The Scottish Government

Dear Colleague,

MANAGED CLINICAL NETWORKS: SUPPORTING AND DELIVERING THE HEALTHCARE QUALITY STRATEGY

The Healthcare Quality Strategy sets out the Scottish Government's intention to build on the collaborative, cross-disciplinary working exemplified by Managed Clinical Networks (MCNs), as a well-established approach to supporting and delivering high-quality healthcare.

The responses to the consultation on refreshing the extant guidance, *Strengthening the Role of Managed Clinical Networks* (HDL (2007) 21 issued on 27 March 2007, suggested that it had stood the test of time reasonably well. Key points were:

- Networks are ideally suited to delivering service re-design, quality improvement, strategy and planning across pathways, working across boundaries of departments, teams, units, sectors, agencies and Boards;
- They also have the potential both to inform and to help deliver the kind of prioritisation needed to ensure value in a context of strict financial limitations, increasing patient demand and rising public expectations; and
- As part of the implementation of the Quality Strategy, MCNs need to adapt and align with other structures that support partnership working with local authorities and the third sector.

In February 2011, the National Planning Forum commissioned a strategic review of national MCNs. Its recommendations, which are set out in the Annex to the guidance, have been endorsed by NHS Board Chief Executives and are relevant to all Networks.

The key message in this guidance, as in HDL(2007)21, is that MCNs cannot work in isolation. NHS Boards retain statutory responsibility and accountability for the delivery of services. There must therefore be close links between MCNs and the appropriate planning, delivery, improvement and governance functions of Boards.

The role of MCNs in improving the quality and efficiency of services across complex whole systems has become even more important in the current financial climate. MCNs achieve their results through consensus and collaboration, by enabling clinicians, patients and service managers to work together across boundaries to deliver safe, effective and person-centred care. It would therefore be unrealistic to think that disbanding MCNs would be a source of easy savings. However, as we look to a future with rising numbers of older people living with multiple conditions, there may be
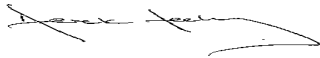
opportunities to better align and integrate local MCNs that share common challenges and solutions.

In summary, MCNs are integral to achieving the 3 Quality Ambitions. They epitomise the ethos of co-operation and collaboration that distinguishes the whole of NHSScotland.

Yours sincerely,

Harry Burns

DEREK FEELEY　　　**SIR HARRY BURNS**
Director General　　　Chief Medical Officer

Introduction

1.   The MCN concept continues to be highly relevant, especially in the context of improving the quality and outcomes of care for people with long term conditions. The Long Term Conditions Collaborative's document *Improving Care Pathways (April 2010)* highlights the excellent progress made by MCNs and the benefits to be gained by NHS Boards and their partners through drawing on the energy, expertise and reach of local MCNs.

2.   The MCN concept has also remained central to local implementation of our revised Action Plans for Heart Disease and Stroke and for Diabetes. That approach has been extended through the creation of respiratory MCNs in each of the territorial NHS Boards. The MCN principles underpin the local implementation of neurological service improvements, in line with the Healthcare Improvement Scotland clinical standards for neurological services. It is therefore essential that each NHS Board fully supports and monitors the work of these MCNs in its area.

3.   Condition-specific MCNs are important vehicles for the delivery of generic approaches, such as tackling health inequalities, promoting anticipatory care and supporting self management, and are well placed to test and support initiatives such as the Health Promoting Health Service and the use of telehealthcare. They are also well-placed to develop and pilot models of care and deliver specific areas of work on behalf of the NHS Board, examples being transitional care and patient experience. In addition, they can help NHS Boards achieve national outcomes that can be measured by the national indicators and HEAT targets.

