

NHS MEL(1999)10



SCOTTISH EXECUTIVE

Department of Health

NHS Management Executive
St Andrew's House
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Dear Colleague

INTRODUCTION OF MANAGED CLINICAL NETWORKS WITHIN THE NHS IN SCOTLAND

Summary

1. The MEL sets out the core principles which should govern the introduction of Managed Clinical Networks in the NHS in Scotland.

Action

2. All Health Boards and NHS Trusts, with their planning partners, are expected to take account of the core principles in working up any proposals for Managed Clinical Networks.

3. Health Boards are requested to circulate this MEL to GPs in their area.

4. This MEL is available on The Scottish Office web site:
<http://www.show-scot.nhs.uk/dtc>

Yours sincerely

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INTRODUCTION OF MANAGED CLINICAL NETWORKS WITHIN THE NHS IN SCOTLAND

Introduction

1. The concept of Managed Clinical Networks (MCN) was set out in the report of the Acute Service Review published in June 1998. It has been well received throughout the NHS in Scotland. Since the concept draws on existing work, such as the surgical networks in the Highlands and Islands and the diabetes network in Tayside, there are many who believe they already participate in a MCN. In addition, there is considerable pressure from many quarters to press ahead with the introduction of MCNs in accordance with their own interpretations of the concept.

2. The Acute Services Group, which is responsible for guiding the implementation of the recommendations of the Acute Services Review, welcomes the enthusiasm generated by the concept but is concerned to ensure that its introduction is properly managed, so as to avoid disruption of services on the one hand and also to enable the concept to be subject to evaluation. The Group's first task has been to develop guidance setting out the principles underlying MCNs and providing a procedure for the creation and dissolution of Networks. This Management Executive Letter articulates that guidance.

Definition

3. 'Managed Clinical Networks' are defined as 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 throughout Scotland. Fuller thinking on the concept is set out in paragraphs 45-64 and 417-421 of the report of the Acute Services Review, and these are attached as the Annex to this MEL.

Types of Network

4. One of the main attractions of the Network concept is its flexibility. It can be applied to many different situations in response to the interests of the patient, local circumstances, the nature of a particular disease or the most effective delivery of a specialty, and individual clinicians can be members of more than one Network. The Acute Services Review identified MCNs for peripheral vascular disease and neurology as prime candidates for early development (see paragraph 10). These represent 2 types of MCN: a disease network and a specialty network. There could be others, such as a functional network, examples being networks for medical receiving, children's services and trauma care.

5. The Acute Services Review recognised that Networks would also cover different geographical territories:

- Local: equating, for example, to Local Health Care Co-operatives which could include MCNs for primary and community care;
- Health Board Area: equating to Health Board boundaries and concerned with networks within that territory, and, through use of the Joint Investment Fund, tackling the boundary between primary and secondary care;
- Regional: equating to aggregates of Health Boards, such as the regions currently recognised in the Management Executive for performance management purposes: west, east and north. There could also be networks for remote and rural communities concerned with a number of

specialties rather than one single specialty or disease;

- National: which would be concerned with those diseases or services which are so rare or specialised that it only makes sense to organise them on a Scotland-wide basis.

Core Principles for Networks

6. The very flexibility of the Managed Clinical Network concept will have meaning only if the operation of each Network is governed by core principles. The concept is negated if all that is required is proclamation of a network's existence. The general principles which should underpin all Networks will be subject to development in the light of the lessons which emerge from the 2 Network pilots being supervised by the Acute Services Group (see paragraph 10).

7. In order to ensure that the necessary overall pattern of provision of services is maintained, those wishing to establish a Managed Clinical Network, or to obtain recognition of their existing arrangements as a MCN, must seek the formal approval of their local Trust and Health Board. The mechanism for doing so is the Health Improvement Programme. Trusts and Boards are responsible for ensuring that proper inter-relation of services in their area is maintained, and will need to be directly involved when a Network envisages cross-border flows and the involvement of other Trusts or regions. Where a national Network is under consideration, approval should be sought from the Management Executive through the National Services Division of the Common Services Agency.

