NATIONAL CLINICAL FRAMEWORK IMPLEMENTATION PROGRAMME

Developing Clinical Networks to support the implementation of the National Clinical Framework

Authors

Rhys Blake, Head of Planning, NHS Wales Health Collaborative
Allan Wardhaugh, Clinical Programme Director, National Clinical Framework
Mark Dickinson, Director, NHS Wales Health Collaborative
Emma Cahill, Karen Birdsall & Seren Richards, Planning Team, NHS Wales Health Collaborative

Contents

1 FOREWORD 3

2 EXECUTIVE SUMMARY 5
2.1 Product summaries 5
2.2 What will be different? 7

3 PRODUCT ONE AND PRODUCT TWO – CATEGORIES AND CHARACTERISTICS OF CLINICAL NETWORKS 9
3.1 What is a Clinical Network? 9
3.2 Product One: Categories of Networks 10
3.3 Links between Categories of Network 12
3.4 Managing Interfaces 13

4 PRODUCT TWO: CHARACTERISTICS OF THE CATEGORIES OF NETWORKS 14
4.1 National Strategic Networks 16
4.2 Implementation Networks 18
4.3 Operational Delivery Networks 22
4.4 Communities of Practice 25

5 PRODUCT 3: PROPOSED NATIONAL STRATEGIC CLINICAL NETWORKS 25
5.1 Proposed List of National Strategic Networks 26
5.2 Drivers and considerations for determining the list of networks 26
5.3 Managing Interfaces 31
5.4 Recommendation 35

6 PRODUCT 4: PROPOSED CORE INFRASTRUCTURE 35
6.1 Establishing a Leadership Group and Model of Clinical Leadership 36
6.2 Supporting/Enabling Functions 37
6.3 Clinical Reference Groups 38
6.4 Role of the patient voice – Citizens' voice 38
6.5 Recommendation 40

7 PRODUCT 5: IMPLEMENTATION AND TRANSITION ARRANGEMENTS 40
7.1 Establishing an Implementation Team 40
7.2 Working Assumptions 41
7.3 Approach 41

8 RECOMMENDATION AND NEXT STEPS 42

9 ENGAGEMENT AND FEEDBACK 42

1 Foreword

As chair of the National Clinical Framework Programme, I am pleased to present this report on the implementation of National Strategic Clinical Networks in Wales. This is the culmination of years of engagement with stakeholders, before and during a time of significant disruption and pressures caused by the Covid pandemic and its ongoing consequences.

The National Strategic Clinical Networks will provide cross system clinical leadership from within the newly formed NHS Executive for Wales and will drive a culture of a learning health and care system. The word 'clinical' appears throughout and reflects an important message: it is multi-professional and multi-disciplinary.

We have had networks and related arrangements before, but their purpose and function was not always sufficiently clear, and approaches were inconsistent across major conditions and service areas. This new approach provides a clear direction of travel and will build on best practice. It creates clarity between the need for strategic, system level thinking and more operational and implementation focused activities via a strengthened and standardised approach to defining specific types of networks to provide specific functions.

Implementation will require a change in mind set, away from special-interest lobbying, and into a sense of shared stewardship of the service. Clinical leaders should act not just in the service's best interests but in the best interests of patients and the wider public. Health boards and trusts will be expected to implement recommended pathways described by clinical networks; whilst they retain autonomy to act for their defined geographical population, they also have a shared duty to ensure agreed national approaches are taken forward.

I would like to extend thanks to all who have worked on this programme, including the Steering Group who have provided important scrutiny and challenge to ensure we are establishing robust and sustainable arrangements.

National Clinical Framework Steering Group membership

Frank Atherton (Chair)	Chief Medical Officer for Wales, Welsh Government
Samia Edmonds	NHS Wales Planning Programme Director, Welsh Government
Rebecca Luffman	NHS Planning Health and Social Services, Welsh Government
Nick Wood	Deputy Chief Executive NHS Wales, Welsh Government
Sue Tranka	Chief Nursing Officer for Wales, Welsh Government
Chris Jones	Deputy Chief Medical Officer for Wales, Welsh Government
Mark Dickinson	Director, NHS Wales Health Collaborative, NHS Wales
Allan Wardhaugh	Interim National Clinical Director,WelshGovernment/NHSWales
Nicola Williams	Executive Nurse Director, Velindre NHS Trust
Iain Bell	Director for Public Health Knowledge and Research, PHW
Claire Madsen	Executive Director of Therapies and Health Sciences, PTHB
Jacinta Abraham	Executive Medical Director, Velindre NHS Trust
Linda Prosser	Executive Director of Strategy and Transformation, CTMUHB

Hayley Thomas	Director of Planning and Performance, PTHB
Abigail Harris	Executive Director of Planning, CVUHB
Heather Giles	Policy Officer, NHS Wales

Dr Sir Frank Atherton, Chief Medical Officer for Wales, Welsh Government.

2 Executive Summary

2.1 Product summaries

This document covers the five 'products' that required delivery to enable the establishment of refreshed networks, with strengthened governance and mandates to support the improvement of services and health outcomes as described in *A Healthier Wales*: they are:

Products 1 and 2: The broad categories and functions of networks (and related structures), each supported by a set of national criteria, which will be required in NHS Wales to meet the challenges of implementing the National Clinical Framework and of supporting system recovery. This comprises:

- **National Strategic Clinical Networks** and **National Implementation Networks:** to form part of the supporting functions of the Executive. To lead, coordinate and oversee directly, the implementation of pathways and other service features as determined by a range of drivers.