4.   MCNs have been established throughout Scotland for a wide-range of clinical conditions and services from cancer to learning disabilities. Opportunities exist to extend the MCN approach further. MCNs are recommended in the Scottish Public Health Network's needs assessment of ME-CFS as the means of improving services for that condition. MCNs are also the basis for the development of services for people with chronic pain, as demonstrated by the highly effective MCN in NHS Greater Glasgow & Clyde. The Government looks to the adoption of this model in other areas as the vehicle for implementing the chronic pain service model, and looks to the Chronic Pain Steering Group to promote and monitor uptake.

5.   The current emphasis on integrated working, and recent developments such as the use of the Change Fund as a driver for Reshaping Care for older people, are intended to strengthen local partnerships between the NHS, local authorities, the third sector and independent providers. This increases the case for MCNs to evolve as Managed *Care* Networks, to provide an integrated approach along the continuum of care.

6.   The Healthcare Quality Strategy refers to MCNs as one of the key elements in a long and strong tradition of providing high quality healthcare. MCNs also feature in the *Delivering Quality in Primary Care Action Plan (August 2010)*. The fourth of its national actions is about ensuring we have in place an up-to-date, agreed suite of care pathways. The Action Plan expects NHS Boards to further develop local pathways, many of which, as it points out, will have been agreed through existing MCN arrangements.

7.   A modicum of pump-priming funding is available from the Health & Social Care Directorates to support the start-up of MCNs where NHS Boards can demonstrate these will support implementation of the Healthcare Quality Strategy (see paragraphs 47 and 48 below).

Core Principles

8.   The core principles of MCN development are re-stated here, with some minor modifications based on practical experience:

8.1   Each MCN must have clarity about its management arrangements, including the appointment of a person, usually known as the Lead Clinician (or 'Lead Officer' if it is a multi-agency Network), who is recognised as having overall responsibility for the functioning of the Network. Each Network must also produce an annual report to the body or bodies to which it is accountable, and that annual report must also be available to the public.

8.2   Each Network must have a defined structure that sets out the points at which the service is to be delivered, and the connections between them. This will usually be achieved by mapping the journey of care. The structure must indicate clearly the ways in which the Network relates to the planning function of the body or bodies to which it is accountable.

8.3   Each Network must have an annual plan, setting out, with the agreement of those with statutory responsibility for the delivery of services, the relevant standards, the intended quality improvements and, where possible, quantifying the outcomes and benefits to those for whom services are provided, as well as their families and carers. The social work Performance Improvement Framework and developing work on joint inspection will be relevant to multi-agency Managed Care Networks.

8.4   Each Network must use a documented evidence base, such as SIGN Guidelines where these are available, and should draw on expansions of the evidence base arising through continuous quality improvement and audit, which all MCNs are encouraged to undertake, as well as relevant research and development. All the professionals who work in the Network must practice in accordance with the evidence base and the general principles governing Networks.

8.5   Each Network must be multi-disciplinary and multi-professional, in keeping with the Network concept. Multi-agency Networks will cover local authority services such as social care. There must be clarity about the role of each member of the Network, particularly where new or extended professional roles are being developed to achieve the Network's aims.

8.6   Each Network must include meaningful involvement of those for whom services are provided, and by the voluntary sector, in its management arrangements, and must provide them with suitable support and build the capacity of these individuals to contribute to the planning and management arrangements. Each Network should develop mechanisms for capturing the

views and experiences of service users and their carers, and have clear policies on: improving access to services; the convenience of services; addressing health inequalities; the dissemination of appropriate, up-to-date information to service users and carers; and on the nature of that information. The 'Voices' programmes run by Chest, Heart & Stroke Scotland and the Neurological Alliance of Scotland can support MCNs in achieving this aim. More details are given in paragraph 35 below.

8.7 Networks' educational and training potential should be used to the full, in particular through exchanges between those working in the community and primary care and those working in hospitals or specialist centres. All Networks should ensure that professionals involved in the Network are participating in appropriate appraisal systems that assess competence to carry out the functions delivered on behalf of the relevant NHS Board or governing body, and that the participating healthcare professionals are involved in a programme of continuous professional development.

