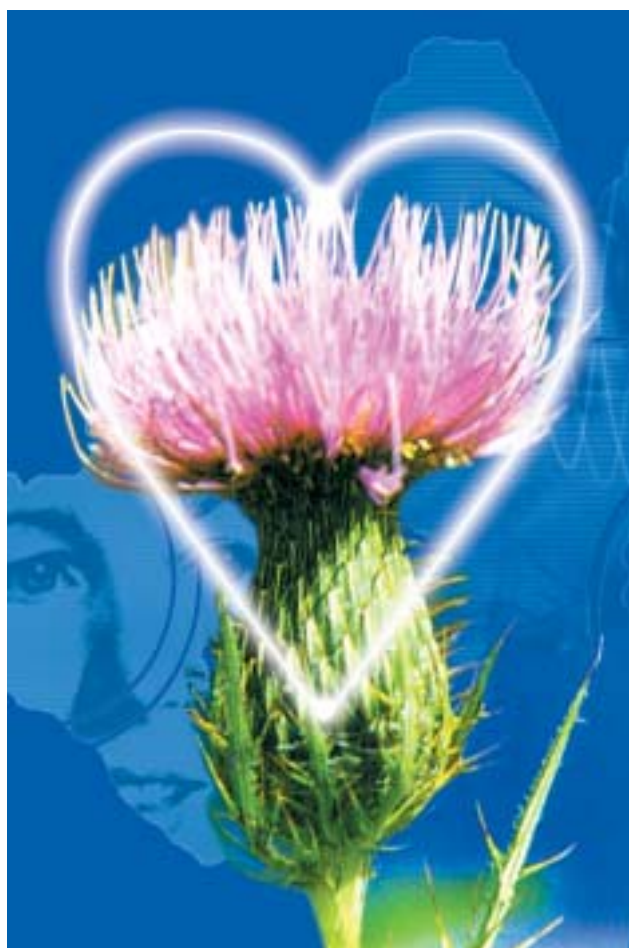


Managed clinical networks: *a guide to implementation*



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Foreword from the Chief Medical Officer for Scotland

The concept of managed clinical networks (MCNs) was first set out in the report of the Scottish acute services review, published in June 1998. The Executive's continuing commitment to the concept was made clear in *Our National Health: A plan for action, a plan for change* (December 2002), which highlighted the potential of MCNs to improve services for those suffering from chronic conditions. The key role which MCNs can play in healthcare delivery also features prominently in the report of the coronary heart disease (CHD)/stroke task force (September 2001), which forms the basis of our national strategy for CHD and stroke; in the *Scottish Diabetes Framework* (April 2002); and in *Future Practice* (July 2002), the fundamental review of the Scottish Medical Workforce.

As our new Health Department letter makes clear, MCNs are an essential mechanism for implementing a range of Scottish Executive policies. They promote our central commitment to involving patients. They help us to achieve our waiting times targets, by looking at services from the patient's point of view and ensuring the care pathway is as smooth as possible. They also take forward our aim of improving the quality of services, and access to those services, across Scotland as a whole.

There is now considerable expertise in Scotland in developing MCNs, and we are keen that this should be shared as widely as possible to avoid unnecessary duplication of effort. These guides are consistent with that aim. Dr Chris Baker, Lead Clinician of the Dumfries and Galloway Cardiac Services MCN, has been instrumental in setting up that network, which has yielded generic lessons of relevance to the development of every type of MCN. He is therefore able to give an authoritative account of the subject. I wholeheartedly commend these guides to those who want to know more about the concept, as well as to those who are looking for some practical help in creating an MCN.

Dr E M Armstrong
Chief Medical Officer for Scotland

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This guide draws on the experiences of the national managed clinical network (MCN) pilot in Dumfries and Galloway to provide practical advice and information for healthcare professionals that are involved in the development of MCNs. It includes a sample timeline and tips on issues such as involving patients, bringing your colleagues on board and developing protocols.

Terms that are defined in the glossary (page 33) are underlined in the text.

The sister publication to this guide – *What are managed clinical networks?*¹ – sets out the case for MCNs. This short, accessible booklet provides a useful introduction to MCNs and explains why they are worth developing. Giving colleagues a copy to read could help to get them involved.

Strategic plans for NHSScotland

The vision for the future of NHSScotland was set out in the NHS plan for Scotland, *Our National Health: A plan for action, a plan for change*.² Integral to the plan is a reduction in the number of structures and organisations in NHSScotland in order to ‘simplify, improve and rationalise the current local decision-making arrangements’.² This has resulted in the formation of a single unified NHS board in each of the 15 health board areas in Scotland. These boards replace the previous separate board structures of NHS health boards and trusts.

Following the Scottish acute services review³ (see *What are managed clinical networks?*¹), a coronary heart disease (CHD)/stroke task force was set up to make recommendations about reducing the burden of death and disability from CHD and stroke in Scotland.⁴ The major recommendation of the task force was that issues should be addressed and services provided through MCNs⁴ – an idea ratified in The NHS Plan: ‘Managed clinical networks will be developed at local level for investigation and diagnosis, linked to a national network for intervention’.² The recommendations of the task force for MCNs for cardiac services and stroke have since been carried forward in the *Coronary Heart Disease and Stroke Strategy for Scotland*, published in October 2002.⁵

In considering chronic diseases, the plan highlights a need to change the system so that it is more focused on the needs of patients with chronic illness, and identifies MCNs as the mechanism that will ensure a co-ordinated approach.² It highlights their potential as an innovative and appropriate mechanism for the management of chronic neurological conditions such as multiple sclerosis, Parkinson’s disease and epilepsy.²

Key principles for managed clinical networks

The principles and key issues to be considered by MCNs were set out in a Scottish NHS management executive letter (MEL) in 1999 (a further Health Department letter (HDL) on the subject was published on 18 September 2002).^{6,7} They are summarised below, and are also included in *What are managed clinical networks?*¹

- **MCNs must be managed** rather than drifting, so they need clear structures and lines of responsibility. A clinician or a clinical manager should take a lead role but there should be clear responsibilities for all concerned.
- **The purpose of the networks is to improve patient care** in terms of quality, access, convenience and co-ordination.
- **Work undertaken must be evidence-based**, using Scottish Intercollegiate Guidelines Network (SIGN) guidelines and protocols where appropriate. Networks will support research and continuous professional development.

- **Outcomes need to be measured** and audit is an integral part of networks. All staff must participate in open review of results.
- **A quality assurance programme** that is acceptable to the Clinical Standards Board for Scotland (CSBS) is required. (From 1 October 2002, the CSBS will become part of NHS Quality Improvement Scotland.)
- **Each network must produce a written annual report** that is made available to the public. It must also have a clear policy about dissemination of information to patients.
- **Networks must be truly multidisciplinary** and multiprofessional. A properly functioning network needs appropriately trained clinicians with adequate facilities, working in partnership. Training and continuing professional development (CPD) should be an integral part of networks.
- **Patients must be involved in shaping the network** and each network must have a policy on disseminating information.

The idea of MCNs has developed further since these principles were written, and a key element has in effect been added by the pilot processes that have occurred. This is the principle that **MCNs should provide a mechanism for patients and clinicians to be involved in disease-specific planning and strategic thinking** with NHS boards. This inevitably also means being involved in discussions and decisions about the allocation of resources.

If MCNs are to be effective and act as drivers for change, it is clear that all of the above key elements will be required. It could be argued that they will define the network, and local circumstances and resources will give the network its form. The principles, even if followed to the letter, allow sufficient latitude so that major variations can occur to accommodate differing geography and demography, while still dealing with the same clinical area. There might even be subdivisions within a network if different locations within an area had widely differing needs or circumstances.

