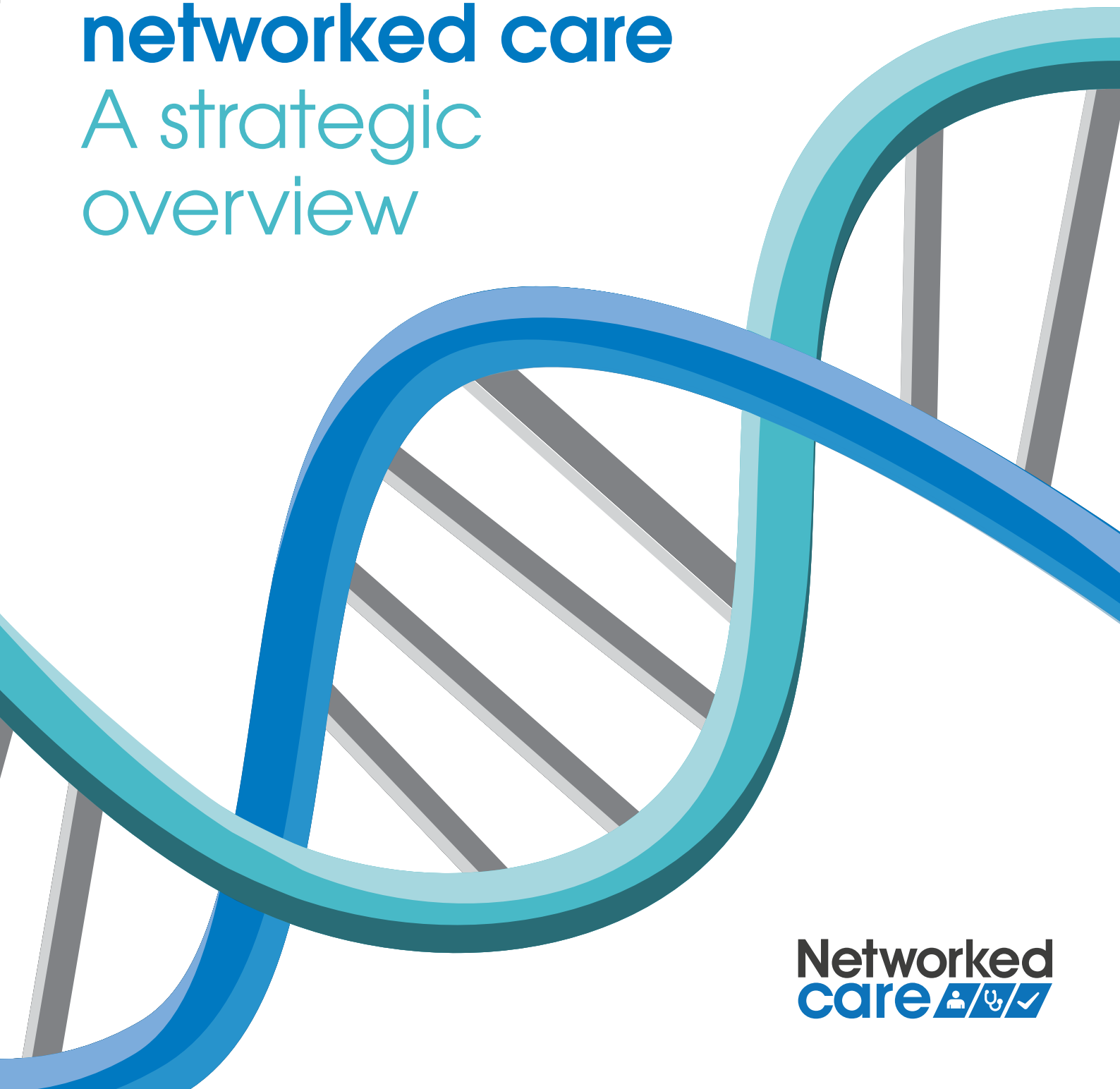
Scaling up single specialty networked care

A strategic overview



Networked care

Contents

Biographies

Sola Banjo, Programme senior project manager

Sola did a Bachelor of Arts degree in business administration, and has spent the past 12 years in the NHS within cancer, strategy and service improvement, research and development and urgent and emergency care teams across a variety of providers, commissioners and arm's length body. In 2017 she was seconded to the Moorfields vanguard team.

Teresa Due, Programme senior project manager

Teresa did a Bachelor of Science degree in biomedical science and a Master of Science degree in control of infectious diseases which led her to work for public health projects at not-for-profit organisations and the United Nations. She worked in New York, Lesotho and North Korea for four years before joining the NHS regulator NHS Improvement in 2015. In 2017 she was seconded to the vanguard team.

Vanguard programme editorial team:

Johanna Moss Programme executive lead

Karen Reeves Programme director

Philippa Hutchinson Programme content manager

Brian Donnelly Programme communications lead

Summary

In January 2015, the NHS invited individual organisations and partnerships to apply to become vanguards for the new care models programme.

This represented one of the first steps towards delivering the NHS England Five Year Forward View by supporting the improvement, standardisation and integration of services. Moorfields Eye Hospital (Moorfields) was successful in bidding to become one of 13 acute care collaborative vanguard programmes.

In April 2017 the Moorfields vanguard team published a unique e-toolkit **(www.networkedcaretoolkit.org.uk)** sharing findings from the research into best practice for single specialty networked care.

The definition of single specialty networked care is a single specialty provider delivering a service across multiple sites.

In 2017/18, the team have been researching the benefits and challenges of scaling up networked care numerically and geographically. This publication shares our findings from semi-structured interviews with more than 35 strategic decision makers across the NHS (providers, commissioners and regulators), and other sectors, as well as a desktop literature review.