- **Operational Delivery Networks** (ODNs): led and managed from within provider organisations. To take a whole-system collaborative provision approach to ensuring the delivery of safe and effective services, across the patient pathway, adding value for all its stakeholders.

- **Communities of Practice** and/or other less formal structures: horizon scanning and advising on future developments and innovations, acting in an advisory capacity to the overarching National Strategic Clinical Network in the development and sharing of pathways, standards, and general guidance on good practice.

Product 3: An evidenced guided approach has been taken to determine what networks are needed to drive the priorities aligned to A Healthier Wales and the National Clinical Framework. A core challenge in dealing with the burden of disease is to ensure evidenced based interventions or best practice is being applied consistently across Wales. There is explicit intent in *A Healthier Wales* to develop a more 'upstream' approach to the way we plan and deliver services and many of these networks cover disease conditions which can be either entirely prevented, or better managed if detected early.

A further consideration informing the list of networks is the service burden where demand or workforce challenges may be creating fragility. In some cases, there will be political imperatives, or other new service or public health issues arising that drive demand to establish new networks outside of the proposed list described in this paper.

A proposed set of future condition/service specific national strategic clinical networks, with the scope of each defined, informed by factors including burden of disease (in population and service terms) and service fragility.

It is intended to establish 13 **National Strategic Clinical Networks** in the first instance. These are:

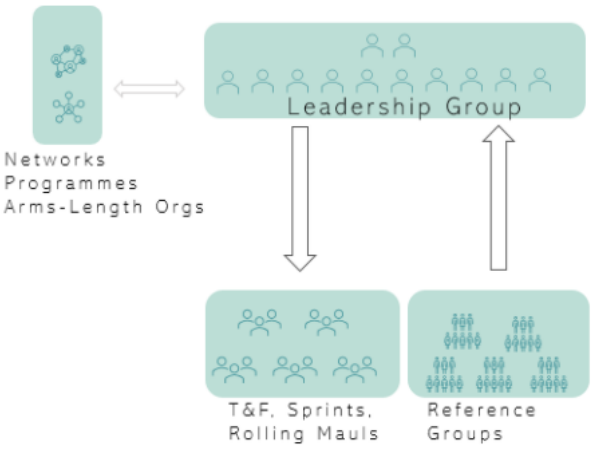
- Cancer
- Cardiovascular conditions
- Musculoskeletal and Orthopaedics
- Neurological Conditions
- Diabetes
- Respiratory Conditions
- Mental Health
- Neonatal/Maternity
- Infectious Disease
- Gastroenterology
- Women's Health
- Critical Care, Trauma and Emergency Medicine
- Child Health

The existing Planned Care Specialty Boards will transition into **Implementation Networks** for the following:

- Dermatology
- ENT Surgery
- General Surgery
- Gynaecology
- Ophthalmology
- Orthopaedics
- Urology

There will be additional Implementation and Communities of Practice established to address ongoing work of existing legacy structures (predominantly implementation groups). The document does not aim to describe the Communities of Practice that might be supported during the first year, but there are already some areas under consideration of this status, e.g. The Welsh Gender Service.

Product 4: A specification of the minimum core clinical, managerial, and administrative infrastructure required to establish, support, sustain and develop a National Strategic Clinical Network. The key leadership component of each network will be the Network Manager and the Clinical Lead. These individuals will work side by side to build, lead the network structures and engagement processes, and will be expected to ensure a broad base of knowledge from across primary and secondary care, across the full range of health and care professionals. They will also be expected to ensure the perspective of patients informs their work and to engage with the range of capabilities that third sector organisations can bring to service design.



Broad based.

Clinical means: doctors, nurses, AHPs, operational managers, local authority, third sector and involve cross-boundary (primary care, secondary care, Public Health, WAST). They also involve the people who will use the services.

Networks are constituted around broad categories, so need a broad base.

A broad base will encourage an 'upstream' focus.

These are networks, not lobbying organisations – Prudent Healthcare principles apply

Broadly constituted networks will start to inform thinking and conversations to developed 'pooled budgets' to foster a truly cross-sector integrated approach.

This approach needs organisational support and investment in 'clinical time'.

Product 5: Actions required to move from the current portfolio of clinical networks and implementation groups to the recommended new configuration of strategic national clinical networks within the supporting functions of the Executive.

The implementation will follow the Public Health Wales Organisational Change Policy in order to ensure that best practice is followed but (and perhaps more importantly), this process will be supplemented by an open and transparent approach that ensures negative impacts are minimised as far as possible, and that opportunities, when they emerge are made accessible in a fair and equitable way.

2.2 What will be different?

- There is a clear **description of purpose** for each type of network. There is a separation into the strategic and the implementation or operational. The strategic is a space for discussing direction, and considering the questions '*are we doing things right?*', but also '*are we doing the right things?*' Having reached a conclusion on those questions, it is through implementation networks, and in some cases operational delivery networks that the planning and delivery organisations are assisted in ensuring 'the right things' are put into effect.

- The relationship between the **different types** of networks is related to their **different functions**, not a hierarchy of importance.

- It is not possible to do everything at once, and nor is it possible to create networks for everything. The approach here uses the **burden of disease** as a main driver for deciding which services will benefit most from the establishment of networks.

- There is also a recognition that the **system needs to focus more on 'upstream'**. We expect all networks to do so, but the creation of specific strategic networks for Maternity and Neonatal Care, and for Child Health is a deliberate push to improve services to

improve health and care 'upstream' in the life course.

