Networked care

A toolkit for sustainable single specialty services

www.networkedcaretoolkit.org.uk

Our thanks to NHS colleagues who contributed to the learning in this toolkit

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Introduction

Johanna Moss, executive lead, Moorfields' vanguard programme

The pressures facing acute hospitals, particularly smaller district general hospitals, are often complex. It is increasingly difficult for these organisations to afford to deliver safe and effective care across all clinical specialties and sub-specialties.

Understandably, smaller clinical specialties are rarely a high strategic or operational priority and often lack the benefits of scale in a local setting. In the absence of a critical mass of patient numbers or specialty workforce, provision of care may become clinically or financially unsustainable. These difficulties are often compounded by competition generated by local commissioning arrangements and other providers.

Moorfields' innovative approach to delivering care across multiple sites has been referenced in various national policies relating to new models of care. NHS England's report 'The Five Year Forward View' highlighted the benefits of our model in helping to sustain local hospital services and enable smaller hospitals to remain viable. The Dalton Review categorised our approach as a contractual arrangement which it described as a service-level chain. Previously referred to as "the Moorfields@ model", our approach has also been cited as an example of franchising or networked care.

We know that many other NHS and commercial organisations have experience of delivering care across multiple sites, both in ophthalmology and other specialties, and have gained a wealth of collective experience. We have asked colleagues dealing with these challenges day after day what it's like for them, what works and what doesn't, in the hope that their experience will help others trying to find the answers to some difficult questions.

In this toolkit you will find our collective learning in a single resource that describes what good looks like for networked care. We hope that it will help organisations as they consider the strategic case for adopting a networked model as well as implementing and sustaining it. We would like to thank all those who so generously and openly shared their learning with us and the national new care models team for its support. Without our partners we could not have created this resource.

PDF **The Moorfields team and collaborators.**

Welcome

Karen Reeves, director, Moorfields' vanguard programme

When we embarked on our toolkit journey we did not really have a firm idea of what it would look like at the end. We became known as the 'different vanguard' because we were developing a toolkit for the wider NHS to use based on our existing networked care model experience. Our toolkit is, in itself, an evaluation of networked care.

Once we started to research and collaborate, it became clear it would be a very iterative process as we were led in different directions by what we learned and needed to build on. This complex path provided a rich knowledge base and the codifying of this learning is the toolkit you are now reading. It is primarily aimed at those considering a networked care solution but it could also be used by anyone reviewing or developing a clinical service.

At the outset I was keen to ensure that our small team could operate within a culture of openness and sharing; all ideas were welcomed and valued. Team members have been supported in their development and benefited from being part of a small team. Their enthusiasm for the programme has been invaluable.

"Through being part of the vanguard team, I have received outstanding mentoring which has enabled me to think outside the box, gain further insight and given me the opportunity to take the lead for some of the work I have been involved in."
Clerical officer, band 2

PDF **The Moorfields team and collaborators.**

Vanguards

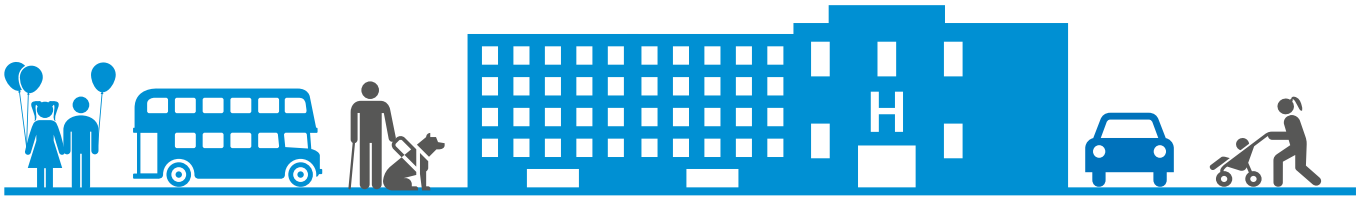
In October 2014 the NHS published the Five Year Forward View (5YFV) setting out a new shared vision for the future of the NHS based around new models of care – what were called 'blueprints' – needed to address the long-term sustainability of the NHS.

In December 2014 the Dalton Review was published, designed to complement the 5YFV by describing the organisational delivery vehicles that could help the NHS translate the theory into practice.

In January 2015, the NHS invited individual organisations and partnerships to apply to become 'vanguards' for the new care models programme, one of the first steps towards delivering the 5YFV and supporting the improvement, standardisation and integration of services.

The 50 vanguard programmes chosen cover the following:

- **Integrated primary and acute care systems:** joining up GP, hospital, community and mental health services.
- **Multispecialty community providers:** moving specialist care out of hospitals into the community.
- **Urgent and emergency care networks:** new approaches to improve the co-ordination of services and reduce pressure on A&E departments.
- **Enhanced health in care homes:** offering older people better, joined up health, care and rehabilitation services.
- **Acute care collaborations:** linking hospitals together to improve their clinical and financial viability.



PDF **About new care models vanguards**

How to use the toolkit

The toolkit contains:

Best practice for a sustainable (clinically and financially), successful, specialist networked care model across multiple locations with the largest positive impact on patients, staff and partner organisations.

Evidenced-based learning to help you decide whether a networked model of care will make your organisation more sustainable.

Practical advice, guidance and frameworks to enable you to establish your own network in the way best suited to your local circumstances.

Select category

This toolkit contains four categories, each of which has three subcategories.
This PDF toolkit is interactive, allowing you to click on* categories, subcategories and resources.

- Prelude
- Purpose
- People
- Practicalities
- Proliferate

Click here to view the 'how to' video

Please click on the 'Networked care' logo (top left on every page) to return to the contents list.

***You will need to be connected to the internet to view the films and access and download the resources. You can use our online toolkit by registering and logging in to networkedcaretoolkit.org.uk**

Resource icons

WEBSITE | FILM | DOCUMENTS | EXCEL FILE | PDF

Choose a category

- Prelude
- Purpose
- People
- Practicalities
- Proliferate

How to use the toolkit

Prelude

This section uses a range of resources to look at the current state of development of the single specialty networked care model in the UK and overseas, examines Moorfields' experience in detail and features case studies on other models.

Moorfields' network history

Moorfields' network today

Why single specialty networked care?

1 What is networked care?

2 Why have organisations chosen this model?

3 Which organisations have adopted networked care?

Moorfields' network history

There were three ophthalmic hospitals in London dating back to the 1800s. They eventually merged on the current City Road site which in 1988 became known as Moorfields Eye Hospital.

We opened our first NHS networked site in 1994 at St Andrew's Hospital, Bow ('Bow Hospital').

We opened our latest NHS service at the Nelson Health Centre, Merton in 2015.

To read more about the network growth please open our Moorfields interactive timeline.

PDF **Moorfields interactive timeline**

Growth of network

The Moorfields network grew as a result of:

- **the 1992 Tomlinson Report which proposed a series of mergers seen as threatening single specialty hospitals.**
- **consultants wanting to sub-specialise in order to offer care for rarer conditions.**
- **a desire to increase the number of general conditions treated to improve sustainability.**

Moorfields made a strategic decision not to specialise only in tertiary ophthalmology, as some other trusts had done, as this was not seen as a sustainable option for maintaining single hospital status. There was therefore a need to grow the general ophthalmology and primary care services to provide enough 'bread and butter' income to help sustain tertiary sub-specialty services.

Moorfields' primary care service was for patients with low-risk eye conditions which, with correct diagnosis and reassurance, would not require further visits – the so-called 'see-treat-discharge' model. General ophthalmology services covered the general conditions usually needing follow up and/or longer-term care.

The first site, at Bow Hospital, kick-started the growth of the primary care, and later more general ophthalmology, creating market share not only to enable consultants to sub-specialise at City Road but also to secure future sustainability.

It met commissioner and patient expectations to improve a poor service, bring good ophthalmic care close to patients' homes and provide a financially sustainable service.

Drivers of network

As the network has grown, certain drivers have underpinned much of Moorfields' rationale for network expansion

We wanted to:

- help other hospitals improve their ophthalmology service outcomes.
- bring care closer to patients' homes.
- meet more demand for eye services from an ageing population.
- respond to invitations by other providers to take over their services.
- meet consultants' aspirations to sub-specialise and treat rarer conditions.
- support the funding of tertiary services by treating more patients with common conditions such as cataracts.
- increase patient volumes to create research base.
- increase potential for private practice income to re-invest in NHS services.

PDF **Moorfields interactive timeline**

Moorfields' network today

We deliver services from more than 30 sites in the UK and three sites in the United Arab Emirates

Our sites

Our City Road site includes a comprehensive range of adult services, a children's centre and private facilities. There are more than 30 other sites designated according to the services they provide.

- We have sites located in 17 CCG localities but we also have patients choosing Moorfields and attending City Road and our other networked sites from around 80 other CCG localities.
- In 2015/16 we treated 542,479 outpatients and 38,620 inpatients (mainly day case surgery) across our networked sites.
- This accounted for 7.4% and 5.3% respectively of all NHS England hospital-reported ophthalmology activity.
- All our main competitors are large NHS trusts. The next largest ophthalmology provider treated 203,445 outpatients and 27,347 inpatients in 2015/16. This accounted for 2.8% and 3.7% respectively of all NHS England hospital reported ophthalmology activity.

Our sites continued

- This activity includes Bedford where the activity is directly commissioned and reported by Bedford Hospital but the care and treatment is provided by Moorfields.
- We do not record activity seen at sites where we provide clinical staff to other trusts or providers.
- These statistics are taken from hospital episode statistics (NHS Digital) and do not include any ophthalmology services provided by other smaller community-based service providers.

Models within our network

Moorfields' network comprises:

City Road: providing comprehensive general and specialist outpatient, diagnostic and surgical services for the local population and for those from further afield who require more specialist treatments. There is a 24-hour A&E for urgent eye problems. Services are delivered from the main hospital, children's centre and private facilities. Our research partners are at the co-located UCL Institute of Ophthalmology.

Moorfields eye centres (five district hubs): co-located with general hospital services, providing comprehensive outpatient and diagnostic care as well as more complex eye surgery; will increasingly serve as local centres for eye research and multidisciplinary ophthalmic education.

Moorfields eye unit (six local surgical centres): providing more complex outpatient and diagnostic services alongside day-case surgery.

Moorfields community eye clinic (15 community-based outpatient clinics): these clinics focus predominantly on outpatient and diagnostic services in community-based locations.

Moorfields partnerships (five partnerships and networks): offering medical and professional support to, and joint working with, eye services managed by other organisations. We also provide clinical leadership to diabetic retinopathy screening services and to networks across London dealing with retinopathy in premature babies.

Models within our network continued

In all models apart from the partnerships, a key feature of our networked care is the overarching governance. This means we own the activity, employ the staff, buy and/or maintain the equipment and pay the host trust or landlord for the space. The only exception is Bedford where the host trust is directly commissioned to deliver the service. Several of our early networked sites were initially on this sub-contracted basis but soon moved to the full ownership model which has given Moorfields the best provider accountability.

At the eye centre hubs we have both lease/licence arrangements for space occupancy and SLAs which cover any mutual clinical support (such as anaesthetic cover to Moorfields; ward visits to host trust).

The eye units have a lease/licence arrangement with the landlord with no clinical service interdependency. These are community hospitals where only low risk surgery is carried out and any anaesthetist cover is provided by Moorfields.

Moorfields' website
Moorfields Private
Moorfields Dubai
Moorfields Abu Dhabi
Moorfields Al Jalila

PDF

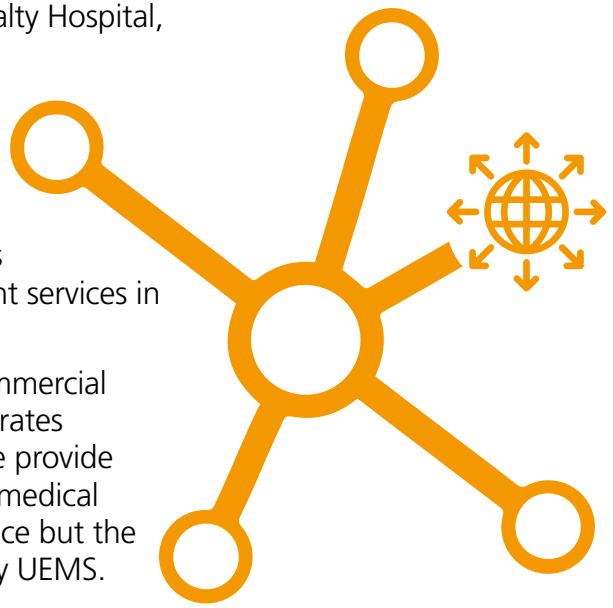
Map: Moorfields' network England
Map: Moorfields' network United Arab Emirates
Moorfields' network: site structure

At the community eye clinics we provide only outpatient services and these range from single-handed orthoptist children's clinics to five or six weekly clinics for a range of eye conditions.

We provide private eye services at the City Road campus, Upper Wimpole Street and at Purley and Bedford hospitals.

We also have three private ophthalmology health services in the Arab Emirates in Dubai (two) and Abu Dhabi. Our latest networked service is at the Al Jalila Children's Specialty Hospital, Dubai.

In Dubai we own and run an outpatient and day surgery centre, renting space in Dubai Healthcare City. The facility at Al Jalila is housed with other outpatient services in a new hospital.



In Abu Dhabi we have a commercial partnership with United Emirates Medical Services (UEMS); we provide and have full control of the medical services, equipment and space but the administration is provided by UEMS.

Why single specialty networked care?

Research for the toolkit has included meeting existing networked providers and host trusts as well as standalone hospitals which might benefit from this model as a sustainability solution.

Choosing a networked care model

We asked our executive colleagues in what circumstances they might consider a networked care partnership

Everyone described the most common scenario as being triggered by a (usually medical) staffing shortage. For example, a DGH may not be able to recruit or retain the consultant medical staff it needed. It would be likely to try to cope for as long as possible until a crisis was reached when help would be sought from a specialty provider. Decisions and solutions might then be needed quickly.

Other drivers were listed including:

- financial losses.
- not meeting service standards.
- critical mass – outcomes and volumes were linked.
- capital investment costs.
- access to tertiary care.

But most people said that staffing was usually the main driver.

View film

Mary Masih, nurse matron at Moorfields Bedford, talks about the experience of being a member of staff before and after the network was established.

Choosing a networked care model continued

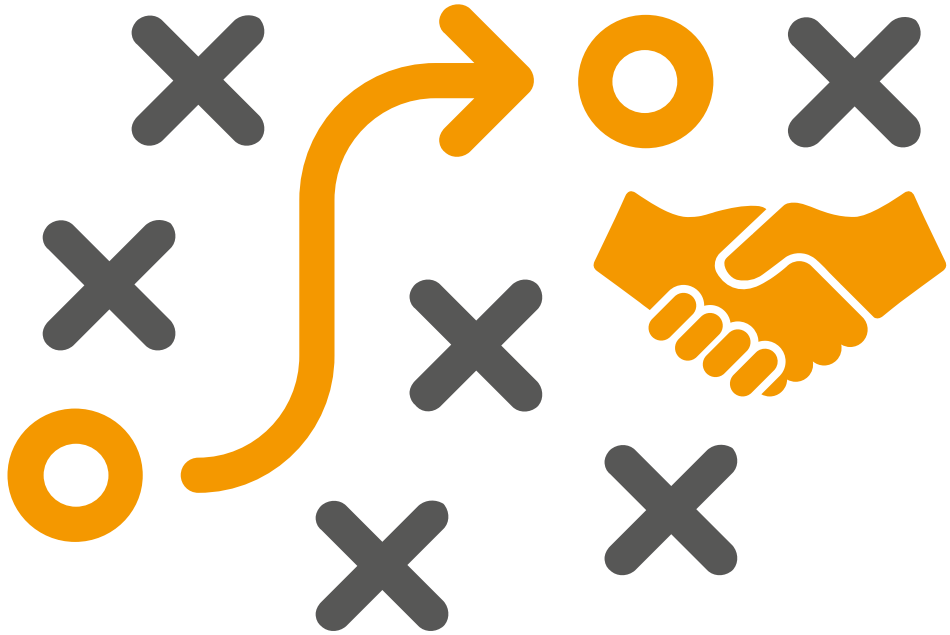
While some single specialty providers like Moorfields and the Walton Centre have developed a networked care model, some other specialty providers have opted not to do so for various reasons, preferring instead to provide advice and support to the hospital to try to improve the service themselves.

Guy's and St Thomas' NHS Foundation Trust is in the process of formalising specialist networked care with Dartford and Gravesham NHS Trust at Darent Valley Hospital (DVH), as part of the development of the two trusts' foundation healthcare group model. DVH is a good example of a local district general hospital where the single specialty networked care model is already part of local service sustainability.

View film

Susan Acott, chief executive officer, and Rachel Otley, head of planning and partnerships, talked to us about their networked care experience.

We are not suggesting that the single specialty networked care model is a fit for all circumstances; organisations need to weigh up the best sustainability solution for them. What we know is that we have a duty to ensure the very best safe and effective care for patients and that support from specialty providers for some more niche services may be the only way to do this sustainably.



Other networked care models

There is not a 'one size fits all' networked care model and Moorfields and other networked providers operate a number of different models. The type of model adopted can be driven by circumstances, everything from a host trust just needing some clinical support to asking another organisation to take over the service entirely.

Best practice should inform the design of any network to ensure it delivers the best patient experience while meeting stakeholders' needs.

The following pages show some examples of different networks we have studied in detail. The first two case studies feature networked care models with primary care practioners; the next four focus on hospital models.

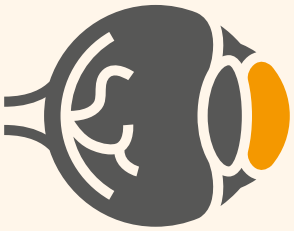
Case study 1

Bedford and Hertfordshire: shared care cataract pathway

There are more than 60 optician practices and 120 optometrists in Bedford and Hertfordshire accredited to see Moorfields patients for pre and post-operative cataract assessment.

Patients attending the accredited optometrist, assessed as suitable for cataract surgery and choosing Moorfields for their surgery at Bedford Hospital or Potters Bar Hospital, can be assessed there and then. They will attend the hospital only for their pre-operative check and day surgery. Following their post-operative recovery period they return to the same optometrist for their post-operative check-up. The refractive outcome from the operation will be measured and the results sent to Moorfields.

Moorfields subcontracts with and pays the optician practice and accredits the optometrists through an initial training protocol and annual review process.



Case study 2

Austin Friars Eye Treatment Centre, Newport

Wet age-related macular degeneration (AMD) – screening, referral, diagnosis and treatment

A pioneering ophthalmic facility, the Austin Fryers Eye Treatment Centre, was launched in September 2016 for Gwent people suffering from wet AMD in a bid to reduce waiting times for assessment, diagnosis and treatment.

With funding from the Welsh Government, the centre has been developed through collaboration between Aneurin Bevan University Health Board and Specsavers, Newport City Centre.

At the centre, the first of its kind in the UK, a high street optician provides initial screening and referrals for people with symptoms of wet AMD. NHS hospital staff deliver treatment for the condition from the same high street location.

Wet AMD damages the macula at the back of the eye. This can permanently distort the ability to see detail and colour and, if left untreated, can cause vision to deteriorate within days. Speedy treatment is crucial.

By bringing primary and secondary healthcare providers together to deliver clinical assessments and treatments in a community setting, more patients will benefit because of reduced waiting times and the central location.

The service, which will create an additional 1,600 appointments a year, involves Specsavers' optometrists providing an initial screening service, the results of which are reviewed virtually by a hospital-based ophthalmologist to speed up the process of diagnosis and referral for treatment.

Patients who would previously have been referred to the Royal Gwent Hospital will instead be seen at the purpose-built centre.

Case study 3

Royal United Hospitals, Bath

The Royal United Hospitals Bath NHS Foundation Trust (RUHB) provides acute treatment and care for 500,000 people in Bath and the surrounding towns and villages of north east Somerset and western Wiltshire.

The RUHB is a major acute-care hospital in the Weston suburb of Bath, about 1.5 miles west of Bath city centre, with 565 beds on a 52-acre site.

In February 2015 the trust acquired the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust (RNHRD) – affectionately known as 'the 'Min'. Due to significant, long-standing financial challenges the RNHRD could not continue in its current form but needed to become part of a larger organisation to ensure the continuation and future provision of its high quality services.

The RUHB undertook to protect and develop the RNHRD brand, which has a national and international reputation for services and research, while also benefiting from the closer integration of services and skill sets from both organisations.

The paediatric chronic fatigue syndrome or myalgic encephalomylopathy (CFS/ME) service is one example.

- CFS/ME is relatively common in children, affecting at least 1% of teenagers. It is probably the largest cause of long-term absence from school.
- Despite this, there are very few teams in the UK who specialise in seeing children with CFS/ME and even fewer who are able to see severely affected children at home.

Case study 3 continued

Royal United Hospitals, Bath

The RNHRD's paediatric chronic fatigue service is now part of the RUHB's women and children's division. A multi-disciplinary team led by Dr Esther Crawley, professor of child health, is supported by doctors, occupational therapists, physiotherapists and clinical psychologists employed by the RUHB.

Key points:

- Networked clinics were originally set up to improve access to services for disabled children in Wiltshire, Somerset and Gloucestershire.
- It became clear that locally-delivered therapy was more efficient and effective than all patients having to attend the RNHRD hub.
- Following demand, another clinic was established in 2011 at Macclesfield, East Cheshire, with a local therapist and paediatric team.
- The local CCG was supportive.
- There are internal referrals as well as those coming from across the north west.
- Local paediatricians have basic training and expertise in children with mild to moderate CFS/ME, but not for more severe housebound patients.
- They also do not have the capacity, and it is not cost effective, to provide NICE-recommended treatments.

To reduce the need for patients to travel to Bath for assessment, or for a member of the Bath specialist service to travel to Macclesfield to see housebound patients, the RNHRD trained an occupational therapist to provide specialist treatment for paediatric CFS/ME in Macclesfield one day a week. This includes activity management and the assessment and treatment of housebound patients, subject to funding approval.

The service is funded on an individual basis by CCGs.

Case study 4

The Walton Centre, Liverpool

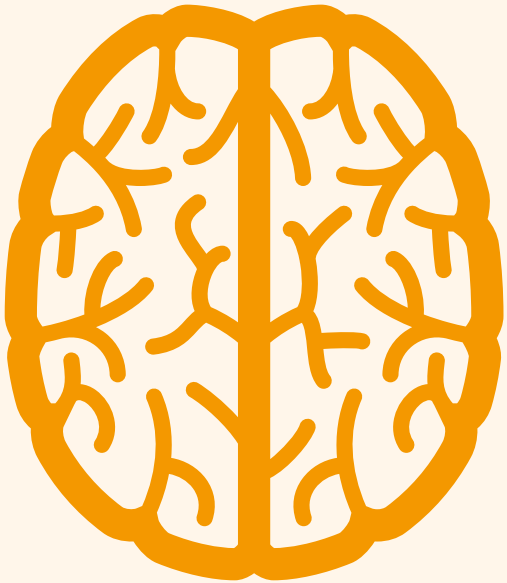
The Walton Centre, formerly known as the Walton Centre for Neurology and Neurosurgery, is a major neurology hospital in Fazakerley, a suburb of Liverpool. Established for 25 years, it is one of the country's leading specialist centres for neurology and the UK's only dedicated neuroscience provider.

The Walton Centre developed its networked care model in response to:

- a large geographical region needing specialist provision.
- a national shortage of neurologists, worst per head in Europe.
- general medical consultants covering neurology as 'best they could' in DGHs.

The Walton Centre Neuro Network is a hub and spoke model with the following features:

- A central specialist unit sends consultants out to other DGH clinics.
- Complex patients travel to the centre and all surgery is done there.
- The trust owns the activity.
- The trust pays host trusts for space and clinic staff.
- Neurology nurses attend widely-spread local health centres and GP units and also deliver some nurse-led hospital clinics.
- Bookings for clinics are administered centrally.
- 60% activity is performed at the centre, 40% at other sites.



Case study 5

Royal Eye and Ear Hospital, Australia

The Royal Eye and Ear Hospital in Melbourne provides an ophthalmology service to a local health service, Eastern Health, which serves a population of 900,000.

The hospital supplies the medical staff and orthoptists and advises on clinical standards and protocols and equipment purchase. The local health service supplies all other staff and is responsible for managing the service.

A partnership agreement was developed outlining the role of each organisation. The primary aim was to provide ophthalmology services and to ensure that clinical quality standards were met. The agreement is reviewed regularly and has changed to reflect evolving requirements.

Benefits include providing care closer to patients' homes, reducing demand on the hospital and reducing waiting times.

Key features of the partnership:

- To address difficulties recruiting to suburban areas, the hospital tries to employ local staff or relocate them from the hospital's main site if they live in that area.
- Junior consultants joining the organisation are expected to undertake some of their rostered sessions (in surgery and outpatient clinics) in non-subspecialist clinics including the spoke or partnership clinics.
- Efforts are made to ensure that outreach staff have access to training at the central site so that they do not become isolated.
- To ensure standardisation in care delivery, all clinical hospital staff who work in the community maintain clinical sessions at the main site.
- Some variation in existing clinical standards and protocols is recognised and work is being done to address this.
- The hospital produces evidence-based, best practice clinical guidelines to streamline processes and audits adherence.
- Specialist nurse training is routinely offered to graduate nurses who are given supernumerary time with senior staff to receive hands-on training.
- Patients are involved in the designing of services.

Case study 6

Central Manchester University Hospital NHS Foundation Trust

Central Manchester University Hospital NHS Foundation Trust (CMFT) comprises Manchester Royal Infirmary, Manchester Royal Eye Hospital, St Mary's Women's Hospital, Royal Manchester Children's Hospital, Altrincham General Hospital and Trafford General Hospital, the University Dental Hospital and wide-ranging community based services. The trust also provides services at DGHs in Rochdale, Bolton, Stockport and Wigan.

Manchester Royal Eye Hospital (MREH) is a dedicated facility providing a comprehensive ophthalmology service to central and Greater Manchester. It is the busy hub of a continually developing network which includes outpatient services at CMFT's Trafford and Altrincham hospitals as well as a dedicated cataract centre at Withington Community Hospital. MREH staff (under its 'MREH@' branding) deliver some ophthalmology services for patients at other DGH and community sites.

All MREH staff are trained centrally so that there is a consistent approach to care provision. Standardising core competencies provide clinical assurance and this is reinforced by weekly site visits and one-to-ones between the MREH matron in charge of those areas and the unit managers.

Assurance is sought by monthly quality care rounds (QCRs) by the unit managers looking at, for example, cleanliness, patient safety and nutrition, and reports on these are submitted centrally. All areas have an electronic patient experience tracker completed by patients and/or carers. Again these are uploaded centrally and the results published on the trust website. A recent addition has been the monthly matron quality round, a shortened version of the QCR.

Patients attending outpatient and the emergency eye department are also asked to complete the Friends and Family Test asking whether they would recommend the MREH.

The trust runs a 'Brilliant Basics' campaign whereby every three months nurses and midwives focus on one of four 'fundamentals of care': communication, harm-free care, leaving our care and care and compassion. These areas are closely aligned to the trust's nursing and midwifery strategy.

Optimal performance is further encouraged by the improving quality programme (IQP), an award scheme for outstanding care and practice. The ophthalmology day case unit has retained gold for the past four years and the MREH outpatients department was chosen as the pilot site for IQP in January 2017.

The MREH runs regular staff engagement sessions which are chaired by the divisional director and well attended. There is also a "thank you card" system where staff can nominate other staff members who they feel are deserving. This is then presented by the divisional director, head of nursing and human resources business manager.

The future of networked care

Local DGHs need to continue meeting their local population health needs while remaining financially viable. Patients want their services to be provided at their local hospital rather than having to travel for care elsewhere. Commissioners want safe, affordable services. Clinicians want to provide safe, high quality services with good outcomes. This challenging context is unlikely to change.

The NHS needs financially viable models to ensure that services can be sustained in the long term against a background of an ageing population, more treatable conditions, expensive drugs, increasing disease prevalence and more high tech equipment.

What must be avoided is poor clinical quality in diagnosis and treatment, duplication of diagnostics, unnecessary appointments and poor clinical outcomes.

As yet, there is no consensus about the best approach to delivering smaller clinical services in this context. There is a risk they will either be subsumed by bigger teaching hospitals or scattered across primary care, neither of which will enhance the quality of local care or support the sustainability of DGHs. Whole-system solutions will need to implemented in order to sustain smaller clinical services.

Single specialty networked care can offer local service sustainability and can be embedded in large-scale transformation planning in hospital groups, mergers and STPs. Of critical importance is identifying where the expertise exists and then seeing how best to share that expertise across a wider geography and developing the right partnerships to achieve this.

Implementing networked care is one way in which clinical services can continue to be delivered locally, avoiding the need for patients to travel further, and preventing local services becoming diluted and isolated with lower standards, compromising care.