When referring to the extension or scaling up of a model it is assumed an existing network is increasing the number of sites it operates. Having clearly agreed definitions is necessary to understand the findings:

- Numerical expansion is extending a network's sites within a single sustainability and transformation partnership (STP).
- Geographical expansion is extending a network's sites across multiple STPs.

Moorfields Eye Hospital was successful in bidding to become one of

13

acute care collaborative vanguard programmes

There are many ways in which single specialty networked care can be delivered as previously evidenced in the toolkit – no one size fits all. Annex A is a table showing the generic characteristics of some of the models which we refer to throughout the publication.

The NHS needs healthcare delivery models that can adapt as the landscape changes and add value to local health and care systems. A number of recurring themes emerged during our research, some of which are more limiting to network growth and others more enabling.

Single specialty networked care is already delivered by a number of providers and has long been recognised as a sustainability solution for services where critical mass does not support local provision or recruitment to specialist roles is problematic. Given the move towards locally integrated health care systems (ICSs) the research indicated greater appetite and opportunities for numeric expansion.

We identified a number of conditions which need to be in place in order to facilitate successful expansion of networked care. These become more critical the further the network sites are situated from each other:

- A shared understanding of the benefits of single specialty networked care to the wider NHS and to systems locally.
- Active support for networked care as a model for service sustainability.
- Aligned priorities between networked care providers, commissioners and other system partners.
- Rigorous standardisation for network assurance and oversight.
- Accurate data and performance indicators to evidence the changes before and after a site is added to the network.
- Collaborative working to ensure that networked services represents best value for patients and other system partners.

1. What role do STPs play in the scaling up of single specialty networked care?

Any plan to expand single specialty network care within an STP or across multiple STPs should consider the benefits networked care can bring to evolving ICSs.

The sustainability challenges facing smaller district general hospitals (DGHs) may continue to create the need for healthcare models that can provide a comprehensive range of services locally, for the best value. Our research indicates that a system approach to health and social care such as an ICS will benefit from single speciality networked care. Allowing a single provider to run an entire specialty network within an STP or ICS may offer more opportunities for efficiencies.

> If anyone is going to network I would suggest it makes sense to be within an STP footprint.

Expansion within a single STP rather than across multiple STPs is considered to be more realistic, as aligning priorities and oversight becomes more complex when sites are more geographically distant from each other.

Mergers, hospital chains, alliances and informal collaborations all help with organisational sustainability. There is clear evidence from the single specialty networked care models currently operating that they help make single specialty services more sustainable and meet local population needs.

STPs are intended to bring about collaborative working and to deliver the best outcomes; a mature STP is likely to foster good relationships and understand the benefits that network expansion could bring.

Our research indicates that some national vanguard programmes have helped to raise the profile of single specialty networked care. Where networked care providers are actively engaged with their STP, system partners have a better understanding of how the networked care model benefits the local health and social care system.

> The primary place we're encouraging people to think about their models of care is across the STP.

It is also considered important for organisational strategies to be aligned with system priorities. Agreeing strategies

which can support networked care growth, such as a workforce strategy which shares staff across a system, is likely to be easier with STP partners. A number of STPs have already begun this process[1 2], which suggests existing networks may be well placed to increase sites within an STP footprint.

How do you get coherence across the system? Probably through networking. It's also how you drive the efficiencies.

Our research was clear about the need for shared understanding about the value of the single specialty networked care model to enable adoption within and across health systems.

We found evidence that:

- system partners should understand the benefits of networking before committing to scaling up the model.
- existing providers may find it difficult to collaborate with a networked care provider if the benefits to the system are unclear.
- commissioners need to understand the challenges facing the existing service provider and how a network will address these.

Evidencing a network's added value, measuring quality and the costs of both existing provision and after implementation of a network, are therefore critical to enabling expansion.

How do you make sure that there's still coherence within the STP if you've got people networking into that?

For a network to operate successfully in a local healthcare system, network providers need to be aware of any system partner concerns about the impact the network will have on existing providers and the local health economy.

It is therefore clear that networked care providers need to understand STP system priorities and ensure that any expansion benefits the wider system as well as its own organisation. This may mean sharing benefits to ensure that any loss of income locally from making one service more sustainable does not have a detrimental impact elsewhere in the system(s). Working collaboratively with regulators and other system partners will ensure that the networked care model is properly understood and will avoid unnecessary discord.

When expanding geographically there are added concerns around affordability. Market Forces Factor (MFF) on tariff, as well as local payment arrangements, may differ between STPs. Networked care will offer better quality and access for patients, but if this comes at increased cost it may not be supported. All system partners need to understand the costs of the existing service and the cost of implementing a networked service. Delivering cost efficiencies to make the solution affordable is considered by commissioners to be a provider responsibility. This may be a challenge within a single STP and prove more complicated when extending geographically.

Existing networked care models tend to have a broader geographical reach despite all these challenges and this would suggest that extending geographically is achievable.

Individual organisational strategy and affordability will be key factors in determining whether network models expand geographically or numerically. As mature STPs develop into ICSs, existing network providers may have to adapt to take account of new system priorities.

> A challenge to sustainability might be that people do have other priorities locally and there are other priorities that get pushed nationally as well.

> The risk is that specialist single providers or networks just don't fit, our network crosses more than one STP… so you feel a bit disjointed.

Considerations
✓ STPs are likely to encourage networked solutions within local health and care systems, which could sustain single specialties at smaller DGHs.
✓ Numeric expansion of existing networks can be delivered at pace in mature STPs.
✓ Networked care providers need to align their priorities with those of an STP when expanding.
✓ System partners need to have the same understanding of the value that networks can offer a system for expansion to be successful.
✓ Evidencing the benefits of networked care and measuring the impact is key in gaining support from system partners.