The ultimate aim of MCNs is to improve patient care in terms of quality, access and appropriateness. To achieve this, the quality assurance programme needs to be based upon the patient journey, with key standards set out at each major stage. To make this realistically applicable for clinicians, the programme and the standards need to be locally agreed (using national guidance where available) and set out in a care pathway that spans the professions and health sectors. The care pathway will need to have clinical protocols at each stage to back it up; these again should be locally agreed using existing materials where available. All of this should fulfil the MCNs' subsidiary aims, which are to ensure that the right treatment gets to the right patient at the right time in the most appropriate place and is delivered by a clinician with appropriate training and resources.

CHD in Scotland – a case study

Scotland has an unenviable reputation as 'the sick man of Europe' because of its high incidence of, and mortality rates from, cancer, stroke and CHD.^{2,8} Death rates from CHD are falling rapidly in most countries in Western Europe,⁹ but Scotland's level is still the second highest.³

While the provision of cardiac services in Scotland is generally of excellent quality, there are aspects where improvement is possible. These include secondary coronary prevention, cardiac rehabilitation and provision for thrombolysis – all of which the acute services review highlighted as in need of attention,³ despite the many highly skilled and motivated healthcare professionals focusing on these areas.⁴

The CHD/stroke task force undertook a multiple-cause analysis of the reasons for these problems.⁴ This suggested that there was a lack of clarity in roles and

responsibilities, particularly in secondary prevention. Poor co-ordination (especially across the primary–secondary care interface) and difficulties in keeping track of patients were also cited as factors. Concerns about resources and incomplete knowledge about the potential benefits of interventions compounded the problems. Although other factors played a part, these key elements apply to all of the problem areas highlighted by the review. The end result is that advice and treatment have not always been timely in getting to the right patients. While not highlighted in the review, similar results are likely to be found when looking at primary prevention, where patient lifestyles, resistance to change and failure to seek advice are also detrimental factors.

It is felt that MCNs would address a lot of the causes of the problems identified in the acute services review, hence the recommendations contained in the CHD/stroke task force report and *Our National Health: A plan for action, a plan for change*.^{2,4} These have been carried forward into the *Coronary Heart Disease and Stroke Strategy for Scotland*.⁵

The Scottish Executive Health Department supported a local MCN for CHD pilot in Dumfries and Galloway. The MCN was launched in July 2001 and has begun to address issues such as secondary prevention, thrombolysis and cardiac rehabilitation. Within nine months of the pilot being set up, secondary prevention measures had improved significantly (even above a very good starting position relative to the rest of Scotland), cardiac rehabilitation services had expanded and a region-wide system of prehospital thrombolysis had begun. Common protocols and care pathways are now being used in primary and secondary care, with a blurring of the boundary between hospital and general practice. Active patient involvement has produced patient information materials that are locally focused and widely distributed. It is too early to observe any changes in outcomes; however, if this approach were to be replicated across Scotland, a significant impact would be expected.

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Planning a managed clinical network

It is unlikely that the development of an MCN will have to begin completely from scratch. Patients and carers, and groups acting on their behalf, will have developed clear ideas about the ways in which services can be improved. Most clinicians already work in well-established informal networks. Both those for whom the service is provided and those who provide the service will probably have become aware of the idea of MCNs, and of the tangible benefits of developing one.

The development of a wide range of MCNs has highlighted the fundamental importance of identifying at an early stage in the process someone who is responsible for taking the lead and acting as the embryonic network's champion. There should be no preconceptions as to the ideal background for the lead person – the main priority is the need for firm leadership and a clinical background. This lead person needs strong administrative support, a role which is performed by the network manager. Both the Dumfries and Galloway MCN and the diabetes MCN in Tayside have appointed network managers and can, therefore, provide information on the job description and grading of the post. The Scottish Executive Health Department has modest pump-priming resources available which may be of help in appointing a network manager. More details of this phase of MCN development are given in the 'Establishing a project team' section (page 25).

The first step in formally planning an MCN is what is referred to in management terms as 'clearing the investment'. This means securing the support and understanding of the key individuals in the local healthcare system who have the control of resources to make the development process either possible or impossible. It is essential that the network fits into local plans and priorities: the development process needs to be resourced in terms of clinician time and management support, and it is the local senior executives who will be able to make that support a reality. Time spent in explanation and securing support is usually the prerequisite for a successful development project.

To develop an MCN, it is necessary to obtain a clear idea of who does what, where, when and how under the present service, and what resources are available and used. Although one might feel confident in one's understanding of what goes on in a service, the aim is actually to consider services across boundaries. The process of service mapping is invaluable in finding out just how much reality differs from what appears on paper. Once an accurate idea of the strengths and weaknesses of existing services has been obtained, consideration can be given to how to develop and make better use of these resources, and what the network should look like in an ideal world. In planning and developing our MCN pilot, we found it useful to plot out the location of resources and services on a large-scale map.

Finding out who does what in different parts of a service is in itself a useful way of making new connections and strengthening old relationships. Ideally, a questionnaire or letter should be followed up with a visit; this can help to clarify issues and give a feel for how a unit works.

At the same time as mapping out existing services, it is important to identify which groups and individuals are key contributors, major users, policy makers, catalysts or inhibitors of change. In management jargon, these are the 'stakeholders'. All of these

people and groups must be involved or consulted in planning a successful network. In the case of the Dumfries and Galloway MCN for CHD pilot, these included:

- Cardiologists
- Coronary care nurses
- Medical ward nurses
- Cardiac rehabilitation nurses
- GPs
- Practice nurses
- Ambulance paramedics and technicians
- Representatives from patient groups (such as self-help coronary clubs)
- Local health council members
- Health board commissioners and executives
- Public health specialists
- Health promotion professionals
- Trust executives – medical and nursing directors.

Obviously the stakeholders will vary for different clinical areas and from region to region. It is important to identify these individuals before embarking upon the development process.

The human dimensions of change

In identifying the stakeholders in a network, the potential scale of the required changes starts to become apparent. Fundamental to the concept of the MCN are changes in ways of thinking about the service, in ways of working, and in ways of outlining professional roles.

There is always an inherent resistance to change, and this can be at different levels – individual, professional group or organisation. At all levels there is the ‘shock of the new’ and an unwillingness to recognise the need for change, in case it implies a failing in the present.

Individuals and organisations usually find security in the familiar, and comfort in a well recognised routine. Change can bring uncertainty about the future, raising concerns about job security, status, salary and working conditions. In developing MCNs, we are explicit about blurring the boundaries between roles and professions, which can highlight fears among professional groups about erosion of their status and power. For individuals, there are likely to be concerns over future competence – how will I cope with new demands upon me, and how will I acquire new skills?

Organisations and professional groups within the NHS tend to be defined by their structure, and blurring these boundaries can appear to threaten their identity. A deliberate focus on patients and services rather than on buildings and organisations is easily seen as a direct challenge to the power and authority of existing NHS structures, and even extrapolated into a threat to future budgets and resources. All these considerations lead to an organisational resistance to MCNs, which can seem daunting. Nevertheless, any change can be actively managed to minimise the inherent resistance to it; how to approach this is discussed in the ‘Getting started’ section (page 23).

Links to existing priorities and planning process

Setting up an MCN demands time and effort, which will need to be supported and resourced. This means that those people who set the local NHS agenda (and who hold the purse strings) should actively support the development and fit it into local priorities. The MCN must be commissioned properly within local processes; unless

there is a firm commitment to support the development, it should not be considered a realistic proposition. Involving one or more senior commissioners or executives in developing the MCN should ensure continued links to the planning process.

Once established, MCNs will gather the most up-to-date information and understanding not only of their local services, but of developments in their clinical field. The involvement of the public and patients in network processes should also instil a clear view of the public's interests and priorities. This combination of up-to-date intelligence, public involvement and contributions from all the key clinicians will mean that MCNs can offer commissioners a broad-based source of ideas and information for use in local health plans.

The structure and processes of the MCN should be designed to facilitate a linkage between the network and the planning process, and to facilitate the involvement of the various groups who can add value to strategic thinking and planning.

If a network is functioning properly, it will be working across the boundaries between the different sectors and professions in the health service; it could be argued that the network should be the major contributor to the appropriate section of its local health plan. Balanced growth will be facilitated if people can be encouraged from the start to consider the potential development of the whole service, and not just the development of their own area.