8. In considering whether or not to confer such recognition, Boards, Trusts and the ME must take into account the degree to which the arrangements proposed satisfy the following core principles and are consistent with the policies in Designed to Care and the report of the Acute Services Review:

8.1 each Network must have clarity about Network management arrangements, including the appointment of a person who is recognised as having overall responsibility for the operation of the Network, whether a lead clinician, a clinical manager or otherwise. Each Network should produce a written annual report to the appropriate Health Board or Trust, which would also be available to the public;

8.2 each Network must have a defined structure which sets out the points at which the service is to be delivered, and the connections between them;

8.3 each Network must have a clear statement of the specific clinical and service improvements which patients could expect as a result of the establishment of the Network;

8.4 each Network must use a documented evidence base, such as SIGN guidelines where these are available, and must be committed to expansion of the evidence base through appropriate R & D;

8.5 each Network must be truly multi-disciplinary/multi-professional and should include representation from patients' organisations in its management arrangements;

8.6 each Network must have a clear policy on the dissemination of information to patients, and the nature of that information, bearing in mind the role of primary care in helping to lead the patient through the system;

8.7 all the health professionals who would make up the Network must indicate their willingness to practice in accordance with the evidence base and with the general principles governing Networks;

8.8 an integral part of each Network must be a quality assurance programme acceptable to the Clinical Standards Board for Scotland, which also has a role in ensuring consistency of standards and quality of treatment across all Managed Clinical Networks;

8.9 the educational and training potential for Networks should be used to the full, through exchanges between those working in the community and primary care and those working in hospitals/specialist centres. Networks' potential to contribute to the

development of the intermediate specialist concept should also be kept in mind, and Networks should develop appropriate affiliations to universities, the Colleges and SCPMDE;

8.10 all health professionals in the Network must produce audit data to required standards and participate in open review of results;

8.11 all Networks must include arrangements to circulate staff in ways which improve patient access, and enable professional skills to be maintained. Each Network should have an appropriate programme of continuous professional development in place for every member of the Network, as well as a mechanism for ensuring the programme is being followed;

8.12 there must be evidence that the potential for Networks to generate better value for money has been explored.

9. The general principles of accountability and clinical governance will apply to Managed Clinical Networks as they do to all other work undertaken within the NHS in Scotland. Members of the Network, including managers, will continue to be accountable to the Boards and Trusts holding their contract of employment. If evidence emerges that an individual is not performing in a manner consistent with the standards agreed within the Network, that is a performance issue for the employer and employee to resolve in the first place, in accordance with accepted procedures.

10. The Acute Services Group on behalf of the Management Executive is establishing demonstration projects which will pilot the development of Managed Clinical Networks in vascular services and in neurology. Further information will be given in due course of the exact location of these projects, but they are expected to last for 3 years. Amongst other things, the demonstration projects will be used to test the core principles set out in paragraph 8 of this MEL, and will also help to inform the way in which concurrent developments of other Networks should be guided. A particular focus of the evaluation should be the extent to which the operation of the Network is understood by patients and is delivering the expected clinical and service benefits set out in accordance with the requirements of paragraph 8.3.

Anne

Clinical Networking

45. As an alternative to the 'hub and spoke' model, some of the networking systems described to the Review feature the sharing of patients, expertise and resources, rather than unidirectional centripetal flow. Such arrangements may more readily accommodate the rise in sub-specialisation since adjacent hospitals can co-operate to provide sub-speciality cover when the population base of each is too small for them to do this in isolation. The Children's Sub-Group recommend joint staff appointments between hospitals as a useful means of improving networking and point to the involvement of community paediatricians in acute receiving rotas as a successful means of integrating care across hospital: community boundaries. The emphasis in clinical networking is on connection and partnership rather than isolation and self-sufficiency, on distribution of resources rather than centralisation, and on maximising the benefits for all patients rather than a fortunate few. The system allows some strands of the 'net' to be thicker and stronger than others, with much of the power and influence lying at the interstices of the net as 'knowledge' or resource centres. Again this model has significant implications for service management, particularly where networks have to develop across traditional boundaries such as those between Health Boards.