2. How can commissioners help single specialty networks to grow?

The commissioning process can be critical to network expansion. Commissioners can be enablers to extending single specialty networks.

The commissioning approach in the NHS has shifted in recent years in response to growing financial and operational pressures. Outcomes-based commissioning, for example, seeks to alter the way healthcare is provided using a more collaborative and integrated approach. Networked care can increase collaboration between providers, reducing duplication and helping patients to access care closer to home.

When researching the impact of commissioning on expanding single specialty networks, there was little evidence that single specialty networked care was a commissioning priority. In addition, providers and commissioners were not always aligned in their definition of how the networked care model operated. Where differences in understanding exist, there is a risk that the benefits of networked care may not be understood and commissioners may therefore not support network expansion. Where networked care is understood and appreciated, it is more likely to be considered by commissioners.

Commissioners and providers were in agreement as to the importance of collaboration and relationship building when planning and delivering networks across a wider geography. Strong commissioner relationships were considered key by networked care providers in expanding numerically. Informed commissioner support was considered to be critical in helping to find sustainable networked solutions, share best practice and enable faster expansion of networked care.

Our research found that commissioners expected providers to lead service improvement initiatives, including proposals to expand networked care. There is a risk that unless a specialty network already exists and is willing to expand or a single service actively seeks a network partner, networked care is unlikely to be considered. Sustainability needs to be system led, not the responsibility of any single system partner, if all possible solutions including networked care are to be considered.

Providers favoured multi-year contracts to incentivise service delivery as many felt that longer contracts were more likely to help economic stability.

> It is of critical importance that we have the explicit support of the commissioners for any expansion of our network.

Longer contracts can provide the time required to improve services when scaling up networked care, particularly where there are significant financial and quality challenges. This could benefit all providers looking to expand, irrespective of the network model.

A specialist provider may require less support when expanding numerically, as the local STP context is likely to be more familiar. When expanding geographically providers considered differences in STP commissioning priorities and processes to be more challenging. Differing commissioning rules, payment structures and performance targets, particularly when crossing national borders, add complexity.

There was consensus that single specialty services should be commissioned centrally or have one host commissioner for the network. It was felt this would make it easier to build a long-term relationship with one commissioner, who is then able to gain a better understanding of the specialty, the network model and the benefits of expansion. This would be easier in a single STP with aligned commissioning arrangements making numerical expansion less complicated. Where there is collaboration to create a single strategic commissioner, it is likely that the conditions that facilitate networked care will follow.

> In my opinion a single commissioner is the best way to go.

Considerations
✓ Aligning understanding of networks between providers and commissioners is critical to successful expansion and can be achieved through collaborative working.
✓ Commissioner support is critical to enable growth of networks, but sustainability solutions for systems need to be provider led.
✓ Multi-year contracts that allow headroom for networked care providers to stabilise challenged services will help network growth.
✓ A networked model will benefit from having a single commissioner who understands the model and the benefits that expansion can offer other STPs.

3. What are the regulatory implications when expanding a network?

Regulators have an important role in facilitating the expansion of networked care services through encouraging and supporting providers to explore innovative solutions.

New ways of delivering care and joint working across systems is changing the provider landscape. Regulation will undoubtedly have to adjust to meet these changes. NHS Improvement (NHSI) and the Care Quality Commission (CQC) have already taken steps to assess how regulation, oversight and inspection can work in this context. The CQC is removing duplication by aligning its 'well led' inspection frameworks with NHS Improvement criteria.

Research indicated that providers and regulators were not always aligned in their definition of how the networked care model operates. There is documented evidence that regulators will support transformational change, offer development support and work with providers to find sustainability solutions[3 4].

Regulators also saw their role as encouraging and supporting providers to explore innovative solutions and help share best practice across the system. Actively promoting networks or helping foster relationships between partner organisations was, however, not considered part of their remit. Regulators' understanding of how networked care can help sustain services is likely to facilitate networked care expansion.

There was concern that when taking on an underperforming service, a speciality provider's regulatory standing could be put at risk and this could be a barrier to expansion. Regulators could help by allowing an agreed period of time for the networked service improvement plan to be delivered. More support would be welcomed in guiding providers through regulatory processes such as transactions, competition rules, the procurement process and other legal barriers.

> Understanding from the regulator that a new network provider will need time to stabilise and improve the service is helpful.

Regulators highlighted the lack of visibility of smaller services, particularly in the context of a wider trust. Often these specialities would not feature heavily in sustainability conversations unless performance or quality deteriorated. Specialty network providers need to find a voice in these discussions to promote networked care expansion as a sustainability solution.

STPs are not statutory bodies and are therefore not regulated. There are no current plans to change this. Instead, regulation is at organisational level. This is unlikely to be a barrier to expanding networked care but clarity around how regulation will apply to emerging systems is needed.

While regulators were supportive of scaling up single specialty networks, the need for clear lines of accountability between networked care and host providers for the delivery of patient care was emphasised. Service level agreements (SLAs) are the way network providers manage these relationships and regulators highlighted the importance of these in providing regulatory assurance.

With no single prescribed model for networked care, getting a consistent approach to regulating these models will need collaboration between network providers and regulators.

> We regulate based on the licensed organisation, and we would need to understand how specialist providers manage any risks associated with delivering care.

> From a regulator's perspective, our concern is a shared risk, but... it has to be absolutely clear who's responsible for the quality.