8.8 Each Network must demonstrate continuing scrutiny of opportunities to achieve better value for money through the delivery of optimal, evidence-based care that adds value from the patient's perspective, optimises productivity and reduces unwarranted variation. Networks should be supported to deliver continuous quality improvement. The value Networks add should also be assessed in terms of their contribution to an organisational culture that promotes learning, quality improvement, collaborative interprofessional and team-based working, adherence to agreed and evidence-based protocols to improve outcomes, equity of access and quality of life.

Links with NHS Boards

9. For MCNs to be successful, they need to be fully integrated and embedded with NHS Boards' planning and operational service delivery and governance arrangements. This could be said to occur when the MCN is seen by NHS Boards as providing appropriate strategic leadership, effective engagement and continuous quality improvement activity and data to support the Board's corporate aims.

10. NHS Boards should agree with MCNs their annual work plan, which will include the service delivery and quality improvements for which the Network will be accountable, and the way in which these will be delivered through local management arrangements. MCNs will be more likely to influence commissioning of services and resource allocation when they can demonstrate the clinical evidence base, and also their ability to respond to the needs of patients and carers in a way that delivers measurable improved outcomes.

11. There needs to be clarity about the reporting and governance arrangements for the MCN within the relevant NHS Boards. Annual work plans and annual reports should be developed and agreed jointly with operational management teams and signed off by Boards. MCNs' governance arrangements should operate through an executive clinical lead such as the Medical Director or Director of Nursing, and in line with the Board's clinical governance structures. The requirement that the diabetes

MCNs need to have their reports to the Scottish Diabetes Group signed off by a senior manager in the Board is an example of this approach in action.

12.   MCNs should be fully involved in discussions on the prioritisation of services in their area, and the process for making informed decisions about disinvestment and resource re-allocation. Prioritisation is a two-way process, with the MCN brokering clinical/service user and carer input to the Board on priorities, and the Board representatives explaining to the clinical and lay members the wider policy context of Scottish Government, local priorities and issues affecting the public health of the Board's population.

13.   NHS Board Chief Executives continue to be accountable for issues such as clinical governance, performance on quality outcomes and HEAT targets, delivery of clinical standards, continuous quality improvement and the use of resources. A good example of this is the support the stroke MCNs provide Boards in delivering the HEAT target for stroke unit admissions.

14.   MCNs have an important leadership and quality improvement role to play, for example through the development of referral pathways, treatment protocols, clinical audit and the provision of high quality, consistent information and health improvement support.

15.   MCNs are well placed to inform and support local Workforce Developments Plans through effective use of skill mix alongside judicious use of knowledge management, educational development and clinical decision-making support to drive quality and productivity, improve staff experience, employee engagement and staff governance.

16.   Some Boards have produced MCN Frameworks, as a way of capturing a clear understanding of the purpose, function and governance arrangements of their MCNs. This approach is commended, especially where reporting and governance arrangements have not yet been clarified, but any such Framework should be tailored to the needs of the Board area and its resident population.

Relationship with CHPs

17.   Health improvement is an obvious area where CHPs and MCNs share a common agenda. Many MCNs, notably cardiac and stroke, already act as vehicles for implementation of Boards' health improvement strategies in relation to cardiovascular disease. MCNs are ideally placed to support CHPs to implement these strategies fully at population level, and will be key to realising the Health Promoting Health Service actions set out in CEL 2012 (1).

18.   Ministers' proposals for integrating adult social care and health are reflected in the '2020 Vision'. These include a proposal to replace CHPs by Health and Social Care Partnerships, which will be the joint and equal responsibility of the NHS and local government and which will work in partnership with the third and independent sectors. As this process develops following consultation, it will be all the more important for MCNs to engage with local authority, third sector and independent sector partners through their local CHPs and the new structures when they are

established. In the meantime, CHPs have a responsibility to facilitate involvement of primary care, and CHP clinical leads could assume a leadership role for MCNs within their overall responsibilities (see next section).

