels of care.</td>
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3.3 Current and potential links with teaching and research

Although teaching and research are outwith the funded value of national services, all nationally designated networks are expected to take a leading role in these areas. This is not only to promote continued clinical development within the service, but so that new and existing techniques can be passed on to ensure future numbers of appropriately skilled staff.

NMCNs must be committed to expansion of the evidence base through appropriate research and development and to maximising the potential of the expertise in the network for education and training.

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<td>Evidence of teaching/research base</td>
<td>Links with NES, universities, clinical/technical training programmes and industry, where appropriate.</td>
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3.4 Network arrangements

NMCNs and NMDNs must have clarity about organisational arrangements and a lead clinician (who may come from any healthcare profession). Designated networks will be supported by a network manager from within an existing Network Office, who will be assigned overall responsibility for the operation of the network and the production of an annual report (this post does not have to be identified prior to the application and will be assigned by NSD and the host Board of the Network Office if designation is approved). Representation from patients’ organisations must be included in organisational arrangements.

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<td>Management structure</td>
<td>The proposed organisational structure, including detail on ensuring active patient/user participation in the network organisational arrangements, and the proposed balance of the Executive Committee.</td>
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<tr>
<td>Quality Improvement and Audit arrangements</td>
<td>All networks must demonstrate active participation in continuous quality improvement and clinical audit programmes. Detail should be provided of existing Quality Performance Indicators and audit arrangements, and any additional proposed national, UK or international audit to be conducted under the auspices of the network</td>
</tr>
<tr>
<td>Communication strategy</td>
<td>There must be clear protocols for involving NHS Board management in decisions on the future development of the NMCN /NMDN if there are cost implications in the context of the many competing priorities for funds. Thought should also be given to communication of audit results and important clinical findings to the wider clinical community in Scotland and the UK.</td>
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<tr>
<td>Development of network participants</td>
<td>Detail of arrangements to maintain continuous professional development for participants (eg through opportunities for secondments, staff rotation within individual centres, education initiatives)</td>
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3.5 Costs and cost effectiveness

As a minimum, networks should identify the anticipated resource requirements in years one and two of the network. Applications should also demonstrate that the proposed network would represent a cost-effective use of resources and should highlight any potential service costs which could be saved through the application of uniform clinical standards.

Applicants are reminded that funding for national networks does not cover:

- any current service costs of network participants – except recompense of any costs incurred by the employing NHS Board of the lead clinician in backfilling their post
- any future capital or revenue required by network participants in order to meet the clinical standards agreed by the network
- backfilling and/or locum costs to facilitate network participation by members.
### Areas for consideration | Information to be provided by applicants
--- | ---
**Network support requirements** | The anticipated resource requirements of supporting the network and the lead clinician. This should include clinical backfill, admin and clerical staff (broken down by WTE and grade, if appropriate), travel costs and sundries (meetings, etc). This information is required to assist in planning how adequate administrative and management support will be allocated through the existing network office structure. No national funding is available for national networks to set up network management separate from the existing national network support office structure.

**Audit support** | Cost of producing audit data to required standard and enabling participants in network to collaborate in an open review of results. (In a NMCN / NMDN, audit programmes may fit NHS HIS criteria or ISD national audit arrangements and be eligible for support from these sources.)

**Communication support** | This may not be applicable in all networks, but comprises additional costs such as support for innovative use of telemedicine and other novel communication techniques.

**Evidence about the costs and benefits** | The benefits might include savings in lives and improvements in the quality of life, such as a decrease in the need for later interventions. Account should also be taken of any savings in costs to the NHS - for example, any savings in treatment costs.

The applicant should detail in this section any additional costs which may need to be borne in other areas of the NHS (e.g. additional prescribing in primary care, etc) as a result of implementing uniform clinical standards. Although these costs are excluded from national funding, they are necessary to inform NHS Boards of the full costs of the network, beyond the element which will be topsliced.

### 3.6 Alternative network arrangements

Local and regional networks are the norm for services which fit the core principles of MCNs or MDNs. There must be clear evidence that any form of local or regional network is inappropriate and there are significant additional benefits from national organisation of the network.

| Areas for consideration | Information to be provided by applicants |
--- | --- |
**Alternative arrangements** | Full reasons as to why alternative local/regional arrangements would not be appropriate for the proposed network. |
3.7 Support

NMCNs and NMDNs by their very nature require to work across NHS Board boundaries. It is crucial that the network has the full support of all staff groups involved in providing the service(s) covered by the network and of clinicians and management from across Scotland.

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<tr>
<td>Evidence of support</td>
<td>Signed statements of support from an NHS Board Chief Executive and appropriate referring clinicians and/or professional bodies (ie Royal Colleges, etc).</td>
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</table>
Contacts for National Specialist Services Committee (NSSC) and National Patient, Public and Professional Reference Group (NPPPRG)

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