Considerations
✓ Allowing providers time to stabilise underperforming services may incentivise network growth.
✓ Including specialist networked providers in sustainability conversations can enable growth of networks.
✓ Clarity around how regulation will apply to growing networks within mature STPs is needed.
✓ Providers need to work more closely with regulators to develop a consistent approach to regulating networks where this is a challenge, as there is no single model.

4. How can financial challenges be managed to enable scaling up of networked care?

The research indicated that scaling up a network will require investment which may be a barrier to expansion. With significant financial challenges already facing the NHS, providers and commissioners had concerns about the costs of expanding a network.

Much has been written about the current financial pressures in the NHS and the impact on providers' ability to continue delivering current services while dealing with smaller rates of funding growth[5 6]. It is within this context that systems need to consider what impact these challenges could have on the way in which care is delivered and how a growing network can improve care in a cost efficient way.

Different stakeholders have different concerns about networked care expansion: the specialist provider (investment and turnaround costs), host provider (loss of income) and commissioner (provider tariff costs and potential increase in activity from an improved service). The biggest challenge is to ensure that expanding a network can balance all the stakeholders' interests and meet patients' needs.

Delivering cost efficiencies is considered by commissioners to be a provider responsibility in networked expansion. It is critical therefore that specialist providers and host trusts work together transparently. It remains important that system partners understand the cost of the existing and future service including the cost of any gaps, such as workforce and quality.

Measuring service performance before and after any change in provider is critical to systems partners' understanding of the impact of networking on financial health and service quality.

MFF on tariff could add complexity to network expansion. This should be less of an issue when expanding within a single STP although there can be variation between providers in an STP, particularly in London. There will be tension between the need for a network provider to recover its agreed tariff and for local commissioners to pay no more than the local provider tariff. This could create a funding gap that any business case will need to take into account. In addition, any difference in the way the workforce is paid can add further complexity. This is more likely to be an issue with geographical expansion.

Providers would welcome incentives such as fixed tariff to take on underperforming services, as long as this did not trigger regulatory levers.

Alternatively external funding, including philanthropy, could play a critical part in helping a network to scale up successfully. Any such funding would need to be carefully allocated to ensure services were sustainable in the long term. Access to STP capital funding may also be available to help support network growth numerically or geographically, depending on the value it can offer the system.

The macro-economic climate and decreased appetite for risk may make it more difficult to access external funding. In this case, where additional investment is critical to expansion of the network, a system-wide financing solution will be required.

> If you're crossing any boundary, there's going to be some potential funding challenge.

Considerations	
✓	Financial incentives, including external and non-recurrent funding, could play a critical part in enabling network expansion.
✓	Funding for capital-related costs in neighbouring STPs may encourage geographical expansion.
✓	The impact of the different payment structures, tariffs and the MFF will need to be considered when expanding geographically.
✓	The current financial climate could drive system partners to focus on possible efficiencies gained by networking within an STP.

5. Are there legal implications when expanding single specialty networked care?

Contracts, service level agreements and legislation are important to how networks can develop and operate. System partners will need to ensure that there are no legal barriers to expansion.

Historically, the NHS has encouraged competition between providers on the assumption that it would drive up standards of care. There is limited evidence that this approach works for all aspects of quality[7] and providers are encouraged to collaborate more, as outlined in the Five Year Forward View[8] as well as the Dalton[9] and Carter[10] reviews. Given the current climate, there appears to be an appetite for formal collaboration. This could provide a platform for growing networks.

The implications of legislation to network growth are unclear. There are opposing views on whether competition limits the opportunity for collaborating with other NHS providers (collaboration being a key component of networked care). Opinions around this stem from different interpretations of the 2012 Health and Social Care Act[11] regarding anticompetitive behaviour.

The risk of being seen as anti-competitive means that providers are often encouraged to engage in competitive processes to expand their existing network. Many stakeholders consider competition and collaboration as complementary to each other and that legislation poses no obstacle as long as clear benefits to patients through collaboration can be evidenced.

Providers are interested in receiving more legal support from regulators when extending their network, especially when this involves bodies such as the Competition and Markets Authority.

The law is about ensuring there is no anti-competitive behaviour.

The legislation promotes competition and collaboration. The two are intended to work together but clarity on how this works in practice is needed.

Workforce

Workforce issues can be one of the most challenging aspects of scaling up networked care. Both the specialty and host providers are legally bound by the requirements of the Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE), which protects the employment rights of transferring staff. As a result, the network provider taking on a service may have to invest in providing additional training and development opportunities to ensure all staff are able to operate the network's standardised clinical and operational protocols.

Agreements and contracts

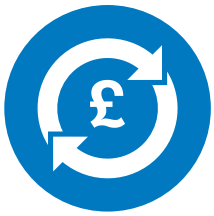
Accountability was raised as a concern by regulators. There was consensus around the importance of having clearly agreed and signed SLAs to cover risk and accountability between specialist and host providers. This was particularly important as most networks were reliant on host organisations for resources such as estates, support services and staff. Some network providers were clear that their SLAs needed to be strengthened to account for risk and that services had often started before agreements were signed.

> The problem with the idea of pooling risk is that it may become unclear whose job it is to address any risks. You've just got to get a service level agreement or contract in place.

Lessons can be learnt from the commercial sector where services are rarely delivered until contracts are signed. It was also noted that even when there were signed agreements in place, not everyone understood them. This emphasised the need for those responsible for delivering services on the ground to be involved in service discussions; a failure to do so could negatively affect relationships and cause delays.