Primary Care Participation

19.   Integration of primary and secondary care has from the outset been one of the stated aims of the MCN concept, and without the engagement of primary care an MCN cannot be considered to be fully functional. It is therefore essential that primary care should participate fully in MCNs' work. The importance of this is underlined by the *Delivering Quality in Primary Care Action Plan*, with its emphasis on the further development of local pathways and its recognition that many of these will have been agreed already through MCN arrangements. The Action Plan also stresses the need for structured dialogue on local implementation and ensuring shared learning between clinical disciplines and across NHSScotland. MCNs offer a golden opportunity for a primary care voice in priority-setting, planning and service development at Board level, and to draw on primary care experience in developing care pathways that are person-centred and deliver quality outcomes.

20.   One way of achieving fuller primary care participation in MCNs would be through closer liaison with local area clinical fora or local primary care strategic groups, in order to engage individual GPs or other primary care professionals who have an interest in the relevant condition, or the work of the MCN. As noted above, CHPs have a responsibility to facilitate involvement of primary care representatives.

21.   Consideration should also be given to the merits of appointing a locally-respected GP as Lead Clinician, with support from a Deputy Lead from the acute sector. Primary care engagement could also be promoted through professional meetings, and by opportunities for personal CPD through MCN-led training, collaboration, knowledge exchange and sharing learning.

Third Sector Engagement

22.   Third sector organisations provide support and services to some of the most vulnerable people in Scotland, and have an increasingly important role in delivering better outcomes for people and communities. The third sector has an acknowledged expertise and successful track record in developing and delivering information, advocacy, support and services that engage, empower and enable people. The importance of this role, and the commitment to engaging fully with the third sector, is embedded throughout the Quality Strategy and re-emphasised in the actions required to achieve the 2020 vision for achieving sustainable quality in Scotland's healthcare.

23.   Full engagement means that the third sector is regarded as a partner in the planning, design and delivery of public services. MCNs have a strong foundation of working effectively with the third sector and are well-placed to strengthen the strategic engagement between Boards, local authorities and the third sector.

Leadership

24. Leadership of an MCN is a distinctive role that benefits from a democratic, consensual style and a willingness to take on board the views of all the interests represented within the Network. MCN Lead Clinicians (who do not need to be doctors) require a number of skills, including clinical authority, an ability to inspire a multidisciplinary team and to work in partnership across professional boundaries and with colleagues from other sectors. They need to be flexible and able to listen to, and responding to, the needs and views of those for whom services are provided, their carers and the voluntary sector. In this way, they can demonstrate a clear focus on outcomes, regardless of their professional or sector loyalties, which in turn promotes a spirit of trust within the MCN.

25. MCN Lead Clinicians should be supported in their role by their local NHS Board, to enable them to become confident and capable leaders for quality services. There should be a clear induction process, to ensure awareness of how the NHS operates locally, regionally and nationally. Training in finance should be provided where necessary, and Lead Clinicians should receive relevant Board documents. MCN Lead Clinicians should be encouraged to engage with the QI Curriculum and the Improvement Lead Group being established by the Quality Hub (hosted by HIS). They should also engage with the Strategic Clinical Leadership Network and access the range of leadership development supports being provided by the National Leadership Unit in NHS Education for Scotland.

26. Where the Lead Clinician is a consultant, his or her Job Plan should recognise the time devoted to leading the Network by allocating specific PAs to the role. Where the Lead Clinician is a GP or other primary care clinician, appropriate remuneration will be required to backfill for the time dedicated to the role.

