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Cardiac Clinical Network Specification

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Contents

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Executive Summary

This specification sets out requirements for the establishment, development and management of cardiac networks.

The specification describes the context and landscape behind the cardiac networks including the NHS White paper, NHS Long Term Plan, and Getting It Right First Time (GIRFT) recommendations.

The specification sets out clear expectations for the networks including key strategic and operational objectives and describes the required governance including lines of accountability, key stakeholders and interdependencies.

Finally, the specification provides key links to support documentation, key deliverables, performance data and indicators.

1. Networks

Specialised services Clinical Networks[1] are a vehicle for specialty level collaboration between patients, providers and commissioners. They should have clear lines of accountability with the national Cardiac Transformation Programme, with Integrated Care Boards (ICBs) including providers and provider collaboratives, and NHS England (NHSE) Regional Teams, to ensure local ownership, alignment and a local mandate.

All networks have an important role in delivering the triple aim, supporting:

- better health and wellbeing of everyone,
- the quality of care for all patients, and
- the sustainable use of NHS resources

This specification sets out the appropriate scope for the work of cardiac clinical networks. This will inform the development of the annual workplans developed in conjunction with the network's commissioners. No network will, or could, focus on all aspects of the scope described, at one time.

In describing the appropriate scope for networks, these specifications refer to the work of the network board and the network's members, supported by the network team. Networks are not expected to assume the legitimate accountabilities and responsibilities of providers who are accountable for meeting the needs of the Service Specification. However, network

[1] While some specialised services Clinical Networks have previously been described as Operational Delivery Networks (ODNs), the range of activity undertaken is now significantly beyond that envisaged for ODNs, reaching into non-specialised services, and in some cases primary and community care and prevention. Some are jointly funded as part of national transformation programmes and have accountabilities outside as well as within specialised services. As a result, as a group they are now referred to as specialised services 'Clinical Networks'.

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responsibilities inevitably overlap with those of providers, because networks aim to improve the ways in which services are delivered operationally and shape how they develop and because providers are members of networks.

2. Strategic Context

Heart disease remains the second highest cause of death in England, with an age standardised mortality rate of 130 per 100,000 population. Furthermore, an estimated 6.1 million people in England currently live with cardiovascular disease (CVD).

There are significant opportunities for earlier diagnosis and better proactive management of CVD, particularly for people in the most deprived areas of England who are almost four times as likely to die prematurely from CVD compared with those in the least deprived areas.

2.1 NHS Long Term Plan

CVD is one of the NHS Long Term plan's eight NHS clinical priorities and presents the biggest opportunity for lives to be saved by the NHS in the next 10 years. The CVD ambitions in the NHS Long Term Plan span prevention, diagnosis, management, rehabilitation and require a networked approach to delivery.

2.2 Getting It Right First Time (GIRFT)

GIRFT has reviewed cardiac surgery and cardiology services in England and has made critical recommendations for change, core to delivery of which is the establishment of cardiac clinical networks.

GIRFT's findings highlighted that acute services were focused around hospitals rather than care pathways, which could be detrimental to patients and risked duplication of provision and unwarranted variations in access to care. GIRFT recommended that networks reviewed cardiac service delivery to ensure that patients are getting high quality care, in a timely manner based on published guidelines, whilst ensuring services were streamlined and cost effective.

2.3 Integrated Care Boards (ICBs)

ICBs will join up care delivered by the NHS, local government and other partners. Cardiac networks will be responsible for strategic oversight of cardiovascular disease transformation for their ICBs, including prevention, detection, investigation, treatment and long-term management of cardiovascular disease in adults. Networks may work across more than one ICB as necessary to ensure the inclusion of a whole pathway, including a specialised cardiac surgical centre.

2.4 Specialised Commissioned Services

Several cardiac patient services such as cardiac surgery and high cost device services are identified as 'prescribed' specialised commissioned services. These services require planning at an aggregated level because they meet four key factors; a small number of

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individuals requiring the service; a high cost to providing the service; scarcity of expertise; and financial impact of the service. These services depend on effective clinical networking to ensure the flow of patients into and out of their services. Delegation of the commissioning of specialised cardiac services to ICBs brings them together with the commissioning of non-specialised services and offers greater opportunity for networks to support integration of the whole pathway.