Purpose

In this section we consider why an organisation might consider a networked care model, the critical success factors, how to assure yourself of the quality and safety of a dispersed service and the potential benefits to the wider NHS.

Assurance

Quality and safety

Standardisation

1 Will a networked care model address your issue?

2 How will you know that patients will be safe at all sites?

3 How will you know the model is sustainable?

Assurance

The development of a networked care model will need to align the aspirations of at least two separate organisations and their trust boards. Both organisations will need assurance that the new arrangements are delivering what they hoped.

Critical success factors

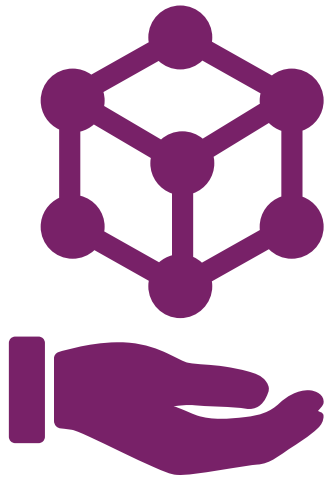
We talked to NHS trusts and other UK organisations as well as private healthcare organisations overseas to understand and share what they thought were the critical success factors for developing networked care.

The list we provide is from these conversations and is not exhaustive. While all considerations below are valid, everyone we spoke to cited the staff as most critical for the success of any service development.

Critical success factors continued

The first group we spoke to were clinical and managerial representatives from more than 18 healthcare organisations about what they saw as critical to a successful network.

- **Excellent staff** who are able to work well at a distance but who know when to escalate.
- **Organisational buy-in:** a clear, strategic narrative on the purpose of your network is required and may need to change as your network evolves.
- **Professional buy-in:** do your consultants believe in your network model and do they support each individual venture?
- **Choice of partner:** be clear on the terms of your relationship and align your understanding of what a successful partnership will look like.
- **An understanding of the health needs of the population** you are seeking to serve and the expectations of those who commission/ purchase care.
- **The importance of reputation:** identify red lines to protect your brand.
- A well thought-out **management structure** with clear lines of responsibility, communication, reporting and escalation.
- **Standardised processes** with tightly controlled variation to ensure consistent quality.
- **Excellent links** between sites and the centre to spread learning.
- **A central learning and development** team who move between sites.
- **A values-based culture**, embodied by strong leadership.
- **Clear agreements** with host sites.
- Excellent remote **connections and systems.**



PDF **Report - health needs market assessment**

Critical success factors continued

We thought it was also important to know what assurance trust boards would need that a networked care model was delivering the required improvements. To understand this, we commissioned 25 board level executive interviews.

Their observations included:

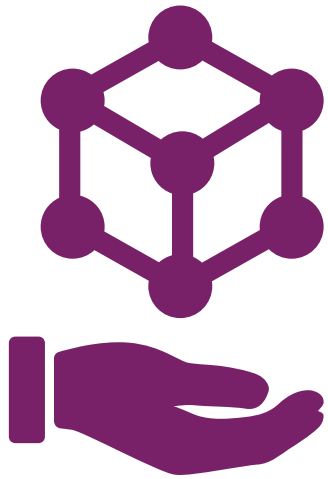
- **standardisation across the network is key** but hard to deliver consistently.
- **balancing network standardisation and local flexibility** to support innovation is challenging.
- **collating data across the network** in a meaningful way is important but complex.
- **there is a complexity of relationships** with multiple commissioners and host organisations.

In non-networked hospitals executives would expect to see evidence of:

- the maintenance or improvement of clinical quality.
- good patient experience.
- transparent clinical governance.
- service standardisation.
- a better range of services.

Existing networked care provider executives said their regular assurance processes looked for evidence of:

- direct support of the trust's strategy/objectives.
- the right experience and care for patients.
- greater organisational resilience, for example contributing to overheads and the bottom line, increased skill base, increased catchment and market, increased influence and reputation.



PDF **Report: board-level enquiry – non-networked care providers**

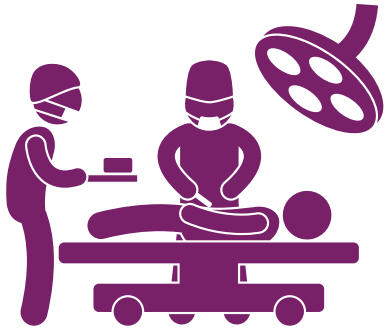
Report: board-level enquiry - existing networked care providers

Resources

Drivers for change

Organisations have been prompted to consider operating a networked care model for a number of different reasons, some proactive, some reactive. Examples include:

- staffing issues, especially among clinical groups.
- need to improve service quality.
- need to increase critical mass to provide sub-specialties.
- financial pressures.
- lack of sustainability.
- demand from patients and commissioners.
- desire to spread best practice.
- clinicians' special interests.



"The clinical driver for us doing something to stop us working as seven silos was to say 'Why don't we just work as one?'"

"The national shortage of neurologists meant a network was the only way we could see to provide patients with the care they needed."

"An inexorable rise in emergency admissions, more complex health problems, an ageing population and increasingly internet-savvy patients meant something had to change."

"We have a national and international reputation clinically but we weren't sustainable as a standalone organisation. By joining forces with another trust we've been able to start planning a franchise of specialist services underpinned by our expert training."

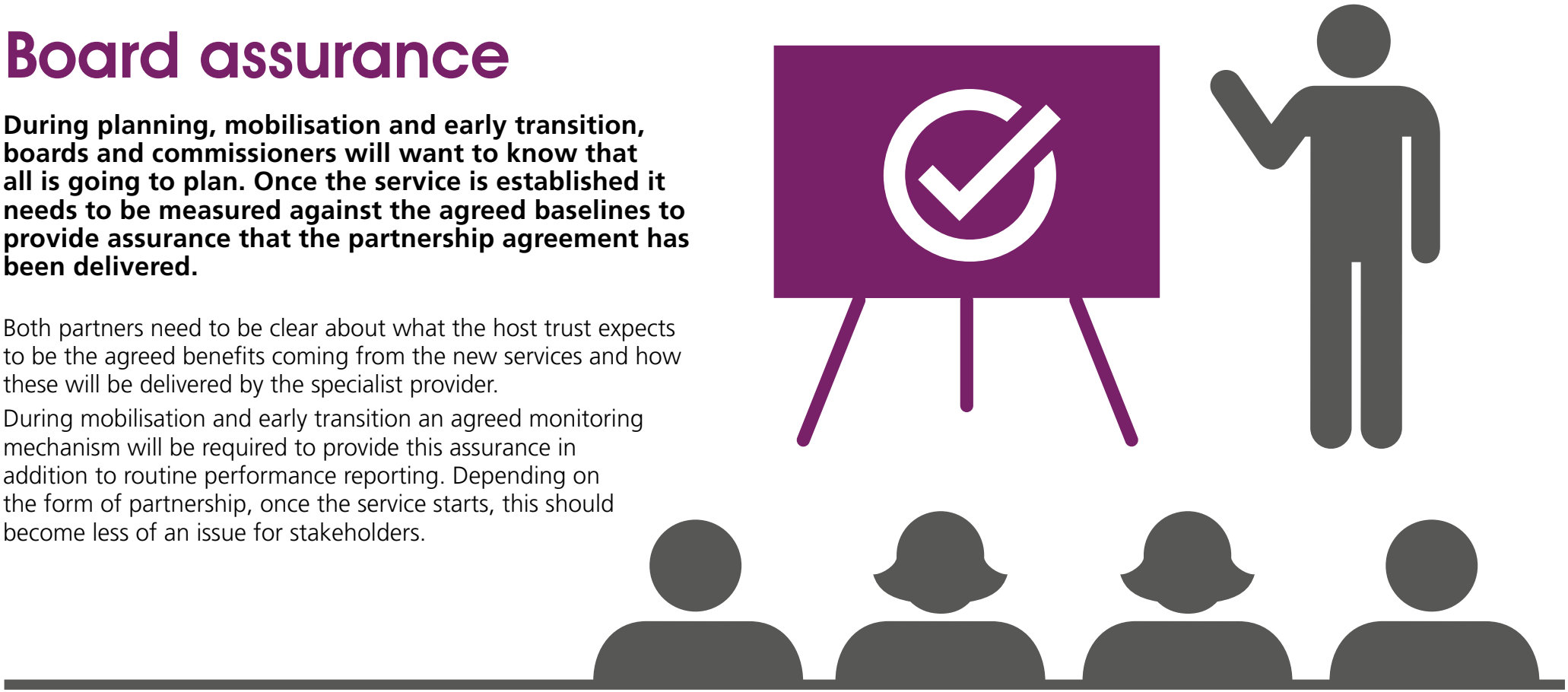
"If your activity numbers are very low that would be a driver. There's so much research to say that patient outcomes are much better if clinicians are undertaking that procedure on a much more regular basis."

Board assurance

During planning, mobilisation and early transition, boards and commissioners will want to know that all is going to plan. Once the service is established it needs to be measured against the agreed baselines to provide assurance that the partnership agreement has been delivered.

Both partners need to be clear about what the host trust expects to be the agreed benefits coming from the new services and how these will be delivered by the specialist provider.

During mobilisation and early transition an agreed monitoring mechanism will be required to provide this assurance in addition to routine performance reporting. Depending on the form of partnership, once the service starts, this should become less of an issue for stakeholders.



PDF **Report: board-level enquiry - existing networked care providers**

PDF **Report: board-level enquiry – non-networked care providers**

Board assurance continued

Board assurance for the new networked service should sit alongside business as usual and within the governance of the partnership agreement so that it is managed appropriately; in the SLA if the service transfers entirely; or in a subcontract if the host trust retains activity ownership. For the specialty provider this should be part of the business case detail.

We have considered board concerns and what sort of defined, measurable metrics might demonstrate both improvement to existing provision and value added by the specialty provider. These are geared towards justifying the move to a new provider rather than monitoring future operational performance. Such assurance could involve measuring the following before and after the change:

- patient complaints.
- Friends and Family Test results.
- staff absence.
- current treatments provided.
- number of patients referred to a tertiary provider.

Other benefits can be evidenced from:

- staff training and development.
- new extended skills roles.
- more tertiary care locally.
- increased staff education.
- patient participation in service development.

Board assurance continued

Expectations around financial benefits to the host trust must be managed carefully. Although costs associated with providing the service and staff costs will be reduced, and there will be new income from renting the space to the specialty provider, this must be balanced against the loss of income. There are also the hidden costs of a failing service: actual and potential litigation, cost of poor or untimely diagnosis and cost of investigating serious incidents.

In this section we looked at whether a balanced scorecard has a role to play in the new model assurance. We concluded that it is an organisational tool to monitor and flag up performance issues to the trust and its commissioners and not the comparative tool needed during early transition.

Board members were, however, concerned about future performance so we have included some performance metrics in our resources section. These are aligned to the CQC domains and a 'dashboard' which individual services can use with their information analysts to measure their own service productivity.

Download to view

Performance metrics

'Dashboard'

Board assurance continued

Board executives told us:

- a networked model must support the organisation's strategy.
- patients must get the right experience and care.
- the new service should improve organisational resilience. This could be by helping overheads and the bottom line; increasing the skill base, catchment and/or market; and/or improving the organisation's influence and/or reputation.
- they would want to be clear on who is responsible for what – who would the regulator hold to account for performance issues?
- that whether there were joint or separate boards, all expressed the need for transparency in reporting and assurances and about delivery on the business case.
- there would need to be a sufficient flow of information from any individual site to the centre (specialty provider) and the right amount of information to the boards (both partners) – not too much or little
- there would need to be assurance on the estate and infrastructure supporting services on all sites including but not limited to compliance with fire safety, water quality (Legionnaire's).
- the board might need extra support to understand the model and its implications.
- there would need to be an understanding of the contractual relationship and its liabilities and implications for staff.
- they would want a clear sense of the network objectives and whether they were being realised.
- they would need a clear understanding of the money flow and risks of a network.
- there would need to be clarity about what happened if either host or specialty provider had a crisis – would they consider the needs of the other organisation?

Board assurance continued

The SLA or other form of contract document is where most of these questions should be settled. We have established that it is critical to a successful partnership to agree and sign up to one before mobilising any new networked service.

"We want to be a world leader in delivering specialist care and research – does networked care enhance that?"

"A key improvement should be a reduction in unwarranted variation in clinical care, quality and the model. Networks can provide a framework that describes what good looks like – not sticking rigidly to organisational viewpoints but what is best. "

"We have a board that sits between the two partners – a steering board – which signs things off and they are then approved by our board. A joint memorandum of understanding binds us together as partners."

"You need an effective way of dealing with someone who doesn't deliver to a good standard."

"We'd want transparency around performance with numbers of cancellations, complaints and so on."

Networked care – value to the wider NHS

The burning question for vanguard programmes is what benefits are there for other organisations through replicating your model? Leaders of the trusts we interviewed identified a number of potential benefits but because of the way that most networks have developed, the evidence for these is not always apparent.

They identified a number of ways they expect a network to benefit the wider NHS including:

- **higher standards and quality.**
- **improved efficiency through more standardisation, less unwarranted variation and less duplication.**
- **improved access to local services that may otherwise not be sustainable and a greater range of sub-specialties.**
- **improved equity of access to services.**
- **better fit with the local commissioning landscape.**
- **greater resilience of specialty providers.**
- **improved careers and opportunities.**

A review of our network and many other models has shown that in almost all cases NHS networked arrangements have been primarily about helping failing services. So the benefits to the wider NHS from a financial perspective will be more related to the counterfactual - what will the costs to these organisations be if smaller services are not supported and developed? What will the cost be to the wider health economy and what cost to patients' health and wellbeing?

It is not easy to evidence the clinical and financial benefits of implementing our networked model of care as baselines for measuring this were not established at the outset of developments. At that stage it was mainly about helping organisations to reduce avoidable costs and improve quality but without the involved stakeholders quantifying them.

The toolkit recognises the need to set these baselines as best practice and to take account of the changing commissioning and regulatory landscape.

Networked care – value to the wider NHS continued

The toolkit brings together up-to-date reflections and information collected from colleagues in our own and other national and international organisations. It's hoped this codified learning will avoid the need to endlessly reinvent the wheel. It also offers a detailed guide, with appropriate document templates, to enable accelerated implementation of a networked care model.

Replicating new care models is intended to reduce the variation in the quality of care delivered by different providers. This is particularly applicable in smaller clinical specialties which are rarely a high strategic or operational priority in district general hospitals.

Setting service baselines at the outset will enable the partners to evidence better clinical outcomes, improved patient experience and more local and timely patient access to sub-specialist expertise. While all these can be measured in existing networked models of care, without the pre-transfer baselines it is much harder to demonstrate the value of the change to the host trust and commissioners.

10 steps to a networked care model has been developed as a result of our own network review, the lessons learned and what other organisations have told us, including board level executives. A key theme is to be able to robustly measure the benefits of the new arrangement.

There is a dual responsibility for establishing service baselines to measure success – a host trust must collect information and data about the existing service and be able to clearly articulate what they expect to happen with a new provider. The 10 steps model includes practical templates to help with early decision making and replicating the model at pace using the suggested methodology.

Networked care – value to the wider NHS continued

While the lack of baselines mean that some of the broader benefits are still to be robustly evidenced, those we spoke to pointed to some specific advantages they had identified, for example with the purchase of equipment.

A large specialty network can use its greater buying power and reputation to drive down costs as well as use its equipment and consumables more flexibly and intensively.

- Bulk buying brings greater economies.
- Suppliers may wish to be associated with the good reputation of specialty providers.
- A network may be able to use the same equipment and consumables at different sites to optimise standardisation or move it across sites when there is equipment failure. First-line and routine maintenance of equipment can be standardised to achieve economies of scale.
- Some equipment needs frequent checks and calibration and this needs to be taken into account.

"Seven trusts came together for the tender. We had seven radiologists, seven PACS managers, seven IT managers and clinicians who came together on certain days and spent the whole day together, looking and exploring with the supplier. But everybody saw that we could do this."

"We didn't really know what we wanted, to be honest. We knew we didn't want what we'd got previously and we wanted to move forward."

"Each trust has an individual contract with the supplier which says that if the trusts continue to work together the supplier will consider them as one organisation for the purposes of cost. And if a trust opts out of the consortium, the supplier will charge them more."

Sustainability

The NHS is now subject to much tighter regulatory controls than in the past and this means there is likely to be less appetite for risk

But conversely there are situations where some risk is supported for longer term potential benefit, such as the Royal Free London vanguard creating a group of hospitals. However such large-scale changes to organisational form need national and local system support.

Developing a networked care model should not be just about putting right what is wrong with the service but about pioneering best practice. A networked care model offers the opportunity to pilot innovation at a particular site without disrupting the whole network.

Extending a service increases the risk of variation; replicating best practice will facilitate standardisation.

Sustainability continued

Researching our network history with past and present Moorfields colleagues, it has become clear that not all decisions made then would be possible in the current regulatory environment. Network growth was a clear strategy to ensure Moorfields' sustainability as a single specialty hospital provider. With more than 30 sites in England and three in the United Arab Emirates, this has been achieved in terms of national and international spread and reputation. We are the largest eye provider in the UK and in London and a world leader in ophthalmology research and education.

The challenge for trust leaders today is to ensure the sustainability of a network created before the regulatory regime intensified.

The single specialty market has less potential for diversification than do multispecialty organisations. Moorfields' strategic pillars of clinical excellence, research and education define our trust as a national and international leader in ophthalmology and will drive future decision making. The scale of our network is unique within the NHS and we learned that the rationale for some of the network development was not always based on what was best for the trust financially, but was always in the best interests of our patients. We always wanted to sustain high quality eye care locally.

The biggest challenge now is the part that financial constraints, critical mass and workforce models will play in deciding where and when high quality services can be networked safely. This is in addition to the contribution they can make to the local and national commissioning agendas.

What is not clear is whether larger organisation-wide system models will address the sustainability issues faced by smaller hospital services. Whole-hospital solutions are just that and may not solve the problems that smaller hospitals regularly raise with single specialty providers.

Will single specialty networked care grow, stay the same or consolidate? These are questions for organisational strategy but what is clear is that sustainability will require tough decisions and brave leaders.

Corporate governance

A networked care model will introduce complexities for both the specialty provider and the host trust in terms of integrating the new site into corporate governance functions and relationships. This may be further complicated depending on the contractual form. "At whose door will the CQC come knocking?" will be a concern of the accountable officer.

Corporate governance should have clear lines of accountability through the organisation, starting at the highest level and supported by robust policies and procedures. It should ensure that resources are well-managed and that the operational plan is delivered.

In our research nationally and internationally the messages were the same:

- Corporate, clinical and organisational standards need to be set corporately and cascaded across the network before you mobilise.
- Common delivery frameworks are needed to compare performance standards across a network.
- Strong clinical governance and organisational policies should set working standards and staff expectations.
- Geography should not be a barrier to delivering replicable quality and performance standards, sustaining reputation or to an organisation-wide performance framework.

Corporate governance continued

- To date Moorfields has prioritised clear governance accountability for networked services by securing ownership of the activity, staff and equipment.
- Our experience has been that hybrid versions, such as the host retaining the activity, blurs the lines.
- Even where we have ownership there can be issues with host trust deliverables such as space availability, medical cover and IT support. Having a service level agreement does not guarantee that the supporting services will be consistently delivered.
- Board executives we spoke to had different ideas on what a governance model should look like from a 'light touch' once a year CEO-to-CEO meeting to a joint board to oversee the working arrangement. The views seemed to reflect positive or negative experiences of working with other organisations.
- One global healthcare organisation told us it never entered a partnership where it had less than a 51% share, ensuring it had overall control.
- Another international healthcare organisation had a clear strategy for increasing market share but had not at the time considered the benefits of a networked care strategy. It was now retrospectively creating network governance.
- We rarely encountered a networked care solution that did not arise from a need to improve or sustain the service.
- A networked care solution can help a service that is failing, perhaps because it cannot recruit or because of its clinical clinical governance arrangements.

A symptom of service failure (or perceived failure) is a lack of trust between corporate and clinical delivery teams. It may indicate that the way in which corporate and clinical governance co-exist is not understood and respected inside the organisation, that corporate or clinical governance is not well managed or that the boundaries between corporate and clinical governance are not clearly understood.

Corporate governance continued

This toolkit is mainly focused on the single specialty networked care model which presents additional challenges for governance compliance as two organisations are involved. There are a number of possible models but whether the specialty provider takes over the host trust's service in all respects or there is some other partnership agreement the questions remain the same:

- How do you align the two organisations policies without creating a burden on staff or line management?
- What about the policies which relate to where you work physically? Whose fire policy applies? Whose mandatory training is more relevant?
- Do incidents have to be reported twice?
- Who do you go to with a safeguarding problem?

Do not underestimate the detail that needs to be considered and the need for the two organisations to work through these issues together. Running a service independently of the host trust may seem to be a clean solution but in practice there are a number of ways in which collaboration may improve staff experience and reduce duplicated costs.

At all times the following principles might help to keep the relationship on track:

- Work together to ensure the service is well understood and that potential problems are mitigated before mobilisation.
- Make sure all the relevant stakeholders internally and externally are involved and/or communicated with.
- Be clear about the form of relationship and have clear accountabilities to each other: staff at both trusts, patients and other stakeholders. Everyone needs to understand who is in charge of the service.
- Treat each other with respect - the leadership behaviours will be clear to staff on the ground and tensions may affect their ability to deliver the service.
- Be open and transparent.

"All our historical growth is based on business cases, not a planned network. With hindsight we made a mistake not to proactively plan and design as a network and so we are now designing retrospectively while operating services."

Quality and safety

It is essential that healthcare organisations provide high quality services which are safe, effective and compassionate and also that they constantly strive for improvement.

Clinical governance framework

Clinical governance is the systematic approach used by healthcare organisations to ensure the quality of their services, provide transparent lines of responsibility for standards of care and continuously drive improvement. Key areas are clinical effectiveness, patient safety and experience.

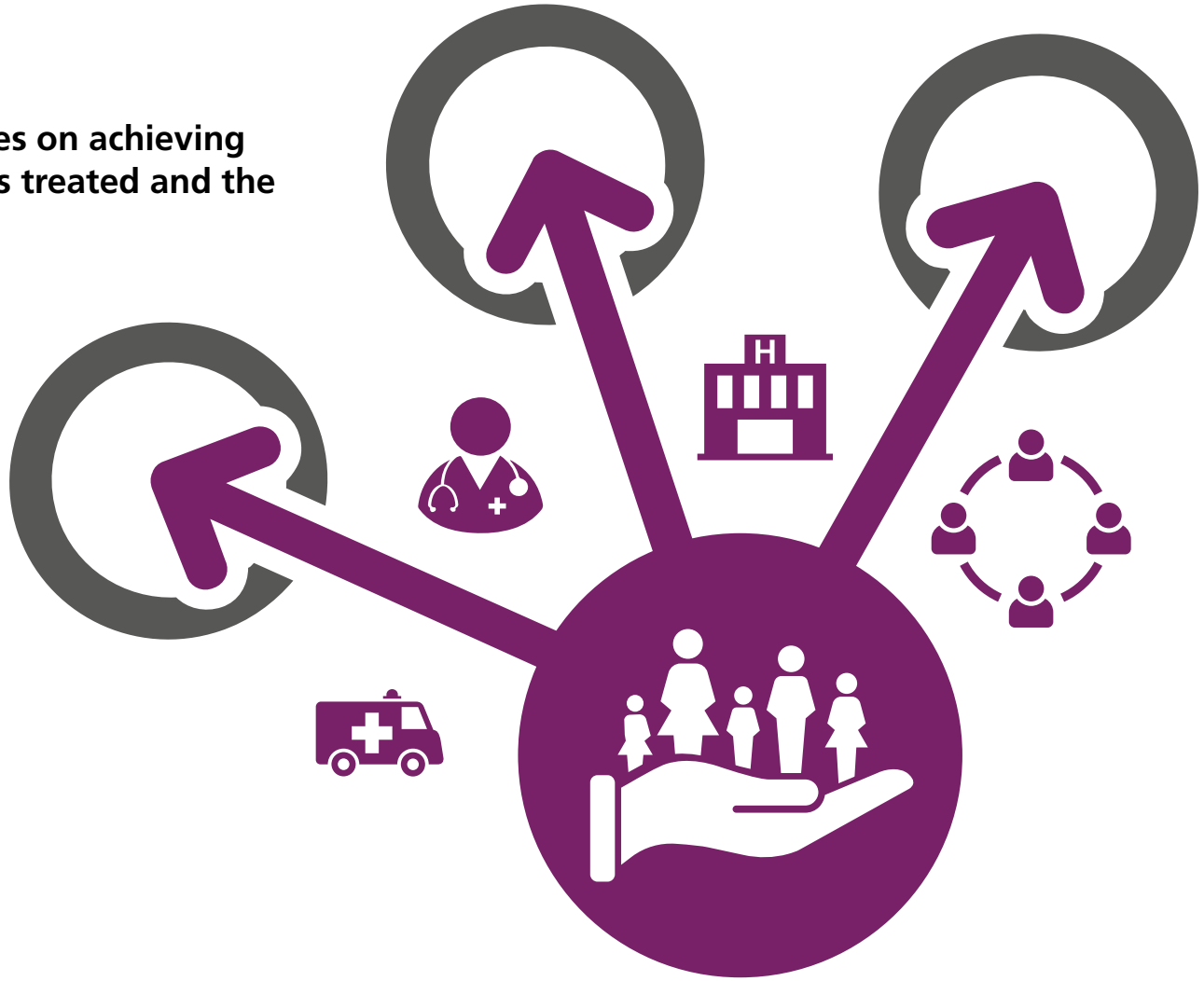
All organisations will have the necessary components of a clinical governance process but they may be distributed among a number of different documents and systems. This toolkit offers a framework which organisations may want to use to bring all the separate elements together.

Download to view
Clinical governance framework

Critical mass

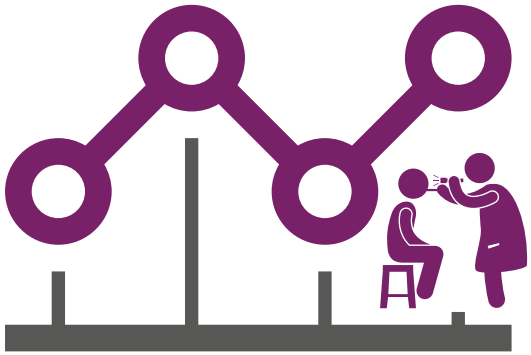
The delivery of safe, effective care relies on achieving critical mass in the numbers of patients treated and the staff caring for them.

- Critical mass means there are sufficient numbers of expert staff and patients to create sub-specialties and the increased quality they bring.
- Critical mass can be easier to achieve with a network.
- Critical mass allows ideas and practices to spread rapidly through a network, promoting and accelerating behaviour change.
- It also enables the network to influence those outside its membership, for example partners and commissioners.



Clinical effectiveness

All healthcare providers want to deliver good quality care to patients; commissioners want to be able to measure and benchmark clinical effectiveness when commissioning healthcare services; and patients and carers want to know the treatment and care is working.



Clinical effectiveness is the impact on health and wellbeing as a direct result of care and treatment. Healthcare providers must strive for the best possible outcomes by complying with evidence-based guidelines. Clinical audit is an essential tool in the delivery of clinically effective care, allowing professionals to measure their performance, including assessing clinical outcomes, and to make improvements where practice does not reach appropriate standards. Patient reported outcome measures (PROMs) are used to ensure patients can tell us how the care and treatment is working for them. PROMS should always be developed with patients to ensure that they are relevant.

The absence of a clear plan to routinely measure clinical effectiveness, including assessing adherence to evidence-based guidelines, clinical audit and PROMS, could be a symptom of a failing or potentially failing service. A specialty provider networking care into a smaller service will provide the framework, knowledge and experience to embed a culture of continuous improvement. The smaller service will benefit from a wider professional support network, expertise and resource for utilising specialty specific measures and the ability to benchmark services not just against national standards but also against the new peer group. For the specialty provider, the learning environment increases.

We have provided examples of broadly agreed generic metrics for colorectal, neurology, orthopaedics and ophthalmology as well as a blank version for other specialties to use. They are by CQC domain and metric group. These documents can be downloaded and adapted.

Clinical audit

Clinical audit is the review of clinical performance against defined standards and the refinement of clinical practice as a result. All networked sites should have an annual multidisciplinary audit plan. Precedence should be given to high priority audits which should include detail about how provider staff will interact with host clinical audit activities and vice versa. Network-wide audits should be encouraged to enable quality benchmarking to highlight best practice and where this might be shared to improve clinical outcomes.