27. To promote a performance management culture, the Lead Clinician should have clear objectives, which reflect the Board's priorities, and be held to account by an identified senior colleague for delivery of a clear project plan, set out in the MCN's annual plan. Consideration should also be given to the development of a 'core team' approach, through which the Lead Clinician is supported by a Deputy Lead, the Network Manager and a small number of other key members of the Network. This would promote consistency of message from the MCN as well as business continuity in the absence of the Lead Clinician, and would also encourage team-building and succession planning.

28. Lead Clinicians should ideally be in post for a fixed term, so that the role can be refreshed regularly. At the time of appointment, an agreement should therefore be drawn up with service managers in relation to return to full clinical duties.

Role of the Network Manager

29. The role of the Network Manager should be focussed on ensuring that the Network functions effectively and achieves tangible progress in developing equitable, high quality safe, effective and person-centred services.

30.   As with Lead Clinicians, Network Managers should have access to leadership training.   Along with the Institute of Health Managers Scotland, the Scottish Government Health and Social Care Directorates are supporting the creation of a learning network for MCN managers, the purpose of which is to provide accessible opportunities to enhance and further develop the leadership, management and associated business skills essential for the delivery of effective MCNs. This, in turn, will improve the planning, co-ordination and delivery of integrated high quality care.

31.   There is evidence of increased effectiveness, quality of support and reduced cost from the establishment of MCN offices within NHS Boards, to provide support to a number of MCNs. In smaller Boards, in particular, this can be cost-effective in terms of sharing administration, project and management resources. In larger Boards, however, with a complex pattern of services, care would need to be taken to avoid a loss of focus, especially if too many MCNs covering relatively unrelated conditions were grouped under a single Manager. It is also important to recognise that Network Managers require a great deal of knowledge and experience of services in a particular clinical area, and their remit should not be spread too thinly across several disease areas, as that could reduce the efficiency of the MCNs concerned.

Patient and Carer Involvement

32.   Each MCN must have a clear strategy for involving those for whom services are provided, and their carers, as well as voluntary sector representatives. That strategy should apply to each aspect of the Network's activities, including the work of sub-groups. In addition to attendance at meetings, this type of contribution can be encouraged through a range of other approaches, including:
- Patient surveys;
- Patient interviews in clinical situations;
- The use of social networking; and
- Establishing a patient forum as a way of accessing patient opinion and enabling involvement.

33.   A model worth considering is the Mutual MCN approach developed by Chest, Heart & Stroke Scotland. Its pathway consists of the following components:

Information Days	Inform patients and carers about the work of the network and how they get involved
Email/mail patient/carer network	Collect contact details of those interested in getting involved and use them for communication and consultation
Discussion groups	Invite patients to meet to discuss specific subjects or topics
Patient/carer subgroup	Encourage those from discussion groups and open days to form or join a Patient and Carer Subgroup, offering user involvement training where possible
Open days	Encourage partnership working by involving patients and carers regularly and asking for feedback and suggestions

34.   Patients and carers who take part in MCN activities must be properly supported to allow them to make as effective a contribution as possible.   An induction pack has been shown to be helpful. MCNs can also benefit from links to their local PFPI (Patient Focus and Public Involvement) team, who can offer support on involving service users. NHS Health Scotland provides a range of support to develop and improve person-centred approaches across services and organisational areas.

35.   One specific initiative that has assumed increasing importance is the development of the 'Voices' programmes. They have been extended successfully to the stroke and respiratory conditions MCNs. The Neurological Alliance of Scotland has been given Government funding to develop a 'Neurological Voices' programme as part of the local improvement of neurological services. In addition, the Long Term Conditions Alliance Scotland is taking forward a module that will aim to allow participants to champion the benefits of self management of long term conditions.

36.   The 'Voices' programmes have therefore established themselves as the 'gold standard' of patient and carer involvement, and should in future form an integral part of all MCN developments, to support MCNs to improve local patient experience and help design and deliver truly person-centred services.