Considerations
✓ Legislation should not be a barrier to network expansion.
✓ The implications of TUPE regulations when transferring staff can affect how a network's workforce expands.
✓ Competition law should not prevent network expansion where collaborative working between providers has a clear benefit to patients.
✓ SLAs and contracts between providers can mitigate risks associated with network expansion.

6. How can scaled up networks remain financially sustainable?



It is important to consider what financial conditions are needed internally to maintain and support the expansion of networked care.

Critical mass is seen to play a key role in network expansion both as a trigger for single specialty networked care (where critical mass cannot sustain tertiary care locally) and as a way of increasing market share and helping network sustainability. This implies that critical mass is an important enabler both for network expansion and sustainability. It will also help determine the point at which a network becomes unsustainable.

In our research, there was consensus that any network expansion should improve the financial sustainability of any networked care provider. The marginal costs of expanding a network will vary depending on the specialty: capital equipment costs, for example, can be a key factor. Regardless, it is important that a single specialty provider can remain financially viable following an expansion of its network.

The research provided no evidence as to the ideal size of a network. It was clear that some networks initially grew to address unmet demand without a clear network expansion strategy. It has already been stated that network providers are expected to find the resources to enable networked care expansion. Regular network reviews will be needed to assess the point at which an expanding single specialty network becomes financially unviable. A balanced scorecard which measures important indicators, such as workforce availability, financial contribution and patient experience, could be used to highlight where the network is sustainable and where there is need for consolidation. This will also indicate if the network as a whole is healthy enough to support further scaling up.

> We have several sites that on a financial basis alone we should close,but because of patient choice and accessibility we've continued to run them.

Regulators and providers alike stressed the importance of financial sustainability and its effect on quality and brand. Understanding the market, income flows and relationships with commissioners were also felt to be critical to expansion. There was a clear need to evidence the financial value of networks, for which reliable data was needed. Difficulty in obtaining specific site-level data was a consistent challenge among network providers.

This reflects a wider issue around data collection in the NHS. Evidence would strengthen the argument for networked care as an option for the sustainability of services.

The financial risk associated with expanding networked care will vary depending on the model used. The research included talking to network providers using a range of different models and analysing the perceived financial impact (see annex A). All networks explored have mainly directly contracted services:

- Network model 1 appears to carry the most risk when expanding as it is resource intensive, employing the staff, buying the equipment and paying to use the space. Any new site should be profitable or at least cost neutral given the potential impact on the financial performance of the entire network. Understanding the cost implications of each site within the network is essential as new sites requiring significant capital investment may not make a return in the short to medium term. Having a clear network strategy aligned to corporate objectives is critical.
- Single specialties in wider organisations delivering care, such as in model 4, appear to have limited financial risk. Although they may be able to retain the income (to be further invested as needed), it is unlikely this model would have a major impact on overall trust finances. Expansion of this network model would depend on both commissioners and the trust executive team having a good understanding of the service and how expansion of the network fits with the wider trust strategy. This could be a challenge. Competing demands for the attention of the executive team could mean smaller services are overlooked, limiting potential opportunities for expansion.
- The level of risk in models 2 and 3 varied and seems to depend on clear and agreed SLAs. From the perspective of the host provider, the full financial implications of moving the service into the network should be considered and understood. Through carefully agreed SLAs and understanding of the impact, both organisations should be able to share benefits, including financial ones.

If something happens that detrimentally impacts on the quality of care, the likelihood is there is going to be a financial consequence.

Finally, it is worth considering the function and purpose that networked sites provide, as this can affect the scale which can be achieved. Some providers have made the most of commercial opportunities internationally. The additional effort and resources needed to set up and maintain a site so far away, although difficult, are seen as worthwhile if it provides income into the NHS.[12]

Considerations
✓ Increasing critical mass may be crucial to network sustainability.
✓ Evidence to determine the ideal size of a network is needed; this can be obtained through regular network reviews that monitor key performance indicators.
✓ Reliable and accurate data is crucial in evidencing the financial value of networks and their sustainability.
✓ Commercial opportunities can provide increased revenue to help sustain NHS services.
✓ The level of financial risk varies depending on the network model, some of which can be mitigated through the use of clear SLAs.

7. What factors can ensure good quality outcomes across an expanding network?

Delivering good quality care to more patients is one of the main drivers for networked care expansion. It is important to consider the quality benefits that scaling up networked care can offer.

Clinical governance and standardisation

Our research found that delivering consistently good clinical outcomes and patient experience were most important to providers. However most respondents noted the difficulty in overseeing staff compliance to maintain consistently good quality across multiple sites.

Geographic expansion could increase the risk to clinical outcomes if staff do not follow agreed practice, policies and processes, but evidence suggests that rolling out a standardised clinical governance framework across the network will reduce this risk.

The benefits of standardisation across a network are well documented in the Networked Care Toolkit published in April 2017. It follows that expanding a network will enable a wider spread of standardised care. Rolling out standardised processes will accelerate mobilisation, reduce duplication and help provide governance assurance.

> It also helps us to be able to say to the DGHs, if your clinicians use our clinical pathways in A&E then that will help you see those patients more quickly and reduce pressure on four-hour waits.

Standardisation was highlighted as critical to expanding a service by commercial companies as it allows for service improvements, efficiencies (through good governance and safety) and control of the supply chain.

There are lessons the NHS can learn from the commercial sector, such as the use of standard operational procedures (SOPs), which do not change and are replicated across all sites. The need for standardised services was recognised by NHS providers, although there was acknowledgement that they were not yet applied with the same level of rigour.

Network providers considered that effective local leadership was essential to ensuring good quality care. Some providers gained assurance by having regular senior clinical staff at sites, working to standardised governance processes which were replicated across the network. Others relied on consultant feedback and patient surveys.