3. Network Scope

3.1 Scope

Cardiac networks include all providers who deliver prevention of heart disease, cardiology and cardiac surgery and cardiac rehabilitation services across the whole pathway of care, including primary care, diagnostics, community services, ambulance services, hospitals (secondary and tertiary care). This includes universal, general and non-specialised hospital care as well as specialised services[2].

Not in scope

- Highly specialised services including heart transplant services and ventricular assist devices as a bridge to heart transplant or myocardial recovery.
- Congenital heart disease services.
- Paediatric cardiac services

3.2 Population Covered

All providers of cardiac services, including community and primary care teams, in England are required to be part of one of fifteen clinical networks which cover the country. The networks are:

NORTH EAST AND YORKSHIRE
North East & North Cumbria
West Yorkshire
South Yorkshire
Humber & North Yorkshire

NORTH WEST
Lancashire and South Cumbria
Greater Manchester
Cheshire and Merseyside

MIDLANDS

[2] The specialised elements of the services are described in detail in the following Service Specifications:

- Cardiac Surgery – Adults (A10/S/a)
- Cardiology: Implantable Cardioverter Defibrillator (ICD) and Cardiac Resynchronisation Therapy (CRT) (Adult) (A09/S/a)
- Cardiology: Electrophysiology and Ablation Services (Adult) (A09/S/b)
- Cardiology: Inherited Cardiac Conditions (All Ages) (A09/S/c)
- Cardiology: Primary percutaneous coronary intervention (PPCI) (Adult) (A09/S/d)
- Cardiology: Cardiac Magnetic Resonance Imaging (CMR) (Adult) (A09/S/e)

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Midlands East
Midlands West

EAST OF ENGLAND
East of England

LONDON
London North
London South

SOUTH EAST
South East

SOUTH WEST
Peninsula
West of England

Wales, Scotland, Northern Ireland & Crown Dependencies

While residents in these geographies may receive specialised care within England, referring services in these geographies are not part of cardiac networks.

4. Network Aims and Objectives

4.1 Network Vision and Aims

"Cardiac networks will deliver better heart health and healthcare outcomes for all"

The aims of the cardiac networks are to:

- Improve overall outcomes, safety, patient and staff experience
- Ensure future sustainability and viability of services
- Ensure population health is the key emphasis across the network geography

To achieve these aims the cardiac networks will adopt the following ways of working:

- Set the strategic direction for local cardiac services including specialised cardiac services including primary care and diagnostic services and drive operational improvement in those services.
- Implement high quality, standardised pathways of care, spanning prevention and diagnosis through to acute and specialist treatment, rehabilitation and end of life care.
- Foster a culture of partnership and collaboration across the whole footprint of the network
- Directly involve patients and communities in planning and design of care to ensure that the focus always remains on the patient experience.
- Once mature, take full responsibility for overseeing and driving improved performance; particularly in clinical outcomes, waiting times and financial resources.

4.2 Network Objectives

The objectives of the cardiac networks are to:

- Reduce mortality from cardiovascular disease
- Take a leadership role in preventing cardiovascular disease and focussing on population cardiovascular health

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- Improve quality and safety of care across the pathway through the delivery of national standards of care
- Improve experiences of care
- Deliver equitable access to high quality care reducing inequalities in outcomes, access and experience
- Restore services and reduce waits following the COVID pandemic
- Ensure services offer best value for money

4.3 Network Functions

***Service delivery**: the network's role in planning and managing capacity and demand*

- Undertake activity monitoring to ensure service capacity matches demand requirements and contingencies are agreed where this cannot be achieved.
- Support access to care in times of crisis by ensuring coordination and continuity of care across the network via the principles of mutual aid. Where services span networks the same principles are applied within the regional footprint.