- It is important that there is an ability for Government, as elected representatives of the population, can also require areas it identifies as of concern to be addressed by a networked approach. The list of suggested networks recognises this, and the NHS Executive will continue to provide a mechanism to **bring into existence new networks** appropriate to address concerns highlighted in this way.

- The people who come together to form networks will be expected to be from a broad background: from **all professions, all sectors of care, and including patient representative bodies, third sector organisations and social care.**

- **Primary Care** is a particularly important area to draw on to contribute to networks, in engagement through reference groups, but also in the leadership of networks.

- The financial resource available to networks is to allow them to exist and discharge their function. This means **buying clinicians' time**, rather than buying technical or service 'solutions'. The latter is the province of health boards and trusts, but the networks will have a key role in advising and describing what some of those solutions might be.

- Networks will, however, be encouraged to bid for time-limited finance enabling the **innovative proof-of-concept work** that some of the previous networks have undertaken. It will be clear, however, that this is for 'proof' of concept: networks will be expected to provide **good quality evaluation** of any such initiatives to inform further spread and scale work should they be successful.

- To date, networks have had 'Executive Leads'. These roles were important as a governance mechanism around how resource was spent. It was also a recognition that support at this level was required in the absence of a clear place in governance structures of the NHS: it made it less likely that the work of networks might be ignored or of considered of lesser importance than local initiatives. The NHS Executive now provides that function, so Executives will be able to concentrate more fully on how National recommendations are implemented in their organisations. They will be important stakeholders collectively, but the need for executive leads has been superseded by the creation of the **NHS Executive**.

- Clinical Networks are a **core part of the NHS Executive**. Their position here gives their outputs much **greater influence and weight** in directing the service. That brings a **greater responsibility** to those leading the networks to ensure their recommendations are considered, including impacts on other service areas.

- Within the NHS Executive, the Clinical Networks will be expected to play a much greater role in **holding the system to account**. This responsibility requires that the **leaders of**

networks approach their role agnostic of their health board of origin: they will be expected to have an impartial view in accountability conversations.

3 Product One and Product Two – Categories and Characteristics of Clinical Networks

This section sets out the specification for Product One, and Product Two.

Product One: The broad categories of networks (and related structures) that will be required in NHS Wales to meet the challenges of implementing the National Clinical Framework and of supporting system recovery

Product Two: The proposed generic purpose, functions, roles, responsibilities, and powers of each of the categories of network defined in Product One

Products one and two are intended to support engagement with key stakeholder groups as identified in the WID, prior to being finalised and submitted for approval to the Programme Board.

It is implicit that the fundamental role of networks is to improve quality and safety. They will need to work in alignment not only with existing national programmes but ensuring primary care linkages and inclusion in all that they do. Shifting models of care away from hospital led services will take time but establishing networks in a consistent way, managing their interactions and aligning their agendas with public health approaches and embedding working with primary care will be done for all as part of the overall approach to supporting their way of working.

3.1 What is a Clinical Network?

Many types of 'clinical network' exist, have existed or have been proposed in NHS Wales, the NHS in other parts of the UK and internationally. Such networks can have multiple purposes and forms. As such, the term 'clinical network' means different things to different people, at different times and in different contexts.

Clinical networks can have a variety of forms and functions, ranging from informal ad hoc meetings of a particular specialty through to managed clinical networks that commission or directly manage the delivery of services. It is important to provide clarity of what we mean by clinical networks, going forward, in NHS Wales.

This paper seeks to specifically define several types of clinical network that should be developed, or evolved, and implemented in NHS Wales to drive and support the implementation of the National Clinical Framework, nationally, regionally, and locally.

All the categories share some common characteristics:

- **they are clinically led**
- **they bring participants together from across organisational boundaries to address issues of common concern**

- **they are focused on improving the quality, safety, and outcomes of patient care at a national, regional and/or local level**

The term 'clinical' is descriptive of the problems and challenges that network are brought together to address. Many of the people comprising each proposed type of network will be 'clinical' in the sense of being nurses, doctors, or other clinical professionals, but many will be from different professions or roles, such as managerial, informatics and digital, data science, together with involvement from outside the NHS, including social care, the third sector and patient groups.

3.2 Product One: Categories of Networks

This section proposes the specific categories of networks (and related structures) that will be required in NHS Wales to meet the challenges of implementing the National Clinical Framework and of supporting system recovery.

Four, interlinked, categories of networks are proposed:

3.2.1 National Strategic Clinical Networks

A portfolio of National Strategic Clinical Networks will be established or, in some cases, evolved from existing networks. These networks will have scopes defied in relation to one of the following:

- Major conditions (e.g., cancer)
- Categories of service (e.g., maternity, and neonatal care)
- Target population segments (e.g., women's health)

The raison d'etre for National Strategic Clinical Networks, in the context of the National Clinical Framework, will be to:

- provide a clinically led and informed, evidence based national perspective for their respective areas of scope
- bring clinicians, and other stakeholders, together to develop nationally consistent principles and pathways of care, agnostic of local organisation, in support of Quality Statements

- support metrics for monitoring, reporting and escalating issues where necessary.

The infrastructure and investment required to establish and maintain National Strategic Networks is such that only a limited number should be established, with the need for existing and further such networks kept under review. Networks Workstream Product Three will propose the initial specific suite of National Strategic Networks recommended for initial development and implementation. The specific National Strategic Clinical Network 'topics' to be proposed will be 'pragmatically evidence based', informed by:

- burden of disease (in population and healthcare terms)
- service complexity and/or fragility
- political/policy prioritisation.