- Audits should be performed according to the audit policy using standardised proposal and reporting templates, include a clear SMART (specific, measurable, achievable, realistic, timely) action plan with leads identified for each action, involve all stakeholders and be registered with the audit department.
- Re-audits should be scheduled and completed.
- Progress and results of audits should be presented at the clinical governance sessions and actions agreed. Learning should be shared across the network.
- The following audits should be mandatory at least annually across all relevant sites:
  - % success of X operation.
  - % infection post X operation.
  - % complications post X treatment.
  - % adherence to X national guidance.
  - % adherence to X local policy.

Clinical outcomes

The most important outcome for patients from any service change is that the quality of their care is maintained or improved. All aspects of this, from the improved health of an individual to better hospital experience, can be measured and the results shared with patients, referrers and commissioners as well as used to drive improvement.

"Really important outcomes must be made available regularly, ideally in real time, to all services and sites."

"We need outcomes that are really important for patients."

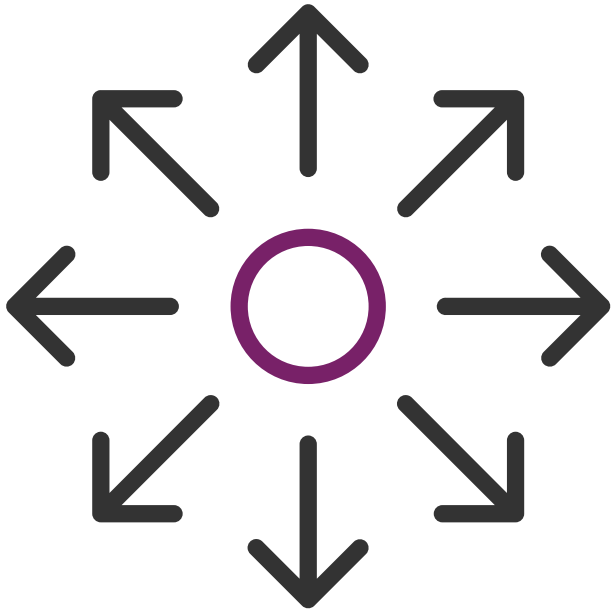
- Decide which outcomes are key to core/frequent activity, high risk, expensive, externally rated, most important for patients.
- There must be measured generic and sub-specialty outcomes.
- Provide comparisons against benchmarks or standards where possible.
- Create a system for urgent action if outcomes fall below acceptable levels.
- Move to an electronic patient record with inbuilt auditing facilities to reduce the burden of manual audit.
- PROMs can provide a patient-led assessment of health and quality of life.
- Find ways to spread best practice across the network.
- Ensure there is a critical mass of staff and patients to enable sufficient sub-specialisation.

Resources

Data

It is especially important in a dispersed organisation that data is used to provide robust assurance about services on all sites.

- Ensure a standard quality of data is collected from all sites which is clear, widely available and used to make decisions.
- Particularly crucial are clinical audits for basic practice standards, site-specific outcomes, adherence to policies and protocols and patient reported outcomes.
- Be wary of data aggregated across the network – make sure it is collected for each site.
- Ensure nurses and admin teams complete audits and compare the results with recognised standards.
- Use consistent templates for reviewing and managing quality and safety and triangulate data on complaints, experience and incidents.
- Ensure data is used to show that senior staff are identifying, acting on and learning from incidents and adverse events.
- Regularly report to the board on quality and safety in an accessible format suitable for trust-wide dissemination.
- A good electronic patient record with audit and a patient management system will be needed across the network to enable live monitoring of performance, activity and outcomes.



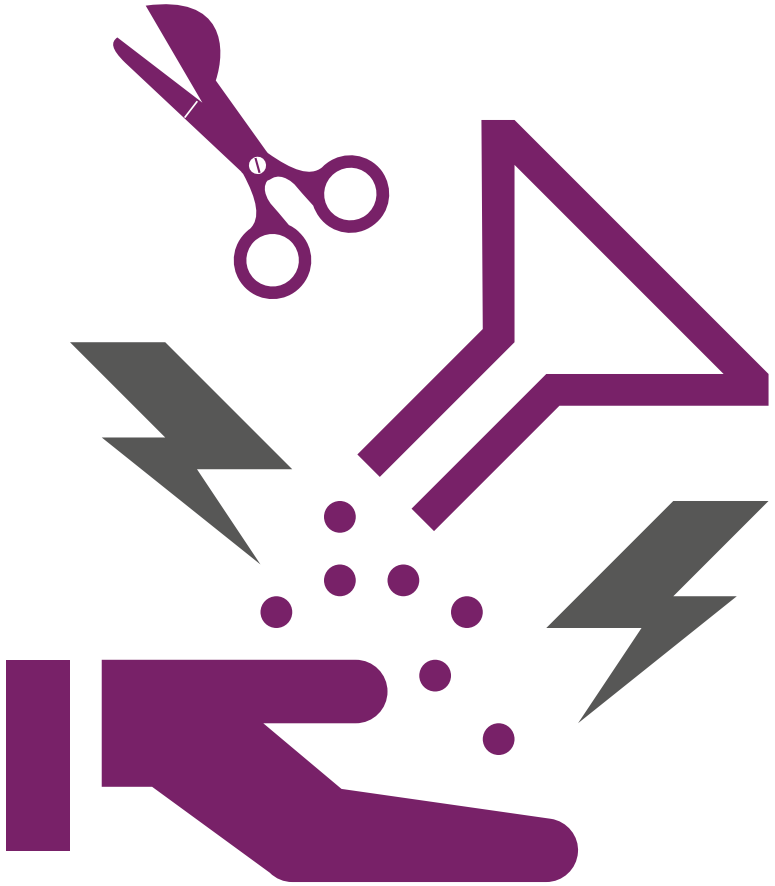
"Core outcomes are good but need to be site specific and shared between sites."

"Nurses and admin teams need dedicated time to do audits and research."

Reporting and investigating incidents

Safety and quality are enhanced in a networked care model because a multisite organisation can offer a whole range of expertise and resources for investigating incidents and other adverse events.

- All staff should be trained in incident reporting and required to immediately report incidents which did harm or could have resulted in harm, including 'near misses'. Details of how to report them will be enshrined in the trust's incident reporting policy.
- Staff from other sites can be used as semi-external investigators, many of them with sub-specialty expertise.
- Host organisations can provide external objectivity and wider expertise.
- There must be a system for jointly investigating with the host site where appropriate, particularly where there is a significant element of host trust involvement because of, for example, the environment, staff or processes.
- Establish early on staff who will be responsible for sharing safety information and communicating about incidents and investigation plans.



Risk assessment

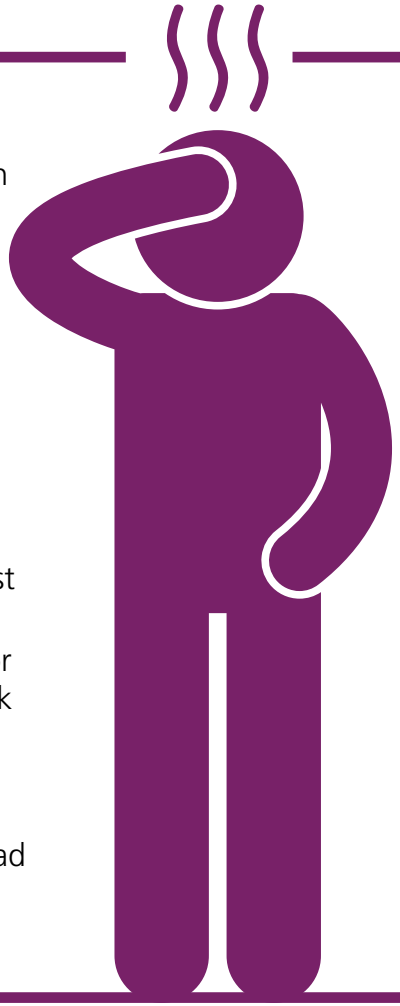
Risk assessments should take place at least annually, more often if there are major changes in care, services or environment or new hazards are identified. They should be performed at all sites, services and clinical areas and also for key clinical issues such as infection control, devices, local high risk procedures and major new practices and treatments.

- Other aspects of care/service may require risk assessments at the discretion of staff where there is potential for significant risk.
- Any hazards identified must be assessed and appropriate controls identified. Completed assessments will be kept by the lead for the relevant area and a copy submitted to the risk department.
- The outcome of any risk assessments must be communicated to staff, along with notification of the actions that are required by them to reduce associated risks.

Risk assessment continued

Risk registers

- Every site, clinical area and department must have its own risk register reflecting its particular risks and degree of severity.
- Registers will be shared or co-managed with the partner trust.
- Risk registers will be kept by the relevant leads and managers and a copy submitted to the risk department.
- All staff must be fully informed of their responsibilities, populate their local risk registers and update the directorate risk register regularly.
- Formal review of significant risks should take place at least quarterly at performance meetings.
- Where it is not possible for a risk to be managed locally or it is significant, it should be escalated to the corporate risk register, via the relevant director.
- The corporate risk register will contain the high level risks that cannot be managed at directorate level or are organisation-wide or strategic in nature. The executive lead for corporate governance will manage the corporate risk register which will be reviewed by the board.



Risk mitigation

Management of risk should take place day to day in all clinical and non-clinical areas. It is anticipated that the hierarchy below, shown in priority order, will be followed:

- **Avoid/eliminate the risk:** for example cease the activity with which the risk is associated.
- **Treat the risk,** ie implement a control measure to reduce either the likelihood or consequence of the risk.
- **Transfer the risk** to another party, such as an insurance company or contractor.
- Considerations:
  - Is the cost of mitigating the risk proportionate?
  - Does the mitigation affect other people who should be informed?
  - Do you have contingency plans in case the risk materialises?

Standardisation

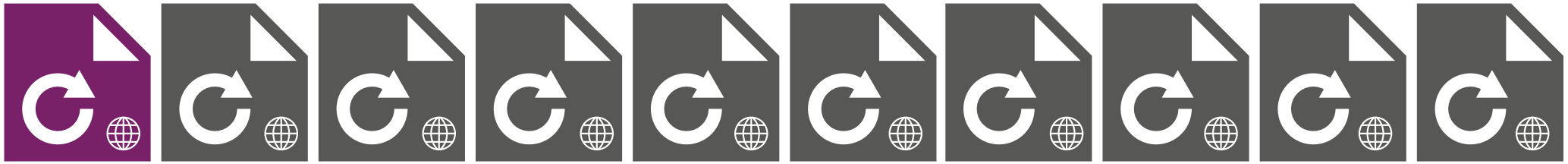
A key aim of the NHS new care models programme is to promote standardisation and replicability across the NHS. Although it is clear that standardisation is the key to best practice in delivering high quality care, it is not always easy to achieve in practice.

Benefits

All specialty providers will have numerous policies, guidelines and procedural documents to govern practice and process. In a network it is crucial to the quality and safety of care that these are standardised. This will also allow staff to make appropriate decisions without constant reference to the centre.

The benefits of standardisation include:

- reduced unwarranted variation in quality between sites.
- improved access to local services offering a greater range of sub-specialities that may otherwise not be sustainable.
- improved equity of access to services across the NHS.
- improved efficiency and reduced duplication.
- a standard model of development and progression for each staff group which will help achieve stability and improve quality of care.
- easier and more effective peer and safety reviews.



Critical success factors

Research for the toolkit has highlighted a number of factors which must be in place for successful adoption of standardised practices:

- Administrative processes should be consistent but where there is local variation the differences should be clearly understood by all.
- Staff must understand why certain processes are required at all networked sites and what their value is for patients and the organisation.
- Information handling and moving must be excellent, ideally with centralised, excellent IT systems accessible to all.
- Everything must be covered by detailed SLAs drawn up before the network opens.
- Strong leadership is needed to explain and reinforce standard processes.
- Staff across the sites should receive standardised specialty-specific customer care training, repeated regularly.
- Flexibility is sometimes needed to adapt to local needs but variations must be agreed, transparent and well described.

Critical success factors continued

It was clear from speaking to a number of networked organisations that neither national nor international geography should be a barrier to standardised governance frameworks. Flexibility for local innovation can be built into standardised models – the need to adapt to local conditions should not be used as a reason not to adopt a standardised approach. One of the international healthcare organisations we met was Mediclinic International, an exemplar for organisation-wide clinical and corporate governance.

Mediclinic international:

- operates 49 acute care private hospitals and two day clinics throughout South Africa and three hospitals in Namibia, with more than 8,000 inpatient beds in total.
- operates 16 acute care private hospitals with more than 1,600 inpatient beds and three primary care outpatient clinics in Switzerland.
- operates five acute care private hospitals and 39 clinics with more than 600 inpatient beds in the United Arab Emirates, mainly in Dubai and Abu Dhabi.

"Sharing patients' notes wasn't considered when the agreement was drawn up and although we've offered the host trust access to our electronic records, they want physical notes, which costs us."

"We know the NHS is now looking for standardisation, replicability, sharing knowledge and experience, not having everybody just doing their own thing."

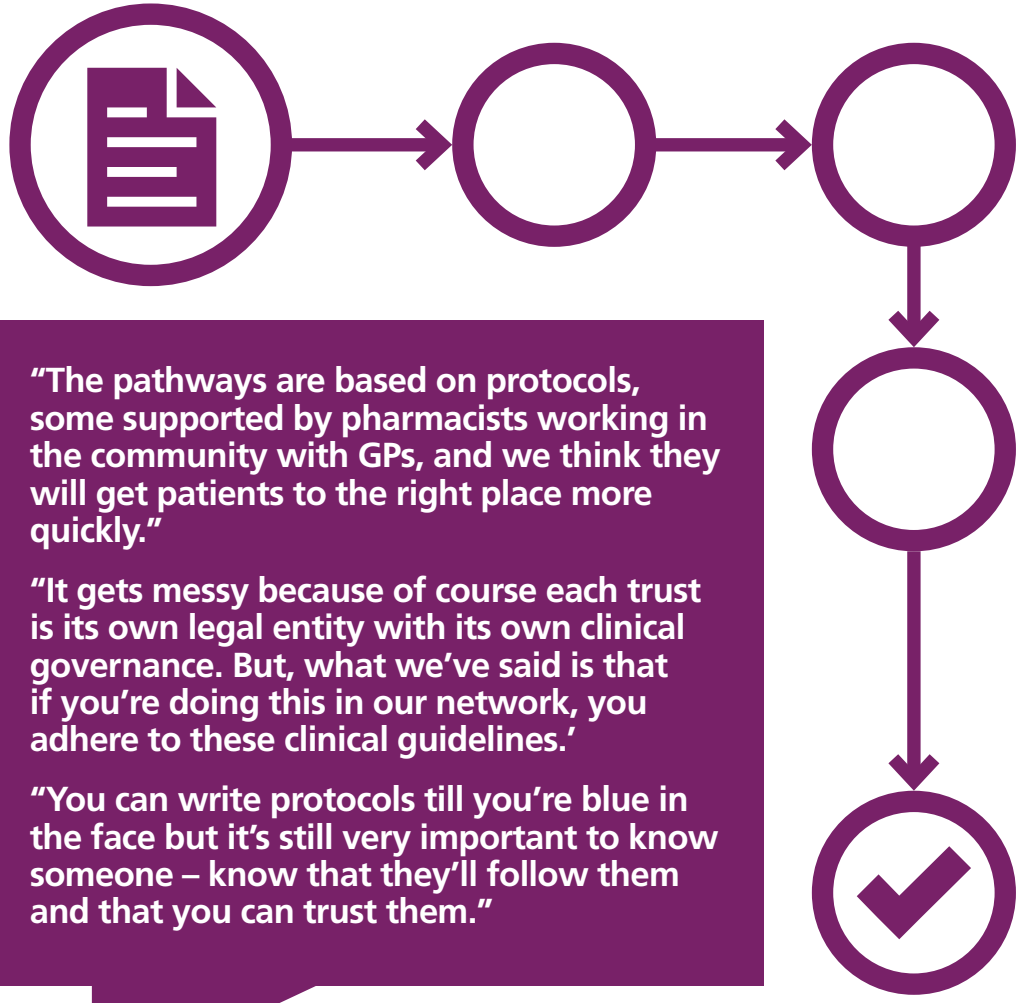
"Standardising the skills of the workforce will ensure that wherever they go they know what their job is."

"We must ensure appropriate specialty benchmarks and standards - we know what good looks like."

Policies and procedures

In any well-governed organisation, everyone needs to know not only what they are supposed to be doing but also how they are supposed to be doing it. Standardising guidelines, policies and protocols across all sites is considered essential if care, surgery and outcomes are to be consistent.

- Some variation is necessary in order to enable individual sites to respond promptly to local conditions: how much is acceptable needs to be established.
- There needs to be a robust clinical governance framework to manage policies and procedures and ensure that the documents are available and clear.
- Shortened, more visual formats such as infographics can be used to provide summaries which are accessible and quick to read.
- Major new policies should be actively promoted for example via mandatory training sessions or via remote educational resources.
- Ensure you have the right policies in the right place, for instance standard operating procedures, procedures for the deteriorating patient, resuscitation in high risk areas.



"The pathways are based on protocols, some supported by pharmacists working in the community with GPs, and we think they will get patients to the right place more quickly."

"It gets messy because of course each trust is its own legal entity with its own clinical governance. But, what we've said is that if you're doing this in our network, you adhere to these clinical guidelines.'

"You can write protocols till you're blue in the face but it's still very important to know someone – know that they'll follow them and that you can trust them."

Resources

Regulation

Trusts are overseen by a combination of statutory and advisory regulators.

Statutory regulators are:

NHS Improvement: replaced the functions of Monitor, the foundation trust regulator, and the Trust Development Authority, the regulator of non-foundation trusts. It holds providers – including independent providers who supply NHS-funded care – to account and, where necessary, intervenes to help organisations meet their short-term challenges and secure their future.

Care Quality Commission (CQC): monitors and inspects services to ensure they meet standards of quality and safety. Its reports are published to help patients choose where they receive care.

NHS England: leads the NHS in England, setting its priorities and direction. It dispenses more than £100 billion to organisations which it holds to account for spending it effectively for patients and efficiently for the taxpayer. It commissions services through contracts with GPs, pharmacists and dentists and by supporting local health services led by CCGs. It has devised a strategic vision for the NHS, the Five Year Forward View.

There are also professional advisory bodies such as the royal colleges and NICE as well as other specific regulatory organisations including the MHRA.

Regulation continued

Governance

A clear governance framework and standards that each site understands it is expected to adhere to are key to providing assurance to regulators.

Even with different models of care within a network, standardisation of types of service offered and central monitoring of compliance should ensure quality and safety and provide assurance for regulators.

Provider-host relationships

If the two parties are not clear about who is doing what, the regulator will be unclear too. Our research has frequently highlighted the need for robust agreements between specialty provider and host trust to be in place before the new service starts. SLAs can be very useful to describe the relationship, what each partner is supposed to be doing for the other and to inform regular reviews. However, they do not usually have the legal standing that formal contract documents offer.

Cultural issues

In some networked models – for instance one where the host trust continues to count the activity provided by the partner in its performance reports – provider trust staff can sometimes feel more part of the host organisation than their own. In this case enforcing the provider's standards can be a particular challenge and will rely heavily on strong local leadership.

Inspection challenges

Because inspectors are less familiar with the networked model, organisations can have difficulties explaining how some aspects work. For example, a manager on one site will be responsible for staff in her area but not for staff in her specialty on another site. Having structures with clear lines of responsibility that staff clearly understand will mitigate this.

Another issue can arise when it is not clear to an inspector where the line is drawn between areas of responsibility for patient care, for instance during surgery and on a post-operative ward. Again, being able to provide evidence of agreed protocols and accountabilities will provide assurance.

"One inspector expected the pharmacist to know about all pharmacy staff's mandatory training across the network, not just at her site, whereas she knew that was not her responsibility."

"As the provider we were responsible for the day case procedure but not for the post-operative nursing and when an issue arose about analgesia on the recovery ward, the inspector didn't understand why we hadn't administered it."

Spreading learning

Multisite networks offer huge potential for spreading learning about good practice, risks and incidents to large numbers of staff for the benefit of patients. But there must be a systematic approach.

As well as putting in place the right suite of meetings – some suggestions below – it is crucial that there is a good number of central risk staff who move around the network as well as a person at each site co-ordinating and disseminating learning about quality. Allowing staff to work at different sites also spreads expertise and learning.

- Specialty-specific multidisciplinary sessions at which attendance is compulsory, other than for those offering emergency care, are powerful ways to share learning.
- Other effective methods include sharing standard templates of issues and learning, email alerts, newsletters and intranet content as well as a dedicated quality team with resources, support and training.
- Incident reports must contain robust and achievable action plans not only for the local site/service but also the rest of the organisation and these must be monitored to ensure actions are completed to a schedule.
- There should be suitably expert risk and safety staff who move around the network and are able to challenge operational and clinical staff effectively.
- Staff at all sites must seriously consider how this could apply to their location and not have a 'it couldn't happen here' attitude.
- Learning after serious incidents and never events is often well done but learning from more minor situations is more challenging.

"When an innovation at a site has gone well, there needs to be effort to roll it out across the network."

"Any network relying heavily on email for important communications must make serious effort to ensure all staff use this address for all their work communication, check it regularly and act on it appropriately."

"It's important to be completely realistic and not to include actions that are vague, cannot be done or won't actually improve safety but are there just for the sake of it."

"Quality partners at local sites are extremely helpful but it's a challenging role to fill."

Spreading learning continued

Sources of learning

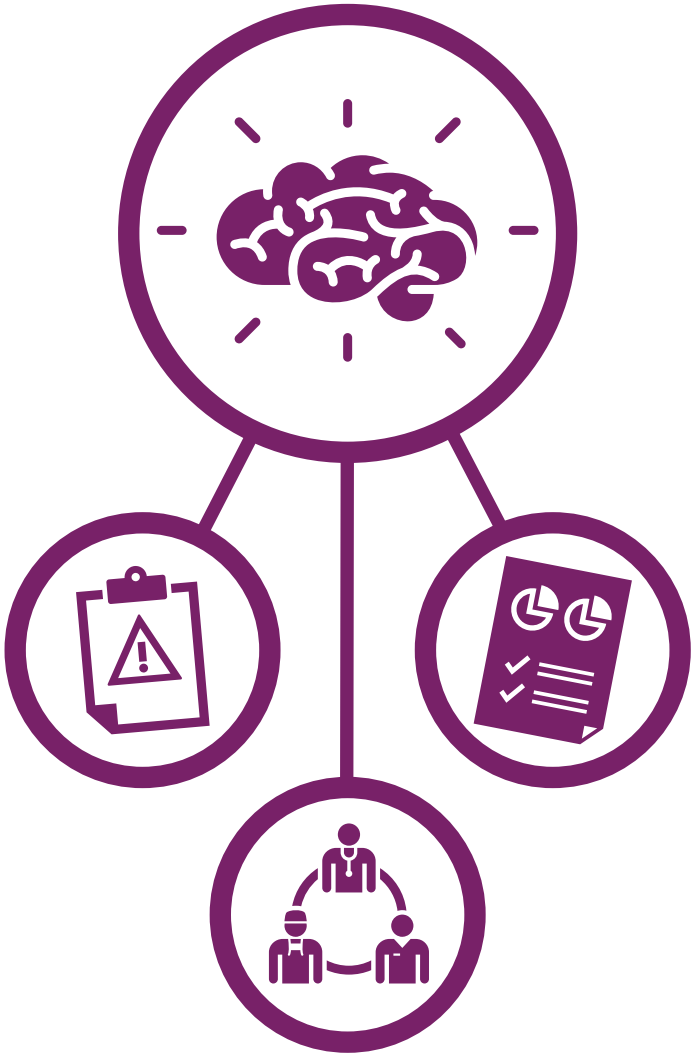
Learning that should be shared can be gained from a wide range of sources including:

- serious incidents, never events and lower harm incident reports.
- internal reviews, quality reports, CQC reports and preparation materials, compliance work.
- external reviews and visits.
- patients.

Meetings

Relevant, well-planned meetings have a role to play in spreading learning.

- Multidisciplinary half days during which all but emergency activity is rescheduled.
  - Use a standardised agenda covering key areas like audit, outcomes, guidelines.
  - Invite speakers, trainers or local leads to present learning from other sites.
  - Ensure full participation of all staff types, not just clinical.
  - Use an attendance register, provide minutes with clear actions to be shared across sites and monitored by risk staff.
  - Make recordings of the event available via the intranet.
- Area-specific meetings, such as a theatres learning group, are also useful but be sure to include and give a voice to all staff types.
- Senior clinicians and managers' forum to receive/disseminate quality and safety information.
- Operational quality meetings such as risk and clinical governance.



Spreading learning continued

Other ways of learning

- Observation of practice and networking across site provides learning for both trainee and trainer and promotes consistent practice.
- Training the trainer – staff at sites are trained to pass on their learning down the hierarchy at their sites.
- Some training may be best delivered to provider employees by staff at the host site such as safeguarding, fire, resuscitation – also promotes functional links between partners.
- When possible, staff should be able to access online learning and assessments or view teaching or lecture videos as well as distance learning resources.

Patients are a rich source of information and learning. This can come from patient participation stories, the Friends and Family Test, social media and complaints, among other routes.

- Sharing standard templates of issues and learning across sites, emails and email alerts, newsletters and intranet clinical governance pages.
- Be wary of over reliance on email – think: how will I know everyone who needs to will get this done by the deadline?

Other thoughts about learning

- Learning from significant adverse events often requires anonymised learning so that staff can be open in reporting and do not feel there is any 'finger pointing' or denigration of particular sites.
- Reporting may need to be available more frequently with headline figures and scorecards or summary templates and less frequently with detailed breakdowns and analyses.
- Whatever is used must be consistent and look familiar across the organisation.
- It must be clear that action has been taken as a result of learning.
- It is important that staff learning from an event at another site see the relevance to them.
- Don't rely on brief feedback in electronic incident reporting systems.
- Our experience is that learning after serious incidents and never events is generally better done than learning from near misses and lower harm incidents.
- Remember to liaise with the host site over any actions involving them.
- Using staff as peer reviewers of other parts of a network is powerful.
- Consider external advice for difficult issues.

Spreading best practice

It is well established that clinical outcomes are improved by setting best practice standards.

Measuring clinical outcomes alone will not be enough. The CQC has the responsibility to monitor, inspect and regulate services to ensure they meet fundamental standards of quality and safety. It publishes what it finds, including performance ratings to help people choose care. The trust board is ultimately accountable for ensuring those fundamental standards are in place.

The best way to spread best practice is to set standards centrally and roll these out as part of the mobilisation process. Replication across all networked sites and measuring compliance will underpin assurance around quality and safety. Induction, mandatory and local training should promote the importance of compliance and peer review should be encouraged to create excellence in care.

"A key improvement should be a reduction in unwarranted variation in clinical quality and service model. Networks can provide a framework that describes what good looks like – not sticking rigidly to organisational viewpoints but doing what is best."

"It's easy to give people documents but that's no guarantee they're being used or being used correctly."

"A particularly important policy for networks is business continuity. All sites ideally need detailed plans for everything that could conceivably go wrong."

"If a new document is being launched, it's wise to introduce the key points at team or service meetings."

Resources

Spreading best practice continued

- Up-to-date policies, guidelines and protocols need to be easily accessible to all staff to enable them to operate at the required standard without constant reference to the centre.
- It should be easy for staff to find those which are relevant to their role.
- Using consistent documentation and systems across the network will help staff moving between sites and enable patients to have a seamless experience.
- Evidence-based specialty-specific policies and guidelines need to be kept up to date.
- Policy owners should lead on compliance monitoring.
- Advanced practitioners should be encouraged to share their skills and knowledge and be allocated time to do this.
- There needs to be clarity about how policies can be adapted to local needs and maintain network standardisation.
- There needs to be a clear process for communication to ensure that service improvements, learning from complaints and incidents and examples of excellence in care are shared across the network.
- This learning needs to be monitored so it is clear how and when it was shared.

Measuring single specialty services

Smaller single specialty departments often form part of a wider clinical group within a hospital. Performance highs and lows can be lost within pooled data for divisions, directorates or the whole trust. It may not be until a problem develops that any indication of quality and safety issues surfaces.

Smaller departments are not always seen to warrant individual assessment, or the specialty expertise is not available within the management team to decide what to measure. Clinical and service management leads for whom this data should be crucial can feel too busy keeping the service afloat to devote the time to measuring performance metrics.

However, not only is it important in a general sense for single specialties to be assessed but it is also crucial to have metrics, judged against standards for achievement (targets) where possible. These can be used to decide whether or not a service can continue as it is, whether changes should be made or a partnership with another specialty provider considered. It is also important for a unit or trust to be able to quantify the specialty performance of any potential partner.

When deciding how to evaluate a specialty, there are a number of generic measures which are collected by any trust and which simply need to be assessed for the specialty separately, for example the number of serious incidents or the compliance with annual mandatory training for the specialty staff.

Beyond that, there are specialty-specific measures but these generally fall within certain predictable categories of information, such as the complication rate for the main specialty procedure or adherence to specialty national guidelines.