46. Medical consultant staff may be viewed as the key 'collegiate' resource if service networks are to be developed across Scotland. This is not to underplay the vital role of nursing and allied

professional staff. The term 'network' implies that care is delivered seamlessly by a chain of interconnected people and operations, and it is the relationship between these people which forms the very structure of the network and governs its operation. It follows that the professional relationships have to be carefully and clearly defined if individual staff members are to function effectively, realise their full potential and feel valued. Networks can therefore be characterised as 'virtual' service organisations, where the skills of the professionals concerned are grouped around the population and service needs, and may not be co-terminous with Trust or Health Board boundaries. Erosion of unhelpful barriers between primary and secondary care is seen as an important objective; indeed it was argued during the Review that in some instances, consultants might be employed to provide care at Local Health Care Co-operative level rather than via an institution. From a patient's perspective, the network should deliver seamless care with smooth transition from one part of the service to another.

47. The network should be seen as a dynamic system, the design and function of which can change as relationships develop and as medicine advances. Some concern was expressed during the Review that the term network can suggest 'non-organisation', loose 'woolly' constructs without authority, defined responsibilities or ability to exert control. Such constructs would be totally unacceptable; clinical networking cannot be a 'free for all', and issues of patient safety, confidentiality, risk management, individual accountability and professional responsibility must be defined and reconciled. It is to underline the importance of these considerations that the Review, in promoting networking, favours the use of the term *managed clinical network* and sees the concept of a lead clinician as having central importance.

48. The Review sees the development of managed clinical networks as the most important strategic issue for acute services in the NHS in Scotland. Such 'distributed' networks offers the best basis for equitable, rational and sustainable acute services, are flexible and capable of evolution and allow greater emphasis to be placed on presented here as an extension of a process of organisational change which has already begun. The Review is satisfied that there is a general feeling among clinicians and managers that the time is now right to place further emphasis on networking and integration in the delivery of acute services. This is not about creating additional structures or committees, but it is about working differently and getting things done. The Review recognises that care will have to be taken to develop a suitable framework for organisation and management and the Report returns to this issue in Chapter 17.

49. Managed clinical networks can of course draw on elements of the 'hub and spoke' as appropriate a good example being the developing Scottish Cancer Network with its 5 Centres and their related Units. The managed clinical network is seen not just as a powerful model for the organisation of clinical services; it has other important connotations. For example, strategic investment in equipment would be driven by the needs of the network rather than the needs of any one hospital, networks will provide a useful focus when considering communication and information flows, and the creation of networks will facilitate the collection of data, research and development.

50. One of the most power examples of potential networking is the Integrated Regional Vascular Service (IRVS) Model (Figure 3.2) developed by the Vascular Sub-Group. The Sub-Group saw the present pattern of delivering vascular services as having resulted in unacceptable variations in the availability and quality of care, in duplication of equipment and in failure to meet defined standards. This is in spite of a background of growth in need for vascular services, technological development and in the scope of care available. Staffing difficulties relating to the need for increasing specialisation, skills acquisition, training, recruitment and emergency rota pressures were being addressed partially at best. Inevitably, individual Trusts were struggling to meet the costs incurred by technological advances in diagnosis and treatment, and the current environment for research and development in the specially was seen as suboptimal.

Figure 3.2 Integrated Regional Vascular Service (IRVS)

Integrated Regional Vascular Service

ideally serves a population of at least 500,000
 provides comprehensive vascular services
 (including round the clock emergency services)
 formed by the merger of two or more vascular services in existing hospitals linked to
 networks of collaborating services and specialties.

To meet emergency work load an IRVS requires a minimum of;

- 3 full-time equivalent (FTE) consultant surgeons
- 3 FTE interventional radiologists
- 1.5 FTE vascular physicians
- appropriate nursing staff and PAM complements
- appropriate technical and equipment support.

An IRVS is recommended in;

- North East (Grampian serving Orkney and Shetland)
- East (Tayside and north Fife)
- South East (Lothian, Borders and south Fife)

In the West, 3 IRVS are recommended with longer term condensation to 2 IRVS

- (in Greater Glasgow Health Board, 5 hospitals currently provide vascular services while in Argyll and Clyde 1 hospital provides services)

A number of regions require special consideration because of remoteness or population density;

- Lanarkshire should integrate with Glasgow, or develop a separate IRVS (without an integral academic centre).
- Local vascular services should be retained in Ayrshire and Highland
- Forth Valley should integrate existing vascular services but would not have the critical mass to form an ideal IRVS and should consider merger.
- Dumfries and Galloway should explore the formation of an IRVS with North Cumbria.