Endorsement (formerly Accreditation) of MCNs

37.   Paragraph 33 of HDL (2007) 21 advised that local MCNs should seek accreditation from their NHS Board, rather than the former NHS Quality Improvement Scotland, as a way of promoting closer working between MCNs and Boards, while recognising the statutory accountability of Board chief Executives for the provision of services. It is clear, however, that further guidance is needed on what is meant by 'accreditation' of local MCNs.

38.   The responses to the consultation showed strong support for a move towards a more pragmatic approach, based on an annual review by NHS Boards of their MCNs' work plans, to ensure ongoing effectiveness and delivery against objectives, coupled with a formal review every 3 years to assess the MCNs' outcomes, impact and fitness for purpose. This process should be referred to as one of 'endorsement' rather than accreditation.

39.   Every proposed new MCN should be subject to a process of endorsement by its NHS Board, to ensure that it can help the Board achieve its aims in terms of the range of issues set out in paragraph 13. Once endorsement has been achieved, MCNs should be subject to a process of annual appraisal at senior management level, drawing on the objectives approved in the annual plan, against Board-wide criteria. The Network Managers' forum offers a mechanism for Boards to share appraisal criteria, so that a similar approach is applied to similar Networks. That process must also take account of the role of MCNs that act as the vehicle for local implementation of national strategies, such as the Heart Disease, Stroke and Diabetes Action Plans and to support the Quality Ambitions.

40.   The same type of arrangements should apply to regional MCNs and should be operated by the Regional Planning Groups. The arrangements for national MCNs

and the relevant recommendations from the National Planning Forum's review of national MCNs will be taken forward by National Services Division.

Information Technology

41.   Good data on quality outcomes should be made available to MCNs on an ongoing basis by NHS Boards through the Network Manager. That must include the wealth of data held in primary care information systems. Sharing of the live anonymised data that are currently routinely collected would be beneficial to the MCNs' role in terms of quality improvement, audit and planning. NHS Boards and MCNs should therefore work together on agreed information-sharing protocols. Since the patient's journey does not occur solely within NHS structures, these protocols should reflect the data sharing arrangements being developed by local planning partners, including social care and housing. These data should be reviewed across the whole patient journey and not as separate, isolated episodes.

42.   While the services covered by MCNs are varied, the underlying information requirements are almost identical. National Services Division (NSD) commissioned the National Information Systems Group to develop a web-based audit data capture system to link securely hospital sites involved in the delivery of care within MCNs. This allows clinicians to register patients and enter basic clinical information to assist them in providing care from various sites. The system, which is available at www.nsd.scot.nhs.uk/services/nmcn/index.html#a3, has been developed with national MCNs in mind, but there is no reason why it could not be tailored to meet the needs of local and regional MCNs.

43.   Because of the way they involve those for whom services are provided and their carers, MCNs are well-placed to promote the development of patient-held records, such as Renal PatientView, which have been shown to be effective in promoting self-management of long term conditions. Some Networks can now deliver more equitable services across the range of care settings and localities through Telehealth and telecare. Examples include: remote clinical decision support for administration of stroke thrombolysis; teledermatology and teleneurology consultations.

Obligate Networks

44.   On 4 March 2009, guidance was issued to NHS Boards on the establishment of Obligate Networks, which the review 'Delivering for Remote and Rural Healthcare' identified as a key building block in sustaining local services and ensuring access to more specialist services not available locally. They build on the well-established MCN approach. An Obligate Network is a formalised arrangement between two or more healthcare organisations that secures access to sustainable services for the whole population served by those organisations. The guidance provides a framework for the development of these Networks.

Managed Diagnostic Networks

45.   The main role of Managed Diagnostic Networks (MDNs), which operate on the same principles as MCNs, is to provide a systematic approach to service re-

design, integration and improvement through the sharing of good practice, influencing change, informing service planning and providing specialist advice and mutual support. However, NHS Boards that provide clinical services retain responsibility for the governance and delivery of the clinical or laboratory service.