3.2.2 Implementation Networks

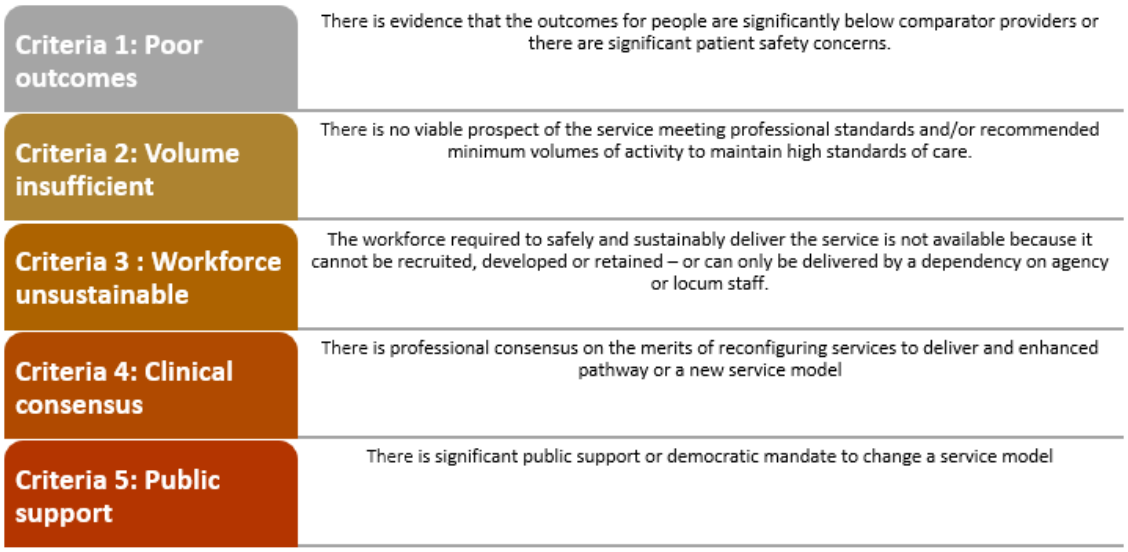
Implementation Networks will be time limited and established under the auspices of a Strategic Clinical Network. They will be established in specific circumstances to provide clinical and managerial leadership and support to the implementation of specific new pathways and/or models of care, developed or advocated by the 'sponsoring' Strategic Clinical Network, across organisational boundaries (nationally or regionally). Implementation Networks will work closely with the health boards and trusts responsible for service delivery. In some cases, the work of an Implementation Network will result in the establishment of a one or more new Operational Delivery Networks (see section 3.3).

Implementation Networks will learn from and build upon previous relevant experience in NHS Wales, including the work undertaken to develop and implement the South Wales Major Trauma Network and the work ongoing to implement significant changes to the delivery of acute stroke care.

3.2.3 Operational Delivery Networks

Operational Delivery Networks (ODN) will be responsible for the operational management of specific services across organisational boundaries, typically on a regional basis. Many clinical services can be appropriately organised, managed and delivered at an individual health board level. Some services, however, have characteristics that make a regional, or even national, approach to service delivery more appropriate.

ODNs require an overseeing and supporting infrastructure, that normally requires investment. The establishment of new ODNs will, therefore, require robust cases to be made (primarily by relevant Strategic Clinical Networks), informed by the specific criteria that were published in the National Clinical Framework and are set out below:



Current examples of ODNs in Wales include the Major Trauma Networks, with relevant work ongoing in relation to spinal, stroke and vascular services.

3.2.4 Communities of Practice

Not all major conditions, categories of service type or target population segments will reach the threshold(s) at which it is deemed appropriate to establish a full National Strategic Network and will also not meet the criteria for the establishment of ODNs. In addition, there will be areas of clinical activity, within the scope of wider National Strategic Networks, which merit a specific focus of clinical discussion aimed at driving improvements in quality, safety, and outcomes. In such cases, the establishment of Communities of Practice may be appropriate. These will be 'light touch' with minimal supporting infrastructure.

3.3 Links between Categories of Network

The National Strategic Networks will provide the national focus for a spectrum of network activity in support of the National Clinical Framework. Within their broad areas of clinical scope, they will:

- **instigate the establishment of Implementation Networks to take forward the implementation of new pathways and service models**
- **recommend the establishment of, and provide the national steer and guidance for, Operational Delivery Networks**
- **oversee the configuration of, and support to, specific Communities of Practice.**

Ideally, and in most cases, Implementation Networks, Operational Delivery Networks and Communities of Practice will have a direct link and 'line of sight' to a relevant overarching National Strategic Network. It is, however, recognised that, because of the limited number of National Strategic Networks, other may have to be some other networks that do not have such a link (at least initially)

3.4 Managing Interfaces

A key design principle running through the establishment of a refreshed set of networks is to ensure there is a clear strategy guiding their work.

It follows that we avoid creating implementation networks, operational delivery networks or communities of practice which are 'orphaned.' A link to an umbrella structure must be in place to ensure activities are aligned to the national priorities and to ensure that we are not duplicating efforts or establishing programmes of works that could have unintended consequences, waste resources, or introduce unwarranted variation.

There may be instances where there is no natural strategic umbrella. In those cases, there will still be a need for a strategic steering body to guide the implementation network, operational delivery network or community of practice.