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The quality agenda

While individual clinicians have always worked hard to provide high-quality services, it is only in the last few years that the requirements for clinical governance to be on a par with corporate governance have forced NHS organisations to give the same focus to quality assurance as they do to financial issues. A structured approach to clinical quality is therefore inherent in all MCNs.

In Scotland, this structured approach is encapsulated in the requirement for all MCNs to have a quality assurance programme approved and monitored by the CSBS. Such a programme needs to be able to demonstrate that the network is actually making a difference. It follows from an MCN's quality agenda that the standards for a service must be the same wherever that service is provided. The fact that the network is expected to operate according to a documented evidence base, such as the guidelines produced by SIGN, where these are available, will help to achieve this. For the Dumfries and Galloway pilot, the existing CSBS standards for CHD in hospitals, which are also based on the relevant SIGN guideline, were extended – with some revision (for example, the standards for discharge letters were mirrored by standards for referral letters) – for use in primary care. Some of the standards (for example, those for cardiac rehabilitation) were simply adopted for use in both primary and secondary care.

While the contents of a quality assurance programme should be locally agreed to ensure 'buy-in' from all the participants in the network, it is useful to have a structure or template to follow. Such a template has been developed in the Dumfries and Galloway MCN pilot and is being used by the CSBS.¹⁰ Although flexible, it has eight key components. These are:

- Disease-specific standards, using established standards where they exist and developing new ones where they do not
- CSBS generic standards, especially those that cover patient involvement (other elements of the generic standards might be better incorporated into disease-specific standards)
- A simple schematic that lays out the patient journey for areas covered by the disease-specific standards, with the identification of key standards at crucial points
- The clinical governance structures and processes of the participating organisations, including how they link to the network and its services
- Equipment levels and safety standards, which should be set out for each level of the network
- A section that covers staff training, and CPD for staff involved in the network
- Clearly detailed clinical audit, self-assessment and patient satisfaction arrangements
- A section that clearly sets out the arrangements for public information and annual reports.

The key standards and components of the quality assurance programme for the MCN in Dumfries and Galloway cover the management of myocardial infarction (MI), from first presentation through to secondary prevention and long-term follow-up. Consequently, at present the schematic of the patient journey only covers this subject. The quality assurance programme has been agreed for a three-year period with a peer review at the end, after which the focus is likely to switch to the management of heart failure. To give the standards a practical format, a structured care pathway has been developed for MI which is used by all parts of the local NHS.

Care pathways and protocols

Having a structured care pathway with supporting protocols is a way of ensuring a degree of uniformity and standard of care. However, this will only happen if they are used by the majority of clinicians – with time, peer pressure should ensure this becomes the norm. To encourage a feeling of ownership, it is important that as many local clinicians as possible are involved in drawing up the protocols and pathway, and although it is easy to simply adopt protocols from elsewhere, any revisions to them should also be considered by a number of people. In the Dumfries and Galloway pilot, all of the protocols relevant to primary care were discussed at open meetings in each local health care co-operative (LHCC); the hospital protocols had already been the subject of wide internal consultation.

It is important to keep the network's care pathway as simple as possible in the first instance, with the detail reserved for the protocols. A simple flow chart is ideal. There is merit in developing proper integrated care pathways with full documentation for each patient and variance reporting, but this should probably be a matter of evolution. The initial pathway should contain the key quality standards for the clinical area, highlighted on the flow chart. The protocols should be built around a combination of the practical needs for the service and the processes and measurements required to meet the key standards.

Protocols for an MCN should be developed by a multidisciplinary team from the outset. This should ensure that they are easy to implement for clinicians from a wide variety of backgrounds. For example, the initial assessment and initial treatment protocols in the Dumfries and Galloway MI care pathway are designed to be used in the community, in A&E departments, in medical wards and in cardiac care units. They are used by doctors, nurses and ambulance staff. It is important that the language used should be accessible and that the treatments and investigations suggested should be universally available.

If protocols are used routinely, paper copies rapidly deteriorate – this is particularly the case where there is a steady turnover of staff or where training occurs regularly. Providing laminated copies of the care pathway and protocols, and supplying all MCN documentation as computer files, are good ideas. In the Dumfries and Galloway pilot, we produced a CD-rom containing all the network materials in Microsoft® Word format. As protocols and pathways need to be revised in line with developments in clinical practice, we plan on reviewing our material annually and producing a new CD-rom if necessary.

Clinical governance

When the concept of MCNs was first discussed, there were concerns about how clinical governance would be addressed. The whole basis of clinical governance is that NHS boards – and chief executives in particular – are made accountable for the quality of care provided in their organisations. Because MCNs function across the boundaries between organisations and allow employees from one trust to work within another, questions were raised about where the ultimate responsibility for clinical governance issues in an MCN should rest, and who would be responsible if things went wrong.

This potentially difficult area can be dealt with simply and effectively by assuming that the clinical governance agenda is set by the quality assurance programme. The subject is best summarised by the recommendations of the working group that considered this, as follows.

'It is clearly the remit of the network to agree standards with the Clinical Standards Board for Scotland in a formal way and to implement them. If there is a problem

involving a clinician working in the network, the lead clinician or manager will need to involve the appropriate employing organisation and its clinical governance procedures and structures. This is clear, and disciplinary or contractual issues will fall out naturally, and chief executives will still be responsible for their employees. The chief executive and clinical governance committees of participating organisations will need to accept and clarify responsibility for clinical and managerial issues that may arise at the interface between professions and organisations. Ideally a protocol should be drawn up to cover the interface issues. These clinical governance issues should be laid out in local health planning documents, ie the CHD section of the local health implementation plan should have a separate clinical governance section that covers these issues.¹¹

The protocol section of the Dumfries and Galloway quality assurance programme that covers the interface issues was developed in partnership with the CSBS, with the aim of providing a template for other MCNs to adopt and adapt.¹²

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Co-ordination and information

One of the main aims of MCNs is to improve patient care through better co-ordination of services and better communication between different sectors of the NHS and with the public. Timely, accurate and effective exchange of information is vital to this. This can take place at three levels: personal communication to keep in touch with patients and colleagues; exchange of data and information about individual patients; and communication and provision of information to patient groups and the wider general public.

The value of informal contact is often underestimated. Keeping in touch with colleagues is invaluable in sharing experiences, and an MCN should be designed to support this process rather than supplanting it with protocols and IT. The lead clinician and network manager should visit the various parts of the MCN on an informal basis as often as is practical. MCN committees and working groups should try to include individuals who will act as conduits for passing information backwards and forwards from their 'community of interest'. If this kind of organic structure can be achieved, the network has a much greater chance of long-term success. In the rural areas, email has much to offer in supporting informal communication, but is not nearly as useful as face-to-face meetings.

The timely exchange of clinical data about patients, especially on referral and discharge, is vital for good patient care. There is little doubt that this is not the norm at present. IT has a great deal to offer here, but can only support the process – it is not a substitute for contact between colleagues. If common data sets are used for referral and discharge, patient care should be optimised and audit facilitated. [Scottish Care Information \(SCI\)](#) has a CHD module and a communications package that links primary and secondary care and outpatient modules.¹³ This combination supports protocol-based referral and can allocate degrees of urgency to appointments. This is undoubtedly the way forward, but, as the introduction of these solutions requires piloting, development and training, it will be some time before there is universal coverage. This should actually give sufficient time to agree upon systems that the IT infrastructure can support – in Dumfries and Galloway, patient-held records have been developed as an interim system. The general use of the core CHD data set for NHSScotland, as set out in the CHD/stroke taskforce report,⁴ will be another big step forward.