***Resources:** the network's role in stewardship of resources across whole pathway and minimising unwarranted variation*

- Undertake comparative benchmarking of current provision to map gaps, health inequalities and unwarranted variation.in cardiac pathways and determine network improvement priorities. This should span the whole pathway of care from prevention through to tertiary care, rehabilitation and end of life care.
- Deliver network wide local care protocols and integrated pathways which reflect the best practice pathways (as developed by the Cardiac Transformation Programme) to reduce unwarranted variation.

***Workforce:** the network's role in ensuring flexible, skilled, resilient staffing*

- Undertake workforce capacity audit and develop robust, creative and sustainable plans to ensure staff capacity matches demand requirements across all service areas, putting in place a strategy to address gaps and shortages, including developing extended roles such as advanced clinical practitioners (ACPs) and physician associates.
- Enable workforce flexibility between providers through the introduction of passporting and other schemes.
- Undertake workforce skills audit and deliver a comprehensive programme of education and continue professional development (CPD) based on a local assessment of need to support clinical staff within the network.

***Quality:** the network's role in improving quality, safety, experience & outcomes*

- Monitor key qualitative and quantitative local intelligence and measures, including but not limited to patient experience, to inform continuous quality improvement and commissioning decisions.
- Implement the principles of continuous improvement through a learning healthcare system and build options to deliver system-wide transformational change. In doing

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so, improve the capability for service improvement, rapid adoption of new technologies and participation in research.

- Ensure system participation in national audits and registries, including CVDPREVENT, National Cardiac Audit Programme (NCAP), and future national accreditation and audit programmes, as well as having a local rolling audit programme to inform patient care and clinical learning.
- Monitor the impact of on-going service improvements to ensure best practice models are embedded and contribute to improved quality and outcomes performance.
- Ensure all identified service risks are managed though regional and system quality structures following agreed escalation processes.
- Share learning from never events and serious untoward incidents through learning, education and continuous improvements to care pathways.

Collaboration: *the network's role in promoting working together across organisations at local, system and national level*

- Develop partnership arrangements with all relevant partners including:
  - patients, carers and families, with an agreed plan for PPV engagement.
  - public health including regional Office for Health Improvement and Disparities (OHID) and local government.
  - between providers across the pathway of care, including PCNs and practices, with a view to optimising cardiac services.
  - with ICBs as local commissioners and to deliver a strategic approach to improving cardiac care pathways.
  - At a regional level, though a strategic oversight group with regional partners such as NHS, local Academic Health Science Networks and with neighbouring network areas to ensure service alignment, the sharing of best practice across boundaries and reduction in variation at a regional level.
  - At a national level with the Cardiac Transformation Programme and Cardiac Delivery Board to discuss plans and progress, agree support where required by the network and to share learning; and with the specialised commissioning clinical reference group, to help build future specifications and standards.

Transformation: *the network's role in planning sustainable services that meet the needs of all patients*

- Improve overall outcomes, safety, patient and staff experience through whole system improvements to cardiac care across specified geographical areas, addressing health inequalities and variation in services particularly for those who are at highest risk but are sub optimally treated.
- Test and spread digital innovations to improve patient experience, manage risk and relieve workforce pressures, and increase data interoperability across the network.
- Work with ICBs to deliver an optimal configuration of cardiac services within their geography.

Population health: *the network's role in assessing need, improving inequalities in health, access, experience and outcomes*

- Review, utilise and create actionable insight from population health management and health service data from a wide range of national sources including OHID, CVD

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prevention data, GIRFT deep dive reports and metrics, Quality and Outcomes Framework (QOF) audits, patient surveys, social care data etc, including the benchmarked data published in the Cardiac Pathways data set on the Model Health System.

- Ensure equity of access for the population to cardiac services and care pathways, working with stakeholders such as patient groups and the voluntary sector to identify and address health inequalities to improve outcomes in deprived, excluded and marginalised populations.
- Deliver a population focus to service development and delivery using a risk based approach to case finding and moving towards anticipatory care through joint work with local government and other partners to address important public health issues determining cardiac outcomes.
- Ensure system participation in statutory population health services such as the NHS Health Check programme.