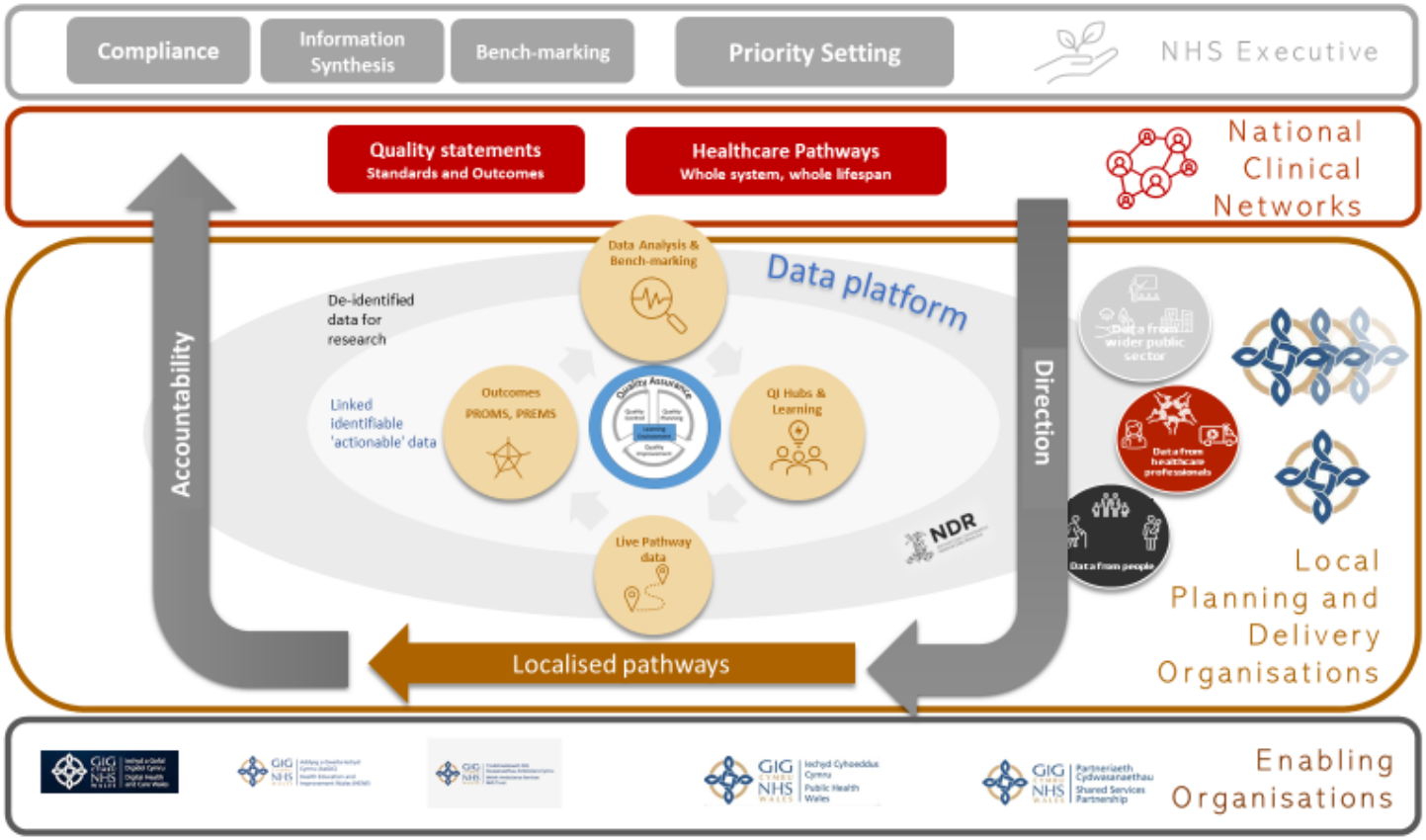
We have tried to achieve a consistency, and a taxonomy that is clear and makes sense. This desire for clarity must be balanced against the reality that healthcare services are heterogeneous, and there is no 'one size fits all' arrangement. Any attempt to produce this will be an approximation and a compromise. Rather than asking if we have achieved perfection, we have asked 'is this better than the status quo. 'Managing interfaces and interdependencies is also equally important to be able to separate strategic activities from operational delivery activities and ensure there is appropriate capacity established to execute with a clear and consistent approach to the delegation of activities across the networks (including working with National Programmes). This approach will prevent strategic networks getting embroiled in operational issues and will ensure that operationally focussed delivery groups are not creating national strategies.