While the provision of information about services and disease is usually considered to be the exclusive province of health promotion and public health professionals, it is clear that MCNs also have a great deal to offer in this area. The direct involvement of patients in developing materials through an MCN can mean that the products are more practical and relevant. Patient involvement in the process in the Dumfries and Galloway pilot led to the development of patient information leaflets about symptoms of MI and what action to take – each GP practice in the region has its own locally relevant version. Patient information leaflets in other languages that reflect the local ethnic mix are very useful. Newsletters can be surprisingly effective at disseminating information, especially if they are short, well designed, written in simple English and not too frequent. It is sometimes salutary to learn how much patients can offer in terms of expertise and past experience.

The internet offers a huge potential for MCNs to provide information about services and health issues. A well-designed website can be invaluable in disseminating information and allowing a variety of groups and individuals to access protocols,

pathways and reports. For the Dumfries and Galloway pilot, a website has been developed that displays the quality standards and clinical governance protocols, as well as the clinical protocols and an interactive map of services in the region.¹⁴ This has proved very effective and there have been no problems at all with patients having access to the materials – it was agreed from the outset that there would be complete openness. Obviously no patient data are available to the public via the web, but the principle has always been that there should be no differential access for clinicians and non-clinicians: if something should not be seen by patients, it should not be posted. Although the pilot project has not used web-based technology to transmit patient data, there are examples, such as the DARTS project on diabetes in Tayside, where this has been employed effectively and securely.¹⁵

Patient and public involvement

There are five main ways in which the public can be involved in healthcare:

- The involvement of an individual patient in decisions about their own care
- The involvement of patients in monitoring and improving the quality of care in an existing service
- The involvement of patients and the public at an organisational level – for example, as members of a trust board or committee
- The involvement of patients and the public in the planning of change in service provision
- The involvement of the public in the wider public health agenda – for example, through community action.

The involvement of patients in decisions about their care is becoming increasingly common and MCNs should encourage this trend. However, the involvement of patients in other areas has often been token or ineffective. Experience of effective patient involvement in the Dumfries and Galloway pilot has been very encouraging indeed. Healthcare systems traditionally characterise the clinician as ‘the patients’ advocate’, but in the pilot project we have witnessed the patient acting powerfully and effectively as ‘the clinicians’ advocate’. When discussing service development/retraction and the use of limited resources, direct refusals from commissioners seem to be much less likely when patients are personally involved. In developing and managing the network, patients have also acted (sometimes unwittingly) as powerful modifiers of clinician behaviour, making consensus easier to broker. At times, patients have been able to ensure that the focus of a group has been brought back to patient care and away from diversions into esoteric medical concepts.

Increasingly, clinicians are having to look to outside sources such as charities (for example, the British Heart Foundation) and the pharmaceutical industry for investment in projects. Explicit patient involvement in developing bids appears to be a significant contributory factor to success.

To enable patients and members of the public to contribute properly to a network, there is a need for some degree of training. This has been successfully undertaken in the CHD project in partnership with Dumfries and Galloway Health Council. The training, which took place one day a week for four weeks, covered:

- How to work in committees
- How to make your voice heard
- How to link to sources of support and information
- NHS organisation and finance
- Disease-specific teaching on illness, investigations, treatment and prevention.

A small group of patients (six to ten) who have been through this training now contribute significantly to the work of the network, at all levels. Real involvement

has engendered great enthusiasm and the level of patient contribution is increasing with time.

Identifying which patients might become involved in an MCN can be a sizeable challenge; existing patient organisations or groups can serve as a useful source. If no such groups exist, or if those that exist would be inappropriate, patients will have to be recruited in some other way, and nurse specialists can be excellent at helping with this.

Involving patients in feedback and monitoring of services has traditionally been undertaken using questionnaire surveys and focus groups. While these are valuable in investigating problems that have already been identified, they are less useful in the initial identification of problems. There is considerable merit in using patient narrative ('tell us the story of what happened to you/your relative') as a tool for identifying problem areas. Patient narrative also has some impact as an educational tool in highlighting 'softer' issues for clinicians (especially about attitude and manner). Obtaining patient stories requires effort, time and development of trust. Demonstrating to patients that they can make a difference is probably the best way to ensure that feedback continues. It has been gratifying that almost all of the narratives in the pilot project have been very positive about clinical care and have highlighted remediable problems.

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Structure and function

MCNs require administration and management. The model used in Scotland depends heavily upon the role of the lead clinician, who takes final responsibility for the work of the network and is involved in managing the process and the clinicians. It has become clear that the lead clinician needs administrative and managerial support. The level of support required will vary with the size and complexity of the network – a number of disease-specific networks in smaller NHS board areas might share managers and administrative support systems, but those in larger boards will need a team to support each MCN. Whatever the size and complexity, it is clear that there needs to be an MCN office (covering one or more MCNs) to support the clinicians in their development and quality assurance work. In the Dumfries and Galloway project, the MCN team comprises a lead clinician (who contributes one or two sessions per week), a network manager with a clinical background (two days per week) and a full-time administrator/secretary.

In addition, each network needs a body that will oversee its function and ensure financial probity. This task could be performed by a management board with lay involvement, or by the local NHS board. There must also be clear links between the MCN and the local commissioning and strategic planning structures. In the Dumfries and Galloway pilot, the two functions have been combined; the MCN is overseen by a cardiac services group of the local NHS board. The board is also responsible for strategic planning of cardiac services, commissioning of tertiary cardiac services and prioritisation of resource allocation. The cardiac services group has 12 members: two patients, two GPs, two cardiologists, two nurses (one hospital nurse and one practice nurse), two NHS board members, the network manager and the lead clinician. This membership ensures that there is a strong clinical and patient voice, and represents the model that is to be used in all the local MCNs for CHD/cardiac services in Scotland.

There is merit in establishing a multidisciplinary forum for clinicians to raise matters of concern and to discuss the development of clinical issues and techniques. Many of the future plans for the network will have their origins in these sorts of discussions, and the breaking down of barriers between professions and between primary and secondary care will progress naturally.

Management of MCNs

The main purpose of an MCN is to improve patient care. To achieve this, the resources of the network must be managed effectively and a quality assurance programme implemented to deliver agreed standards. The NHS is traditionally reasonably efficient in managing buildings, materials and budgets, but tends to be less successful when trying to ‘manage’ clinicians. Hence it is important for MCNs to consider a different approach to management.

It is reasonable to expect a network manager to take responsibility for managing finance and infrastructure in an MCN, but it is generally unreasonable to expect them to be involved in managing clinicians. This role falls more to the lead clinician. The success of a network will largely depend upon how well this role is discharged.

In hospital services, there is a hierarchical structure to medical management: from junior doctor to consultant to clinical director to medical director. This does not really have a parallel in primary care. In nursing management, the differences between primary and secondary care are less marked than in medical management, but they still exist. GPs are independent contractors to the NHS, and, as such, have never been managed. Consultants and hospital doctors may be employees but they practise in a largely independent way. A realistic measure of management control has only ever been exerted over GPs and consultants by use of reason, persuasion, peer pressure and leadership. To achieve positive change and development across the NHS boundaries, the lead clinician will need credibility in all parts of the local system, as well as considerable persuasive and diplomatic skills.

There needs to be some consideration of how to proceed if there are problems with the performance of individual clinicians. Agreement should be reached about how the lead clinician and network manager fit into local medical and nursing management structures and processes *before* a network is launched. It is important to work within existing structures and processes wherever possible, but some functions may need to be devolved to the network. For MCNs to work across professional boundaries, it will mean some clinicians expanding or retracting their roles. The existing clinical management arrangements can support clinicians in the assumption of roles usually discharged by other professions or in the relinquishment of others, but the same arrangements can also act as an obstacle. In these circumstances, it would be sensible to delegate the professional development and performance management of clinicians to the MCN management team. The exact details of which responsibilities are devolved to MCN management and which are retained by trusts will vary according to local circumstances, but it is essential that there is clarity before the network starts to function.

The involvement of a wide range of clinicians throughout the development of the MCN and new services should minimise difficulties. However, it would be a mistake to underestimate the effects of NHS tribalism and the resistance to change that is inherent in NHS management structures.