4.4 Annual workplan

The network board will agree an annual workplan with its commissioners. This will reflect national, regional and local priorities, including areas of focus for Cardiac Transformation Programme, and any additional nationally funded schemes supporting cardiac improvement. This plan should be tested with stakeholders including patients and the public, and the Office for Health Improvement and Disparities. The network board should manage risks to its delivery.

The network board will publish an annual report detailing its activities, accounts and delivery against the agreed annual plan.

5. Governance

5.1 Accountability

Hosting

The network will be hosted by a named organisation within the network geography determined by the network's commissioners, but will operate at arm's length, for the benefit of the network and not the host organisation.

Accountability and responsibility

The network board will agree an annual workplan with its commissioners. This will reflect national, regional and local priorities, including areas of focus for Cardiac Transformation Programme, and any additional nationally funded schemes supporting cardiac improvement. This plan should be tested with stakeholders including patients and the public, and the Office for Health Improvement and Disparities. The network board should manage risks to its delivery.

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The network board will publish an annual report detailing its activities, accounts and delivery against the agreed annual plan.

5.2 Network governance and architecture

Members and stakeholders

The cardiac networks will include all providers who deliver cardiology and cardiac surgery services across the whole pathway of care including providers of:

- Prevention (including the Office for Health Improvement and Disparities and local Directors of Public Health)
- Primary care
- Diagnostics
- Community services
- Ambulance
- Secondary
- Tertiary care

Network Boards will include an evenly balanced partner representation from stakeholder organisations across the network, plus wider professional representation including nursing and allied health professions. Patients and third sector organisations will be core stakeholders within the networks. Clinical representation should cover the whole multi-disciplinary team and pathway of care.

Each network will include at least one tertiary provider of cardiology and cardiac surgery services.

Cardiac surgical centres within a region will also be required to network on a wider regional footprint to ensure alignment in their working.

Networks will align to one or more ICBs as appropriate to care pathways; this will mean that many networks will span several ICB areas and relationships will need to form accordingly.

Networks will have strong relationships with and draw membership from local PCNs, to enable meaningful engagement with primary care, across the network footprint.

Trusts who provide significant volumes of care for a network's registered population, yet who do not sit within the network geography, should also be network members.

The board

The board should meet on a regular basis and operate under the oversight of a suitable chair with agreed terms of reference.

The chair will be an appropriately experienced, impartial leader who is credible across the whole network and will be appointed through a fair and open process.

- The chair should not be the network clinical lead, and ideally should not have the same main employer as the Network Clinical Lead in order to mitigate the risk of (real or perceived) conflicts of interest.
- They could be a board member or senior clinician from one of the provider organisations in the network (ideally not the host, to underpin the collective nature

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of these arrangements) or a patient representative where a suitable candidate is available.

5.3 Risk Management and risk sharing

Networks do not manage risk independently but within a system of national, regional and system level arrangements. Networks support risk identification, assessment, mitigation and may facilitate any agreed response.

Specific local risk management arrangements and governance processes should be managed locally through MOUs/ SOPs etc which are clear and signed off. Escalation processes for risks within a system should be clear and explicit, with any quality concerns escalated through agreed systems and regional processes.

5.4 Interdependent Relationships

Key interdependencies include:

- Highly specialised cardiac surgical service and low volume services such as those providing heart transplant services and ventricular assist devices (VADs) as a bridge to heart transplant or myocardial recovery.
- Other local network interfaces; other neighbouring CVD networks, congenital heart disease, children and young people, critical care, respiratory, PCNs
- The networks will be expected to engage with the Cardiac Transformation Programme:
  - When developing their network architecture, plans and priorities.
  - To identify support required from the national team, to supplement regional support. This could include support from the Transformation directorate (including GIRFT, IST and digital care models), clinical policy unit (for Long Term Plan priorities), and specialised commissioning.
  - To share learning with other networks as part of a network collaborative.
  - To review progress and discuss further support needs, on a regular basis.
  - By identifying a single representative to join the Cardiac Delivery Board per region (on behalf of all networks in the region).
  - To access coordinated support from wider national partners.