51. The resulting IRVS model is based on the premise that the outcome for patients depends on

professional skill levels and experience, multi-disciplinary team working, continuous availability of staff, clinical networks and having the tools for the job. The minimum population base needed to sustain an IRVS was identified as 500,000, taking account of audits of clinical activity, staffing requirements, rota needs of a consultant-led emergency service, clinical throughput required to meet training standards, and critical mass to warrant appointment of specialist senior staff. Each IRVS would be formed by integration of adjacent existing vascular services, with emergency and 'high technology' care being undertaken in a single centre. Local access would be enhanced by a network of local services such as clinics, day surgery, venous surgery, post-acute care and rehabilitation.

52. The Vascular Sub-Group laid great emphasis on the minimum critical mass needed to sustain an IRVS and the value in having an academic centre as well as DGH and primary care components. They expressed concerns about the lack of an academic component in any IRVS which might form in Lanarkshire or Forth Valley, while at the same time recognising the need for pragmatism in Ayrshire, Highland and Dumfries and Galloway.

53. Establishing managed clinical networks and operating them effectively presents new challenges to cultures and attitudes and the agenda for change requires flexibility and a developmental attitude on the part of those working within health care. Consultant staff will owe allegiance to a clinical network (in some cases more than one) which may not be contiguous with the area served by their employing Trust. Consultant appointments will have to be seen in the broader context of the skills and expertise needed by the network, an approach which may be made easier by the arrangements for consultant appointments proposed in the *Designed to Care*. More mobility may be required of senior staff and a more effective electronic infrastructure will be needed to ensure information flow and support remote consultation or monitoring. Across the network, protocols will have to be developed to determine which clinician should provide a given service to which patients and in which location(s). The agenda for change extends to patients and the general public, and requires a growing awareness and acceptance that all specialist and/or high technology clinical services cannot invariably be provided by their nearest local hospital.

54. Figure 3.3 sets out an example of the services and care provided by an IRVS. Each IRVS will require access to collaborating services to function effectively. These include trauma services, ITU/HDU, general medicine, cardiology, diabetology, neurology, renal medicine including renal dialysis, haematology and blood transfusion medicine. Integral on-site supporting services include specialist pharmacy, specialist physiotherapy, occupational therapy, orthotics, dietetics, podiatry, rehabilitation medicine and limb fitting. For preference, dermatology and rheumatology should also be available on site. For other clinical networks the crucial interlinked elements will be different, underlining the need to retain an overview to ensure that change in one part of the network does not compromise the overall function of the NHS in Scotland.

55. Strategic planning above Trust and Health Board level may be needed to define and manage regional and national networks for some specialist services. For example, formal and effective consortia of Health Boards may be required for planning (following the model being developed for cancer services), with the new Acute Hospital Trusts and Primary Care Trusts collaborating to address operational and management issues. It is clear that the concept of managed clinical networks presents a major organisational and leadership challenge to the NHS in Scotland; these issues are developed further at various points in this Report.

56. Continued development and function of managed clinical networks will be a key feature of Health Improvement Programmes and Trust Implementation Plans, and the Review sees deployment of Joint Investment Funds as having a major influence. Progress in network implementation will need to be monitored through the Accountability Review, Annual Report and Performance Management process. Overall performance of the service will be an issue for development within the context of a national clinical quality assurance and accreditation programme (Chapter 8).

Managed Clinical Networks and Primary Care

57. Managed clinical networks are consonant with a renewed emphasis on the role of Primary Care in acute health care. Far from favouring centralisation, such distributed networks will promote the delivery of acute services in new collaborative organisations, transcending traditional boundaries between hospitals, community hospitals and primary care. Managing and operating the networks will require all of the clinicians concerned to collaborate in developing detailed descriptions of services, integrated protocols and pathways.