Links to outside organisations

Although the most important initial focus for MCNs will be internal communication, links will also need to be forged with a variety of outside organisations. There is a particular advantage in making links with neighbouring MCNs in the same clinical field, and it will be vital to establish links with whatever network or organisation covers tertiary services in that field. For example, all local CHD/cardiac services MCNs in Scotland will need to establish firm and clear links to the Scottish Cardiac Intervention Network (Figure 1, opposite). This should ensure that local clinicians and patients have a key role in discussions about tertiary service arrangements and quality. It is proposed that there should be MCNs for palliative care in each NHSScotland board area, and all developing MCNs should establish links to these. Links should also be set up with the developing MCNs for diabetes, details of which are given in the *Scottish Diabetes Framework* (April 2002).¹⁶ In fact, many primary care clinicians will be part of a number of local networks covering different fields, thereby creating an automatic link.

All MCNs in Scotland will need to establish links with the CSBS because of the requirements of a quality assurance programme. The standards board will continue to conduct peer reviews of clinical services in the national priority areas, and in the future this will include MCNs. Some of the clinicians from MCNs will contribute to the work of the CSBS by direct involvement in peer reviews in other regions. This will give

insight into the standards board's quality agenda and ways of working, but it will also give access to examples of best practice elsewhere.

Those MCNs that cover chronic debilitating conditions or mental health will need to develop close links with local authority departments and social services, and it might be sensible to involve representatives from these outside groups in the initial development process. This should also allow a broader-based approach to services and help to minimise the problems that can occur at the boundary between health and social services.

Links with voluntary organisations and charities are of increasing importance in the NHS, especially in providing support and as a source of patient and public involvement. Some charities, such as the British Heart Foundation, have a history of funding health service developments and are very helpful in supporting short-term projects. In the Dumfries and Galloway pilot, the MCN has been able to aid and support local patient self-help groups – these relationships can be mutually beneficial and sustaining.

While, traditionally, there has been a degree of reluctance in NHS institutions to working closely with the pharmaceutical industry, this attitude appears to be changing. A non-promotional approach from the industry seems to be encouraging joint working outside the narrow confines of research. Educational grants and support are becoming increasingly important in the development of patient information materials and records. In the development phase of an MCN, open meetings will be required to make the process inclusive. Drug companies are likely to be very helpful in sponsoring such meetings, as well as supporting educational and professional development meetings once the MCN exists. Establishing links with the industry during the development phase may prove to be very helpful later on.

It is also worth considering establishing links with university departments, who will be interested in developing research opportunities, but who will also have much expertise to offer in educational processes and the development of materials.

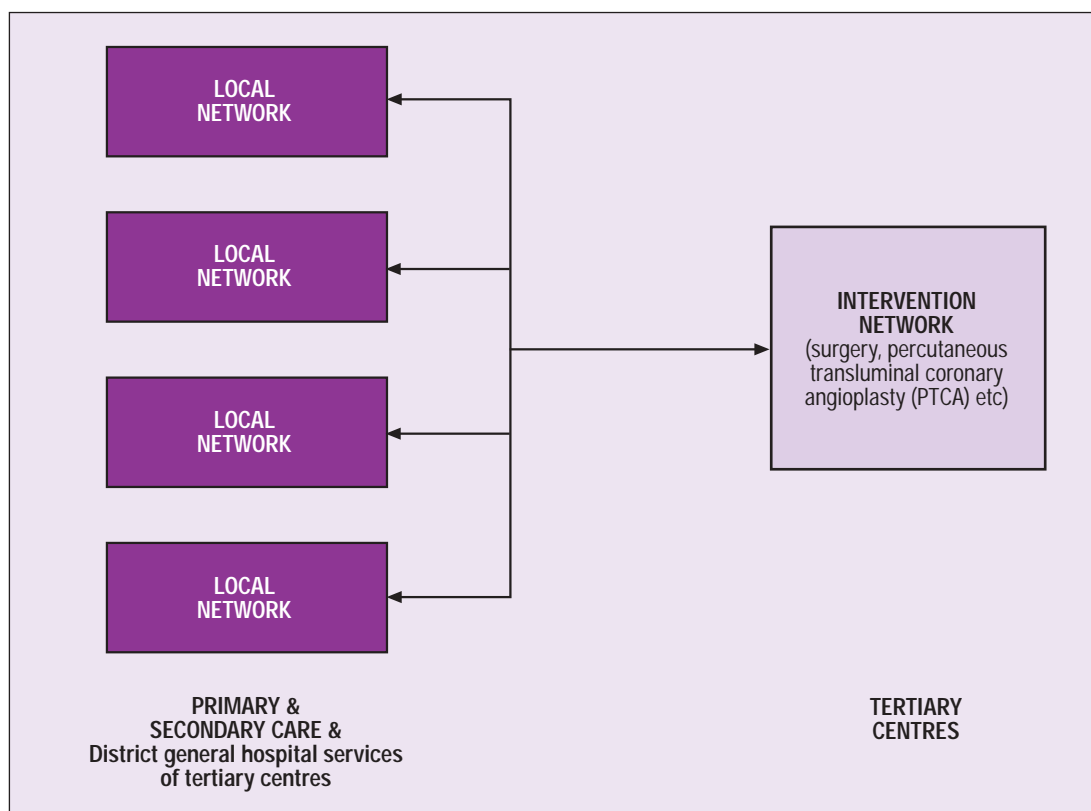


Figure 1. The national linkages

Introduction

*Basics and some
key issues*

*Quality and
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Communication

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Getting started

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How to set up a managed clinical network – getting started

There are several key stages in the development process for an MCN. Box 1 sets out these stages – from gaining agreement for development to launching the MCN. The development process is likely to take around 12 months; remember that it will be focused on more than one area at a time (Figure 2, overleaf).

Box 1

Project plan: key development areas

Area of development

1. Secure agreement for MCN development and outline funding from board

2. Identify and appoint project leader and manager
Secure administrative/secretarial support and a base or office

3. Identify the key clinicians in the area
Secure the involvement of a project team

4. Draft a development plan and timetable
Appoint project leader and project manager

5. Hold first meeting of project team to:
 - Agree development plan and timetable
 - Discuss use of allocated budget and identify any potential shortfall
 - Agree number and remit of working groups
 - Discuss possible membership of working groups
 - Identify obstacles to progress and key clinical issues to focus on in development
 - Agree responsibilities

6. Establish working groups and:
 - Agree work programme and working methods for each
 - Agree timetable and key outcomes
 - Undertake development work

7. Arrange regular project team meetings to review, co-ordinate and guide working groups' progress
Produce regular newsletters

8. Hold open meetings to consult on and refine:
 - Quality assurance programme and standards
 - Care pathways and protocols
 - Any core documents, eg referral and discharge documents

9. Finalise and agree quality assurance programme with CSBS

10. Appoint lead clinician (not necessarily the same as project leader) and ratify transfer of project manager and support staff to MCN