Case study: Standardisation

Compass Group UK & Ireland is part of Compass Group PLC, a world-leading food and support services company. In the UK & Ireland it employs about 60,000 people across thousands of sites from hospitals, schools and oil rigs to corporate headquarters and major sporting venues.

In the UK, Compass Healthcare provides food, support and retail services in five areas of healthcare (illustrated below), within NHS hospitals, retail healthcare (under partnership), care and residential homes and the private healthcare market.

Figure 1: Compass Healthcare brands

The Compass Healthcare team stressed the importance of due diligence when bidding for contracts, in particular ensuring budgets were sufficient to meet service specifications, whether benefits of standardisation could be leveraged, and having a clear understanding before committing.

Where there was deviation from standard processes, these needed to be analysed and understood. Any variations should then be agreed at the beginning of a contract. Contract variations should not replace SOPs, rather they should be seen as an enhancement. Geographical expansion was not seen as a limiting factor to standardisation; on the contrary, scaling up was seen as crucial to making the most of the benefits from standardisation.

Key features of standardisation:

- Flat governance structure: Accountability sits with a few contract managers who report to regional directors. This is overseen centrally by one managing director.
- Development of SOPs refined and tested over many years: These are centrally developed, ratified and maintained and enable processes to be replicated across multiple sites. Services are also process dependent, avoiding quality dependence on any one person.
- Ensuring employees are trained to the same standard: whether recruiting new employees or when merging with other companies.

Leadership

Strong leadership is considered key to the success of networked care expansion. Networked care providers take different approaches to leadership when extending a network. Some place great importance on having regular visits by the executive directors to all sites. The main reason cited was to understand and help with the challenges around embedding organisational culture and ensuring all staff working at networked sites felt part of the specialist provider organisation. The ability to travel easily between sites was seen as crucial by these executives, reducing the likelihood of expanding to areas that do not meet this criterion.

> When you're setting up a site, you may need to reinforce your on-site leadership intensively for a short period of time.

> I'd be able to review a site in Newcastle as well as in Barking. What I wouldn't be able to do is go up and spend time there. The local manager would be speaking to us via Skype, but it wouldn't provide the same oversight.

Challenges faced by providers in having oversight of the network were mitigated to some extent through the use of technology such as Skype, e-mail and other tools to review network site performance remotely.

Other network providers do not see distance travelled as a limiting factor for growth. While executive visibility in the organisation is still considered important, it focuses on where most of the staff is based. This allows the spread of the network to be more geographical.

Some network providers found that having a senior leadership team running the day-today operations provided the necessary assurance, reducing the need for executive director presence across the network. This approach was more likely in bigger organisations such as large teaching hospitals. The benefit of this approach was that senior leaders could manage the day-to-day business more autonomously. There were concerns, however, that the network could lack executive visibility resulting in limited understanding at board level of the specific challenges facing individual network sites.

A finding from the commercial sector was that scaling up was possible where standardised processes were applied. These could easily be tailored to individual clients where necessary. When comparing the challenges faced by commercial and NHS organisations, it is apparent that the need to have continuous executive and senior level leadership across the network could be minimised by improving and implementing better standardisation of services.

> One of the most important things is that you have to get out and walk your sites and that's difficult.

> I don't think we have much visibility outside the hub, to be honest. We talk often about executive visibility here at the trust, and actually as an executive team we're really visible…in terms of our presence at sites I don't think it makes any difference necessarily.

Workforce

Employing and training the right people was critical to ensuring good quality outcomes and to expansion generally. Networked care providers needed to understand existing workforce issues before extending the network, particularly where these issues could be a contributing factor to an underperforming service.

If recruitment issues are a factor in network expansion, consideration will have to be given as to whether the specialist provider can address these. Increasingly services can be delivered by advanced practitioner nurses and allied health professionals. Developing standardised roles and processes and rolling them out across a network could make better use of current skills and help to address some of the workforce sustainability issues.

Research and innovation

Networked providers found that expanding a network could provide more opportunities for research. Providers and commissioners agreed that patients participating in clinical trials could have improved clinical outcomes and this is supported by other research.[13 14] Staff training and development through being involved in research could improve career development.

Some providers were exploring ways to incorporate technological advances to deliver services, the extent of which may depend on the specialty. It was recognised that there were also opportunities to improve quality outcomes through technology such as, remote review of radiology and ophthalmology images that enable clinicians to work virtually across the whole network.

> Telemedicine substitutes for us being there all the time. It could be a more efficient way of being able to deliver services closer [to patients' homes].

Considerations	
✓	Standardised governance, processes and roles are critical to providing consistent care across a growing network and in providing assurance to senior leadership.
✓	NHS providers could apply processes similar to those used in the commercial sector to ensure standardisation, such as the use of SOPs.
✓	On-site leadership is essential in ensuring good quality care across a network. Executive presence is one of several ways of achieving this.
✓	Clinical research is more likely to happen across a larger network, which can improve patient outcomes and staff career development.
✓	Technological advances may provide opportunities for improved quality and geographic expansion.

8. Do workforce challenges act as a barrier or a catalyst for network expansion?

Network care growth can provide solutions to staffing issues but care must be taken than solving one set of problems doesn't create others.

NHS[15] employers face increasing recruitment and retention challenges but there are differing views on the impact of workforce when expanding a network.

Nursing workforce in particular has seen a sharp decline in registrations. This has already resulted in more agency staff being used by providers, which can have unintended financial and quality consequences.[16 17]

Pressures resulting from workforce shortages and the potential impact of leaving the European Union (EU)[18] were raised as both a risk and an opportunity in expanding networked care. There was speculation that the impact could be challenging for expansion if EU nationals working in clinical roles repatriate. In contrast, these challenges could also drive providers to network more, in order to make the most of the available workforce. This may include staff working across multiple providers in hard-to-recruit roles.