Reliable sources for specialty-specific quality requirements and targets include guidance from NICE, royal college or national specialty body guidelines and recommendations, national audits, patient reported outcome measures and the CQC.

If a smaller service has not been appropriately measured, the potential specialty partner will need to undertake appropriate due diligence.

We have provided examples of broadly agreed generic metrics for colorectal, neurology, orthopaedics, ophthalmology, blank version for other specialties to use and a template for quality sharing. They are by CQC domain and metric group. These can be downloaded (below) and adapted.

Resources

XLS

Metrics: ophthalmology

Metrics: orthopaedics

Metrics: colorectal

Metrics: neurology/neurosurgery

Metrics: generic

Metrics: quality sharing

Download to view

People

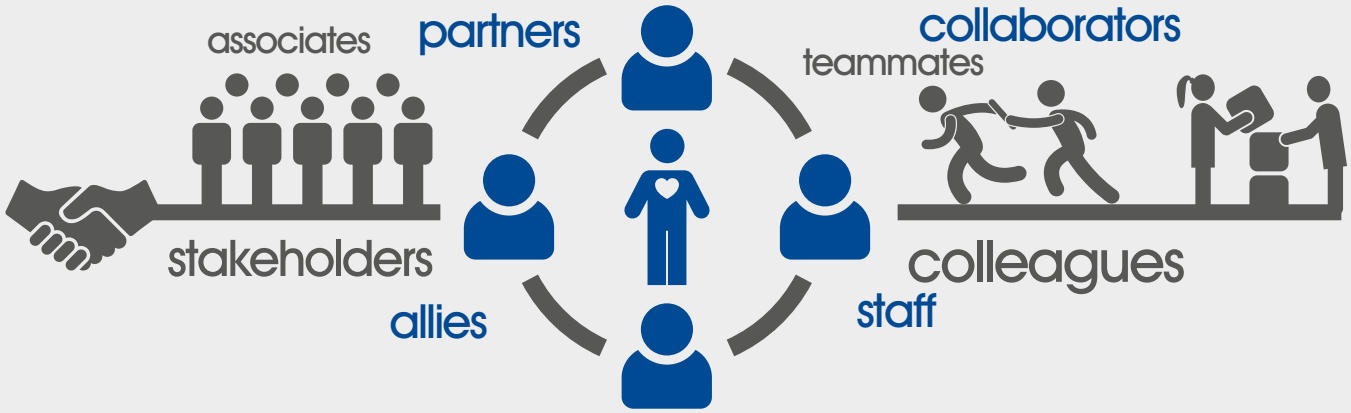
The care provided to patients will depend on the quality of the workforce caring for them and the extent to which they are true participants in their care. We consider a model for working in partnership with patients as well as ways to overcome some of the pressing challenges facing the NHS workforce.

Patients | **Workforce** | **Partners**

1 How will patients be involved in developing the service?

2 What are the implications for your workforce?

3 What sort of relationship will you and your partner have?



Patients

In order for health and social care systems to be resilient, responsive to the needs of their communities and sustainable, they must involve patients and service users at every level. Understanding how best to do this for hospital services in a networked care model has been a key project for our vanguard programme.

Patient participation

Working with the New Citizenship Project we have explored how, when and where patients currently get involved in our own network and how we can share and replicate examples of great patient participation across the whole system.

Working With Patients for a Brighter Future

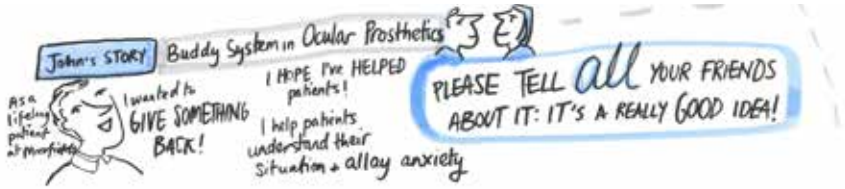
Patient participation film

Resources

Patient participation continued

We found that the language surrounding the role of patients is often poorly understood with terms representing very different ideas – interaction, participation, experience, engagement, involvement – being used interchangeably across the trust (and more widely across the NHS). As a result there seemed to be no clear framework for understanding the significance and quality of existing patient interaction or making recommendations for improvement.

- We used 'appreciative inquiry' to focus on identifying what is working well, understanding why it is working well and then how this can be replicated across the network. To do this, we:
  - defined the terms associated with patient participation and gathered best practice examples from inside and outside the networked care model; and
  - reviewed existing patient interaction to understand critical success factors that make it effective



Proposed terminology

- **Patient experience**
  Initiatives that relate to patients as customers, gathering personal feedback in order to understand and improve service provision, but which fundamentally see patients as 'them' not 'us'.
- **Patient engagement**
  Initiatives that seek to further inform patients about their condition and to create the conditions for patients to become more active participants in their care or that of their local or condition community, providing information or other resources, but which do not actively seek to structure or harness the outputs this might create.
- **Patient involvement**
  Initiatives that actively seek to harness the expertise-from-experience of patients as a crucial input and as peers alongside those with other forms of relevant expertise.
- **Patient interaction**
  All forms of interaction with patients, from experience through to involvement.
- **Patient participation**
  A term which can be used to cover both engagement and involvement.

Patient participation continued

The next step was a workshop with 40 people including 15 patients to co-create an initial set of recommendations for improving future patient interaction and participation.

After this we:

- developed a patient interaction framework identifying the different levels of interaction patients can have with a hospital or unit and its services: patient experience, patient engagement, patient involvement and patient participation.
- made recommendations for the further development of patient participation within Moorfields.
- drew out the consequences of this approach for any single specialty service in providing networked care.
- created a step-by-step guide for single specialty services to best harness patient interaction in a networked care model – 'the five steps' guide.

The guide can be used by any organisation wanting a process to embed and provide evidence for the benefits of patient participation across a network. The patient participation report provides more detail (small file or very large file with embedded films).

"Despite the growing acknowledgement of the value of engaging patients in their healthcare, the term 'patient engagement' is at risk of becoming nothing more than a 'hot buzz phrase,' as it lacks a shared definition and, consequently, shared guidelines for interventions."

From: The Challenges of Engaging patients in Healthcare, Journal of Participatory Medicine, 2014

Participation stories

Test your knowledge – five steps to patient participation tool

Report – Patient participation (small file)

Report – Patient participation (250mb file with embedded film clips, will take a while to download)

Workshop – Graphic illustration

Five steps to patient participation

Step 1:

Know your brand and harness its potential value across the networked care model

- Find out how well your brand is trusted and if there's a gap between that and perception of your partner organisation.
- Trust in your brand can generate patient confidence and staff pride, improving outcomes.
- You may want to clearly articulate your brand to differentiate your service.

Step 2:

Find out how well you are interacting with patients now

- Use our 'Test your knowledge – five steps to patient participation tool' and seek out examples across your organisation – you may be surprised how much is happening.
- Identify one or more existing patient champions and involve them from the outset.
- Establishing a baseline will help you evaluate any changes you make.

Step 3:

Co-design the new service with existing patients

- Identify any patients in your existing service who live in the catchment of your potential host trust.
- Talk to them individually or in groups; seek their stories and jointly generate ideas for the new service.
- If there aren't many, you could collaborate with patient groups or the local Healthwatch.

Step 4:

Make sure patient experience is right

- All levels in the 'hierarchy' of patient interaction matter.
- Engagement and involvement are more participative than experience in the tool but regular surveys of experience and other feedback opportunities should still be provided at all sites.

Step 5:

Harness as much patient participation as you can

- Once a new unit starts, share any central site initiatives but also mine it for ideas.
- Consider creating structures to encourage ideas such as an innovation fund or a prize.
- Do things 'with' patients, not 'for' them.

Test your knowledge – five steps to patient participation tool

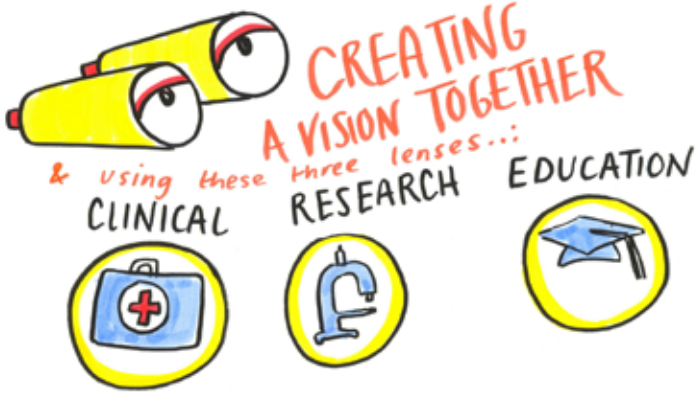
Five steps to patient participation continued

Examples of the Moorfields' experience:

"There's far more patient interaction going on than we thought. It's patchy, but where it's being done well, it unlocks a range of positive initiatives which benefit everyone."

"There are aspects of host hospitals that patients with sight loss are much more sensitive to, such as lighting, which they can swiftly identify."

"We have glaucoma seminars for patients at one hospital and volunteer hand holders for surgical patients at another. If we celebrate these across the network we may encourage more good ideas."



Test your knowledge – five steps to patient participation tool

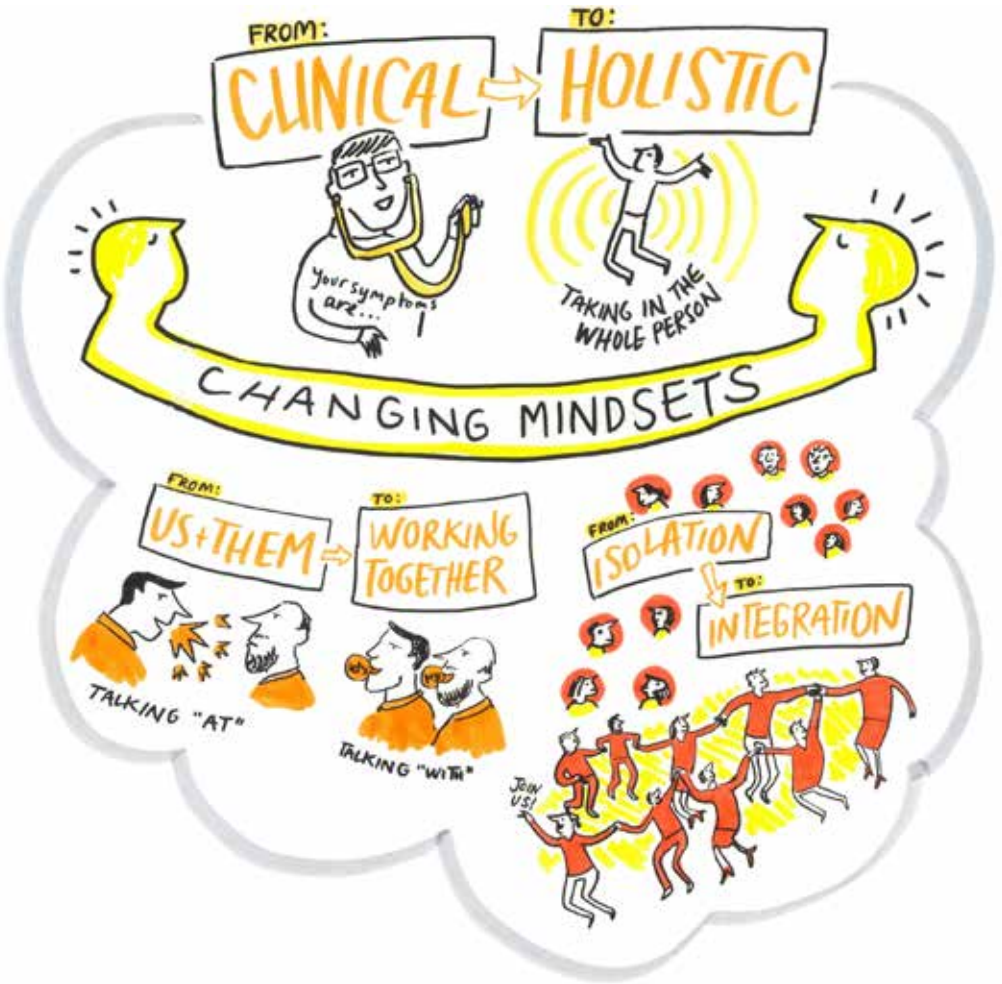
Patients as partners

The voluntary, community and social enterprises (VCSE) sector plays an important role in improving health outcomes by working in partnership with healthcare organisations to not only deliver services but also shape their design. A key role is ensuring the voices of patients and carers are heard and understood.

NHS England is committed to co-designing national strategies with VCSE organisations and legislation and strategy documents such as the Five Year Forward View 2014, have promoted the role of VCSE organisations in improving outcomes.

And since August 2016 all organisations which provide NHS care or adult social care are required to follow the Accessible Information Standard which is designed to ensure that people who have a disability, impairment or sensory loss receive information they can access and understand.

"I found that talking about and sharing my experiences was incredibly liberating - it was therapy like no other. I'd not expected it to feel so good and positive; I'd just wanted to get my story across."



Resources

Workforce

For many trusts, worries over staffing are becoming even greater and more urgent than those over funding. Solving current issues with, for example, leadership, culture and skill mix will be key to future sustainability.

Future proofing

A 2016 survey by NHS Providers found that only one in four trust leaders (27%) was confident of having the right staff numbers, quality and skill mix to deliver high quality healthcare for patients and service users. Fewer still (22%) were confident about having the right staffing levels six months later.

And the top leadership itself is part of an unfolding recruitment crisis with the average tenure of a trust chief executive reported as 30 months and fewer senior managers wanting to take up the challenge.

Future proofing continued

The single specialty networked model of care has some intrinsic advantages for overcoming some of the challenges to a sustainable workforce, but it is far from a panacea. A key advantage is its ability to test on one or two sites different ways of working without disrupting the rest of the network.

Among the solutions that will be needed are:

- addressing workforce shortages.
- shifts in skill mix.
- retraining/repurposing the current workforce.
- addressing any inequalities on spending on training across the workforce.

Advantages of the specialty networked model include:

- a wider cohort to draw on, learn from, develop and grow.
- more pulling power of a specialty provider's reputation (for potential staff who want to work in that specialty).
- more opportunities for local autonomy and leadership development.
- ability to test innovations like new roles, without disruption to the rest of the network.
- staff may be keen to work across different sites.

Future proofing continued

Moving to this type of model will not solve all problems. If the unit is in a location that is difficult to reach and without many facilities, it may still not attract staff even if taken over by a specialty provider. If so, it may be necessary to consider whether the unit is viable, whoever runs it.

As we have seen in so many contexts within this toolkit, good leadership is crucial, both centrally and locally. And staff are more likely to be attracted to a facility where they can learn, develop and increase their competencies.

Organisations more often turn to a specialty provider when a service is either failing or in danger of doing so. It can be tempting to think that if a specialty provider can get the service back on its feet, the problem is solved. But like any service, today's solution may be tomorrow's problem and networks have to keep pace. What they can offer is the opportunity to embed best practice at a new site from day one and to test different workforce solutions as the network develops. Commissioners and the host trusts expect to see the service improve and do things differently, not to just patch up the current model.

Future proofing continued

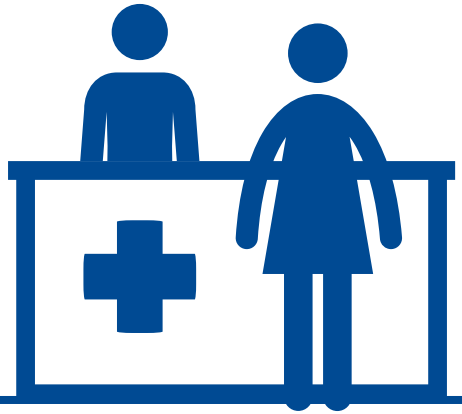
A significant problem for hospitals is today's reliance on consultant clinicians, around whom the care model traditionally revolves. There are not always enough of them to sustain the services needed. The NHS is increasingly looking to develop service models that do not entirely rely on consultants delivering the care.

The Heart of England Foundation Trust is replacing its largely medical workforce model, which relies heavily on locum and agency workers, with consultant-led teams including advanced clinical practitioners (ACPs). They are experienced non-medical clinicians such as pharmacists and allied health professionals who are trained to work as senior clinicians and will be able to substitute for doctors.

Over the next five years Heart of England plans to train up to 250 new ACPs and fund some of this by withdrawing up to 120 locum and middle-grade medical posts. The trust believes that this investment will deliver a flexible clinician-led workforce (consisting principally of permanent doctors and ACPs) to deliver care that is more consistent, timelier and safer for patients.

The Buurtzorg Model, Netherlands, sees skilled nurses provide comprehensive community care to vulnerable older people at home. In the past, care was provided by a constellation of different staff, many of them unskilled staff.

Iora Health, USA, provides comprehensive primary and community care to complex older patients with a very small number of GPs supported by health coaches, nurses and social workers working to help patients take better control of their health.



"Advanced practice was delayed by the organisation as there was fear of any complications which could occur with a nurse performing the task. If she's been doing over 20 of these injections a day for years, why does she need a doctor supervising her?"

Leadership

Good leadership is consistently cited by networks as crucial to success. Suitable leaders must be identified or recruited, trained, developed, supported and allowed enough time to perform their role well in addition to any clinical work commitments.

Essential elements are:

- strong and visible corporate leadership articulating an inspirational vision and narrative about quality of care at all sites.
- strong and visible local leadership committed to effective, efficient performance in line with the organisation's strategic goals.
- good people management and employee engagement skills fostering enthusiastic team working.
- frequent articulation and sense checking of the vision for the network.
- agreed level of local autonomy.

"We know how to solve the problem and it's good when we're given the power to get on and do it."

"It makes such a difference when the executive team come out and see what we're doing."

"I've trained the sister so she can act as matron when I'm not around, otherwise the matrons can be very thinly spread."

Leadership continued

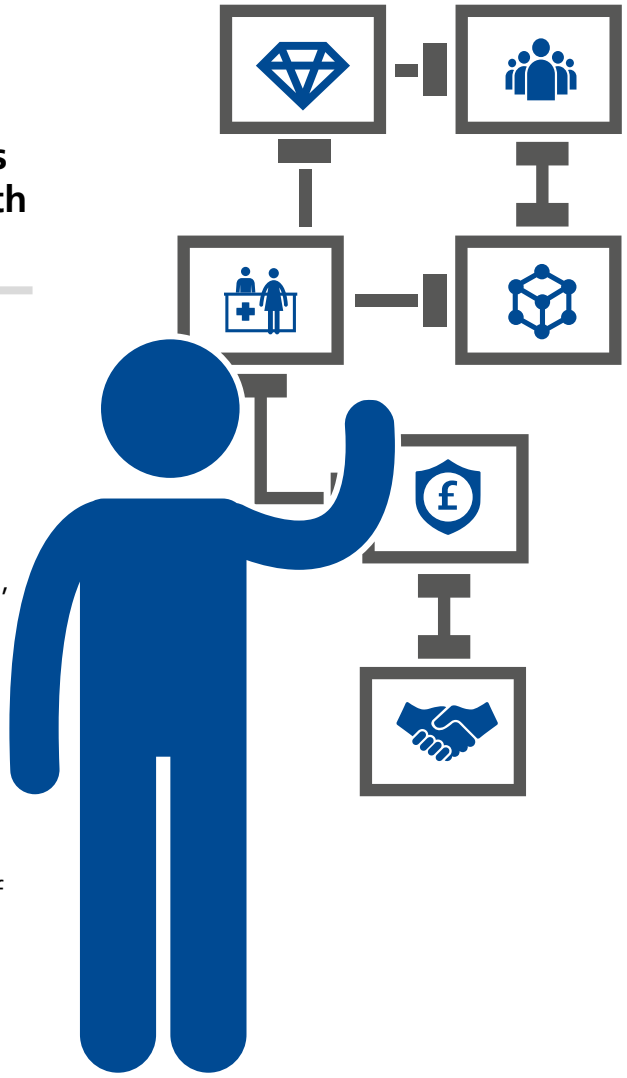
Sites within a network offer great potential for developing staff, testing innovations and creating excellent patient experience. Strong local leadership is key, particularly to ensuring that all sites operate to the right standards and with the right culture.

Planning

- The leadership of the site should be considered early in the planning process. Don't assume the existing structure can be stretched.
- You may not need more people. It may be a question of repositioning and reorganising existing resource, perhaps giving someone the chance of greater responsibility.
- Experience has shown that the more dispersed the network is, the more diluted the management. Sometimes the answer will be more managers, sometimes it will be a more senior manager.
- Leaders must be given time to perform their role well in addition to any clinical work.

Structures

- A clear management structure is crucial to proper authority and accountability and to allow prompt escalation. It should be mirrored by clear financial, performance and workforce processes.
- Clinical services are best led and managed by the senior clinician on site. This ensures they are supported, motivated and able to challenge poor standards.
- Each site and sub-specialty should have an identified manager and clinical lead. Appointing a nurse lead and allied health professional leads may also be appropriate.
- Networks offer greater potential for a dedicated specialty manager and more flexible clinical leadership. Apart from formal line management, it is important that staff know when and how to access advice. Much risk will be mitigated by clear protocols and clinical guidelines.
- Aim for a mix of local and posts shared with other networked sites – working across more than one site provides more experience and wider shared learning.



Resources

Leadership continued

Patients

- Leaders should be mindful that a new provider taking over a flagging service can provide continuity of care for patients who would otherwise have to travel elsewhere.
- Workforce sustainability may be enhanced by developing staff who wish to remain in their local area.
- The recruitment of local staff with an investment in the area and the service can improve patient experience.
- Staff should be encouraged to challenge poor practice (see 5 courage to challenge posters) and to understand how it impacts on patient care. CQC visits can happen any time and social media makes it easy for patients to complain in public. High standards of quality and safety should be business as usual.

Integration

- Leaders are key to ensuring that a new site feels properly integrated into the rest of the network. A risk is the creation of an isolated, unconnected service which may already be going through the trauma of transfer to a new employer and new ways of working.
- All staff must be encouraged to feel responsible for everything that goes on at a site.

Communications

- Managers are responsible for ensuring that their staff receive communications from the centre and that they understand the role their site plays in the network. If a team brief system is in place, ensure all staff attend meetings regularly and can feed back to the centre.
- It may be worth swapping newsletters between providers and hosts to keep abreast of each other's news.

"Good leadership is essential to successful standardisation across a network."

"The local management team should be the champions on behalf of the network who educate and train the teams they are responsible for."

"If you don't feel you can afford the right level of leadership that might be a reason not to take on a site."

Resources

PDF **A guide to team briefing** **5 courage to challenge posters**

Culture

To deliver consistently excellent care, staff need to understand their purpose, be motivated, embrace the values of their organisation and speak a common language. It requires extra care in a dispersed organisation to ensure that all parts feel equally valued.

Key elements include:

- inspirational vision and narrative focused on quality of care, frequently articulated.
- commitment to effective, efficient performance based on goals and objectives.
- good people management and employee engagement – compassionate leadership.
- continuous learning and quality improvement.
- enthusiastic team-working, cooperation, partnership and integration.
- staff understanding of why some decisions have to be taken centrally and when they can be made locally.

Some thoughts about possible tools:

- A formal series of commitments around behaviours can be useful; if in place it should be used at the point of recruitment onwards.
- Remuneration is important to recruitment and retention; differences between inner and outer city weighting can undermine retention in some areas.
- Results of the annual NHS staff survey should be analysed by site where possible to differentiate areas of excellence and difficulty.

Culture continued

"Some roles are quite mechanical and people may think they are not as valued as much as those with more complex skills, yet these roles are crucial to the patient pathway."

"Newer staff who come into the organisation have some really good ideas and it is important to support them so that they can be shared with the wider network."

"Some staff find it hard to make decisions without consent from everyone. I warn people not to include too many colleagues in their emails to avoid wasting time with unnecessary discussion."

"Nurse managers who allow matrons to approve bank shifts avoid delayed payments and retain the goodwill of bank staff."

"Traditional hierarchies need to adapt to the pace and amount of change coming from the front line."

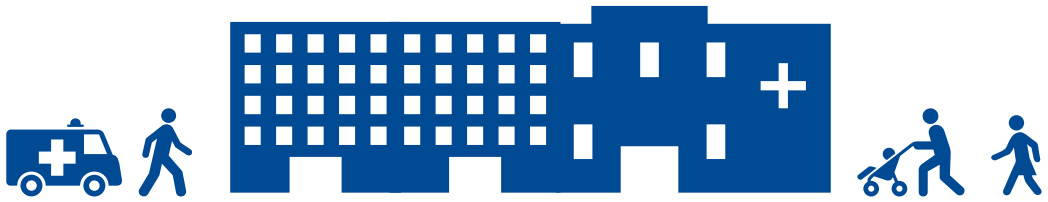
Culture continued

A values-led culture

If an organisation is thinking of opening a new site, it is a great opportunity to embed the right culture so that everyone knows not only what the organisational values are but also how to live them. It is important that after a site mobilisation the values are continually reinforced and embedded.

Potential benefits:

- People can care for others well only if their own basic needs have been met. If we want staff to be caring towards patients, the staff have first to feel cared for - by the organisation and each other.
- Many issues dealt with through mediation, the disciplinary process and even employment tribunals could be dealt with much more quickly and locally.
- Once embedded into the leadership at all levels, many issues will be resolved locally, freeing senior leadership time.



PDF The Moorfields Way

Culture continued

Essential elements

Defining the values – these should reflect the status quo as well as the organisation's aspirations so that staff can see they are rooted in reality.

Living the values - Although many trusts have identified the standards of behaviour they expect staff (and patients) to abide by, and there may be widespread awareness of them across an organisation, the extent to which they actually affect behaviour can vary. This is likely to be because people need to know:

- what, specifically, they need to do to meet the standard, such as say hello and introduce themselves, answer the phone within five rings, check everyone's had a chance to contribute at a meeting.
- what to do if they are on the receiving end of inappropriate behaviours. This can be particularly challenging for more junior members of staff when a senior colleague behaves inappropriately.

Communication – staff must be able to see how the values affect them personally, how they benefit the team and help the organisation. Workshops are helpful to tease out what the desired behaviours look like in practice.

Leading by example – the most cited reason by those in the public sector for lack of engagement is that there is one rule for senior managers and one rule for everyone else. So if respect is one of the values, the leadership team must demonstrate this at all times; if another is excellence, quality should always be held in as high regard as financial considerations.

Embed them from the start – setting expectations at the beginning of the recruitment journey is crucial to how staff see the values. If you are clear at the outset about the culture and nature of your business, it is more likely you will attract and retain like-minded colleagues.

Consequences – staff must see the consequences of going against the values. Leaders must be prepared to deal with infringements whether through training or the disciplinary process. If values are to be given the priority they deserve, they need to be regarded in the same light as policies and contracts – it is, after all, the organisation's reputation at stake. Similarly, those who excel at embodying them should be rewarded.

Reinforcement – values are for life. Make sure they are brought to life at regular intervals to ensure they stay an integral part of everything you do.

