Vanguard board level enquiry: existing networked care providers

1. Objectives and method

Semi-structured telephone interviews were held with a number of chief executives and directors to understand their views on the conditions, drivers and requirements for networked care. The objective was to provide a board perspective to the developing Moorfield's vanguard toolkit.

Five questions were used:

i. Describe the decision-making process when considering working with a new partner.

ii. In your experience, what are the things that drive a service towards networked care options?

iii. What assurances do you (in your role on the trust board) need to have in place for the care provided in a network?

iv. What does your trust board expect to be delivered by networked care?

v. How can the NHS benefit from networked care?

2. Key themes from each question

2.1 Describe the decision-making process when considering working with a new partner.

There was broad consensus on a set of high level criteria that trust boards should use when deciding whether to work with a new partner/service:

Strategic fit	Most people put alignment with, or furthering, the organisation's strategy first. Some described wanting to test this before evaluating other criteria. Strategic fit and alignment weren't described purely by size of catchment, but as supporting wider organisational objectives such as sector leadership and research. People also described looking for a common strategic objective with the other organisation, some sense of a win: win.
How achievable is it?	Assessing the risks of delivering the network - with an emphasis on understanding the size of the task, checking operational stretch (bandwidth), clinical commitment and geography.

Accountability	Everyone described the need for clarity on accountability in the new arrangement. One chief executive described wanting to be clear about who the Care Quality Commission (CQC) would want to talk to if something went wrong. Another chief executive described needing to act as the accountable officer regardless of detailed responsibility – "if it's our name across the door".
Financial case and flows	Everyone described the need for the new arrangement to make sense financially and to factor in the investment (staff and equipment) that is often needed to make it work. There was a sense that in the past organisations could be tempted to be 'soft' on the financial case in favour of the strategic opportunity (eg new market share) but that this was happening less. A number of people described uncertainty about how money would flow in the future as the NHS moved away from payment by results (PBR) to a more planned system.
Clinical/ cultural fit	Some people described the importance of clinical fit – often meaning the relationship between the clinicians who would be working together in the networked arrangement. One chief executive described this as wanting evidence of a "healthy clinical discussion" as part of the due diligence.

Everyone described the need for all of the information required to support the decision to come together in a business case for approval at either executive or board level, depending on scale. It was important that the case could be used to support a "no" decision as much as a "yes" (ie there was objectivity).

There was a broad acceptance that the decision-making process on issues like this could be improved, eg with a consistent checklist. There was a balance to be struck between having enough good information to support decisions and not making it too big and slow. There may be a capacity and capability gap in some organisations to do this well.

2.2 In your experience, what are the things that drive a service towards networked care options?

Everyone described the most common scenario as being triggered by a (usually medical) staffing crisis. For example, a district general hospital (DGH) may not be able to recruit or retain the consultant medical staff it needed. It would be likely to struggle on for as long as possible until some sort of crisis was reached when help was sought from a specialist provider. Decisions and solutions may be needed quickly.

Other drivers were listed including:

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

But people were clear that staffing was usually the main driver.

2.3 **What assurances do you (in your role on the board) need to have in place for the care provided in a network?**

Everyone described the need for clarity on who was responsible for what in a networked care arrangement. They would often describe this as being clear about who the regulator would hold to account for performance and issues.

One of the chief executives described needing to act as the accountable officer regardless of who was contractually responsible – "because it is our name across the door".

Everyone described the need for a similar level of assurance information for a networked service as they received for services provided on their main site (including clinical governance, quality, finance and performance). Making sure that there was a sufficient flow of information from the networked site to support this was seen as a key assurance in itself.

A couple of people also described the need for assurance on the estates and infrastructure supporting a service on another site, including compliance with standards such as for Legionnaires' disease, fire safety and so on.

Some people described wanting assurance that there were good lead clinicians and effective triumvirate management teams in place for the service.

One chief executive described an expectation that the service and working relationship would be "underpinned by proper discussions". Business as usual should include regular 1:1s and meetings.

2.4 **What does your board expect to be delivered by networked care?**

There was a high degree of unanimity on what boards should expect:

- the model should directly support delivery of the trust's strategy/ objectives
- patients should get the right experience and care
- the organisation should become more resilient, eg the model should contribute to overheads and bottom line; increase skill base, catchment, market, influence and reputation.

As with all services, getting the flow of information to the board right was important – not too much and not too little.

A number of people described the importance of the board understanding the risks of providing care in a network and being visible across the network. Boards would

want to know that their partner organisations were playing their part and doing what they said they would.

One chief executive wondered whether NHS boards held a concern that networked care was the “thin edge of a wedge” that could threaten the future of their organisation. Support to understand the positive role of networks for organisations as well as services and patients would help this.

2.5 **How can the NHS benefit from networked care?**

Again, a high degree of unanimity of the benefits to the NHS:

- Higher standards and quality
- Improved standardisation and reduced unwarranted variation
- Improved access local access to services – that may otherwise not be sustainable – and a greater range of sub-specialities
- Improved equity of access to services across the NHS
- Improved efficiency through standardised practice and processes and reduced duplication
- Greater resilience of providers
- Improved careers and opportunities.

One chief executive described the potential for the NHS to build and benefit from “mature inter-provider relationships” as they worked together to develop networks.