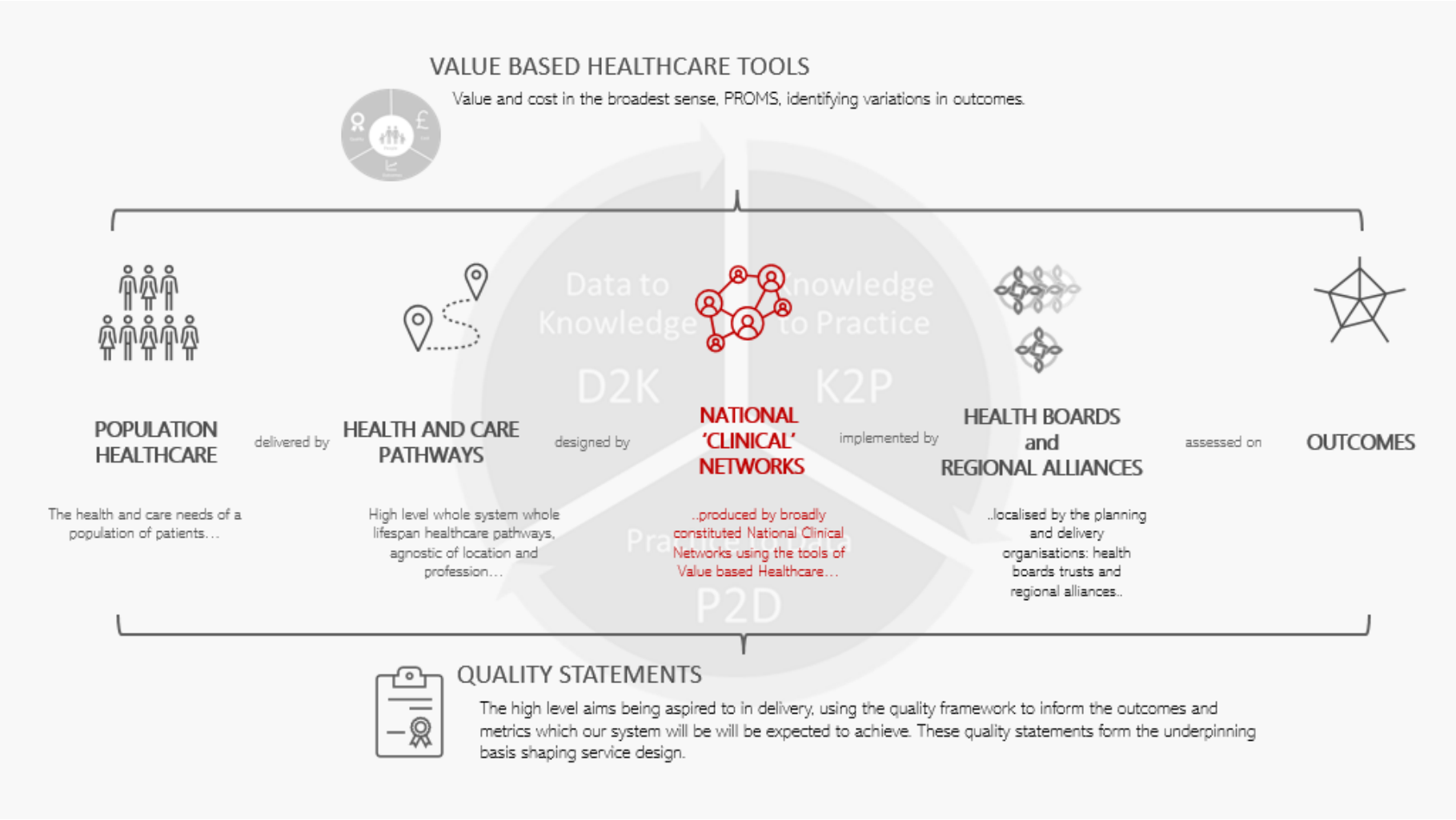
There will be interdependencies and relationships with other national programmes of work. For example, there are several strategic networks whose services are also involved in or impacted by, the scheduled and unscheduled care programmes, national diagnostics programme as examples. Likewise, there may be nationally directed activities identified as a priority which require a response or input from networks.

The infrastructure that will be developed to enable the distinct types of networks to fully succeed in the aims and objectives as set out in the National Clinical Framework will be developed and set out in the scope of 'Product 4' together with consideration and proposals on how to manage these interfaces, as well as supporting challenges and maximising opportunities around co/multi-morbidities.

4 Product Two: Characteristics of the Categories of Networks

This section proposes the generic purpose, functions, roles, responsibilities, and powers of each of the categories of network defined in Product One. It builds on the content above and provides additional detail. The placing of networks in the learning health and care system is illustrated in the diagrams below:




VALUE BASED HEALTHCARE TOOLS
Value and cost in the broadest sense, PROMS, identifying variations in outcomes.
POPULATION HEALTHCARE
The health and care needs of a population of patients…
delivered by
HEALTH AND CARE PATHWAYS
High level whole system whole lifespan healthcare pathways, agnostic of location and profession…
designed by
NATIONAL 'CLINICAL' NETWORKS
..produced by broadly constituted National Clinical Networks using the tools of Value based Healthcare…
implemented by
HEALTH BOARDS and REGIONAL ALLIANCES
..localised by the planning and delivery organisations: health boards trusts and regional alliances..
assessed on
OUTCOMES
QUALITY STATEMENTS
The high level aims being aspired to in delivery, using the quality framework to inform the outcomes and metrics which our system will be will be expected to achieve. These quality statements form the underpinning basis shaping service design.

4.1 National Strategic Networks

The purpose of each of the National Strategic Networks will be to:

- act as the system custodians for a major condition, category of service type or target population segment
- provide national direction on how best to organise, deploy and develop resources
- determine and promulgate ways to secure improved outcomes by using evidence-based approaches to delivery

The table below summarises the proposed roles, functions, and powers of National Strategic Networks. It is important to ensure that the context of the 'powers' of the networks are in the context of the powers of the NHS Executive. Networks in and of themselves do not hold power:

Function	Roles	Responsibilities	Powers (in context of NHSE)
Providing Direction: Inform the development of quality statements for their network with WG policy teams	Co-ordinate the inputs that will contribute to the production of a quality statement that reflects political, clinical, and public aspirations/expectations	Ensuring clinical and public voices are engaged and reflected in the product	
Securing Outcomes: Use the quality statements to develop high-level service specifications, standards and expected outcome measures, especially standardised Patient Recorded Outcome Measures (PROM) and Experience measures (PREMS).	Co-ordinate and engage the stakeholders and system level experts (UK wide) to inform the production of an agreed service specification Develop appropriate national data sets to evaluate delivery against the specifications and secure ongoing reporting of PROMs and PREMs	Informing the NHS Executive of areas with poor outcomes, poor experiences (PROMS and PREMS), or where stakeholders raise concerns about these areas	Data access & ensuring performance against national pathways or specifications is routinely reported and available to the wider NHS Executive in a timely manner to support any onwards escalation or intervention as determined as necessary by the NHS Executive
The Population:	Develop recommendations in terms of service configuration, or	Ensuring necessary changes or interventions are implemented	Escalating issues of non-delivery of recommended

Function	Roles	Responsibilities	Powers (in context of NHSE)
Consider the whole population of patients under their remit, necessarily understanding the nature of their population, where inequities might be present and how they can be reduced and describing 'upstream' preventative interventions that might help prevent people progressing any further along the pathway or commissioning/undertaking population level needs assessments to better understand where resources need to be deployed	delivery for Health Boards to implement (may be supported by an Implementation Network) Where unwarranted variation occurs, the networks will be involved in taking actions to address that variation by improving pathway implementation	and escalate where issues prevent	implementation to the NHS Executive leadership team for determining the appropriate response
Value Based Healthcare Tools: Use the tools and techniques of Value Based Health care in designing high-level 'population-level' pathways of care	Lead the development of pathways using national and international evidence bases or reviewing and adapting existing standards and evidence base	To ensure that the condition groups represented as National Strategic Networks all have comprehensive pathways in place underpinned by health intelligence data to support improvement	Pathways should be evidence guided and data informed as much as possible, making recommendations on what *should* be done and what *should not* be done
Data to Knowledge Describe what data should be collected to understand the patient population needs, outcomes as well as pathway delivery	Having described expected outcomes and metrics, networks will play a role in the NHS Executive in interpreting outcome data	Ensuring data integrity and delivery of timely reports	Escalation, flagging of issues where additional support or intervention may be needed from other functions within the NHSE – for example financial

Function	Roles	Responsibilities	Powers (in context of NHSE)
			intervention or Quality Improvement
Joining Up: Inform the development of workforce & digital strategies, but also recognise existing workforce and infrastructure constraints and develop mitigating strategies for enabling service delivery across a range of professionals working at the top of their license in the most effective way	Bring together the resources and expertise to enable commissioning and delivery of supporting initiatives or programmes of work that will be required to ensure strategies are implementable and a sustainable approach to improving outcomes is taken	To ensure and oversee delivery and execution of plans to operationalise the strategy. Holding delivery organisations to account through the established performance management mechanism under the NHS Executive	Determine priority areas for action with HEIW and DHCW

4.2 Implementation Networks

As defined above the Implementation Networks will be time limited and established under the auspices of a National Strategic Network. They will be established in specific circumstances to provide clinical and managerial leadership and support to the implementation of specific new pathways and/or models of care, developed or advocated by the 'sponsoring' National Strategic Network, across organisational boundaries (nationally or regionally).

The purpose of each of the Implementation Networks will be to:

- lead, co-ordinate and oversee directly, the implementation of pathways and other service features as determined by a range of drivers
- ensure that implementation is undertaken in a planned and joined up way and that progress is made consistently across Wales
- identify issues or pathway elements requiring more direct, nationally organised support

The Planned Care Transformation and Recovery Programme has seven 'Speciality Boards' constituted to address the following seven areas:

- Dermatology
- ENT Surgery
- General Surgery
- Gynaecology
- Ophthalmology
- Orthopaedics
- Urology

These specialty boards will be transitioned into Implementation Networks in 2023. In the case of Gynaecology and Orthopaedics, there will be National Strategic Networks within which they will sit.

The most recent outlining of Cancer services recovery will lead to development of a Cancer Service Implementation Network, receiving its strategic direction from the National Cancer Strategic Network.

There will be an expectation that these Implementation Networks will work in partnership with Health Boards and Trusts, helping to spread learning from what is working, and to help uncover and address obstacles preventing transformation of service delivery. This will include site visits.

The table below summarises the proposed roles, functions, and powers of Implementation Networks:

Function	**Roles**	**Responsibilities**	**Powers (In context of NHSE)**
Through national collaboration with NHS and other partners, planning and making recommendations on service innovation, transformation, change and improvement	Supporting a consistent national approach to reduce the variation and inequality that the population experiences when health delivery organisations fail to share best practice and seek only to deliver a local solution	For escalating areas where there is a sub optimal response from providing organisations	Request or specify intervention from very senior management within the NHS Executive
Leading the commissioning, procurement, and	Central Programme and Project Management	Responsible for ensuring appropriate arrangements are in	

Function	Roles	Responsibilities	Powers (In context of NHSE)
implementation of schemes where national approaches are identified as being required. This would apply to defined service areas and the wider change programme associated with these developments		place with all providing organisations	
Leading the development of business cases for service change and improvement, to inform prioritisation for revenue and capital funding	Ensuring business cases are developed in an engaging and inclusive way commissioning necessary aspects of business case development with a range of internal and external partners	Ensuring high quality cases underpin service changes that are nationally directed	
Delivering key actions within national policy and strategy	Providing capacity to design and oversee implementation arrangements for the necessary actions	Ensuring robust implementation plans are in place where required	
Supporting the development of local, regional, and national service specific plans, to deliver on policy and strategic intent	Supporting teams within individual organisations to ensure that plans are produced, scrutinised, and strengthened so that delivery of change can be effectively undertaken	Ensuring that where local, regional, or national plans are required, that the implementation network effectively acts as the editorial and scrutiny board for the production of said plan	
Facilitating citizen engagement and consultation, where required, for major service change			