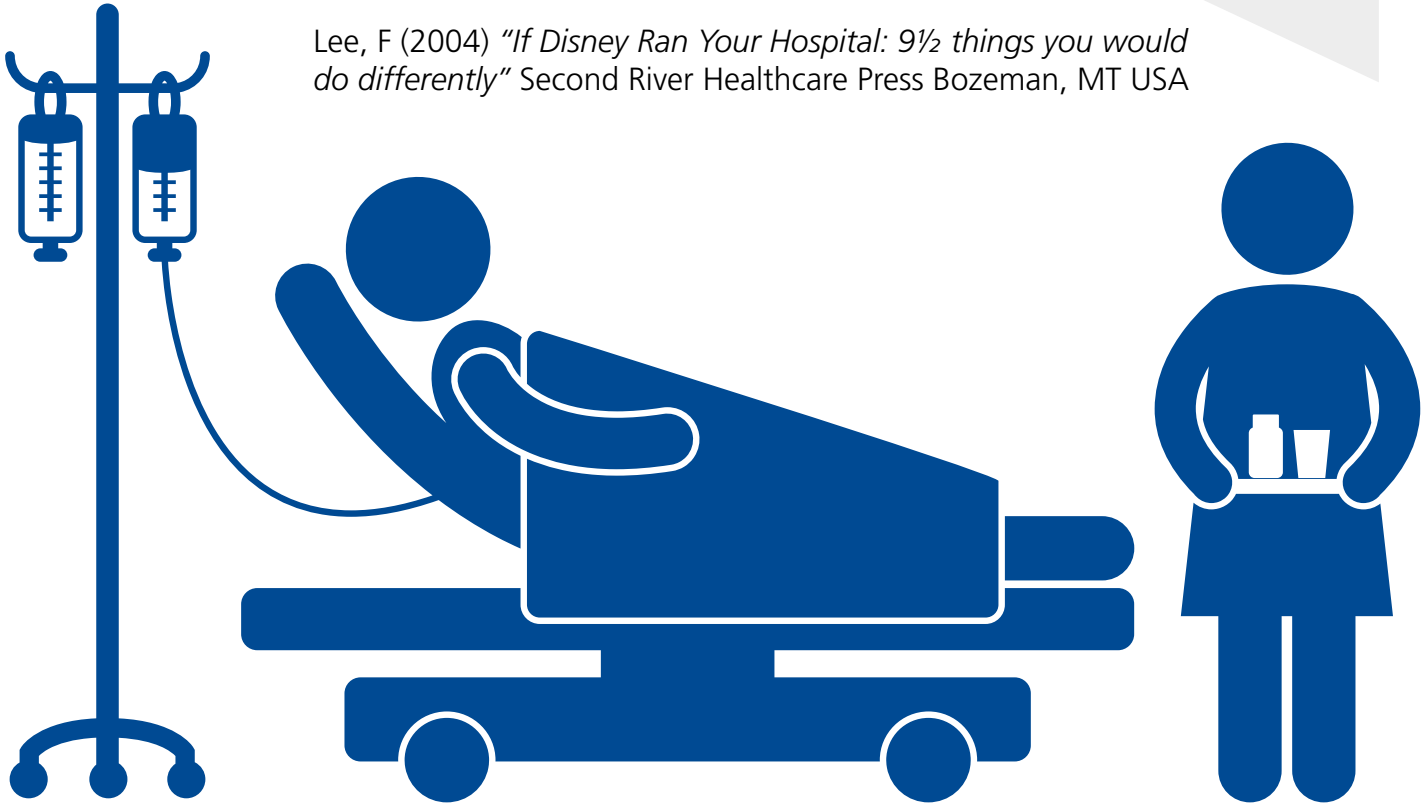
Culture continued

Techniques which could be used include:

- auditing current practice across the organisation to 'pulse check' the level of awareness and adherence.
- creation of safe places for staff to role-play difficult situations and learn how to handle them in line with the values.
- creation of widely-understood tools to help staff recognise where the values are not being lived and help them challenge the situation, for instance a 'yellow card' when someone steps over the line and a process for follow-up.

"Action follows thought, and if our thinking is changed we will find the ways to create a culture that inspires caregivers and reshapes the patient's experience towards a more trusting and compassionate environment for healing to take place."

Lee, F (2004) *"If Disney Ran Your Hospital: 9½ things you would do differently"* Second River Healthcare Press Bozeman, MT USA



PDF **5 courage to challenge posters**

Skill mix

As a network grows a significant challenge can be having enough people to support all the specialties that develop. Investment in training and development is key.

- Recruiters must ensure that potential staff have the right attitudes and skills to work at a distance from the centre.
- Highly skilled staff need the time and support to share their skills with their colleagues.
- Many advanced skills can be learned and practised by nurses, freeing doctors to focus on other aspects of care.
- Allow people to develop services where their passions lie but make sure the offer overall is balanced.
- Make sure staffing needs, including administrative support, are considered at the initial planning stage.
- Sometimes the centre needs to allow local flexibility, for instance around recruitment processes or some aspects of mandatory training.

"The consultant might want to provide a particular service but are the patients' needs coming first?"

"When the consultant left, the service stopped and now the patients have to travel much further."

"Staff who work in different places need to feel there is one place that is their 'professional home'."

"We all need to know what the rules are but sometimes we need to make sensible alterations to attract the right local staff."

Training

Regular training is essential and can be delivered at different places and in different ways across the network.

- A central learning and development resource is seen as very powerful, as is having a local site team to teach and record competencies.
- If travel is necessary, ensure as many training items are delivered during the session as possible.
- Peer-to-peer training is very valuable, providing learning for trainee and trainer and promoting consistency.
- Some training is best delivered by the host trust because of local variation, such as fire and resuscitation modules. This promotes links between partners.
- There are many distance learning tools and resources which can be exploited to increase access to training.

"Best practice is to have a recognised model of development rather than people just picking the study days they fancy."

"When investment is made in training staff to a high level, it is important to give them appropriate autonomy to build their confidence and find solutions."

"Having access to support, education and expertise are all benefits of being part of a network."

Development

A network can offer huge potential for continuous professional development and training, using the expertise available among professionals at other sites as well as buddying, mentoring and support for staff in difficulty.

- Appraisal and continuous professional development are particularly important in a network to ensure that staff are adhering to standards and to identify and address training needs.
- It can be helpful for some appraisals to be performed by staff from a different site to facilitate integration and prevent staff becoming too inward looking.
- Where training needs are identified, time and any travel costs must be considered essential.

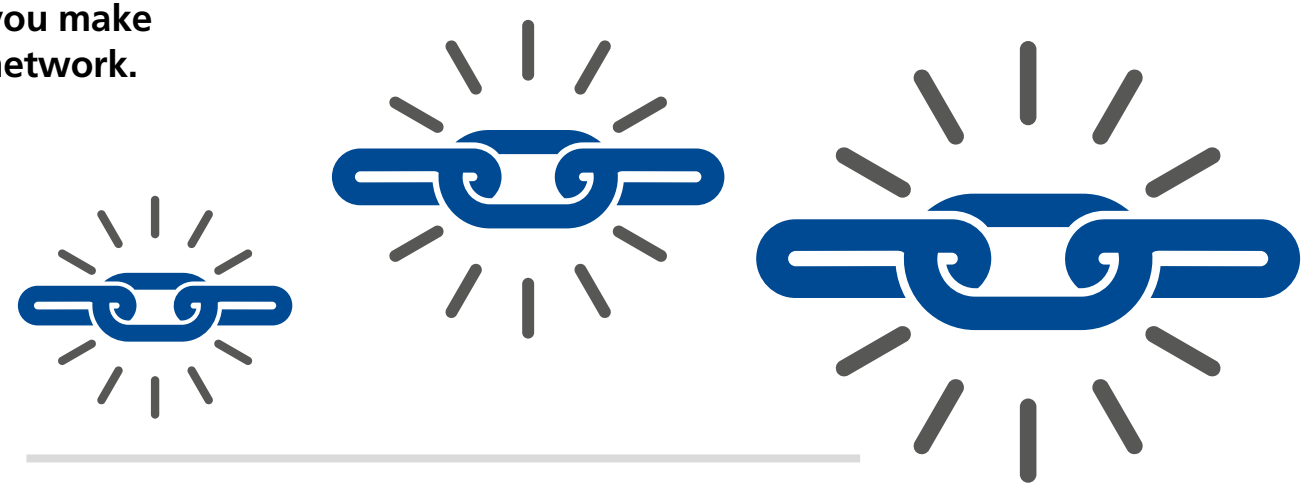
"It's good to get out sometimes and do an external course – it stops you getting too internally focused and you find out what other people's issues are."

Partners

The choice of partner and the relationships you make will strongly influence the success of your network.

Shared vision

Be clear on the terms of your relationship and align your understanding of what a successful partnership will look like. If you cannot choose your partner (perhaps circumstances necessitate collaboration) the relationship will need more work. Several organisations told us that agreements were continually compromised by changes in corporate and clinical leadership.



It may be useful here to share the learning from Moorfields' networked care history and relationship experience.

In most cases in our model, host trusts and landlords have little or no day-to-day involvement in our services unless they are providing support such as anaesthetic cover or cleaning as part of the lease/licence. The exceptions are our partnerships where we provide only clinical support.

Interdependencies tend to focus on issues such as IT connectivity, space constraints, environmental issues and the clinical support agreed in any service level agreement.

Shared vision continued

The level of integration with our partners varies across our network depending on how the services developed. Determining factors include:

- the host trust had no further business interest in the service being transferred (it was no longer a host trust priority).
- the service exists as a tenant arrangement only (for instance where the services are independent of the landlord).
- our preference is to own and run the service autonomously under the Moorfields brand.
- smaller ambulatory services are not so co-dependent on other local clinical services.

When we interviewed standalone (not providing networked care) DGH board members, they expressed a clear expectation that not only should there be a relationship between the host and specialty provider, there would also be a need to routinely report into the host trust through something like a joint management board.

A smaller DGH with a number of its services networked to specialty providers had from experience not seen the need for more than a light touch CEO-to-CEO relationship annually with the clinical relationships between the specialty provider centre and the networked site being managed by the specialty partner.

Shared vision continued

We talked to 25 executive board members – potential providers and host trusts – to understand what they would want to know about the potential networked care solution. They said they would ask:

- Will it be better for patients?
- Is there a good strategic fit between the two organisations?
- Is there a good cultural fit?
- What are the risks of doing it and of not doing it?
- Will I be taking on a lot of issues rather than providing a sustainable alternative?
- What kind of governance is needed to keep the relationship on track?

"Who will the CQC want to speak to if something goes wrong? I think I'd feel responsible if it's our name above the door."

"You do need a bit of give and take - it's impossible to try and come up with an arrangement that always works well financially for everyone."

"You're all good friends at the beginning but there's a danger that everyone becomes complacent after a while. You need a joint management board."

"We're trying to get people to think of the thing as one NHS footprint rather than seven individual organisations."

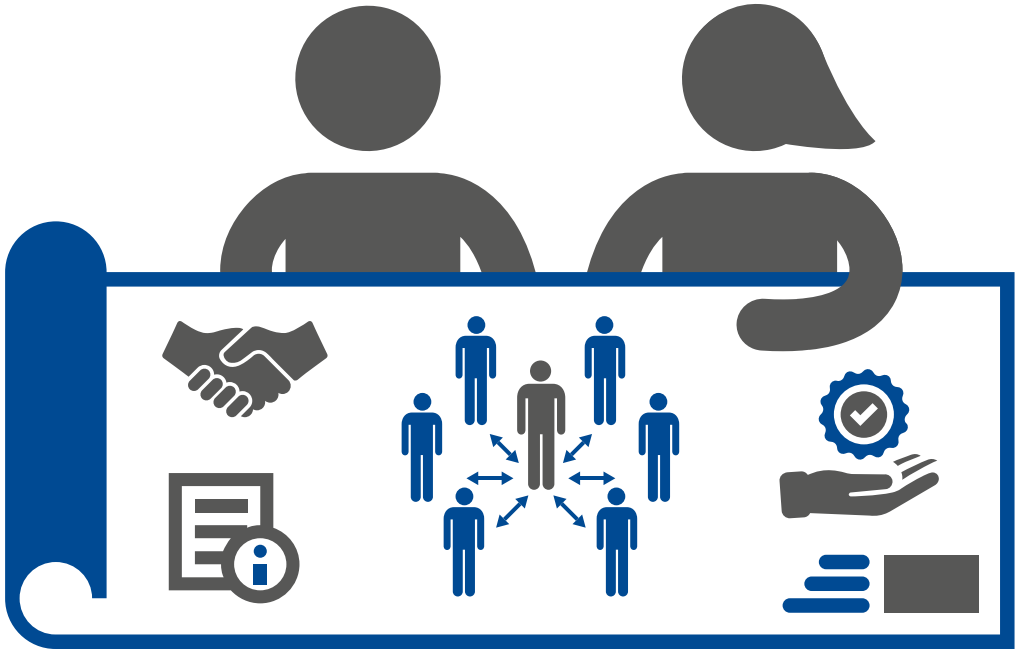
"We recognise that no one provider can afford the other one not to exist. If one provider fails that's a problem for everyone so we need to proactively manage things."

"You can go only at the pace of the slowest."

Working together

Whatever the type of arrangement, a good relationship between a provider and host trust is essential to the success of that part of the network. If this is your first networked site you may create a blueprint for future collaborations if your network expands. A formal agreement, good working relationships, training, IT connections and the way you share information will all play a part.

The operating model for any service hosted and delivered at a host site should be clearly defined from the outset and incorporated into staff training. This will include not only processes relevant to the staff delivering the clinical service but also interactions with the specialty provider site and partner site processes and services (such as theatre recovery areas, dispensing pharmacy services, IT support).



Different types of arrangement for specialty provider host networks:

a. service delivery and accountability is wholly outsourced to the specialty provider, or

b. services are delivered by the provider, who is held accountable for performance by the host trust, or

c. service delivery remains with the host trust using the governance framework of the specialty provider.

Regardless which of these, or other options, are in place, the relationship between the two parties will be key.

Working together continued

- The relationship should be managed both formally, via a partnership agreement and informally, via good working relationships.
- It may be useful for provider and/or host to sit on some of each other's committees.
- A monthly meeting between both parties can ensure compliance with the agreement.
- Good links between the organisations at service level will ensure operational aspects run smoothly and technical issues can be resolved quickly.
- Consider making available staff communications such as newsletters to each other's organisation to aid understanding.
- Encouraging the provider's IT team to develop a good working knowledge of the host site and the services operated there will guard against the host site staff perceiving the specialty provider as detached and uninterested in its needs and challenges.
- Consider whether some mandatory training (such as fire training, resuscitation) is best delivered at the host site rather than requiring travel to the centre to allow local variation.
- Information-sharing agreements should be put in place between the organisations. This will be particularly important where systems are integrated and patient details shared. The agreement will need to incorporate the wider NHS's confidentiality, information governance and security requirements as well as statutory data protection provision.
- There are likely to be differences in the way the operating model works for different sizes and types of site. Variables include different levels of integration and interaction with the host's systems and whether particular services like surgery are offered, requiring additional systems and procedures.
- Business continuity planning should include liaison between the organisations in the event of a system or infrastructure failure. Shared procedures and/or technical resources that the provider can use in the event of failure of its own systems might be useful.
- Any information that may be held on the host site's systems should be backed up regularly and recoverable on demand.

Partnership agreements

An SLA defines the clinical services the specialty provider and the host trust will provide. In the NHS SLAs are often used for clinical services between host trusts and partners.

An agreement should include:

- the business objectives to be achieved in the provision of the services.
- the service deliverables.
- clear descriptions of who is responsible for which parts of the service.
- the performance standards the host provider expects from the specialty provider.
- a reporting mechanism for measuring the expected performance standards.
- mechanisms for remedy/compensation where standards are not achieved.
- a mechanism for review at set intervals or if one party requests it.

Most of the trusts we spoke to had issues agreeing or enforcing SLAs, particularly if they were complex.

Problems can arise when key people and organisational knowledge is lost. Some had issues because it was not clear whether the host or the specialty provider owned the development of the SLA if their partnership involved two-way shared services.

Dartford and Gravesham NHS Trust has developed an innovative approach known as the Dartford Health Partnership. The model seeks to establish a process for review and standardisation of each of its key partnership SLAs. The first stage has prioritised 34 agreements across 11 partner organisations accounting for 80% of the value of all SLAs.

The trust has a clear process to achieve success and will be sharing its progress in the toolkit in the coming year. In the first instance the trust has made available its draft model SLA and process diagram.

PDF **Dartford & Gravesham NHST SLA draft**

Dartford & Gravesham NHST SLA process

Commissioners

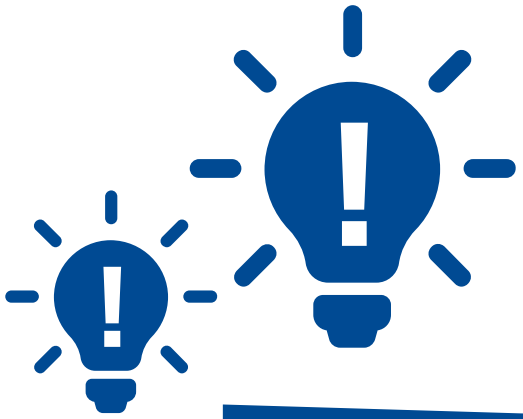
Commissioners will expect the new provider to add value. This might be, for example, by creating pathways to reduce waiting times and hospital stays, improving patient and clinical outcomes or integrating with existing local services. They will require clearly defined reporting processes.

Experience and research with commissioners highlighted some key assurances they would expect from the new provider:

- How patient outcomes will be improved is paramount.
- How will shared expertise work?
- When services are being provided over a bigger geographical area, they will want to see that they support and are integrated with existing local services.
- They will want to see that due diligence is done thoroughly for proposed new sites and that an organisation can provide an effective service when geographically distant from the centre.
- Additional costs or financial efficiencies will need to be clearly evidenced and justified.
- Commissioners will be concerned if a network appears to create a monopoly in an area - which can create a bigger problem if the provider fails - so any proposal needs to address this risk.
- They will expect the new provider to bring innovation to the service.
- Commissioners may expect to have a single lead commissioner across the entire network with clearly-defined responsibilities and reporting arrangements able to hold the provider to account across all its sites.
- A networked care model across a wide geographical area is likely to have implications for the lead commissioner who has a duty to visit all sites. This needs to be considered in planning.
- There will need to be standardisation of care but also flexibility to develop local bespoke pathways where needed – not just one way of doing things.
- Clinical leadership will be seen as important. Involving local GPs in delivering the services should be considered.

Commissioners continued

Top tips when drawing up a case for the commissioners:



- The host trust should engage its local commissioner at an early stage when considering bringing a specialist provider to ensure the sustainability of an existing service.
- The host trust will need to ensure that the new provider understands both the host and provider commissioners' needs, challenges and priorities.
- Look at the relevant CCG's stated intentions, performance against measures of public health outcomes and its financial situation, for example the actual spend per weighted population compared to the allocated spend.
- Ensure commissioners are behind you and try to identify what they want from the service – will that work for you?
- Commissioners should understand the implications of adopting a new model, which may include an increase in the number of patients attending the service.

Practicalities

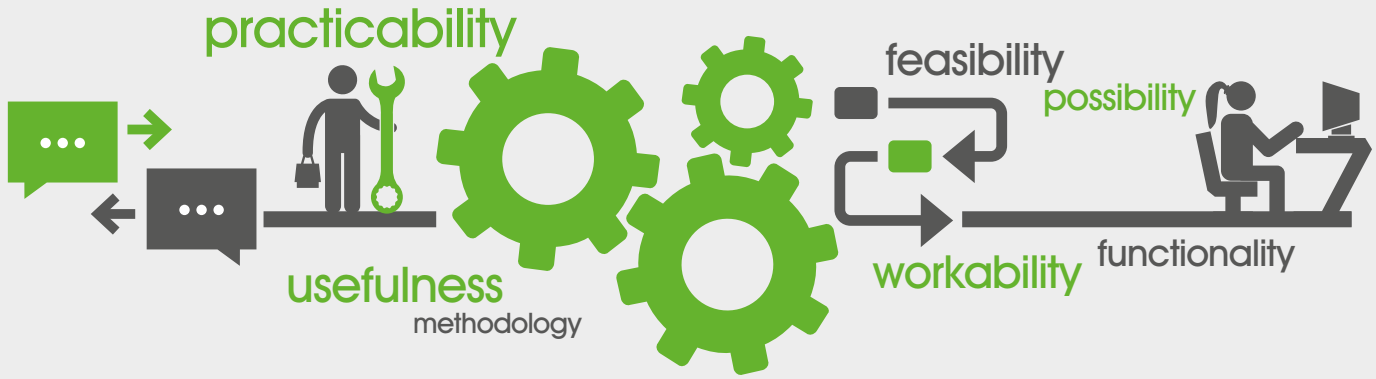
A series of guides and tools based on the experiences of a wide range of providers to help any organisation setting up a networked care model.

10 steps to a networked care model

1. Is there a clear partnership plan?
2. Has it been adequately resourced?
3. Has it been well communicated?

IT considerations

Communications



10 steps to a networked care model

It is clear from all we have learned that standardisation must be employed from the start if it is to be achieved across a network.

Methodology

To help and to reinforce our aim to provide a replicable model, we have developed a methodology to:

- guide prospective partners through the process.
- enable standardisation of approach.
- use consistent documentation.
- evidence decision making.
- enable replication at pace.

While this is primarily intended for developing a single speciality networked care model, it could be applied to other forms of service development. It is designed to enable organisations to move through a structured process from when a (host) trust starts to consider alternative service delivery models through developing a partnership, to mobilisation and service transition. It is supported by practical tools (templates) which can be downloaded and adapted for you to use within your own organisation.

We have provided a partnership programme plan which is linked to the 10 steps methodology as template 8 and you may choose to use this from step 1 through to transition.

Methodology continued

Step 1:

Identify service concerns or other reason for review

It is important, regardless of the reason for the service review, that as far as is possible, the host trust (the organisation currently providing the service directly or indirectly) gathers sufficient information to make an informed decision at each key stage.

We have provided a template for you to capture some initial scoping information template 1. We have also provided a scoring template. The scoring document is a way of quantifying the information collected into a simple evidence-based format to help make decisions. At this stage consider whether it would be better to collect more detailed information to save time later. The template 3a and template 3b provide this more detailed approach.

- As far as is possible clear baselines will be needed so that the success of any decision and future performance can be judged.
- Measurement against national and local quality standards will enable you to assess current performance. Sample metrics are provided to help you to do this.
- The local sustainability and transformation planning group and commissioners should be involved from the start so that time is not wasted on a solution which is not supported.

Patients

Resources

Methodology continued

Step 2:
Agreeing a specialty review

As this toolkit is primarily aimed at developing single speciality networked care, the scoring template encourages a specialist review. The absence of local clinical expertise to lead and mentor a smaller specialty can be a symptom of service failure or risk of failure. It can also make it difficult for hospital management to make informed choices about a service's future.

There are times when it can be beneficial for an organisation to commission an independent, expert review of the service to understand what it currently looks like and provide a gap analysis for what is needed to create longer-term sustainability.

- Metrics are helpful but do not tell the whole story.
- An external review by a small multidisciplinary specialty team, with a specific remit and questions to answer, can help the organisation to consider options.
- Options could include continuing with the service and trying to bridge the gap or seeking a partnership with a specialty provider.
- The information gathered will be useful whether you go into partnership or not, as the basis for future improvement, whatever the model.
- A review can help develop a service specification if there is a decision to use a procurement process.
- The review team can be different from the eventual partner but if you have a partner in mind it is prudent to use it so that the review can serve as due diligence if you proceed.

All steps in the methodology are designed to provide assurance that a robust process has been followed.

Methodology continued

Step 3:
Planning the review visit

This is potentially the start of building a relationship with a prospective partner.

- Contact the specialty provider. Be clear about who is best to provide this expert review.
- Steps to planning the discussion (telecom or short visit from speciality provider):
  - Discuss the overarching question or concern for review – be clear about your concerns or objectives.
  - Agree the key questions which need to be answered as part of the report so that the expected outputs are clear to both parties. This should include whether the host trust wants any specific recommendations about future management of the service.
  - Agree information required before the visit.
  - Agree the visit date(s).

Template 4 is a template for the review agreement.

Having agreed the review, the specialty review team will need you to send more detailed information than may have been collected at step 1. This is why we suggest using template 3 at that early stage. Send detailed information to the specialty review team template 3a (Excel) and template 3b (Word). Please note that some information may not be able to be shared at this stage due to commercial or potential TUPE regulations. However if the partner has already been identified, it may be helpful to consider accelerating the process to include agreeing the memorandum of understanding and data sharing agreements (step 5).

- The review team will also gather information about the local health economy and other providers unless the host trust can provide this.
- The more information the host trust can gather, the more comprehensive the overall review report will be. The host trust should start gathering financial detail but it may not be shared at this stage with the review team unless this is the prospective partner.

Patients

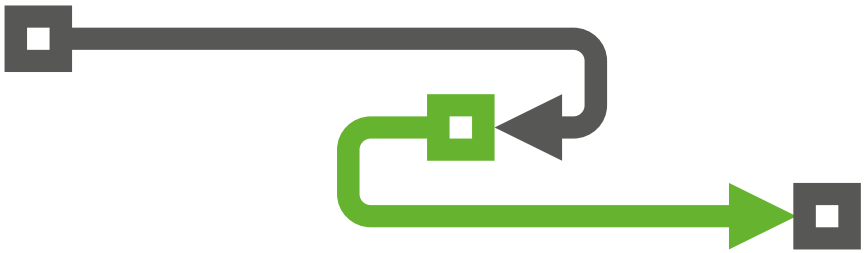
Methodology continued

Step 4:
Review visit methodology

The onus now shifts to the specialty provider review team responsible for both the review visit methodology and report structure. But it is important to ensure that the host trust is clear about the process.

We have provided a template that can be used for planning the review visit template 5 although local circumstances will vary so it can be adapted accordingly. The specialty team will need access to all relevant clinical areas in order to carry out an effective review. The team will want to spend as much time as possible with frontline staff and patients and will need planned interview slots for key local service leaders.

At the end of the visit the review team clinical lead will share with the service clinical lead and manager any clinical concerns needing urgent attention. Some positive feedback on something observed which deserves special mention can help to leave things on a positive note. No further discussion should be entered into until all the team members can assimilate their findings.



Step 5:
Review visit report and feedback meeting

The review team should share its findings and recommendations in a formal written report and at a face-to-face meeting with the host trust. Template 6 is a framework for the report and information to be collected during the review although, again, this will vary according to local circumstances.

The host trust should now be in a position to decide how to proceed.

The following steps assume the host trust decides on a single speciality networked care provider solution. However the steps and templates can be adapted for other solutions.

Methodology continued

Step 6:

Developing a memorandum of understanding (MoU)

There will be a period between the decision to work together to see if a mutual solution can be agreed and any final decision and business case. There should be transparency between the two parties to ensure that the best outcome can be achieved:

- The MoU states the responsibilities, activities, outcomes and lead contacts between the host trust and the specialty provider. It is non-binding and mutually beneficial.
- There is no agreed formal structure for an MoU but one or more of the parties are likely to have an organisational template it is required to use.
- The MoU's purpose is to ensure both sides deliver what is agreed: the host trust to supply information and the specialist team to plan how the new service will address gaps and innovate.
- The MoU will inform the business case so the host will have to share financial data.
- Consider involving the commissioners in the MoU as their co-operation and support may be needed.
- The framework for the agreement needs to be discussed - how the service will be managed, financial agreements and so forth. Are both parties in agreement as to how the service will be managed?

Both parties must sign a data-sharing agreement in respect of sharing any identifiable patient and staff information.

The information governance leads for each partner must be involved in this process to ensure that all safeguards are in place.

Methodology continued

Step 7:
Developing the networked care solution

- The host trust now supplies more detailed information to enable the specialist partner to see if a networked care solution can be developed. The template 3a and template 3b detail will now need to expand to include the financial data to help the specialty provider assess business viability. For example:
  - Activity remuneration: there may be local prices and agreements which the specialist provider will need to understand. The contracting department can provide a full year activity costing.
  - Staff costs: the specialty provider will need to know the grades and spine points in order to accurately cost the existing staff resource. This may still need to be without names and some more sensitive information which cannot be provided until TUPE information can be requested (if a transfer is imminent) or after staff transfer (if they transfer). However the full staff costs should be shared at this stage.
  - The specialty provider will need to make a decision about equipment – will it transfer, is it suitable for transfer and any costs. There is likely to be a need for capital investment so this will be a key part of any business case development.
  - Space: what are the space costs? After staff, revenue costs of space are usually the next highest cost for any new provider.

The partnership arrangement (or contract form) will be key to the specialty provider business case. Our board-level interviews showed some differences in the way organisation executives think about networked care partnerships. Both parties need to be clear from the outset about what they want to get from the partnership and the level of control or autonomy each party expects to have. Key considerations:

- Joint meetings and two-way information exchanges will help develop solutions.
- It is essential to bring together key internal stakeholders from both organisations to ensure that agreements are reached and at the right level, for example resuscitation-officer-to-resuscitation-officer; pharmacy-to-pharmacy and so on.
- Commissioners must be kept informed as the process develops.
- Performance baselines should be agreed so that success can be measured before and during service transition.

Methodology continued

Step 8:
Designing the improved service

The review report, further discussions and information sharing will now enable the specialty partner to develop the revised service plan. We have provided a comprehensive planning checklist template 7a (Excel) and template 7b (Word) which has multiple functions:

- It can be used instead of templates 1 and 3 as a more comprehensive current service review.
- It will help the specialty provider to ensure all aspects of the potential service are identified.
- It will enable both partners to identify the internal stakeholders needed to agree/sign off aspects of the service, for example the resuscitation arrangements.
- It will become the mobilisation checklist when adapted from the planning phase.
- It will ensure all staffing, space, equipment resources and costs are identified for the business case.
- It provides assurance that the service has been planned well.
- The detail collected at step 3 and updated at step 7 will accelerate the business case detail and mobilisation planning. It will ensure that all activities and costs are captured avoiding problems once the service is being mobilised. Plan for every eventuality, then plan again!

Step 9:
Business case

The business plan will need to be developed by the specialty partner for its board-level approval. Depending on the proposed partnership, this may not be straightforward, for example if the host trust wants to retain some financial or managerial interest.

A business case template, template 8, can be used although most organisations have their own.

Patients

Resources

Methodology continued

Step 10:
Mobilisation and transition

We have provided a partnership programme plan template 9 which can be used from step 1 throughout the process. It is a template which will need to be populated in more detail locally.