Although providers indicated a preference for recruiting and training their own staff, in practice the likelihood is that staff will transfer under TUPE when a network model expands. Delivery of standardised care can be more difficult when there is variation in staff skill and competency and could create a barrier for extending networked care. However a specialty provider could provide additional training so that all staff are able to operate the network's standardised clinical and operational protocols, enabling the growth of a network geographically or numerically. Specialty networked care can also benefit staff with restricted development opportunities in their current organisation. This needs to be highlighted as a benefit for expanding networked care.

A particular challenge when expanding geographically is recruiting specialists in different areas of the country. This was considered an issue by both providers and regulators, particularly where travel times and remoteness were factors. Some felt this was a significant obstacle to overcome when expanding networks geographically. Other providers and commercial organisations facing the same challenge considered this less problematic. Training other provider staff to follow standardised pathways has worked for some network providers and can help with network expansion.

The effect of network expansion on local workforce markets should be carefully considered if it has the potential to destabilise a system by concentrating staff in one provider.

Network growth may incentivise innovative solutions to address the workforce challenges. For instance some staff could be

We don't employ the staff but our lead nurse is involved in any recruitment at the site and we support staff training.

We have both trusts employing staff but everyone is trained the same way.

given tasks which might alleviate pressure points for other staff groups (see case study on DART programme below). Medical and nursing vacancies were highlighted as a key challenge, so enabling new roles was considered a way in which networked care might address workforce sustainability.

Case study:
Managing capacity challenges

Domestic Abuse, Recovering Together (DART), is a programme rolled out by the National Society for the Prevention of Cruelty to Children (NSPCC) to different organisations where children and their mothers can talk to each other about domestic abuse, learn to communicate and rebuild their relationship.

The issue

DART requires four members to run each session. One local authority said: "It's taken four members of staff out of doing their 1-to-1 work for a whole day every week for 10 weeks. So there was a big financial commitment, not only for resources and co-ordinating how people were going to get there, but worker time as well."

What NSPCC learnt

We needed to think of ways to address staffing capacity without compromising the way DART works.

What NSPCC is doing

We are developing new ways for DART to be delivered that stay true to the model. One option is running the programme with two volunteers and two trained practitioners. The staff would be the leaders and the volunteers would be supporting co-facilitators. This option would need careful cost-benefit analysis but it could work well for the organisations with established volunteer support. The use of volunteers could have an added benefit for the local community, helping members of the public learn how to identify and address the signs of domestic abuse and signpost routes to support. We're also developing a 'train the trainer' model so organisations can train their own staff, reducing their reliance on us and making the service sustainable.

Considerations
✓ Workforce challenges can be an opportunity for networked care growth as they drive the need to use staff more efficiently.
✓ Extending staff roles and providing training to transferred staff might facilitate network expansion in offering potential solutions to recruitment challenges.
✓ Expansion into new areas could offer recruitment opportunities for a networked care provider, but they would need to recognise that workforce attrition may destabilise a health system.

9. Are brand and reputation critical to extending networked care?

A strong brand could facilitate expansion and should be considered in the context of the network model chosen.

A brand is a name or other feature that distinguishes an organisation or product from its rivals in the eyes of the customer. Reputation is how the organisation or product more generally is viewed by others. Each can have an impact on successfully expanding a networked care model.

From the research it is clear that brand and reputation have different functions in expanding networked care.

Reputation is considered critical to successfully growing a network; being recognised for delivering good quality outcomes will help with numerical growth in an STP but having a national or international reputation was considered to be a more effective enabler across a wider geography. Patients may be less resistant to change if the new provider is well known for excellence. This could mean that without a strong reputation there may be limited opportunities for geographical network growth. It is well established that it is easier to damage reputation than to build it, so it should be carefully protected when expanding a network.

Reputation may enable network providers to secure support from commissioners and potential host trusts, particularly when expanding across a wider geography.

Once the service is established, having a visible brand may be important to patients and other stakeholders. Research indicated that the extent to which a network provider considered branding important to their service varied depending on the network model (see annex A). Niche single specialties that were the only provider in their region, and in particular outside main cities, see little need to brand and distinguish their service.

The importance of branding a service depends on organisational preference but also has to take into account local circumstances including the host trust. For example, there may be resistance to individual organisation branding, as it may be seen to confuse patients.

The workforce is more likely to recognise the benefits that a provider with a reputation for excellence can bring to the unit and this will help with recruitment and retention.

A strong reputation may help where there were previous recruitment challenges. There may be reputational risk if any current recruitment and service issues are not fully understood or there are unrealistic expectations which are then not delivered. Understanding and measuring existing service performance is critical to ensuring that improvements can be delivered and reputation protected.

> If you are a specialist trust, brand may be far more important because you are selling excellence and an excellent reputation is easy to damage.

There are other factors over which a network provider may have limited or no control which can indirectly impact on the service and therefore reputation. The host trust will control important aspects of the patient experience such as the space, the condition of facilities, cleanliness and accessibility. It is through leases, licences and SLAs that the providers seek to address these but most agreed that SLAs were difficult to agree and manage and that the risk increased when managing multiple sites, especially over a wide area.

A strong brand can be immensely powerful in communicating values, reputation and reliability to patients.

There was consensus that network providers lacked a consistent approach to brand across their services, so this may not be critical to networked care expansion. Much depended on demand and availability – niche services had less reliance on brand, whereas a specialty which was more widespread may rely on reputation to compete and considered brand as essential to reputation.