11. Launch

MCN = Managed clinical network
CSBS = Clinical Standards Board for Scotland

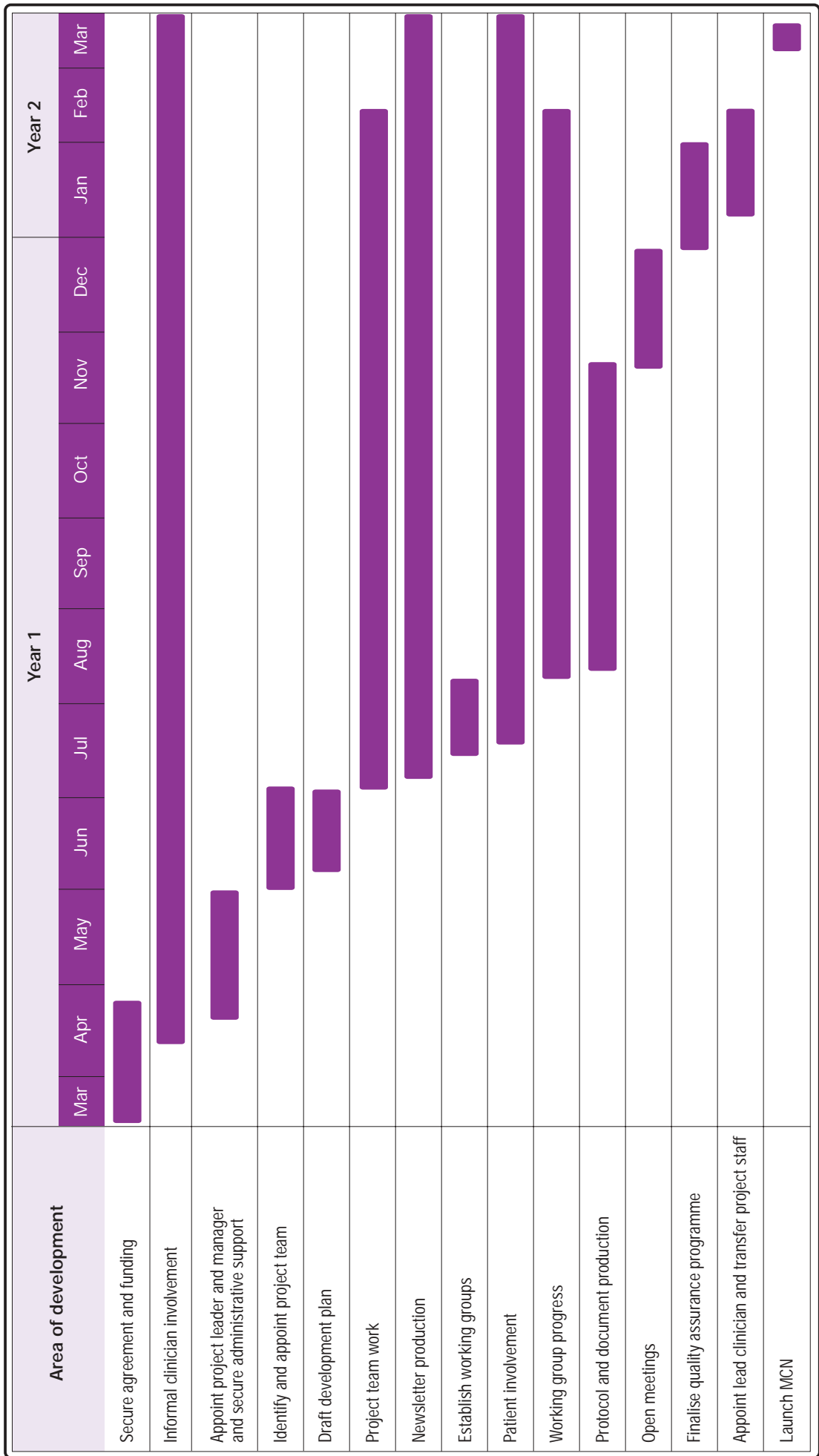


Figure 2. Example of an MCN development timetable

Clearing the investment

The first step towards developing a network is to obtain the understanding and support of the most senior people in the local NHS; that is to say, chief executives, medical and nursing directors (see page 7). To do this, a clear idea is required of the benefits an MCN will bring to the local healthcare system – for patients and for the local organisations. There is a useful introduction to MCNs and a discussion of their benefits in *What are managed clinical networks?*¹

There are significant development costs (and lesser running costs) for a network and these will have to be justified in terms of health gains. It is much easier to convert doubting clinicians if there are demonstrable problems in service quality or provision, and it also helps to identify where working across the boundaries can increase efficiency. If a clinical service is functioning well and there is no obvious gain to be made through an MCN, it will be much harder to justify the development process.

Obtaining support and investment in a network development process takes time, especially if it has to pass through health planning and prioritisation processes and then be included in planning documents. To facilitate the process, it is worth giving some thought to identifying the key individuals who will have to be behind the development – they are likely to be at a level immediately below the chief executives. Once identified, they will need to be convinced that the MCN is important enough to be fitted into local priorities. Similarly, it is important to identify who are the ‘movers and shakers’ among the clinical community in primary and secondary care. At this stage, informal discussions with key clinicians will help to gather general support for the concept and may help to influence the prioritisation processes.

It would be wise to draft an outline of a development plan for the network at the outset so that a reasonable estimate of development costs and timescale can inform the initial discussions. This can later serve as the basis for a formal funding application and a full development plan.

A number of areas should be considered when trying to estimate development costs. To date, all of the MCNs that have been developed, or are being developed, have had a project manager appointed on at least a part-time basis. Once an MCN is functioning, there will still be a need for significant management input, but during the development phase it is crucial.

While some meetings will be held in the evening – especially the multidisciplinary meetings to discuss protocols and standards – a number will have to be held during the day, thereby generating some costs for clinician cover. Travel costs and the costs of catering and venues for meetings also need to be considered.

A development project will need a base, and even if there are no rental costs, equipping an office with PCs, telephones and faxes is expensive. Consideration should be given to secretarial and administrative support, and some provision should be made for postage, printing and stationery costs.

Establishing a project team

Developing an MCN requires a small team of people to drive the process forward.

The smallest possible team would comprise a project leader, a project manager and a secretary or administrator. Much of the development work would also have to involve a few senior clinicians from more than one profession. The project leader should be a clinician who, as stated earlier, needs clinical credibility, diplomacy, leadership skills and determination. The choice may be self-evident from the start, or it may be that a leader emerges from the development group. However they are chosen, the project leader must have protected time so that they can devote themselves to the process, and

this time needs to be built into the original costings for the project. It is imperative that the project leader has a mandate from the local healthcare system and visible support from the top.

The project manager should ideally have a clinical background, management and project management skills, experience of a multidisciplinary environment, and some experience of managing improvement programmes in the NHS. The project manager will probably need to be appointed or seconded to work full-time, and would usually be able to assume the role of network manager once the network has been developed; the time commitment required after launch will depend upon the size and nature of the MCN. The project manager and project leader will need secretarial and administrative support. If the project manager has a clinical background, it would be of great benefit if it complemented the background of the project leader rather than duplicating it.

Ideally, the project team would consist of five or six people, including the manager and leader. This team should have members selected on the basis of what they can offer to the process, rather than on the basis of the organisation that they represent. Each region and clinical specialty will have different needs; the backgrounds of the members of the project team will therefore vary considerably.

The project team should begin by drawing up a development programme (or considering a previously prepared one) and agreeing a draft timetable, with key milestones and targets. It is important to allocate responsibilities, and the project leader and project manager will probably need to draft a rough version of this before the group meet. There are a number of distinct areas to the work that are needed, such as drawing up a quality assurance programme, drafting a care pathway with protocols and bringing patients into the process.

Because it is impractical for all of this work to be undertaken by one group, and because it is important to involve as many stakeholders as possible in the process to promote buy-in, it is best for the work to be carried out by three or more working groups, each with a different remit. In the Dumfries and Galloway pilot, five working groups were used. These had responsibility for:

- Service mapping and care pathways
- Quality standards and clinical governance
- Administration and finance
- Patient involvement and information provision
- IT and evaluation.

One of the functions of the pilot was to answer generic questions about how MCNs work in practice and to evaluate the impact of the process – other projects will not necessarily need to do this. They might, therefore, not need an evaluation group; however, a group handling IT and audit could be useful.

The management group will need to oversee the work of the other groups and their members to ensure that they keep on track in terms of time and outcomes. It aids co-ordination if each working group includes either the project leader or project manager.

The development process

Just as the key players must be identified at a strategic and commissioning level, so must the key clinicians, executives and managers who will affect the success or failure of a network. Some of the significant clinical figures should be obvious, but thought must be given to identifying those people whose influence is not always so apparent. There is also great benefit in identifying people who are likely to be ‘difficult’, and deliberately involving them from the outset. There are several reasons for this. First, participation and involvement can create long-term allies. Second, it is much better

to address concerns at the development phase than to wait for them to surface later as major problems. Finally, being seen to secure the support of those individuals that everyone expects to be awkward can have an extremely positive impact on general opinion.