Critical success factors for mobilisation include:

- a robust engagement and communication strategy, starting from the decision to develop a business plan to the opening of the new facility.
- an experienced project leadership and governance structure supported by project management methodology.
- a project team who research operational requirements and costs thoroughly in order to inform the business case and service level agreement.
- use of easily-accessible approved templates to improve learning and communicate plans.
- an agreed stakeholder project group for every new operational service development project ensuring that services are co-created with patients.
- understanding what success looks like for finances, reputation and market share.
- robust analysis tracking the impact on clinical outcomes, patient experience, activity and contribution.

"Had someone senior undertaken with total clarity the operational requirements, costs, site requirements and SLA before mobilisation, most issues would probably have been avoided."

Once the service starts, review the process and see what can be learned. If toolkit methodology and/or toolkit templates are used please let us know how useful they are using the website feedback form or by emailing enquiries@networkedcaretoolkit.org.uk

Template 1: host trust internal review
Template 2: scoring

Template 3a: detailed review information

Template 3b: detailed review information
Template 4: review agreement
Template 5: review visit methodology
Template 6: review visit report framework

Template 7a: planning and mobilisation checklist

Template 7b: planning and mobilisation checklist
Template 8: business case framework

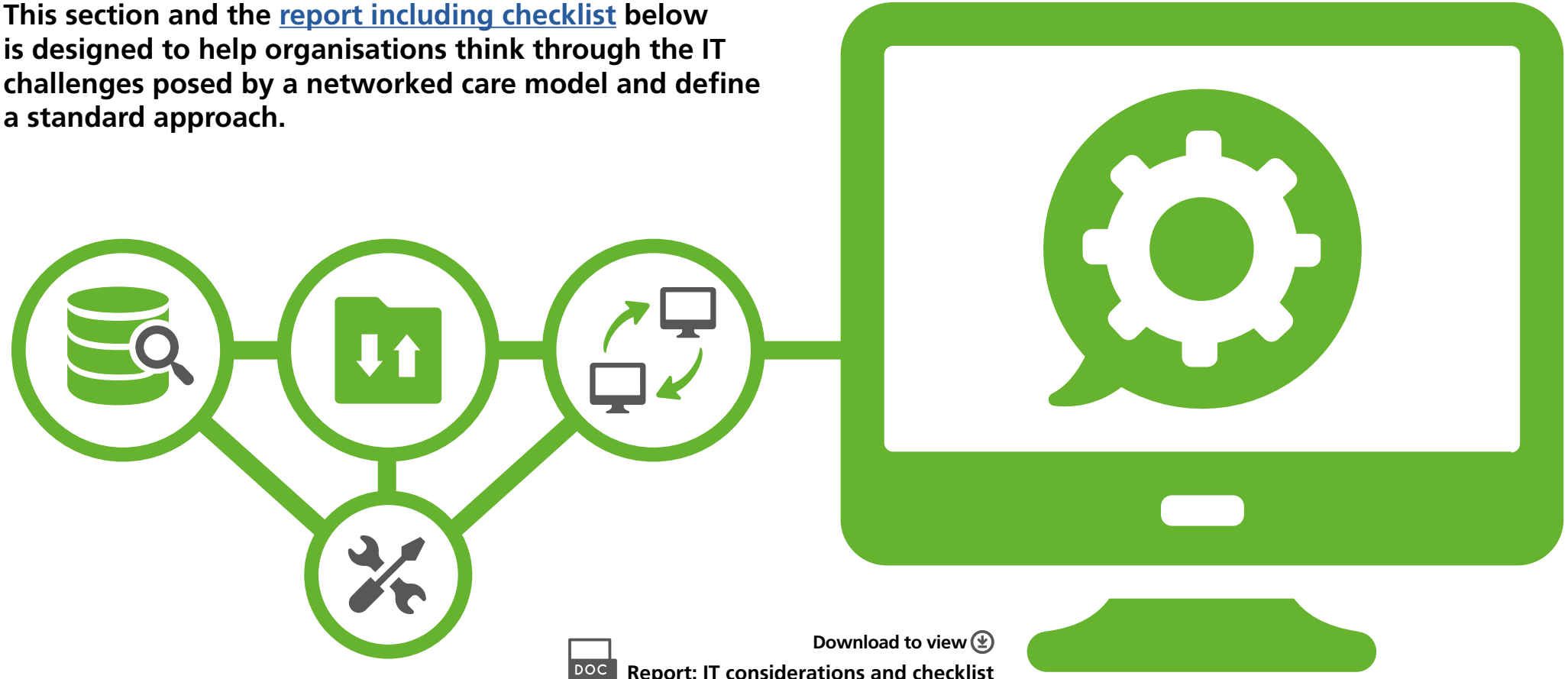
Template 9: partnership programme plan

Communications framework: new networked site

Download to view

IT considerations

This section and the report including checklist below is designed to help organisations think through the IT challenges posed by a networked care model and define a standard approach.



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Report: IT considerations and checklist

Critical success factors

Modern, robust IT systems designed in partnership with host organisations and backed up with testing and recovery plans are crucial to success. You will need:

- the ability to share patient data quickly and easily – may require investment.
- involvement of all relevant parties from the outset, particularly host site IT teams.
- increased use of electronic records instead of paper.
- communication tools to reduce travel time.
- robust SLAs between organisations, regularly monitored.
- sufficient testing and support during implementation and go-live.
- improved technology resilience in combination with enhanced business continuity planning and disaster recovery procedures.
- robust performance management and capacity planning of systems and services supporting all networked sites.

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Report: IT considerations and checklist

"The desire for greater efficiency is now focused on 'connect all rather than replace all', ie the reuse and joining up of services rather than their replacement with a new set of national (spine) services."

"Some networks have been able to use innovative technology to use data to target preventative interventions on high risk patient groups, reducing hospital admissions."

"Technology allows specialists at our trust to give clinical advice to GPs without them needing to refer the patient to us."

Context

National, regional and local priorities will strongly influence an organisation's willingness and ability to support and fund initiatives. Developments shown to further existing agendas are more likely to succeed.

National priorities

- Cost savings and greater efficiency.
- Bringing care closer to home.
- 'Seamless' patient pathways across different providers.
- Rationalisation of estate.
- Paperless patient records.
- Patient access to health records.

Regional priorities

- STPs to create sustainable services.
- Local digital roadmaps to facilitate STPs and aid digitisation of the NHS.

Organisational priorities

- Vision and strategy for the whole organisation – networked care model needs to fit in.
- IT strategy – needs to describe systems and services required to support the model.
- Impact of new model on existing plans, for instance procurement of new clinical system.
- Estate changes.

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DOC **Report: IT considerations and checklist**

Operational considerations

Due diligence is needed to ensure that in extending into another organisation, the provider understands the risks. These may include ageing IT equipment and loss of knowledge of any bespoke IT systems associated with a specific service.

Both organisations should be willing to share relevant risk and costs.

Technical considerations

A detailed breakdown of all the elements that will need to be considered is contained in the reference document below and includes:

- governance, security and delivery.
- network: connecting the central and other units, connections within the local site and telephony and conference facilities.
- common services such as information security, back-up and recovery services.
- servers and storage: physical or virtual infrastructure owned and operated by the provider or host or a combination.
- applications: access to admin, clinical and departmental systems of the provider and host.
- integration: any interconnection of systems between the provider and host.
- information management: information needed by both parties to report on services.
- end-user devices: the various equipment staff use such as PCs, laptops, phones, printers and medical devices.

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Report: IT considerations and checklist

Operational considerations continued

Checklist

The document below provides a checklist against which the IT aspects of a single specialty networked care model can be developed.

It includes the areas that should be covered by the business case such as:

- the size of the potential market for the proposed networked care services.
- relationship management defined through an SLA.
- a statement of technical requirements and costs.
- due diligence to identify potential issues.
- risk management.

Other considerations will include:

- a clear definition of the operating model and how it varies between sites.
- staff and patient interactions such as meetings.
- space requirements.
- information-sharing agreements.
- good working relationships managed via the SLA and day-to-day operational relationships.
- business continuity and disaster recovery planning.
- effective communications.
- training and awareness of each organisation's sites and services.
- data quality.
- deployments.
- improvements in system-enabled processes such as reducing missed appointments.

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Report: IT considerations and checklist

Operational considerations continued

The business case will also want to consider:

Electronic records: A key objective for the NHS is to achieve a 'paperless' system and the deployment of new systems should optimise the use of electronic records. Business cases should include the costs associated with transport and storage of old paper records.

Sharing information systems and services: Opportunities to increase these between organisations should be considered, for instance shared folders that could better support business continuity processes.

Patient communications: These can be enhanced by creating more services for patients such as the ability to cancel and re-book appointments by text or online and creating patient portals with further information and services.

The reference material also contains a wealth of detail on technical considerations.

Resources

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DOC **Report: IT considerations and checklist**

Communications

When two organisations come together in a new arrangement, they will need clear channels of communication with all parts of the network as well as between the network and its external partners. The communications and relationships involved in this new way of working are inextricably linked. Both should be two-way and given priority so that people have the right information to do their jobs and so provide optimal care to patients. Staff working at the new site(s) must be made to feel a valued part of the network and external partners must be clear about the new arrangements.

Critical success factors

Within the network, key factors include:

- senior leadership frequently visible at all sites.
- relevant, timely communications with feedback mechanisms.
- knowing when technology can help and when face to face is needed.
- rapid responses by central decision-makers to messages from all sites
- support for site leaders.
- understanding why some decisions are made at the centre and where there is local autonomy.
- ensuring all staff check provider email regularly, acknowledge receipt and/or action it reliably.

"When the exec team meets on our site we can explain a lot of our issues and suggested solutions and things happen much faster."

"Skype is great but sometimes you need to be in the room to be properly part of the conversation."

"Often messages from the centre aren't relevant to us and we sometimes feel the centre doesn't really understand what our site does."

Externally, it is essential to publicise any new site and make the right new relationships so that:

- patients know how to access the service.
- local people understand the purpose of the new arrangement.
- commissioners understand what the funding is being used for.
- the regulators can assess it appropriately.

The communications framework below can be used to publicise the new site or adapted to other situations where you need to liaise with external audiences.

PDF **Communications framework: new networked site**

Reputation and brand

Networks are most likely to be developed by an organisation with a good reputation and well-known brand. There may be concerns that creating or extending a network could 'dilute' that brand and reputation. This is a particular risk if there is a perceived difference in the quality of the existing service compared to that of the single specialty provider.

"The way patients are spoken to is very important to establishing reputation."

"The trust we've joined has undertaken to protect and develop our brand, which has a national and international reputation for services and research."

"Suppliers may wish to be associated with the good reputation of specialty providers and that way you can drive down costs."

- The incoming provider will want to ensure that everyone understands the key elements of the new brand, re-building and sustaining service reputation.
- Publicising the opening of the new site is an excellent opportunity to reinforce the brand and enhance the reputation of the service.
- Consider how you can brand your service at the new site to ensure that patients know they are 'under new management'.
- If having your corporate branding is a deal breaker, ensure this is part of the early discussion with the host trust or landlord.
- Consider if a corporate uniform for frontline staff (including administration) could help with both branding and staff owning the change of provider.
- Ensure all staff know and understand what is expected of them, promote staff excellence awards and be clear about what is unacceptable behaviour.
- Positive patient experiences and recommendations create and enhance reputations. Monitoring feedback via the Friends and Family Test and through other local systems will help to highlight how well the new service meets patient expectations.
- Make it clear to patients how to make a complaint and share both positive and negative feedback with all staff.
- Encourage staff to tell the central communications team about any innovations or other "good news" stories at their site – they may want to publicise them, enhancing the site's and the trust's reputations.
- Ensure you use the correctly-branded corporate materials such as letterheads, newsletter templates and patient information. There are strict rules about NHS branding and you will damage your trust's and your own site's brand if you ignore them.

Resources

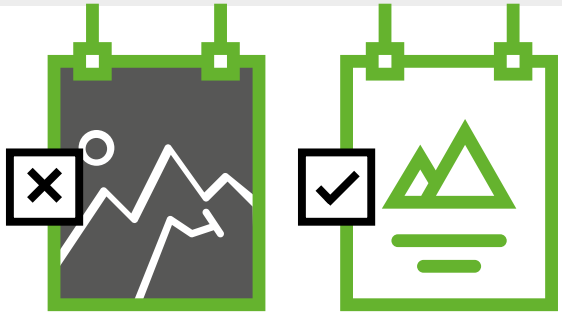
PDF **Communications framework: new networked site**

Reputation and brand continued

Even if the brand is consistently applied and there is no discernible service quality variation between sites, it is clear that in some networks patients perceive the quality of care they receive at the centre to be superior to that they receive at other sites within the network.

"The same consultants attend the central site and other parts of the network but there is a perception that clinical care is better at the centre."

"I asked a Moorfields patient how he had got on with his appointment at a smaller networked site…He said it was really good, but he was getting a second opinion – from Moorfields City Road."



Meetings

One of the benefits of a networked care model is an increased workforce and access to greater learning. However as you extend your organisation and many people are based away from the centre it can be a challenge to work out how they participate in major decision making. It is important to prevent feelings of isolation, especially if the distances between the centre and sites are long.

Internet-based technology has some answers; so does the right suite of meetings in the right place:

- Central governance meetings should always include representatives from sites other than the centre and should be held at different networked sites.
- A forum for senior clinicians, managers and nurses to receive and send out quality and safety information and learning from across the network is invaluable.
- A weekly serious incident panel with senior multidisciplinary staff can respond swiftly when required.
- Clinical governance half-days led by a committed consultant, governance or audit lead for all staff within a service or site are effective channels for sharing learning.
- Dedicated meetings for specific clinical areas across sites, such as outpatients and theatres, help to ensure consistency and learning.

"We talk about the issues in staff meetings and often the small things are the best to address and the most telling."

"We've had to work at joining up central and local meetings in order to share learning. Before, clinical governance meetings and service meetings were led centrally, site-based ones were just that and there was no shared learning."

"At clinical governance meetings nurses and admin staff need to feel properly included or they won't benefit from the learning."

Terminology

There are different types of networks and different names for them (MCP, PACS), different names for the same networked model (franchise, service chain) and different ways of describing different parts of a network. Language is important, not only so that everyone, especially patients, understands the type of network, but also so that all parts of a network feel equally valued.

- Different models are not described consistently. Moorfields' model has been described variously as a service-level chain, franchising and networking.
- Terminology within vanguards also varies according to how organisations are working together within it and the sort of contract they have.
- The terms used for different parts of a network are also important. Labels like "outposts", "outreach" and even "satellites" can make people who work at those sites feel that the senior leadership places more value on the centre than on other parts of the network. Asking staff in all parts of the network for their views will be a first step to developing terminology which enables everyone to feel equally valued.
- The toolkit working definition of networked care is when a single organisation is responsible for delivering care across multiple sites.
- It is important to remember that the patients and the wider public can be easily confused by NHS terminology. Service developments should be described in plain, jargon-free English and always focus on how they will improve the patient experience.

"England is too diverse for a 'one size fits all' care model to apply everywhere. But nor is the answer simply to let 'a thousand flowers bloom'. Different local health communities will instead be supported by the NHS' national leadership to choose from amongst a small number of radical new care delivery options, and then given the resources and support to implement them where that makes sense. "

NHS England (2014) *Five Year Forward View*

Proliferate

Extending networks can improve sustainability. Key to success is the standardisation of processes across sites and the involvement of patients in designing services.

Scaling up networked care

Spreading best practice

Improving networked care

1 Will scaling up networked care improve sustainability?

2 How will standardising clinical outcomes nationally help efficiency?

3 How can staff and patients working together improve networked care?

Scaling up networked care

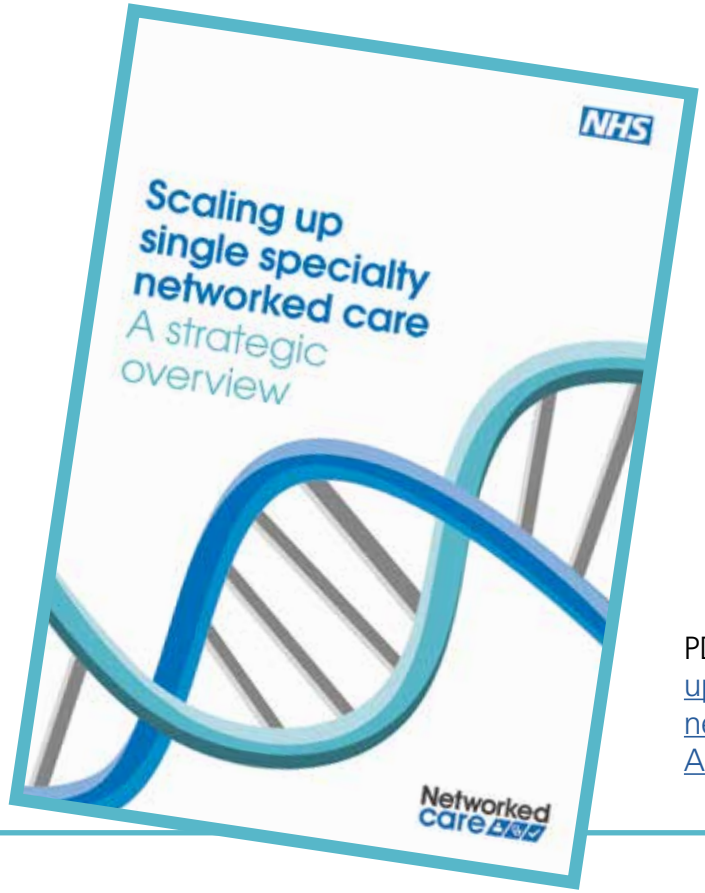
Summary

In the first year of the vanguard programme we identified the critical success factors for when and how a single specialty networked care model might be developed. The learning from that work is shared in the first four categories of the toolkit.

The definition of single specialty networked care used for the toolkit is one provider delivering a single specialty across multiple sites.

In 2017/18 we widened our research to consider the critical success factors when scaling up networked care. 'Scaling up single speciality networked care: a strategic overview' was published in March 2018 and we share some of the learning from that research in this new toolkit subcategory.

The publication can be downloaded from the resources section of this toolkit.



PDF Report 'Scaling up single specialty networked care: A strategic overview

Summary continued

The NHS needs healthcare delivery models that can adapt as the landscape changes and add value to local health and care systems. A number of recurring themes emerged during our research, some of which are more limiting to network growth and others more enabling.

Single specialty networked care is already delivered by a number of providers and has long been recognised as a sustainability solution for services where critical mass does not support local provision or recruitment to specialist roles is problematic.

Given the move towards locally integrated health care systems (ICSs) the research indicated greater appetite and opportunities for numeric expansion.

Summary continued

There are many ways in which single specialty networked care can be delivered as previously evidenced in the toolkit - no one size fits all. This table shows the generic characteristics of some of the models which we refer to in this section:

Characteristic	1	2	3	4
Corporate entity	Single specialty provider trust.	Single specialty provider trust.	Single specialty provider trust.	Acute provider trust with single specialty expertise.
Who employs the staff?	All staff employed by specialist provider; working across one or more network sites.	Medical staff employed by specialist provider work across sites. Other staff employed by host trust, recharged to specialist provider via SLA.	Some staff employed by specialty provider working across sites. Other staff employed by host trust, recharged to specialist provider via SLA.	All staff employed by the acute provider trust, working across one or more network sites.
Who is paid for the network activity?	Single specialty provider trust.	Single specialty provider trust.	Single specialty provider trust.	Acute provider trust with single specialty expertise.
Network geography	Crosses more than one STP.	Crosses more than one STP.	Single STP.	Single STP.
Who pays for the equipment and space?	Specialist provider owns the equipment. Space paid to host trust via (SLA, lease and/or licence agreement).	Specialist provider owns no equipment or space. Recharged by host trust through SLA agreement.	Mixed arrangements: owns some equipment; leases some equipment. Owns some space, leases some space.	Specialist provider owns most of the equipment and space with some lease arrangements.
Are networked sites branded?	Most network sites are branded.	Network sites are not branded.	Some network sites are branded.	Some network sites are branded.
Network sites	More than 25.	More than 20.	Between 5 and 10.	Between 5 and 10.

Summary continued

In this section of the toolkit we share our findings from semi-structured interviews with more than 35 strategic decision makers across the NHS (providers, commissioners and regulators), other sectors and from a desktop literature review.

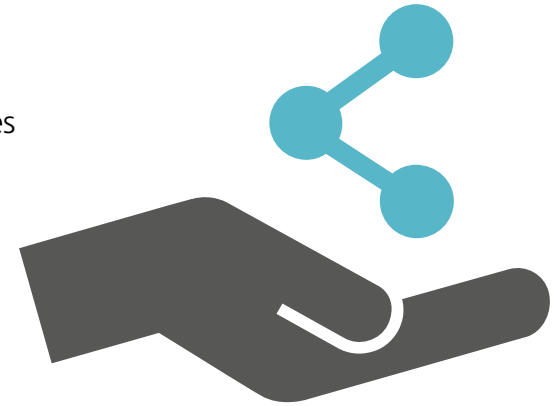
Our research has focused on the benefits and challenges to scaling up networked care numerically and geographically.

Our definitions of these terms are:

- **Numerical expansion** - extending a network's sites within a single STP.
- **Geographical expansion** - refers to an increase in networked sites across multiple STPs.

We identified a number of conditions which need to be in place in order to facilitate successful expansion of networked care. These become more critical the further the network sites are situated from each other:

- A shared understanding of the benefits of single specialty networked care to the wider NHS and to systems locally.
- Active support for networked care as a model for service sustainability.
- Aligned priorities between networked care providers, commissioners and other system partners.
- Rigorous standardisation for network assurance and oversight.
- Accurate data and performance indicators to evidence the changes before and after a site is added to the network.
- Collaborative working to ensure that networked services represent best value for patients and other system partners.



What role do STPs play in the scaling up of single specialty networked care?

Any plan to expand single specialty network care within an STP or across multiple STPs should consider the benefits networked care can bring to evolving ICSs.

The sustainability challenges facing smaller district general hospitals (DGHs) may continue to create the need for healthcare models that can provide a comprehensive range of services locally, for the best value. Our research indicates that a system approach to health and social care such as an ICS will benefit from single speciality networked care. Allowing a single provider to run an entire specialty network within an STP or ICS may offer more opportunities for efficiencies.

Expansion within a single STP rather than across multiple STPs is considered to be more realistic, as aligning priorities and oversight becomes more complex with distance.

Agreeing strategies which can support networked care growth, such as a workforce strategy which shares staff across a system, is likely to be easier with STP partners.

Networked care providers need to understand STP system priorities and ensure that any expansion benefits the wider system as well as its own organisation.

There is a need for shared understanding about the value of the single specialty networked care model to enable adoption within and across health systems. Evidencing a network's added value, measuring quality and the costs of both existing provision and after implementation of a network, are therefore critical to enabling expansion.

Considerations:

- STPs are likely to encourage networked solutions within local health and care systems which could sustain single specialties at smaller DGHs.
- Numeric expansion of existing networks can be delivered at pace in mature STPs.
- Networked care providers need to align their priorities with those of an STP when expanding.
- System partners need to have the same understanding of the value that networks can offer a system for expansion to be successful.
- Evidencing the benefits of networked care and measuring the impact is key in gaining support from system partners.

Resources

How can commissioners help single specialty networks to grow?

The commissioning process can be critical to network expansion. Commissioners can be enablers to extending single specialty networks.

We found that providers and commissioners were not always aligned in their definition of how the networked care model operates.

Where differences in understanding exist, there is a risk that the benefits of networked care may not be understood and commissioners may therefore not support network expansion.

Commissioners and providers were all in agreement as to the importance of collaboration and relationship building when planning and delivering networks across a wider geography:

- Strong commissioner relationships are considered key by networked care providers in expanding numerically.
- Informed commissioner support is considered to be critical in helping to find sustainable networked solutions, share best practice and enable faster expansion of networked care.

"It is of critical importance that we have the explicit support of the commissioners for any expansion of our network."

How can commissioners help single specialty networks to grow? continued

Providers favoured multi-year contracts to incentivise service delivery.

There was consensus that single specialty services should be commissioned centrally or have one host commissioner for the network. It is easier to build a long term relationship with one commissioner, who is then able to gain a better understanding of the specialty, the network model and the benefits of expansion.

When expanding geographically providers considered differences in STP commissioning priorities and processes to be more challenging. Differing commissioning rules, payment structures and performance targets, particularly when crossing national borders, add complexity.

Considerations:

- Aligning understanding of networks between providers and commissioners is critical to successful expansion and can be achieved through collaborative working.
- Commissioner support is critical to enable growth of networks, but sustainability solutions for systems need to be provider led.
- Multi-year contracts that allow headroom for networked care providers to stabilise challenged services will help network growth.
- A networked model will benefit from having a single commissioner who understands the model and the benefits that expansion can offer other STPs.

What are the regulatory implications when expanding a network?

Regulators have an important role in facilitating the expansion of networked care services through encouraging and supporting providers to explore innovative solutions.

New ways of delivering care and joint working across systems is changing the provider landscape. Regulation will undoubtedly have to adjust to meet these changes. NHSI and the CQC have already taken steps to assess how regulation, oversight and inspection can work in this context.

Regulators saw their role as encouraging and supporting providers to explore innovative solutions and help share best practice across the system.

Regulators' understanding how of networked care can help with service sustainability is likely to enable networked care expansion.

There was concern that when taking on an underperforming service, a speciality provider's regulatory standing could be put at risk and this could be a barrier to expansion. Regulators could help by allowing time for the networked service improvement plan to be delivered (within an agreed timeframe).

While regulators were supportive of scaling up single specialty networks, the need for clear lines of accountability between networked care and host providers for the delivery of patient care was emphasised. SLAs are the way network providers manage these relationships and regulators highlighted the importance of these in providing regulatory assurance.

With no single prescribed model for networked care, getting a consistent approach to regulating these models will need collaboration between network providers and regulators.

Considerations:

- Allowing providers time to stabilise underperforming services may incentivise network growth.
- Including specialist networked providers in sustainability conversations can enable growth of networks.
- Clarity is needed around how regulation will apply to growing networks within mature STPs.
- Providers need to work more closely with regulators to develop a consistent approach to regulating networks where this is a challenge, as there is no single model.

How can financial challenges be managed to enable scaling up of networked care?

The research indicated that scaling up a network will require investment which may be a barrier to expansion. With significant financial challenges already facing the NHS, providers and commissioners had concerns about the costs of expanding a network.

Different stakeholders have different concerns about networked care expansion. The biggest challenge is to ensure that expanding the network can balance all the stakeholder's interests and meet patients' needs.

It is critical that specialist providers and host trusts work together transparently.

It remains important that system partners understand the cost of the existing and future service including the cost of any gaps, such as workforce and quality.

Market Forces Factor (MFF) on tariff could add complexity to network expansion.

"If you're crossing any boundary, there's going to be some potential funding challenge."

How can financial challenges be managed to enable scaling up of networked care? continued

This should be less of an issue with expansion within a single STP although there can be slight variations between providers in an STP, particularly in London.

In addition, any difference in the way the workforce is paid can add further complexity. This is more likely to be an issue with geographical expansion.

Providers would welcome incentives such as fixed tariff to take on underperforming services. Alternatively, external funding including philanthropy could play a critical part in helping a network to scale up successfully.

Any such funding would need to be carefully allocated to ensure any services were sustainable in the long term.

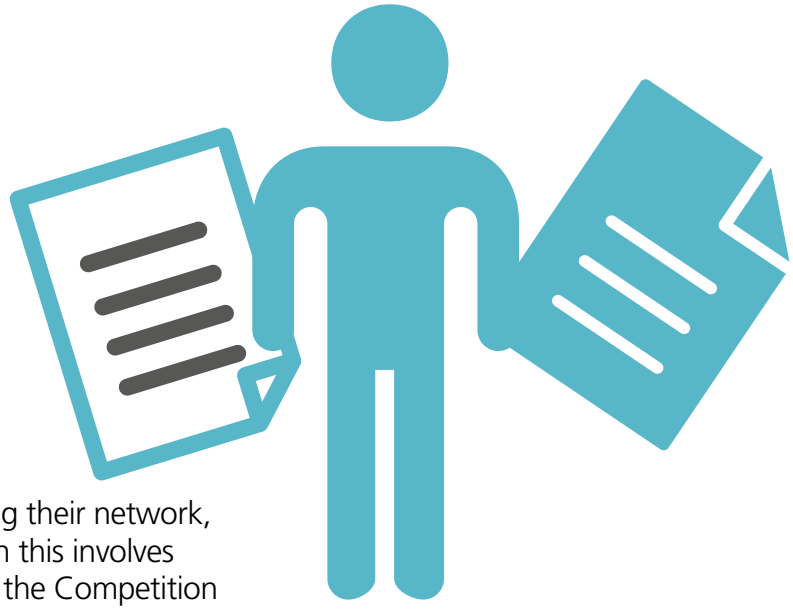
Access to STP capital-related funding may be available to help support network growth numerically or geographically depending on the value it can offer the system.