Figure 3.3 Integrated Regional Vascular Services as an Example of a Managed Clinical Network

LEVEL	SERVICE OFFERED	DEVELOPMENT NEEDS
living at home, not using GP services	Advice	community pharmacists trained and able to give advice
local GP surgery	GP consultation, screening for vascular conditions (eg aneurysm), onward referral	joint protocols for managing vascular disease, defined referral criteria agreed with network consultant(s)
Specialist GP surgery	GP specialist undertake some forms of circulatory testing, nurse-led clinics held by visiting vascular specialist nurse or leg ulcer nurse	training in equipment use, agreed referral criteria, vascular nurse exports expertise from vascular centre (eg technical developments) links to specialist pharmacists
Community hospital	outreach clinics, local rehabilitation following surgery, community leg ulcer clinic	minimal equipment needs, links to rehabilitation services with support by PAM and limb-fitting services
local acute hospital	day case and inpatient operating (up to intermediate level), emergency receiving operates across area in conjunction with other DGH(s) limited imaging/vascular laboratory services (perhaps on outreach basis).	agreed operating procedures, managed emergency rotas (running with consultants from network hospitals), consultant with a major interest in vascular surgery, general nursing staff (core with specialist vascular interest and skills)
Ambulatory care centre	day case varicose vein surgery	efficient day case service

Specialist centre in Integrated Regional Vascular Service (IRVS)	major surgery, invasive vascular radiology requiring specialist radiological interest and equipment, Centre for limb fitting services and beginning rehabilitation in ward prior to discharge to local area	specialist vascular physicians, surgeons and radiologists, wards staffed by nurses with specialist interest, Vascular laboratory staffed by specialist technologists, rehabilitation skills (nursing and PAM), good communication networks with transfer of patients to local services for continuation of care
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58. The Review is conscious of the formidable logistic task already being undertaken in Primary Care to assimilate and implement the many evidence-based guidelines flowing into the NHS in Scotland. Care will have to be taken in network development and local enterprise rather than central edict will be the way forward. The concepts of 'intermediate care' ('services that do not require the resources of a general hospital but are beyond the scope of the traditional primary care team') and 'intermediate specialist', defined in the Anglia and Oxford Intermediate Care Project (1997), represent important areas of opportunity. As described to the Review, intermediate care could mean the development of special skills on the part of a general practitioner working in a practice, Co-operative or Primary Care Trust, or a shift in the locus of activity of a hospital specialist. Either model has great potential to strengthen a network and improve the service to patients. The success of community gynaecology offers a further demonstration of the potential of intermediate care.

59. Primary care has a record of successfully managed chronic conditions through protocols. **Coronary heart disease (CHD) has been suggested to the Review as an area where this success could be extended.** Most patients with CHD are treated in primary care, and work in this priority area could be used to model managed clinical networks and evaluate the concept of intermediate care provided by intermediate specialists. A more coherent approach to modifiable risk factors (which are common to stroke and vascular disease) would be encouraged, investigative protocols could be extended to primary care, and direct access to hospital based investigations could be provided. Nurses and other professionals working at the interface between primary and secondary care could play an increasing role in implementing treatment protocols, patient education, clinic supervision, preadmission and discharge planning, drug therapy monitoring (for example, anticoagulants, antihypertensives, aspirin), and prescribing review. **The present unacceptable situation with regard to inadequate secondary prevention is seen as a key area for development, as is cardiac rehabilitation, particularly after acute myocardial infarction or revascularisation.**

60. Thrombolysis following acute myocardial infarction provides an example of a situation in which improved collaboration between primary and secondary care might reap major benefits. It is now clear that early thrombolysis can save lives. It is estimated that giving this treatment in hospital can prevent 20-30 deaths per 1000 acute myocardial infarctions in the first month while giving it in the community can prevent an additional 21 deaths per 1000 per hour of earlier treatment (and may prevent as many deaths again over the next 5 years). In urban areas it may be best to 'scoop the patient and run' to the receiving hospital to keep the 'call to needle' time as short as possible. In more remote rural areas, GPs are usually the first medical contact and are best placed to give early treatment. Paramedics are barred from giving such treatment at present and in any event, not all

ambulances have a paramedic on board.

61. The Review has been impressed by a Grampian survey of attitudes and practices of peripheral GPs and hospital consultants (J Rawles and L Ritchie, personal communication). While most practices possessed an electrocardiograph (87%) and defibrillator (76%), only 37% had a policy of giving thrombolytic therapy, this figure rising to 50% on review after one year. Few practitioners had received encouragement from any source to use this treatment, hospital consultants' attitudes to GP thrombolysis were generally negative, and support was lacking. The Review appreciates that the area is controversial and that there is more to the management of these patients than thrombolysis; however, **it finds the present situation unacceptable and in need of national stimulus** (see also MEL(1998)34). Patients must be encouraged to dial 999 at the onset of chest pain, those at risk should be supplied with a copy of their ECG (so new changes can be distinguished from old), and modern communications (faxing ECGs, telemedicine) could be used to assist in diagnosis and determine whether thrombolysis is appropriate. Protocols in A&E departments should ensure that there is no continuing delay if thrombolysis has not been given and nursing staff could be allowed to institute treatment if a doctor is not immediately available. Continuing audit of pain-call-needle times is vital to ensure that lives are not being lost needlessly.