An inclusive development process will necessarily involve a large number of people, all of whom are busy with their own jobs. It is vital to have people actively participate but this will not occur if meetings are scheduled at unreasonable times or too often.

The key message for those leading the development is therefore: ‘maximum preparation; minimum meetings’. A great deal of work must be done by the development team prior to meetings – especially lots of informal contact and discussion. Before any major meeting, the ground needs to be prepared and potential problems identified, so that they can be aired during the meeting. There is no point in bringing a number of clinicians together, only for the meeting to end with everyone aware of problems that have not been discussed. The lead clinician and network manager need actively to draw out the issues from those present.

When developing or considering standards, protocols or materials, it is vital to have something on paper that is reasonably developed for discussion. There is a great deal to be said for adapting existing materials from elsewhere, and it is better to start with something of limited value than to start with nothing. If material is criticised and pulled apart, this should not be taken by its author as personal criticism, but seen as an opportunity to involve someone else in its development.

Most people attending meetings (particularly clinicians) will have needed to make a considerable effort to be able to give their time. It is important to meaningfully involve those who have taken the trouble to attend. Their opinions should be sought in a way that suggests that their background and perspective are valued and that their views will be taken into account. The lead clinician and manager need to ensure that everyone contributes to a meeting and feels that it has been worthwhile attending. This helps to engender enthusiasm, to increase the value of the development process, and, ultimately, to improve the likelihood of success.

Careful minutes need to be taken of all meetings. These should be distributed at draft stage to all attendees, with the message that anyone can suggest amendments. Accuracy and prompt distribution of minutes will minimise problems. From all of the working group meetings in the development period of the Dumfries and Galloway pilot, amendments to the minutes were made on only three occasions.

However one might try to separate the workload between the different working groups, there is bound to be considerable overlap in scope. For example, it is difficult to consider care pathways and protocols without reference to clinical standards and audit, and vice versa. It is therefore important that each of the working groups has access to the meeting minutes and materials of the others.

Examples of specific working groups

Service mapping

As suggested earlier, to develop an MCN the project team will need to obtain a clear idea of where things stand at present. This means getting a clear picture of who does what, where, when and how in the service concerned, and what resources are available and used. Plotting services and resources on a geographic map is very helpful and has immediate impact. It will probably be necessary to conduct some sort of survey using a simple questionnaire or tick list, and to use the results as a guide to where further enquiry is needed. Entering the results on a database or spreadsheet facilitates analysis and enables easy manipulation of data. It is important not to rely solely on

questionnaires and, if practical, to visit the different parts of the service. This always leads to greater insight, and often highlights problems that are unlikely to be identified by any other means. Visiting diverse sites also gives opportunities to spread the MCN message and recruit support.

Mapping the service should help to identify gaps in service provision in terms of staffing, equipment, training and facilities. It should also be a valuable tool in helping to identify the key strengths and weaknesses of a service, as well as any deficiencies. It may even be possible to use mapping to draw others into the development process. Once the key issues have been identified, the next step is to try to develop an ideal patient journey. A practically attainable new set of services must then be agreed upon; this will lie somewhere between the current situation and the ideal.

Next, an implementation plan must be developed, setting down how to carry out the changes required to improve services. This will, in effect, set much of the future agenda for the new MCN. This information needs to be shared with a much wider audience – probably through open meetings. Account will need to be taken of the quality issues and clinical governance issues being covered by another working group. It is sometimes helpful to develop a service map of the proposed network, since these things are often easier to understand in graphic form. It must be accepted that there should not be change for its own sake; if a service is working well and there is reasonable equity of access, it can remain unchanged.

Quality and clinical governance

A dedicated working group will need to develop a quality assurance programme involving a reasonable spectrum of clinical views, which can then be considered by the wider clinical community prior to adoption. It is important that the programme relates to nationally agreed standards and targets, where they exist. Where standards do not exist, they will need to be developed and agreed. In developing standards, it is important to stick to the unequivocal at first and only cover areas where there is a high-quality, widely accepted evidence base. This also applies to developing protocols and most other clinical resources during the development phase. Agreement is much easier to achieve in these areas, and the more contentious issues should not be tackled until there is an established MCN and relationships. For example, in developing the MCN for CHD in Dumfries and Galloway, the work on quality during development focused on thrombolysis and secondary prevention (which has an excellent evidence base) rather than on heart failure (where differing opinions about open-access echocardiography might have created divisions).

The quality assurance programme must be locally relevant and there should be buy-in from the majority of local clinicians. For this reason, it is important to circulate copies of a draft programme, then consult, revise the paper and consult again. This process will need to be repeated until a consensus is achieved. The quality assurance programme should have sections that cover patient involvement and provision of information. It is important to involve individual patients in developing these sections and it is useful to consult with a wider group for revision and redrafting.

A clinical governance section needs to be included in the quality assurance programme, and it should cover what happens at the interfaces between primary and secondary care and between the different professions. Including someone who is involved in clinical governance committee work from each participating organisation should ensure that this section remains locally appropriate. The clinical governance section of the Dumfries and Galloway CHD network quality assurance programme offers a useful template for work in this area.¹² Once the quality assurance programme is in its final form, it will need to be agreed by NHS Quality Improvement Scotland.

Care pathways and protocols

In developing a multidisciplinary care pathway and its supporting protocols, it is important to involve as wide a range of clinicians as possible. This will probably necessitate the involvement of nurses, doctors and allied health professions (AHPs) from both primary and secondary care, as well as ambulance staff. It is sensible to use any existing protocols or pathways as a starting point and adapt them to local circumstances. The language used needs to be as simple as possible and the use of abbreviations and acronyms kept to a minimum. A common format should be used for all of the protocols that relate to a given pathway – use a simple, clear typeface that is large enough to read easily.

Setting out a care pathway in graphic form helps to show what protocols will be needed – usually one for each key stage of the journey. It also helps to work out who will use the protocols – and who, therefore, needs to be involved in their development. It is easy to think in terms of GP referral, hospital and discharge back to primary care, but thought must also be given to the inclusion of A&E departments, the ambulance service and community hospitals (Figure 3). The protocols and care pathway should be linked to standards, so that key standards are embedded in the protocols and consideration is given to the collection of data for audit purposes. The quality assurance programme may require a schematic of a patient journey, with key standards identified at key stages; obviously this will be best derived from a care pathway.