Considerations:

- Financial incentives, including external and non-recurrent funding, could play a critical part in enabling network expansion.
- Funding for capital-related costs in neighbouring STPs may encourage geographic expansion.
- The impact of the different payment structures, tariffs and the MFF will need to be considered when expanding geographically.
- The current financial climate could drive system partners to focus on possible efficiencies gained by networking within an STP.

Are there legal implications to expanding single specialty networked care?

Contracts, service level agreements and legislation are important to how networks can develop and operate. System partners will need to ensure that there are no legal barriers to expansion.



The implications of legislation to network growth are unclear. There are opposing views on whether competition limits the opportunity for collaborating with other NHS providers (collaboration being a key component of networked care). Opinions around this stem from different interpretations of the 2012 Health and Social Care Act regarding anti-competitive behaviour.

Given the current climate, there appears to be an appetite for formal collaboration. This could provide a platform for growing networks.

Providers are interested in receiving more legal support from regulators when extending their network, especially when this involves bodies such as the Competition and Markets Authority.

The risk of being seen as anti-competitive means that providers are often encouraged to engage in competitive processes to expand their existing network. But many stakeholders consider competition and collaboration as complementary to each other and that legislation poses no obstacle as long as clear benefits to patients through collaboration can be evidenced.

Are there legal implications to expanding single specialty networked care? continued

Workforce issues can be one of the most challenging aspects of scaling-up networked care.

Both the specialty and host providers are legally bound by the requirements of the Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE), which protects the employment rights of transferring staff.

The network provider taking on a service may have to invest in providing additional training and development opportunities to ensure all staff are able to operate the network's standardised clinical and operational protocols.

Accountability was raised as a concern by regulators. There was consensus around the importance of having clearly agreed and signed SLAs to cover risk and accountability between specialist and host providers.

This was particularly important as most networks were reliant on host organisations for resources such as estates, support services and staff.

Considerations:

- Legislation should not be a barrier to network expansion.
- The implications of TUPE regulations when transferring staff can affect how a network's workforce expands.
- Competition law should not prevent network expansion where collaborative working between providers has a clear benefit to patients.
- SLAs and contracts between providers can mitigate risks associated with network expansion.

How can scaled up networks remain financially sustainable?

It is important to consider what financial conditions need to exist internally to maintain and support expansion of networked care.

Critical mass is seen to play a key role in network expansion both as a trigger for single specialty networked care (where critical mass can't sustain tertiary care locally) as well as a way of increasing market share and helping network sustainability.

> **"We have several sites that on a financial basis alone we should close, but because of patient choice and accessibility we've continued to run them."**

The research provided no evidence as to the ideal size of a network. It was clear that some networks initially grew to address unmet demand without a clear network expansion strategy. Regular network reviews will be needed to assess the point at which an expanding single specialty network becomes financially unviable.

A balanced scorecard which measures important indicators, such as workforce availability, financial contribution and patient experience, could be used to highlight where the network is sustainable and where there is need for consolidation. This will also indicate if the network as a whole is healthy enough to support further scaling up.

Regulators and providers alike stressed the importance of financial sustainability and its effect on quality and brand. Understanding the market, income flows and relationships with commissioners were also found to be critical to expansion.

There is a clear need to evidence the financial value of networks, for which reliable data is needed. Difficulty in obtaining specific site-level data was a consistent challenge among network providers. This reflects a wider issue around data collection in the NHS.

Evidence would strengthen the argument for networked care as an option for the sustainability of services.

How can scaled up networked remain financially sustainable? continued

The financial risk associated with expanding networked care will vary depending on the model used. The research included talking to network providers using a range of different models and analysing the perceived financial impact.

All networks explored have mainly directly-contracted services:

- Network model 1 (see table 1 on the next page) appears to carry the most risk when expanding as it is resource intensive, employing the staff, buying the equipment and paying to use the space. Any new site should be profitable or at least cost neutral given the potential impact on the financial performance of the entire network. Understanding the cost implications of each site within the network is essential as new sites requiring significant capital investment may not make a return in the short to medium term. Having a clear network strategy aligned to corporate objectives is critical.
- Single specialties in wider organisations delivering care, such as in model 4, appear to have limited financial risk. It is unlikely this model would have a major impact on overall trust finances. Expansion of this network model would depend on both commissioners and the trust executive team having a good understanding of the service and how expansion of the network fits with the wider trust strategy. This could be a challenge.
- The level of risk in models 2 and 3 varied and seems to depend on clear and agreed SLAs. From the perspective of the host provider, the full financial implications of moving the service into the network should be considered and understood. Through carefully agreed SLAs and understanding of the impact, both organisations should be able to share benefits, including financial ones.

How can scaled up networked remain financially sustainable? continued

Table 1

Characteristic	1	2	3	4
Corporate entity	Single specialty provider trust.	Single specialty provider trust.	Single specialty provider trust.	Acute provider trust with single specialty expertise.
Who employs the staff?	All staff employed by specialist provider; working across one or more network sites.	Medical staff employed by specialist provider work across sites. Other staff employed by host trust; recharged to specialist provider via SLA.	Some staff employed by specialty provider working across sites, Other staff employed by host trust, recharged to specialist provider via SLA.	All staff employed by the acute provider trust, working across one or more network sites.
Who is paid for the network activity?	Single specialty provider trust.	Single specialty provider trust.	Single specialty provider trust.	Acute provider trust with single specialty expertise.
Network geography	Crosses more than one STP.	Crosses more than one STP.	Single STP.	Single STP.
Who pays for the equipment and space?	Specialist provider owns the equipment. Space paid to host trust via (SLA, lease and/or licence agreement).	Specialist provider owns no equipment or space. Recharged by host trust through SLA agreement.	Mixed arrangements: owns some equipment, leases some equipment; owns some space, leases some space.	Specialist provider owns most of the equipment and space with some lease arrangements.
Are networked sites branded?	Most network sites are branded.	Network sites are not branded.	Some network sites are branded.	Some network sites are branded.
Network sites	More than 25.	More than 20.	Between 5 and 10.	Between 5 and 10.

How can scaled up networked remain financially sustainable? continued

Finally, it is worth considering the function and purpose that networked sites provide, as this can affect the scale which can be achieved. Some providers have made the most of commercial opportunities internationally. The additional effort and resources needed to set up and maintain a site so far away, although difficult, are seen as worthwhile if it provides income into the NHS.

Considerations:

- Increasing critical mass may be crucial to network sustainability.
- Evidence to determine the ideal size of a network is needed; this can be obtained through regular network reviews that monitor key performance indicators.
- Reliable and accurate data is crucial in evidencing the financial value of networks and their sustainability.
- Commercial opportunities can provide increased revenue to help sustain NHS services.
- The level of financial risk varies depending on the network model, some of which can be mitigated through the use of clear SLAs.

What factors can ensure good quality outcomes across an expanding network?

Delivering good quality care to more patients is one of the main drivers for networked care expansion. It is important to consider the quality benefits that scaling up networked care can offer.

Strong leadership is considered key to the success of networked care expansion. Some providers place great importance on having regular visits by the executive directors to all sites. When comparing the challenges faced by commercial and NHS organisations, it is apparent that the need to have continuous executive and senior level leadership across the network could be minimised by improving and implementing better standardisation of services.

Employing and training the right people is critical to ensuring good quality outcomes. Having the right people in place was identified as critical to expansion.

Providers and commissioners agreed that **patients participating in clinical trials** could have improved clinical outcomes, and staff training and development, through being involved in research, could improve career development.

There are also opportunities to improve quality outcomes through **technology**. For example, remote review of radiology and ophthalmology images that enable clinicians to work virtually across the whole network.

Geographic expansion could increase the risk to clinical outcomes if staff do not follow agreed practice, policies and processes, but evidence suggests that rolling out a **standardised clinical governance** framework across the network will reduce this risk. It follows that expanding a network will enable a wider spread of standardised care.

Standardisation was highlighted as critical to expanding a service by commercial companies as it allows for service improvements, efficiencies (through good governance and safety) and control of the supply chain.

What factors can ensure good quality outcomes across an expanding network? continued

Case study: standardisation

Compass Group UK & Ireland is part of Compass Group PLC, a world-leading food and support services company. In the UK & Ireland it employs more than 60,000 people across thousands of sites from hospitals, schools and oil rigs to corporate headquarters and major sporting venues.

In the UK, the healthcare arm of Compass provides food, support and retail services in five areas of healthcare (illustrated below), within NHS hospitals, retail healthcare (under partnership), care and residential homes and the private healthcare market.

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The Compass healthcare team stressed the importance of due diligence when bidding for contracts, in particular ensuring budgets were sufficient to meet service specifications, whether benefits of standardisation could be leveraged, and having a clear understanding before committing.

Where there was deviation from standard processes, these needed to be analysed and understood. Any variations then needed to be agreed at the beginning of a contract. Contract variations should not replace SOPs, rather they should be seen as an enhancement. Geographical expansion was not seen as a limiting factor to standardisation; on the contrary, scaling up was seen as crucial to making the most of the benefits from standardisation.

Key features of standardisation:

- **Flat governance structure:** accountability sits with a few contract managers who report to regional directors. This is overseen centrally by one managing director.
- **Development of standard operating procedures (SOPs) refined and tested over many years:** these are centrally developed, ratified and maintained. This enables processes to be replicated across multiple sites. Services are also process dependent, avoiding quality dependence on any one person.
- **Ensuring employees are trained to the same standard:** whether recruiting new employees or when merging with other companies.

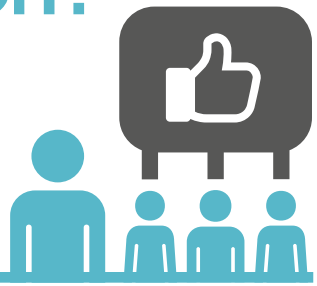
What factors can ensure good quality outcomes across an expanding network? continued

Considerations:

- Standardised governance, processes and roles are critical to providing consistent care across a growing network and providing assurance to senior leadership.
- NHS providers could apply processes similar to those used in the commercial sector to ensure standardisation, such as the use of SOPs.
- On-site leadership is essential in ensuring good quality care across a network. Executive presence is one of several ways of achieving this.
- Clinical research is more likely to happen across a larger network, which can improve patient outcomes and staff career development.
- Technological advances may provide opportunities for improved quality and geographical expansion.

Do workforce challenges act as a barrier or as a catalyst for network expansion?

Employing and training the right people is critical to ensuring good quality outcomes; and having the right people in place is critical to expansion.



NHS employers face increasing recruitment and retention challenges but there are differing views on the impact of workforce when expanding a network.

Nursing workforce in particular has seen a sharp decline in registrations. This has already resulted in more agency staff being used by providers, which can have unintended financial and quality consequences.

Pressures resulting from workforce shortages and the potential impact of leaving the European Union (EU) were raised as both a risk and an opportunity in expanding networked care. There was speculation that the impact could be challenging for expansion if NHS EU nationals repatriate. In contrast, these challenges could also drive providers to network more, in order to make the most of the available workforce, such as sharing staff in posts that are difficult to recruit to.

A particular challenge when expanding geographically is recruiting specialists in different areas of the country. This is considered an issue by both providers and regulators, particularly where travel times and remoteness are factors.

Some felt this might be too big an obstacle to expanding geographically. Other providers and commercial organisations facing the same challenge did not see it as insurmountable. Training other provider staff to follow standardised pathways has worked for some network providers and can help with network expansion.

Network growth may incentivise innovative solutions to workforce challenges. For instance some staff could be given tasks which might alleviate pressure points in other staff groups (see case study on DART programme below). Given that medical and nursing vacancies were highlighted as a key challenge, this was considered a way in which networked care might address difficult workforce issues.

Do workforce challenges act as a barrier or as a catalyst for network expansion? continued

Case study: managing capacity challenges

Domestic Abuse, Recovering Together (DART), is a programme rolled out by the National Society for the Prevention of Cruelty to Children (NSPCC) to different organisations where children and their mothers can talk to each other about domestic abuse, learn to communicate and rebuild their relationship.

The issue: DART requires four members to run each session. One local authority said: "It's taken four members of staff out of doing their 1-to-1 work for a whole day every week for 10 weeks. So there was a big financial commitment, not only for resources and co-ordinating how people were going to get there, but worker time as well."

What NSPCC learnt: We needed to think of ways to address staffing capacity without compromising the way DART works.

What NSPCC is doing: We're developing new ways for DART to be delivered that stay true to the model. One option is running the programme with two volunteers and two trained practitioners. The staff would be the leaders and the volunteers would be supporting co-facilitators. This option would need careful cost-benefit analysis but it could work well for the organisations with established volunteer support. The use of volunteers could have an added benefit for the local community, helping members of the public learn how to identify and address the signs of domestic abuse and signpost routes to support. We're also developing a 'train the trainer' model so organisations can train their own staff, reducing their reliance on us and making the service sustainable.

Considerations:

- Workforce challenges can be an opportunity for networked care growth as they drive the need to use workforce more efficiently.
- Extending staff roles and providing training to transferred staff might facilitate network expansion in offering potential solutions to recruitment challenges.
- Expansion into new areas could offer recruitment opportunities for a networked care provider, but they would need to recognise that workforce attrition may destabilise a health system.

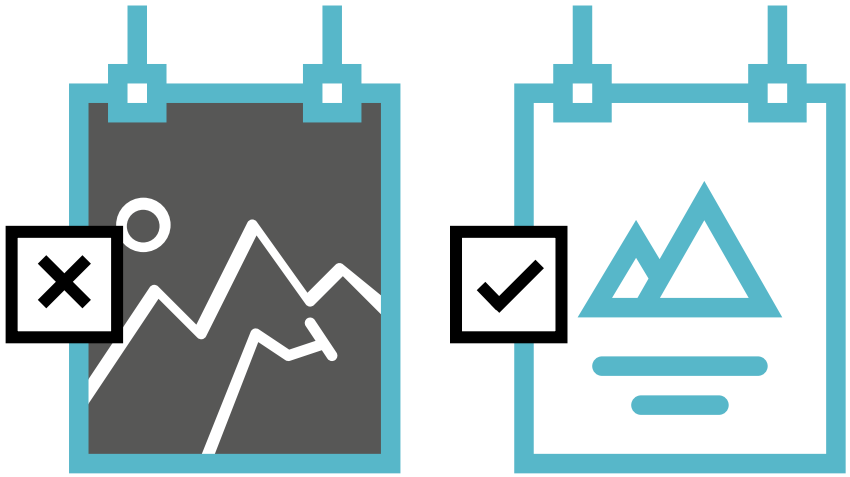
Are brand and reputation critical to extending networked care?

A strong brand could facilitate expansion and should be considered in the context of the network model chosen.

A brand is a name or other feature that distinguishes an organisation or product from its rivals in the eyes of the customer. Reputation is how the organisation or product more generally is viewed by others. Each can have an impact on successfully expanding a networked care model.

Reputation is considered critical to successfully growing a network; being recognised for delivering good quality outcomes will help with numerical growth in an STP but having a national or international reputation was considered to be a more effective enabler across a wider geography. Patients may be less resistant to change if the new provider is well known for excellence. This could mean that without a strong reputation there may be limited opportunities for geographical network growth.

Reputation may be a strong enabler when looking to expand the network in securing support from commissioners and potential host trusts, particularly when looking to expand across several STPs. A strong reputation may help where there were previous recruitment challenges. However this is not a given and any recruitment issues need to be clearly understood.



Are brand and reputation critical to extending networked care? continued

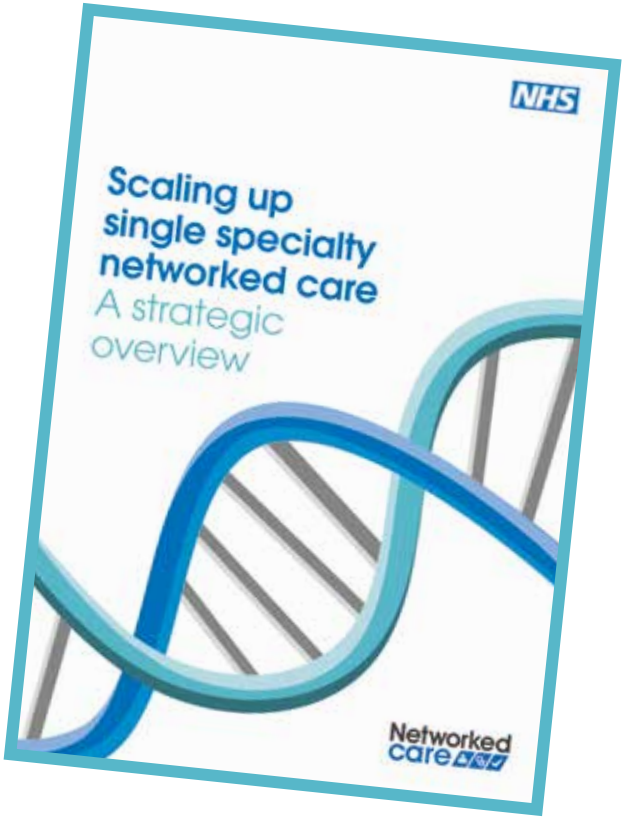
Once the service is established, having a visible brand may be important to patients and other stakeholders. The need to visibly brand a service depends on organisational preference but also has to take into account local circumstances including the host trust. For example, there may be resistance to individual organisation branding, as it may be seen to confuse patients.

There may be reputational risk if any current service issues are not fully understood or there are unrealistic expectations which are then not delivered. Understanding and measuring existing service performance is critical to ensuring that improvements can be delivered and reputation protected.

It is clear that there is a subtle difference between reputation, which is seen as critical to network growth; and branding, which varied in importance. Networked care providers need to carefully consider this so that it fits with their strategy and network model.

Considerations:

- A reputation for excellence can help with staff recruitment and attract more NHS and private patients, which can facilitate growth.
- The decision to brand a network can depend on local circumstances, such as competition, as well as provider and host preferences and does not limit expansion.
- Reputation alone can facilitate expansion, whereas branding without a good reputation could have a detrimental effect. Ideally, networked care providers should have both reputation and branding to expand at scale and at pace.



PDF **Read the full report here**

Spreading best practice

The UK Ophthalmology Alliance (UKOA)

Introduction

One of the key learnings from the toolkit research was the impact that standardisation and collaboration can have on improving clinical outcomes. Building on that theme we have established the UK Ophthalmology Alliance (UKOA), consisting of NHS ophthalmic providers and other key stakeholder organisations working together on best practice initiatives.

Working with the National Orthopaedic Alliance (NOA) vanguard programme we have replicated its alliance membership model. This section of the toolkit shares our experience and advice from replicating the NOA model across ophthalmology nationally.

This section of the toolkit shares some of the learning from our publication 'Spreading best practice – UK Ophthalmology Alliance' launched in March 2018.

Report -'Spreading best practice – UK Ophthalmology Alliance'

The UK Ophthalmology Alliance (UKOA) continued

What is the National Orthopaedic Alliance?

First formed in the early 2000s, the Specialist Orthopaedic Alliance (SOA) was a coalition of hospitals and other providers which contributed significantly to raising the quality of care for orthopaedic patients in England. National vanguard funding was secured to develop the SOA model and increase membership. In July 2017 the SOA became the National Orthopaedic Alliance (NOA). By providing a group voice for high volume and specialist orthopaedic providers, close links to the Getting It Right First Time programme (GIRFT) and additional activities such as benchmarking, mentoring and buddying, alliance members have been leading the way in delivering better care and value through improved outcomes and productivity.

The aim of the NOA vanguard programme was to create a UK-wide alliance of orthopaedic providers to deliver outstanding and consistent care in more areas. The NOA vanguard has developed a consistent benchmarking framework, describing not only 'what good looks like' in orthopaedic care but also the components of a quality improvement journey. The alliance partners participate in self-assessments against those standards as well as creating a standardised toolkit to drive quality improvements in other orthopaedic providers across the NHS. Forty trusts are now members.

Why was ophthalmology chosen to replicate the NOA model?

A key driver for all vanguards was to create replicable blueprints that could be rolled out quickly elsewhere in the NHS. The NOA programme was funded on the basis that its alliance model could be replicated across other, non-orthopaedic, specialties.

As single specialty vanguards, Moorfields and the NOA had already developed a relationship through the national vanguard programme. Moorfields also has close relationships with other key national eye care bodies and several of our clinical staff are in leadership roles nationally within the standards, efficiency and commissioning arenas, including GIRFT.

The vanguard clinical lead, Melanie Hingorani, was clinical director for quality and safety at Moorfields for a number of years and, at the time of this publication, is chair of professional standards for the Royal College of Ophthalmologists.

These factors were instrumental in ophthalmology being identified as a specialty likely to be able to replicate the NOA model in year two of Moorfields' vanguard programme.

It was therefore agreed that an ophthalmology alliance would be developed as part of the NOA vanguard programme in 2017/18, but driven clinically by the Moorfields programme team.

The UK Ophthalmology Alliance (UKOA) continued

When is an alliance model a good fit?

Before any work is undertaken it is helpful to think through the reasons for forming an alliance model. It is also useful to ensure there is sufficient interest. The concept should be discussed informally with other provider and stakeholder colleagues to ensure that the work involved in planning is supported. It is useful to consider whether:

- the specialty is well-defined.
- the specialty has defined quality metrics or standards, not necessarily with consistent national performance.
- the specialty providers have shared concerns that would benefit from national collaboration; these could include funding, resourcing, efficiency or workforce.
- interested clinicians, managers and executives will want to get involved.
- the specialty providers and stakeholders are willing to work together.
- existing work is being led on quality improvement by other organisations, for example professional colleges.
- a more focused alliance (in geography or ambition) is workable if a full alliance is not possible.

Before establishing the UKOA, the clinical lead for the Moorfields' vanguard programme contacted a number of providers and stakeholders to gauge interest. This indicated sufficient interest to warrant an inaugural meeting.

How do you secure funding?

The ophthalmology alliance was fortunate to be funded from the national vanguard programme in 2017/18. However the fixed term nature of this funding created challenges. The first alliance meeting was held in August 2017 and this left only seven months to establish a functioning alliance. Replication of the NOA model enabled progression at the fast rate needed.

It was clear the alliance would not be mature enough to become self-funding through membership contributions by March 2018 and members were keen not to lose the progress made. GIRFT was approached and agreed to fund the clinical lead for a further year as the alliance would be a vehicle to help GIRFT implement its findings nationally.

A key ambition for the UKOA, true to the collaborative spirit of the venture, is that governance is shared and not dependent on a single trust. It follows that the responsibility for funding the work is also shared. The aim is that the alliance will become self-funding from membership fees after March 2019.

An alliance model which has been established (NOA) and replicated successfully (UKOA) may provide evidence to support business cases for other specialties wanting to create their own alliance models.

The UK Ophthalmology Alliance (UKOA) continued

How to learn from existing alliances

The NOA pioneered the alliance model and those following can benefit from its experience. Learning from the UK Ophthalmology Alliance, the first specialty to replicate the NOA model, is now also available.

Understanding the challenges that the NOA faced through developing the orthopaedic alliance will enable the ophthalmology alliance to better navigate its success. This in turn will help other specialties.

A key learning is not to replicate unthinkingly - consider how your specialty and what you need may differ. Our clinical lead attended the quarterly NOA meeting, observing and taking part in their activities; this helped to accelerate the UKOA replication process.

Leadership

The aim of any alliance will be to share governance between its members but in the early stages there has to be a core group driving the initiative.

It is very important that this is clinically led but has strong management support as well. Considerations include:

- Dual leadership is preferable; identifying senior clinical and managerial leadership accelerates implementation.
- The clinical lead must be a recognised speciality expert and/or work at a unit which is a recognised centre of excellence.
- Involving individuals who hold national positions of influence with professional colleges, regulators and commissioners will help to inform and influence the formation of an alliance. These individuals can also offer insight which helps to join up work across different organisations. This was key to establishing the UKOA.
- A dedicated project manager is needed to support the leads – this may be part-time or shared but the manager will need protected time to manage the administration. One day a week worked flexibly was successful for the UKOA, with some ad hoc additional hours when needed.

The UK Ophthalmology Alliance (UKOA) continued

Clarify the aims and develop the message

The NOA has a very clear purpose to "create a powerful voice which can negotiate locally and nationally for the benefit of orthopaedic commissioning and resourcing and which champions the specialty". This purpose has been adopted by the ophthalmology alliance and its principles exemplify the benefits of being part of an alliance model:

- One voice.
- Power in numbers.
- Forum for networking and learning.
- Join expertise of clinicians with managers, trust and national agency leaders, all professionals, patients and commissioners among others.
- Establish widely-accepted quality standards and best practice or efficiency pathways.
- Provide or support web portals with activity and financial and quality data, allowing benchmarking to drive up standards.
- Provide buddying, support and mentoring.
- Lobbying and negotiation.

The UK Ophthalmology Alliance (UKOA) continued

Members and stakeholders – how inclusive?

It is important to consider how inclusive an alliance wishes to be. In the spirit of collaboration and shared governance this has to be something the founder members discuss and agree. There is a clear distinction between the numbers during the establishment phase and the reach of the alliance longer term.

Considerations are likely to include:

- UK vs England vs regional.
- providers: aiming for all or just some big specialist and/or district general hospitals (DGHs)?
- specialist societies.
- patient groups.
- charities and the voluntary sector.
- professional bodies including those from whole multidisciplinary team.
- commissioners.
- any key workstream or agency in the sector.

It is also important to consider who will be members (those who pay), and who will be stakeholders (advised, informed and co-opted), who do some of the work.

Identifying key stakeholders outside the specialty is also important.

These may include:

- **procurement.**
- **national safety.**
- **Regulators.**
- **GIRFT.**

At this stage a number of carefully-chosen founder members should be invited to ensure the alliance is manageable in the establishment phase, with a view to expanding membership later. UKOA is UK-wide and a mix of different sizes and types of unit were invited to join rather than starting with only the large specialist providers. To be as inclusive as possible the alliance founder member invitation included influential organisations such as the Royal National Institute of Blind People and the College of Optometrists. This was to ensure there was strong multidisciplinary professional input and active patient and external stakeholder involvement.

The UK Ophthalmology Alliance (UKOA) continued

The UKOA has 27 founder members:

- Addenbrooke's Hospital, Cambridge University NHS Foundation Trust (NHSFT)
- Bolton NHSFT
- Bristol Eye Hospital University Hospital Bristol NHSFT
- Gloucestershire Hospitals NHSFT
- James Paget University Hospitals NHSFT
- Leeds Teaching Hospitals NHS Trust (NHST)
- Leicester Royal Infirmary, University Hospital of Leicester NHST
- Manchester Royal Eye Hospital, Manchester University NHSFT
- Moorfields Eye Hospital NHSFT
- Newcastle Eye Centre, Royal Victoria Infirmary, Newcastle upon Tyne Hospitals NHSFT
- Norfolk and Norwich University Hospital NHSFT
- Oxford Eye Hospital, John Radcliffe Hospital, Oxford University Hospitals NHSFT
- Queen Elizabeth Hospital, University Hospitals Birmingham NHSFT
- Queen's Medical Centre, Nottingham University Hospitals NHST
- Royal Cornwall Hospitals NHST
- Royal Glamorgan Hospital
- St Paul's Eye Unit, Royal Liverpool and Broadgreen University Hospitals NHST
- Sunderland Eye Infirmary, City Hospitals Sunderland NHSFT
- United Lincolnshire Hospitals NHST
- University Hospital Southampton NHSFT
- British and Irish Orthoptic Society
- College of Optometrists
- Ophthalmology clinical reference group (specialised commissioning)
- Ophthalmology GIRFT
- RCN Ophthalmic Nursing Forum
- Royal College of Ophthalmologists
- Royal National Institute of Blind People

The UK Ophthalmology Alliance (UKOA) continued

Key learning - developing a specialty alliance model

- Leading the way in delivering better care and value through improved outcomes and productivity is best achieved through collaboration and not duplication.
- Governance should be shared, not dependent on a single trust.
- Someone has to drive the process in the establishment phase.
- Principles for developing an alliance need to be agreed to develop an implementation plan.
- Founder members should ensure the alliance is manageable in the establishment phase.
- Founder members should be representative of the specialty (not just all the largest services).
- It's good to replicate other models but tailor each sub-specialty alliance as appropriate.

The UK Ophthalmology Alliance (UKOA) continued

Gathering evidence for your first alliance meeting

It is important not to underestimate the initial planning work. Even with the advantage of being able to replicate the NOA's methodologies, a very engaged and driven clinical lead and project manager were critical to the success of the UKOA. Timescale and delivery will be dependent on who is driving the project and how much time can be dedicated to this work. The development of the UKOA is proof that with the right drive and commitment, quick replication is possible.

Developing an implementation plan, based on the principles used by the NOA, is encouraged. Replicating the NOA methodology was very effective for the UKOA.