It is clear that there is a subtle difference between reputation, which is seen as critical to network growth, and branding, which varied in importance. Networked care providers need to carefully consider this so that it fits with their strategy and network model.

Considerations	
✓	A reputation for excellence can help with staff recruitment and attract more NHS and private patients, which can facilitate growth.
✓	The decision to brand a network can depend on local circumstances, such as competition, as well as provider and host preferences and does not limit expansion.
✓	Reputation alone can facilitate expansion, whereas branding without a good reputation could have a detrimental effect. Ideally, networked care providers should have both reputation and branding to expand at scale and at pace.

Annexe A

Characteristic	1	2	3	4
Corporate entity	Single specialty provider trust.	Single specialty provider trust.	Single specialty provider trust.	Acute provider trust with single specialty expertise.
Who employs the network staff?	All staff employed by specialist provider, working across one or more network sites.	Medical staff employed by specialist provider work across sites. Other staff employed by host trust, recharged to specialist provider via SLA.	Some staff employed by specialty provider working across sites. Other staff employed by host trust, recharged to specialist provider via SLA.	All staff employed by the acute provider trust, working across one or more network sites
Who is paid for the network patient activity?	Single specialty provider trust	Single specialty provider trust	Single specialty provider trust	Acute provider trust with single specialty expertise
Network geography	Crosses more than one STP.	Crosses more than one STP.	Single STP.	Single STP.
Who pays for the network equipment and space?	Specialist provider owns the equipment. Space paid to host trust via SLA, lease and/or licence agreement.	Specialist provider owns no equipment or space. Recharged by host trust through SLA agreement.	Mixed arrangements: owns some equipment, leases some equipment, owns some space, leases some space.	Specialist provider owns most of the equipment and space with some lease arrangements.
Are networked sites branded?	Most network sites are branded.	Network sites are not branded.	Some network sites are branded.	Some network sites are branded.
Network sites	More than 25.	More than 20.	Between five and 10.	Between five and 10.

References

1 North West London CCG 'North West London Workforce Transformation Strategic Plan' 2016 – 2021 www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/nwl_stp_workforce_strategic_plan_2016-2021_0.pdf (accessed 5 Feb 2018)

2 East Sussex Better Together 'ESBT Strategic Workforce Group', (2016) https://southeast.unison.org.uk/content/uploads/sites/41/2017/01/East_Sussex_Better_Together_STP__Workforce_Strategy_October_2016.pdf (accessed 5 Feb 2018)

3 Richards, M. (2017) 'The role of regulation in supporting transformational change' NHS England, 26 July https://www.england.nhs.uk/blog/the-role-of-regulation-in-supporting-transformational-change/ (accessed 5 Feb 2018)

4 Mackey, J. Creating the conditions for change – the role of NHS Improvement, NHS Improvement, NHS Providers

5 NHS Providers, Mission Impossible – The Task for NHS Providers in 2017/18 (March 2017)

6 The Health Foundation Lafond, S. Charlesworth, A. Roberts, A (2016).
A perfect storm: an impossible climate for NHS providers' finances? March, 2016

7 The Health Foundation, 2011, Evidence Scan: Competition in Healthcare (April)

8 NHS England, Care Quality Commission, Health Education England, Monitor, Public Health England, Trust Development Authority (2014). NHS five year forward view. London: NHS England www.england.nhs.uk/ourwork/futurenhs (accessed 20 February 2018)

9 Department of Health and Social Care (2014) 'Examining new options and opportunities for providers of NHS care: Dalton Review', 2014 (December) www.gov.uk/government/uploads/system/uploads/attachment_data/file/384126/Dalton_Review.pdf (accessed 20 Feb 2018)

10 Lord Carter of Coles. 'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations'. An independent report for the Department of Health. www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf (accessed 20 Feb 2018)

11 Health and Social Care Act 2012, c.2. www.legislation.gov.uk/ukpga/2012/7/contents/enacted (accessed 03 Feb 2018)

12 Plimmer, G. (2016) 'NHS expands private care to help fill £20bn funding gap', Financial Times, 2 March

13 National Institute for Health Research (2016), Patients more likely to survive in research active hospitals, 20 October https://www.nihr.ac.uk/news/patients-more-likely-to-survive-in-research-active-hospitals/4712 (accessed 5 Feb 2018)

14 National Institute for Health Research, (2018) Research to be recognised by regulators for its role in improving patient care, 11 January https://www.nihr.ac.uk/news/research-to-be-recognised-by-regulators-for-its-role-in-improving-patient-care/7737 (accessed 5 Feb 2018)

15 NHS Providers blog 'NHS trusts are struggling to recruit and retain staff they need',19 December www.nhsproviders.org/news-blogs/news/nhs-trusts-are-struggling-to-recruit-and-retain-the-staff-they-need (accessed 2 Feb 2018)

16 NHS Improvement (2016) Evidence from NHS Improvement on clinical staff shortages: a workforce analysis (Feb 2016) www.gov.uk/government/uploads/system/uploads/attachment_data/file/500288/Clinical_workforce_report.pdf (accessed 20 Feb 2018)

17 Harrold, A. (2017) 'The Brexit effect', Nursing in Practice, 24 July 2017
www.nursinginpractice.com/article/brexiteffect (accessed 13 Feb 2018)

18 NHS providers blog 'Cavendish coalition publish Brexit impact feedback from NHS employers', 09 Feb 2018 www.nhsproviders.org/news-blogs/news/cavendish-coalition-publish-brexit-impact-feedback-from-nhsemployers? utm_medium=email&utm_campaign (accessed 20 Feb 2018)