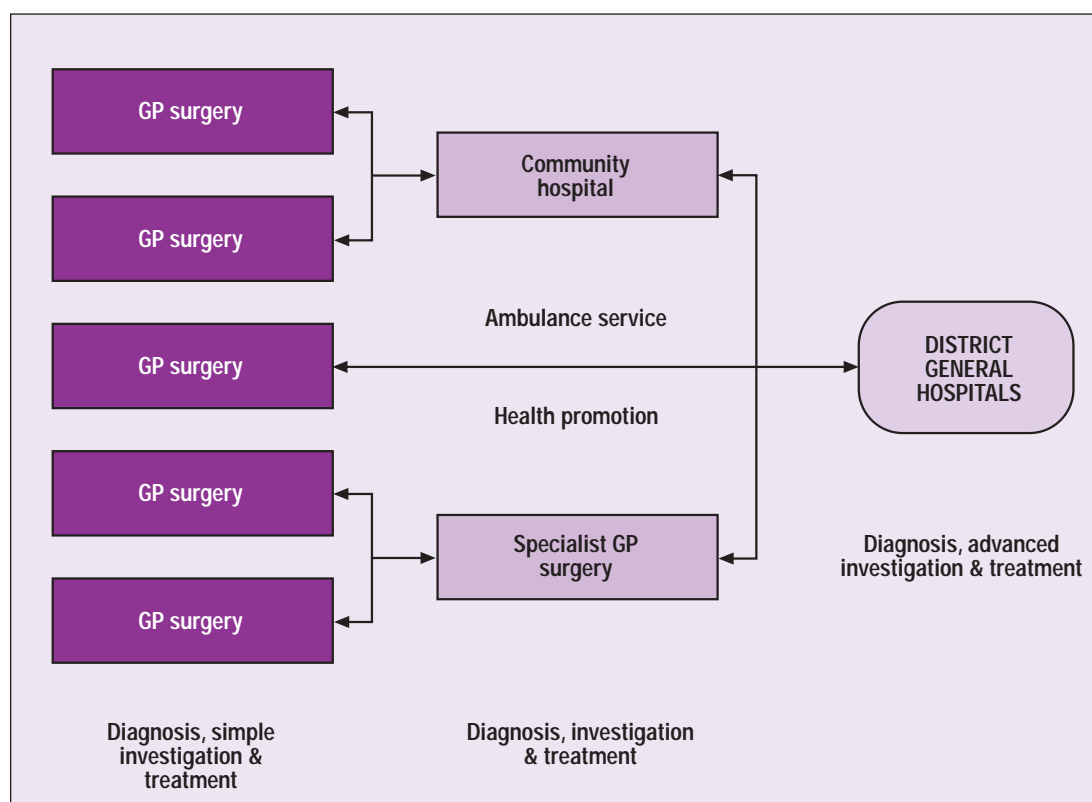


Figure 3. The local linkages

Public/patient involvement and information

The key to patient involvement is to identify appropriate, motivated individuals and then to support them in their involvement, which includes providing training. Specialist liaison nurses and rehabilitation nurses are a useful means of access to patient groups and a useful source of advice about suitable candidates. Paying patients' travel expenses to meetings is important and needs to be included in the budget. Where self-help or voluntary groups are in existence, it is sensible to work with them. Visiting these groups and explaining about MCNs and the reasons for setting one up locally is a valuable process; the personal contact is greatly appreciated and fosters support. A patient involvement working group could be formed from members of these groups, who would represent a large 'community of interest'. This has been the case in Dumfries and Galloway, where all of the local self-help coronary clubs have contributed members to a working group.

Involving patients and the public means being prepared to provide lots of explanations and to interrupt meetings to explain difficult issues or jargon. Such interruptions can be useful in guiding clinicians to use an appropriate level of language. It is as important to involve patients in meetings as it is to engage clinicians – again the project leader or manager will need to be active here. However, care must be taken not to appear patronising.

The local health council will prove a useful ally in the early stages and is likely to welcome the involvement and help. The health council may also be able to help with training for patients.

The patient group will be important in developing patient information materials and newsletters. As with the clinical groups, it is best to develop pre-existing material through discussion, rather than trying to create something from scratch. Again, consultation and revision will be required.

Launching the network

The lead clinician must be appointed when the MCN is launched, and for this role a different type of clinician from the project leader may be needed. It is sensible that the project manager and administrator/secretary continue to perform similar functions in the network, although their time commitment may need to be reviewed.

Before launch, it will be necessary to clearly document:

- Working arrangements
- Management and performance management arrangements
- Links to local trusts and health board/strategic health authority
- Financial arrangements
- The quality assurance programme.

A formal launch can generate good publicity and offers a way of publicly saying thank you to those who have helped.

Then the real work begins.

Keys to success

- Overcome resistance to change by offering explanations and information; encouraging participation and involvement; and identifying and confronting concerns from the outset.
- Include 'difficult' people in the development process.
- Have as few meetings as possible and prepare thoroughly for those that are held.

- Support people in their participation and actively involve them when they attend meetings.
- Make as much use as possible of informal contact and involvement.
- In developing standards, start with areas which have a high-quality, widely accepted evidence base.
- Always have material to discuss or work from. Use any existing material and modify it through the process of discussion; it is much easier and quicker than starting from scratch.
- Take careful minutes of meetings and circulate them soon afterwards, so that people can suggest revisions while they are still fresh in the mind.
- Hold at least one or two open meetings to discuss material before finalising – listen, modify, recirculate, modify and so on.
- Keep people informed about what is happening via newsletters, websites and so on.

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Allied health professions (AHPs) – currently there are 12 professions regulated under the auspices of the Health Professions Council (HPC): chiropodists/podiatrists; dietitians; occupational therapists; orthoptists; physiotherapists; radiographers; medical laboratory scientific officers; speech and language therapists; clinical scientists; art therapists; prosthetists/orthotists; and paramedics.¹⁷

Audit – a systematic examination of current practice to assess how well an institution is performing against set standards. Audit should be an integral part of the work of MCNs, allowing the organisation to measure performance against agreed targets.

Care pathways – see [integrated care pathways](#).

Clinical Standards Board for Scotland (CSBS) – a statutory body, established as a special health board in April 1999. Its role is to promote public confidence that services provided by NHSScotland are safe and that they meet nationally agreed standards, and to demonstrate that, within the resources available, NHSScotland is delivering the highest possible standards of care. Current plans are that the board, along with Scotland's two other central clinical effectiveness organisations (the [Health Technology Board for Scotland](#) and the [Scottish Health Advisory Service](#)), will be integrated into a single new health board, NHS Quality Improvement Scotland. Further information on CSBS can be found on the organisation's website (www.clinicalstandards.org).

Health Technology Board for Scotland (HTBS) – an organisation which provides evidence-based advice to NHSScotland on the clinical effectiveness and cost-effectiveness of new and existing health technologies (medicines, devices, clinical procedures and healthcare settings). Further information on HTBS can be found at the organisation's website (www.htbs.org.uk).

Integrated care pathways (ICPs) – locally agreed, evidence-based standards used to manage and monitor clinical processes. They attach clinical interventions to a timeline. ICPs are intended to reduce variations in patient care.

Internal market – this policy was passed into law as the NHS and Community Care Act 1990.¹⁸ Under this system, 'purchasers' (health authorities and some family doctors) were given budgets to buy healthcare from 'providers' (such as acute hospitals and ambulance services). To serve as 'providers' in the internal market, health organisations became NHS trusts – competitive organisations managed independently.

Managed clinical networks (MCNs) – in Scotland, linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, unconstrained by existing professional and health board boundaries, to ensure equitable provision of high-quality, clinically effective services.

Management executive letter (MEL) – old name for the main series of circulars issued by the Management Executive to the National Health Service in Scotland (now NHSScotland). MELs are now known as Health Department letters (HDLs).

Mapping – See [service mapping](#).

Patient journey – the pathway a patient takes while receiving healthcare; for example, from GP referral to discharge from hospital following treatment.

Protocol – a set of agreed procedures for a specified circumstance or patient group.

Quality assurance – improving performance and preventing problems through planned and systematic activities including documentation, training and review.

Scottish Care Information (SCI) – a joint initiative, involving the SEHD Management Executive; NHSScotland service providers and supporting agencies; and commercial suppliers. The key aim of the programme is to develop consistent IT systems and standards to support clinical communication across Scotland. Further information can be found on the organisation's website (www.show.scot.nhs.uk/sci).

Scottish Health Advisory Service (SHAS) – in Scotland, an independent organisation that helps to improve health service care and quality of life for people with a mental illness, for people with a learning disability or physical disability, and for older people. As a signatory to the Scottish Executive Charter for Inspectorates, SHAS provides professional advice and information to Scottish Ministers, the general public and other colleagues in the Scottish Executive. Further information on SHAS can be found on the organisation's website (www.show.scot.nhs.uk/shas).

Scottish Intercollegiate Guidelines Network (SIGN) – a body formed in 1993, with the aim of improving the quality of healthcare received by patients in Scotland. Its work covers the development and dissemination of clinical guidelines for effective practice, based on the best available evidence, to reduce variation in practice and outcomes. SIGN guidelines can be downloaded from the organisation's website (www.sign.ac.uk).

Service mapping – a method of systematically recording the way services are organised. Service mapping usually focuses on a complete process – for example, the patient journey from GP referral to hospital treatment and discharge. All the steps in a process are recorded, with notes on which people and facilities are involved. It provides a snapshot of the current situation and helps to identify potential problem areas – for example, avoidable long waits in the system. The mapping process should involve a multidisciplinary team.