Wider stakeholders including local authority, public health/prevention, local senates, academic health science networks (AHSNs), local education and training boards (LETBs) and others as appropriate to the local network.

6. Resources

Network funding provided to the host is ring-fenced for the network programme of work.

Each network should have a team to support its work that provides clinical leadership, management and administrative support. Networks should also have arrangements for analytical and business intelligence support. Commissioners must ensure as part of the annual planning process that the scale of resource made available to networks is sufficient to support the agreed programme of work. The capacity of the network to deliver its

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programme of work does not reside solely in the network team but also in the support of all network members including its commissioners.

As part of the annual planning process, commissioners must ensure that:

- the scale of resource made available to networks is sufficient to support the agreed programme of work
- networks have access to the data they need and the analytical capacity and capability to turn this into actionable improvement programmes

Roles such as administration, network management and analytical support may be appropriately combined across networks, with further opportunities to increase the value from these investments, share learning across networks and improve the sustainability of networks through the provision of a pool of staff to support networks across a region.

7. Deliverables, Service Indicators & Outcomes

Indicators and metrics of network performance come from three principal sources:

1. Generic indicators of a well set up, well-functioning network
    - There is an appropriate network management team in post with the skills to deliver the specification
    - The network board meets at least three times per year, is quorate, and minutes, actions and risks are recorded
    - As appropriate to the network spec, there are regular network specialist Multi-Disciplinary Team (MDT) meetings (or equivalent)
    - There are IT facilities in place that enable communication across the network, supporting image transfer and remote participation in the MDT.
    - There is an annual workplan agreed with the network's commissioners
    - There is an agreed plan for PPV engagement
    - There is an analysis of the service needs of the population served by the network, a gap analysis and a plan, agreed with the network's commissioners to meet those needs
    - There are network agreed patient pathways, procedures and protocols
    - There is an analysis of workforce requirements and a plan, agreed with network members to meet these requirements
    - There are arrangements (for example passporting) that enable workforce flexibility between providers within the network.
    - There is an analysis of training needs, and an annual network training plan agreed with network members
    - There is an analysis of the network's data and information needs and a plan, agreed with network members to meet these requirements
    - There is a network agreed research strategy including access and participation in clinical trials
    - The annual workplan includes at least one quality improvement initiative
    - An annual report is produced, summarising the work of the network and its outcomes. The report includes a financial statement
    - The network participates in the national network of networks

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2. Nationally agreed indicators and outcomes for all networks of this specialty, for example as defined by a national transformation programme, or included in the service specification and delegated to network leadership.

All nationally agreed in-year key deliverables, alongside service indicators & outcomes data can be found at: https://future.nhs.uk/NationalCardiacImprovement/grouphome

3. The network's individual locally agreed annual workplan, which should build in metrics and indicators for each element.

The network board will agree an annual tracked workplan (see 4.4 above) with its commissioners which will include:

- the expected nationally-agreed in year deliverables
- activities to underpin the effective delivery of its functions (as set out in detail in 4.3)
- arrangements to ensure the effective operation of the network including:
  - that there is a network management team in post
  - the network board meets at least three times per year, is quorate, and minutes, actions and risks are recorded.

There is an analysis of the network's data and information needs and a plan, agreed with network members, to meet these requirements.

8. Further support and information

All programme references and support (including standards, pathways and GIRFT resources) will be made available via the Cardiac Transformation Programme FutureNHS workspace: https://future.nhs.uk/NationalCardiacImprovement/grouphome

The full suite of materials covering what clinical networks do, commissioning of specialised services clinical networks and the clinical networks operating model together with model materials for use by networks and their commissioners can be found on the Future NHS website here:
https://future.nhs.uk/NationalSpecialisedCommissioning/view?objectID=34094320

Access requires membership of the site and permission to access the workspace. This is straightforward for all NHS employees.

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