Pre-planning communications

A draft communications and stakeholder plan is needed from the start.

Identifying very senior individuals who are willing to promote the alliance and be visible during the establishment phase will help external communications.

It will be helpful if the project lead has informal conversations with people identified as potential founder members. The formal invitation letter, setting out the purpose and aims of the alliance can then be sent.

Consider who will sign the first invitation letter. It is advisable to ask a chief executive or medical director from a major unit to co-sign.

The initial invitation should be sent to clinical leads, medical directors (MDs), CEOs, presidents, as appropriate to the organisation. Ensure they understand who is best to attend and that it should be a multi-disciplinary team including a clinical lead or senior consultant, manager and nurse.

The UK Ophthalmology Alliance (UKOA) continued

Draft terms of reference

To enable discussion with potential members and stakeholders as well as provide context for the first meeting, it is helpful to set out the proposed aims and benefits of the alliance. The UKOA agreed it would:

- Be a forum for regular liaison and discussion on efficiency, quality and other mutual areas of interest between key stakeholders for ophthalmic services.
- Bring together the expertise of clinical professionals, managers and trust leaders in commissioning, operational management and financial flows. This joint expertise would establish quality standards and best practice or efficiency pathways in consultation with the key professional bodies, providers and patient bodies covering care provided by any ophthalmic professional in any setting.
- Provide or support a web portal populated by NHS digital data and provider-supplied data, informed by GIRFT results, allowing benchmarking of processes and outcomes to drive up standards.
- Enable buddying and support to improve quality and efficiency between providers with good and less good performance in specific areas.
- Create a powerful voice which could negotiate locally and nationally for the benefit of ophthalmology commissioning and resourcing and champion the specialty generally.

The UK Ophthalmology Alliance (UKOA) continued

Developing a methodology for agreeing clinical standards

Following the NOA process, the UKOA leads decided to invest in developing a first set of standards to demonstrate the methodology and show potential for success. If this process is followed by future alliances, it is recommended that the project lead(s) identify potential areas of focus before the inaugural meeting. It is useful to work up a potential quality standard or a guideline and generate a list of other potential quality standards for the members to comment on. It may be useful to consider standards:

- that do not exist but should.
- that people are already asking for.
- for key safety issues which should be in place.
- which would benefit from co-design with all stakeholders.
- for patients including co-developed patient education and support materials.

To help think this through, it may be useful to consider how the UKOA approached this stage of the process.

Before the first alliance meeting the UKOA project team assessed various options for evidence searches and literature reviews and found that the British Medical Journal Evidence team, who had conducted the work for the NOA, were best placed to support this work. Working with them, the team built on their NOA work to develop a template against which to analyse literature for our ophthalmic standards and a list of what those potential ophthalmic standards might be.

The UK Ophthalmology Alliance (UKOA) continued

The two pilot topics chosen for quality standards were:

- treatment of amblyopia ('lazy eye') in childhood (this was because it relates to all clinical professionals, not just ophthalmologists).
- selection and insertion of intraocular lenses (IOLs) for cataract surgery (this was because it is the single biggest cause of surgical 'never' events).

Professional links and contacts were invaluable. A procurement efficiency lead from GIRFT was recruited, key national ophthalmology procurement leads were identified and NOA members suggested priorities for ophthalmology procurement which the NOA could support. In addition, information was shared about how the procurement landscape would change and how the alliance could influence that. This formed the basis of those involved in the subsequent procurement working group.

Key learning – preparing for your first alliance meeting

- Agree the communications plan at the outset.
- Canvass potential founder members informally.
- Don't underestimate the planning needed before any first alliance meeting.
- Agree the implementation plan.
- Be clear about proposed alliance aims and benefits to share with members.
- Do some groundwork to bring topics for discussion to the first meeting.
- It's good to replicate other models but tailor each sub-specialty alliance as appropriate.
- Remember this is collaboration so things may change once the members meet.

The UK Ophthalmology Alliance (UKOA) continued

First alliance meeting

The key to a first successful meeting is getting the right people together. For the UKOA, given the number of founder members, its geographical spread and the spirit of shared governance, it was important that the alliance met on neutral territory rather than becoming associated with any particular trust.

The agenda

These suggestions are based on the UKOA experience:

- It is important that there is evidence of executive support. Asking one of the trusts' CEOs to make a welcome speech should be considered.
- Ensure that the intended purpose and aims for the alliance are shared with the members. Listen to feedback and adapt accordingly – they should be shaped by the members.
- Showcase the preparation work – in the UKOA's case this was the literature review leading to the suggested pilots and the groundwork for a procurement workstream.
- Show potential for efficiencies, for example cost savings, and demonstrate the potential for quality improvement that the alliance could achieve.
- Invite the experts you have been working with to be part of the day to share the learning.

The precedent for collaboration and shared governance should be established early and this is best achieved by seeking feedback from members. The UKOA meeting spent the afternoon in groups working on various questions. This work helped with planning the next steps for the alliance and ensured all members felt engaged in shaping the future work programme. Members discussed options for work which helped to develop a framework.

Workstreams

It is important to focus members on active work programmes that can be delivered. Asking members which standards they are interested in developing will ensure the workstreams will be relevant and more likely to be of interest.

There was significant consensus from UKOA members as to the priorities and they generated many topics of interest. These broadly fitted under three key workstream headings:

- data and costs.
- quality standards.
- services and staff.

To garner interest and enthusiasm, look for:

- quick wins.
- what people want.
- ways to make savings.
- who will do the work and how.

Members volunteered at the UKOA meeting or by email afterwards. Getting people to volunteer for particular pieces of work on the day of the meeting is a way of ensuring that these gain traction quickly.

The UK Ophthalmology Alliance (UKOA) continued

Updating the communication plan

During pre-planning a draft communications plan should be put in place and once the alliance begins to develop this should be updated.

The form of your alliance will dictate how you decide to communicate. For a national alliance (like the UKOA and the NOA), it will be important for members to agree how to communicate in their workgroups, how to share information, how to report progress and then how this progress can be shared between full membership meetings. The UKOA decided on quarterly meetings. Channels can include email, Skype, conference calls, website and newsletter.

The communication plan should be updated to include this information. It is also important that the alliance members share the learning within their own units as well as with other members.

Once the alliance is formed it will need an identity. Suggestions for a name were collected at the inaugural ophthalmology meeting and then members voted through an online survey.

The UKOA decided to develop a website and newsletter and to use email and conference calling for workgroups to communicate.

Key learning from the first alliance meeting

- Have the meeting at an accessible location.
- Share the planning but let members change and decide things.
- Sign up workstream volunteers on the day or as soon as possible afterwards.
- Keep stakeholders involved.
- Don't duplicate work but implement existing standards.
- Give the alliance an identity as soon as possible.
- Agree how the members will communicate.

The UK Ophthalmology Alliance (UKOA) continued

Ways of working together in an alliance

It is useful to consider different ways of bringing alliance members together to make the best use of time and resources. Ideas generated by UKOA members included:

- Showcasing excellence and/or innovation to spread best practice quickly.
- Hosting workshops on key subjects bringing members together to get richer input.
- Holding relevant education seminars.
- Running joint clinician and manager workshops to better understand each other's roles and challenges.
- Producing and using information and outputs to generate documents and guidelines which can be shared with other members and published for wider use when appropriate.

Sustaining the alliance model

As well as the initial funding to get an alliance established, there needs to be consideration given to how it will be funded and managed longer term. Members will need to agree where the alliance secretariat will be based once fully established (a 'home').

Consideration needs to be given to how the alliance will be driven – a balance will need to be struck between having leads driving it and the need for shared governance (membership approach). Actions to be considered:

- Create a small board of leaders/secretariat and decide who will host or oversee the alliance. Consider funding designated leads to ensure the alliance momentum is maintained.
- Decide what administrative support is needed. This should include communications, website and data management – this could all be one post.
- Draft and agree the formal governance structure, representative leadership model and any liability issues.
- Decide on source(s) of funding and how it will be administered: will this be membership fees and/or other funding?
- Develop a business case whatever the source of funding as it will ensure there is a way of demonstrating planned activities and outputs against what is delivered. It is a useful way of capturing the pre-alliance planning and the value the alliance has added to the specialty.
- Ensure your aims and results meet any funding criteria.
- Agree how the alliance will support other specialties wanting to develop a similar model.

The UK Ophthalmology Alliance (UKOA) continued

Key learning from the first alliance meeting

- Use different ways to bring alliance members together.
- Run interesting workshops (free if possible) using member organisation facilities.
- Share excellence and innovation to spread best practice.
- Document and share workstream outputs.
- Be clear about the structure and leadership of the alliance.
- Don't underestimate costs, but have a lean secretariat.
- Decide where the alliance should be hosted.
- Capture the aims and plans in a business case so that the benefits can be evidenced later.

Read the full publication here

Improving networked care

Staff and patients
Improving networked services

Introduction

During 2016/17 the vanguard team worked with experts in citizen innovation and participation to understand how patients can best be involved in the delivery of networked care in order to improve outcomes. We wanted to understand how best to involve patients and service users in helping to ensure that a network remains resilient and responsive to the needs of patients and their carers. We came to understand that this needed to be by staff and patients designing services together.

In 2017/18 we have been working with the Point of Care Foundation (POCF) to understand the best methods and tools which can be used to embed staff and patient co-design of services across a single specialty network.

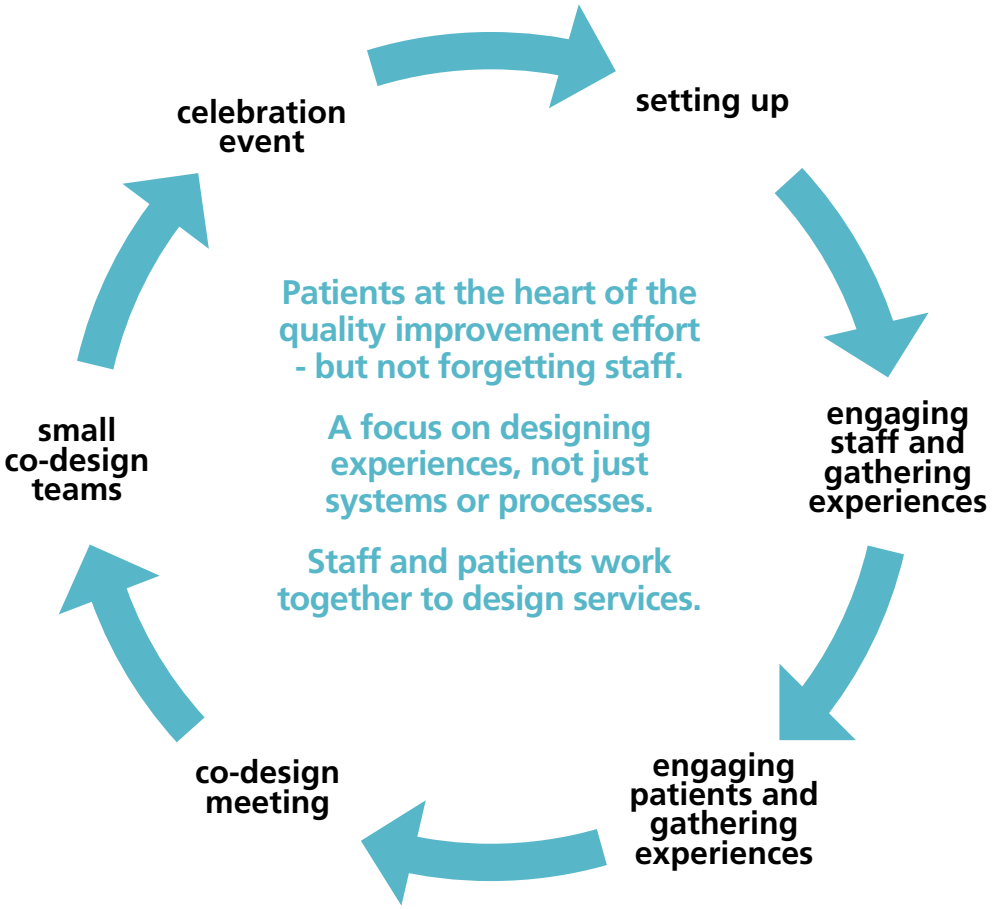
The POCF is an independent charity with a mission to humanise healthcare by making radical improvements in the way we care and are cared for. The POCF delivers this mission by providing evidence and resources to support health and care staff in caring for patients. It works to improve patients' experience of care and increase support for the staff who work with them. It delivers support to NHS and other organisations in the UK and abroad, to implement patient-centred approaches to improving the quality of health and care, focusing particularly on patients' experience of care.

Approach

The vanguard programme commissioned the POCF to develop team skills in using the technique of experience-based co-design (EBCD).

EBCD involves gathering experiences from patients and staff through in-depth interviews, observations and group discussions, identifying emotionally significant points and assigning them as positive or negative. A short film, showing how patients experience the service, is created from the interviews and shown to staff and patients separately. They are then brought together to explore the findings and work in small groups to identify and implement activities that will improve the service or care pathway. This approach was designed to help the NHS develop simple ways to offer patients a better experience of treatment and care. Similar user-centric design techniques have been used by leading global companies for years.

The vanguard team and the POCF worked with five teams across the Moorfields' network to pilot the tools and techniques. As well as starting the process of embedding co-design as 'business as usual', we wanted to establish how best to standardise this approach across all the network sites.



Robert G, Cornwell J, Locock L, Purushotham A, Sturmey G and Gager M. (2015) 'Patients and staff as co-designers of health care services', *British Medical Journal*, 350:g7714

Process

The POCF worked with Moorfields' head of patient experience to engage with teams at the sites involved, delivering several workshops from September to November 2017.

An experienced co-design practitioner used a mentoring and coaching model to support all the teams to learn the co-design approach and overcome obstacles. This involved repeated visits to boost training in short bursts, attending steering groups and meetings of team leaders and providing phone support and additional guidance as needed.

Most of the teams focused on the outpatient setting or on a particular care pathway. Although not all teams arrived at training with a specific focus for their projects in mind, most decided on their projects soon afterwards.

The training was well received, evidenced through regular participant evaluation feedback.

It was important that people understood why they were attending training and what part they would be expected to play in the co-design process. Some people attended out of interest but did not intend to get involved in a co-design project.

Critical success factors

The POCF has identified a number of features of the most successful projects and teams. It is important that teams are clear about the following:

- The 'strategic fit' of their project in the wider organisation's mission.
- Whether co-design projects are standalone or integrated with other work.
- Their focus on what is targeted for improvement. Whether that is solely patients' experience or includes efficiency, safety and wider improvement issues.
- The care pathway, department, area, specialty or particular group of patients which are to be the subject.
- The strategy for leading the projects, including organisational sponsorship.
- How, and to whom, they are accountable.

It is crucial that organisations and managers understand that it takes time for projects to become established and to build the relationships needed to embed an enduring culture of co-design. Teams also need to appreciate that EBCD is essentially exploratory in nature: goals emerge as part of the process and it is not possible to clearly describe the anticipated outcomes at the outset.

It is natural for staff to find change unsettling. Successful project leaders overcome this by taking time at the outset to clarify the vision, aims and change strategy, connecting the project to existing structures and systems and building consensus and understanding around goals and methods.

Project leaders need to build alliances at both organisational level and within departments, including with people who might be seen as 'informal leaders' and opinion formers, as well as people who are regarded as leaders because of their hierarchical position. The co-design process connects people with their motivation for working with patients and, in time, people who use the method move from being allies and supporters to being strong advocates and champions for it.

The speed of this process depends on the strength of these relationships at the outset.

Case study: Improving clinic flow

When clinics overrun it is frustrating for patients and staff. The staff working in this clinic have wanted to improve flow to reduce late running clinics for sometime. The EBCD project work is helping to accelerate progress. The clinic has very little space and sees a 30% increase in patient numbers each year, but there is optimism and confidence that improvements are possible when staff and patients work on solutions together. Strong project management and staff engagement characterise this team's approach.

Members of the stakeholder group were selected to include staff at every level, including some who had not been involved in anything like this before. It was no surprise to find that receptionists and care assistants could describe what it was like to work in the clinic and had brilliant ideas about what could be changed to make improvements. Seeing their ideas implemented convinced staff that they had the power to make a difference.

Some of the stakeholder group had training in the use of the EBCD tools and helped those team members who hadn't. The lead manager had used the method before and was able to build understanding about the principles and benefits of working this way. Although the stakeholder group could not meet face to face as often as they would have liked, the lead manager and others ensured that all the staff were kept updated. This combination of leadership and involvement is a recipe for success even though the service is busy and the improvement work is being done as part of the day job.

Patients were recruited for interviews and for the patient feedback and joint staff/patient event with a conversation in clinic with a member of staff they already knew and a follow-up phone call with more explanation.

The POCF training emphasises the importance of identifying and engaging with key stakeholders from the outset, understanding their interest in the co-design work and designing engagement and communication strategies accordingly. It also emphasises the importance of strong project management, establishing governance structures for projects, a clear plan, timeline and milestones.

Challenges

In settings that do not already have a culture of patient participation, the idea of patient involvement can initially be seen as a challenge.

- Having a trust strategy for patient participation provides a wider context for and understanding of EBCD.
- For EBCD to succeed, obtaining commitment, oversight and expectation from senior operational managers from the very beginning is of paramount importance. This provides not only recognition of the significance of the work but also the required time and resources, making the aims more achievable.
- Having strong local leadership cannot be over emphasised, but having strong members of the team who feel involved and empowered to carry on the work in the absence of the project lead, in the event of long-term unplanned absence, is equally important for success.
- Another challenge can be the perceived lack of time available to do this work, with busy clinics, difficulty in getting staff released and annual leave commitments.
- Events, activities and staff availability need to be planned in advance.
- Train only those staff to be included in subsequent activities and consider who these staff members need to be.

From the staff's perspective, there is a risk that the model appears over complicated and time consuming, requiring skills and equipment that they may not have locally.

It is important to emphasise the flexibility of the tool to reassure staff that as long as the core elements of the tool are met, they can adapt it to their local circumstances.

Recruiting patients for the project can be a challenge – it is not easy to explain a complicated project during a busy clinic and some teams may struggle to find enough patients willing to commit.

Setting up a database and webpage of patients willing to become involved makes the process of recruiting patients easier.

Posters and leaflets emphasising the local nature of the work can help.

A positive feature of the work by one of the teams was in identifying interested patients before the process started.

Adapting to local needs

The quality improvement literature shows that having a clear, easily explained methodology is key to co-design, as is the ability to tailor approaches to local circumstances.

One of the teams adapted the methodology to reflect its already-established working relationships with a patient group. They chose to start working with these patient representatives to prioritise key areas for improvement that had already been identified, then set about the process of co-design during the POCF training session.

Case study: Improving customer care

When patients know that you have time to listen to their experiences of services and their ideas for change, they have so much to offer. When staff are given time to listen to patients, it reminds them of their core values and reconnects them to their purpose.

This has certainly been the experience of staff from one of the teams and colleagues working with them. A patient survey highlighted the need for customer care training and patients and staff have started to design a suitable training programme. This will include improved training and development for clerical and reception staff which will result in a better patient experience and improve staff job satisfaction.

Having patients in the group changes and enriches the nature of the discussion. Patients bring perspectives from a range of different eye conditions, degrees of visual impairment, life experience and their experiences of other hospitals. This makes the patient voice a genuine part of the process.

Staff have found the experience motivating and refreshingly challenging. Staff recognise that they are able to be honest and transparent with each other and barriers to change are openly discussed and understood and the team are motivated to design something which will offer an improved patient experience.

Organisational priorities

For optimal progress, patient engagement must be an organisational priority, with senior leaders taking an active interest in embedding processes like EBCD across the organisation. Co-design work needs a 'home' in its host organisations. Related to this is the importance of getting the right people involved and trained in the co-design process. This is critically important to the chances of success.

External factors can be a powerful driving force. The CQC's 'caring and responsive' requirement, for example, can be evidenced by the use of EBCD and this can be a convincing argument in favour of its adoption.

Sometimes practicalities interfere. One team was in the middle of moving to allow for refurbishment: they saw the timing of the project as unhelpful.

Support for those implementing co-design

It is important to consider how well the co-design methodology fits with the cultural norms in an organisation. EBCD works best when staff feel empowered to lead and make changes. The best project leaders are proactive and do not wait to be given permission.

Practical support for teams who are building their confidence really helps, as do patience and encouragement. Having support to help with some tasks can really help, as long as it doesn't weaken local staff engagement.

Experience of, and confidence with, the method really helps teams to make rapid progress. Identifying a project champion who is comfortable with the method at the outset helps get things started. People's initial reluctance usually stems from apprehension when they haven't been involved in anything like this before. POCF trainers are used to seeing this but once the training gets underway, there is a realisation that the approach is an appreciative one, in which all progress to greater patient engagement is to be applauded, and confidence grows rapidly.

What is apparent from people who implement the co-design approach, is that it is easier to apply than people anticipate. Practical support to help start a project and the inclusion of more confident practitioners early on can have a huge impact on progress. Although the process cannot rely on a single 'heroic leader' if it is to be sustained across an organisation, an enthusiastic, confident champion is a valuable starting point.

Permission and determination to take the time to apply the method are critically important. This requires strong clinical and non-clinical leadership and a recognition that co-design is an inherent part of clinicians' and managers' everyday jobs.

Finally, support for the implementation of co-design needs to be tailored to the needs of the organisation. There is a need to carefully balance practical support for the teams implementing co-design, while on the other hand not de-skilling or disempowering those whose role it is to take ownership to make the changes and improvements.

Case study: Reducing the wait

The prospect of 120 booked outpatients, many having to wait a long time in the department, was the regular situation facing staff on a Monday morning. By December 2017 new nurse-led clinics for patients with a stable eye condition had been introduced enabling some patients to be seen, tested and discharged in around an hour. Under the new system their results are reviewed by a consultant within three days and a message is sent to the patient to confirm the outcome and any further appointment. It has also been arranged that some patients needing long-term review can now be seen at clinics run on a Saturday, further reducing the numbers at Monday clinics.

Local medical consultant leadership has been very important. A new consultant works alongside an experienced colleague to help instigate and implement new ideas. Similarly, local leadership from department managers has been key to getting started with EBCD.

Experiences will continue to change at this site as patients, doctors, nurses, clerical staff and patients are interviewed about what it is like to deliver and receive the service.

Waiting in clinic is the top concern for patients and uppermost in the minds of staff too.

Interviews and observation are helping staff to explore what long waits feel like and to provide the foundation for involving patients and staff in designing improvements.

Some staff had training about the tools used in EBCD, while others heard about the process during interviews and because of the 'buzz' of discussion in the department. The team have identified patients who frequently come to the Monday clinic to invite them to become involved, aiming for 10 patients to work with staff on service improvement projects.

Staff are excited that new ideas are being implemented and want to showcase the pathway changes they have made. They want patients to know they are making improvements. They don't want to miss the opportunity to get feedback from patients about their experience in clinic and gauge how successful the changes have been. They also want to find out what else can be done in time to improve the experience for staff and patients.

Case study: The Point of Care Foundation

The Sweeney Programme

Patient experience and staff experience go hand in hand. That is why we focus on making sure that when it comes to healthcare, everyone's needs are met, to provide compassionate care and a fulfilling work life. We believe that staff can provide the best care by stepping back and seeing the care they give through the patient's eyes.

The Sweeney Programme enables staff to do just that. Through the programme, we deliver training in quality improvement tools and techniques, including Experience Based Co-Design (EBCD) and Patient and Family Centred Care (PFCC). We help staff see their routines and practices in a new light, to produce sustained improvement and cultural change. We run it as a collaborative, bringing a number of teams together for learning events so they learn from each other. The programme usually consists of two or three learning events over six to nine months with implementation support (coaching and mentoring) in between.

As of early 2018, 750 healthcare staff have taken part in Sweeney training and returned to their organisations with the skills, motivation and inspiration to create sustainable changes to improve the quality of care. The Sweeney Programme builds staff confidence and skills, to drive sustainable, bottom-up change in their services using insights into patients' experience of care, producing tangible changes for patients and carers, staff and organisations.

Read the impact report here or by downloading from the toolkit resource section.

PDF **The Point of Care Foundation**

Conclusion

Several sites have made a promising start in a short period of time in implementing EBCD. Some have moved further and faster than others. Service pressures and unplanned absence can be challenging when teams are trying to improve quality and find different ways to work with patients. Some teams manage to make progress despite these difficulties. It is important to reflect on what makes the difference.

It is clear from these case studies that some of the teams are making headway because of confidence, enthusiasm and the willingness of key practitioners, despite not yet having all the critical success factors fully in place. The learning gained from sites where progress has been slower is also contributing to building confidence and equipping teams to be in a better position for future co-design work.

What is also common across all the teams is how they value having the time and other support to really listen to patients.

Some are beginning to move from 'projects' to seeking opportunities to use co-design approaches in a wide range of service developments. This is the first step in moving EBCD from a new initiative to business as usual.

It will not happen quickly, but if teams are given the time, resources and other support, there is plenty of evidence that the approach can be applied to its full potential across a networked care model significantly improving patient and staff experience.

Read the full publication here

Resources

A guide to team briefing
About new care model vanguards
Clinical governance framework
Communications framework: new networked site
5 courage to challenge posters
Dartford & Gravesham NHST SLA draft
Dartford & Gravesham NHST SLA process
Dashboard
Map: Moorfields' network England
Map: Moorfields' network UAE
Moorfields' network: history timeline
Moorfields' network: site structure January 2017
Moorfields network site structure March 2018
Metrics: colorectal
Metrics: generic
Metrics: neurology/neurosurgery
Metrics: ophthalmology
Metrics: orthopaedics
Metrics: quality sharing
Report: health needs market assessment
Report: IT considerations and checklist
Report: patient participation (small file)
Report – Patient participation (250mb file with embedded film clips, will take a while to download)
Report: board-level enquiry - existing networked care providers
Report: board-level enquiry – non-networked care providers
Scaling up single specialty networked care: A strategic overview
Spreading best practice: UK Ophthalmology Alliance
Staff and patients: Improving networked care
Template 1: host trust internal review
Template 2: scoring
Template 3a: detailed review information (Excel)
Template 3b: detailed review information (Word)
Template 4: review agreement
Template 5: review visit methodology
Template 6: review visit report framework
Template 7a: planning and mobilisation checklist (Excel)
Template 7b: planning and mobilisation checklist (Word)
Template 8: business case framework
Template 9: partnership programme plan
Test your knowledge tool
The Moorfields Way
The Point of Care Foundation – Our impact: The Sweeney Programme
Workshop: graphic illustration

You will need to be connected to the internet to view the films and access and download the resources. Please also use the online toolkit here **networkedcaretoolkit.org.uk**

Resource icons

WEBSITE FILM DOCUMENTS EXCEL FILE PDF

Glossary

ACP	advanced clinical practitioner
CCG	clinical commissioning group
CEO	chief executive officer
CQC	Care Quality Commission
DGH	district general hospital
MHRA	Medicines & Healthcare Products Regulatory Agency
NICE	National Institute for Health and Care Excellence
PACS	picture archiving and communication system
PROMs	patient reported outcome measures
SLA	service level agreement. Defines the clinical services to be provided by the parties to each other
STP	sustainability and transformation partnership
TUPE	Transfer of Undertakings (Protection of Employment) Regulations

2016/17 Moorfields vanguard programme team:

Johanna Moss, executive lead
Karen Reeves, programme director
Melanie Hingorani, clinical lead
Irenie Ekkeshis, patient lead
Rebecca Kingdom-Kruszewski, communications lead
Mary Masih, workforce (nurse) lead
Konstantina Prapa, project manager
Serena Green, project support
Ricardo Farnell, project support
Philippa Hutchinson, toolkit content support

Additional team support from:

Harinder Grewal, Darzi optometrist
Charlotte Lee, ex-Darzi fellow
Kaajal Chotai, compliance and quality improvement
Andrew Scott, consultant ophthalmologist
Valerie Juniat, consultant ophthalmologist

Moorfields patients:

Alan Bates
Annie Folkard
Catherine Fleishmann
Chris Clarke
Elaine Manna
Gabrielle Richardson
Jean Higgins
Jill Wakefield
Joanna Bracey
John Allen
John Thomas
Rob Jones
Steve Rattray
David Quigley

2017/18 Moorfields vanguard programme team:

Johanna Moss, executive lead
Karen Reeves, programme director
Melanie Hingorani, clinical lead
Gabrielle Richardson, patient lead
Teresa Due, senior project manager
Sola Banjo, senior project manager
Brian Donnelly, communications lead (2017/18)
Rebecca Kingdom-Kruszewski, communications lead (2017)
Tim Withers, patient experience lead (2017/18)
Mary Masih, patient experience lead (2017)
Philippa Hutchinson, content support manager
Gergo Szecsko, administrative officer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Our thanks to other sector partners who contributed to the learning in this toolkit.