62. The fact that networks will be rooted in primary care but will link secondary and tertiary care elements of the network has profound implications for information flow which need to be addressed. Similarly, there will be resource implications in providing enhanced intermediate care. The Review recognises that these developments may actually uncover latent demand but sees them **as ideal for pilot developments and the use of the Joint Implementation Funds proposed in Designed to Care.**

The Development of Managed Clinical Networks

63. The Review recommends that managed clinical networks should be developed in the first instance for patients with atherothrombotic disease. The NHS in Scotland priority area of coronary heart disease/stroke will be considered further in this Report and the Review sees vascular services as an ideal area for network piloting. Providing such acute services through distributed networks is consistent with the aims of *Designed to Care* in that it preserves the operational role of Trusts and the strategic role of Health Boards. However, it is clear that mechanisms will have to be established which will allow some networks to be developed across Health Board boundaries.

64. The Clinical Assurance and Accreditation systems advocated elsewhere by the Review (Chapter 8) will assist both in the definition of appropriate networks and in monitoring the care provided to patients. Clinical ownership of the networks and accreditation systems will be a crucial factor to clarify in developing the clinical governance of Trusts.

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Managed Clinical Works

417. The Review sees the development of managed clinical networks as arguably its most important recommendation. Such networks offer the best prospect for delivering high quality services which make optimal use of resources and offer more uniform access to patients than is the case at present. Development of networks is not the same as centralisation and any need to concentrate high technology services will be balanced by the increased outreach services for the population served.

418. Network development will require major shifts in working practice on the part of all

professionals and the traditional boundaries between disciplines and professional groups will need to be broken down and/or redrawn. Consultant staff will be a key resource and the powers of appointment proposed for Health Boards in *Designed to Care* will be important levers in establishing networks, providing contracts which reflect allegiance to a network service rather than an institution, and ensuring an appropriate distribution of staff. Appointment of consultants, specialists nurses, therapists and technologists to networks rather than Trusts will be desirable, strong local contacts being maintained by having staff take responsibility for specific outreach services. The 'lead clinician' concept now introduced to manage the Scottish Cancer Network will prove useful in developing and driving managed clinical networks. Although this Report has used integrated regional vascular networks as a model, the network concept has wide applicability although the structures and implications will differ from area to area and from service to service. In any reorganisation of services, issues of access, transport and travelling times will need careful consideration with close involvement of the Scottish Ambulance Service.

419. The Review is anxious to capitalise on Scotland's academic strengths and the potential that networks offer for research and development. It favours a structure in which wherever possible, networks comprise a blend of academic tertiary centre, district general hospitals and primary care. It sees this as: promoting equity for patients; providing a stimulating environment for staff in which there is equal access to resources; facilitating multidisciplinary working, skill enhancement and professional development; strengthening training programmes for all staff; and fostering research and development.

420. The Review recognises that in many cases a managed clinical network might be best constructed to serve a larger population than that contained within existing Trust or Health Board boundaries but would not be large enough to become a national service to be commissioned by the National Services Division (NSD) of the Common Services Agency. While it might be relatively easy to plan, deliver and drive a very small number of services without any regard to Health Board boundaries, the Review appreciates that the NHS is an extremely complex organisation and that the totality of its needs cannot be subordinated to a drive to develop a number of specific services. In some instances the Review envisages that the network model could be used as a means of organising and delivering services at subregional level, for example local services where there is currently a significant primary: secondary care interface. The strategic planning needs and organisation of managed clinical networks will be considered further below.

421. Managed clinical networks will need to be developed carefully, with establishment of appropriate pilots, and particular attention will need to be paid to the ways in which networks intermesh and support each other. The Review has considered atherothrombotic disease and cancer as two areas in which networks might be piloted. Given that work is either underway or signalled in this Report in the priority areas of cancer and coronary heart disease/stroke, the Review recommend vascular services as an ideal area for pilot development in the first instance.