46. The Diagnostics Steering Group, a Scottish Government body that advises on the strategic direction and planning of diagnostic services across NHSScotland, has overall responsibility for MDNs, and work is under way to align them with the recommendations of the National Planning Forum review of national MCNs.

Pump-Priming Funding

47. The Health & Social Care Directorates continue to have a small amount of pump-priming funding available to encourage the development of MCNs. The current priority for the uncommitted funding is to foster an MCN approach to the implementation of the chronic pain service model, as indicated at paragraph 4 above.

48. The Directorates would, however, as in the past, continue to welcome bids for other innovative proposals at Board or Regional level that could act as demonstrators of the continuing value of the MCN concept. Support for such bids could be available up until the end of 2014-15 in appropriate cases. Approval of bids will take account of Board or Regional priorities and the realisation of the Quality Ambitions.

RECOMMENDATION FROM NATIONAL PLANNING FORUM REVIEW OF NATIONAL MCNs

Recommendation 1: SGHD and NHS Boards should continue to support national and Scotland wide networks.

Recommendation 2: SGHD to further develop systems to include the accurate assessment of the economic impact of networked care with a requirement for every national network to have in place a clear plan for how it can collaborate with clinical services to generate efficiencies through the work it does such as service redesign and reinvestment of cost efficiencies achieved.

Recommendation 3: SGHD should strengthen accountability and governance arrangements for Scotland wide networks.

Recommendation 4: SGHD should develop clear definitions and criteria for networks. This should be informed by NHS Grampian Framework for Managed Clinical/Care Networks and the Review of Nine Managed Clinical Networks undertaken by NSD.

Recommendation 5: SGHD to introduce a more strategic approach to MCN / MDN / MSN commissioning, performance management and structuring, with consideration being given to a standard single channel for approval of central funding for all managed clinical / diagnostic networks operating at the "all Scotland" level.

Recommendation 6: SGHD to define the governance arrangements for each type of "all Scotland" network – e.g.: via NSD, Scottish Diagnostic Steering Group, or through another mechanism.

Recommendation 7: SGHD should introduce consistent management and support arrangements for all national and Scotland wide networks through organisational review and redesign with a view to achieving parity of funding and resourcing within three years as well as a strategic approach to organisational and individual development that will ensure the long term efficiency, effectiveness and sustainability of network management and support.

Recommendation 8: NSD and SGHD should explore whether further economies and benefits could be achieved by bringing together support for Scotland wide MCNs along with national MCNs; and explore options for rationalisation of the number of network offices.

Recommendation 9: NSD, in partnership with NHS Boards which host NMCNs should develop appropriate risk management for recruitment to network offices, and clarity on grading and career pathways for network managers and support staff.

Recommendation 10: SGHD should review of the current leadership model and organisational support for lead clinicians together with a learning needs assessment to facilitate future arrangements for appropriate education, training and support systems to enable Lead Clinicians to fulfil their role effectively. This should be agreed by the relevant professional lead within the host NHS Board and Medical Director, NSD. Any additional support should be through the funding made available in the MCN.

Recommendation 11: SGHD should revise policy and associated systems for commissioning and resourcing networks including recruitment and recompense for Lead Clinicians. Revised arrangements to require:
- applicants for Lead Clinician posts to have the confirmed support of their employing NHS Board including arrangements for backfill/recompense.
- the role to be incorporated into job plans and for this to be reviewed annually within relevant performance review systems and processes.

Recommendation 12: SGHD to establish a quality assurance/governance structure that recognises and involves stakeholders e.g. a national NMCN QA group that oversees the development, implementation and monitoring of QA including non clinical MCN standards, quality and performance indicators, reporting schedules and formats. It is recognised that this links with findings that are emerging from the concurrent NPF Review of Efficiency of National Specialist Services and it is suggested that there are potential synergies and efficiencies to be achieved by establishing a single structure in this area.