Function	Roles	Responsibilities	Powers (In context of NHSE)
Supporting local, regional, and national commissioning			
Ensuring robust programme management, design, and delivery	Deployment of expert national programme management and clinical leadership	Ensuring national programmes of work ascribed to implementation networks are undertaken as a best-in-class endeavour	To direct, where appropriate organisational resource in support of delivery
Supporting and advising Health Boards and Trusts in implementing national pathways and operationalising them	Deployment of subject matter clinical and managerial experts and ensure appropriate resourcing	Ensuring that advice and guidance is incorporated into delivery by providing organisations	Escalating where deviation occurs

4.3 Operational Delivery Networks

As defined above Operational Delivery Networks (ODN) will be responsible for the operational management of specific services across organisational boundaries, typically on a regional basis. Unlike the Implementation Networks, which are time limited, the ODN will plan for the long-term sustainability regional coordination of services.

The purpose of each of the Operational Delivery Networks will be to:

- Ensure effective patient flows through the organisational system through clinical collaboration and 'operational authority' for networked provision of services.
- Take a whole-system collaborative provision approach to ensuring the delivery of safe and effective services, across the patient pathway, adding value for all its stakeholders.
- Promote and support cross-organisational multi-professional clinical engagement to improve delivery of care pathways.
- Enable the development of consistent organisational guidance and improved service standards, ensuring a consistent approach to improving patient and family experience and maintaining equity of access for an entire population.
- Focus on quality, safety, and effectiveness through facilitation of comparative internal and external benchmarking and auditing of services, through the national clinical audit with implementation of required improvements, providing assurance to providers and commissioners of all aspects of quality.
- Advise commissioners and providers on future service provision, including the commissioning, delivery, designation of services, e.g., in response to changes in legislation or guidance, emerging published evidence or technological developments.
- Support providers in coordinating resources through a value-based healthcare approach to secure the best outcomes for patients across wide geographic areas.
- Support providers and commissioners in the assessment of need, and the development, implementation and review of demand and capacity plans, at a national, regional and Health Board level.
- Apply a 'Value in Health' approach to service delivery and planning, including future service developments.

The table below summarises the proposed roles, functions, and powers of Operational Delivery Networks:

Function	Roles	Responsibilities	Powers (In context of NHSE)
Operational delivery	Develop a coordinated, patient clinical pathway between services over a defined geographical area to ensure access to care. Support capacity planning and activity monitoring for collaborative matching or demand and supply	Responsible for proactive monitoring of day-to-day capacity across the network through multi-model surveillance systems, agreeing and working to an escalation plan (with agreed thresholds for escalation triggers) for both within and across the network to monitor and manage surges in demand	Powers to direct resources to match demand and ensure operational resilience
Partnership working	Engage with third sector organisations	Embed communication strategies and key communication deliverables to support ODN objectives	
	Maintain working links with other relevant networks		
Improving quality and standards of care	Ensure the quality of the network is monitored and subject to a process of continuous quality improvement through clinical audit and peer review	Ensuring organisations have appropriate plans in place to respond to issues and findings from peer review	To escalate organisations that are not responding to outcomes of peer reviews or where plans require significant strengthening
Tactical advice and support to commissioners	Provision of local information, data, and intelligence to support performance monitoring of the network (i.e., clinical reports, process measures, key performance and quality indicators, case-mix		

Function	Roles	Responsibilities	Powers (In context of NHSE)
	standardised outcomes, workforce data).		
Strategic service planning	Provision of senior programme management resource	Responsible for ensuring that all participating organisations have appropriate local service plans in place and that these are reflected in the network-wide plan	Ensure IMTP/relevant local plans reflect the delivery and support requirements of the ODN

4.4 Communities of Practice

The purpose of each Community of Practice will be to provide a forum, with appropriate administrative support, for clinicians and other stakeholders in a defined aspect of clinical practice to come together to discuss areas of common concern and to agree recommendations aimed at improving quality, safety, and outcomes of services within their scope.

Functions of Communities of Practice will include:

- horizon scanning and advising on future developments and innovations
- acting in an advisory capacity to the overarching National Strategic Network (where relevant)
- developing and sharing pathways, standards, and general guidance on good practice
- supporting the development of the evidence base
- coordinating focused peer review

Communities of Practice will be far less formal than the other categories outlined above and will have no specific powers.

5 Product 3: Proposed National Strategic Clinical Networks

This section sets out the specification for Product three, as set out in the Workstream Initiation Document (WID):

Product Three: The proposed set of future condition/service specific national strategic networks, with the scope of each defined, informed by factors including burden of disease (in population and service terms) and service fragility

Whilst there is an inter relationship and potential interdependencies, particularly with the national programmes, the scope of this work is restricted to the establishment of strategic networks as set out in products 1 & 2.

The term ‘clinical’ is descriptive of the problems and challenges that networks are brought together to address. Many of the people comprising each proposed type of network will be ‘clinical’ in the sense of being nurses, doctors, or other clinical professionals, but many will be from different professions or roles, such as managerial, informatics and digital, data science, together with involvement from outside the NHS, including social care, the third sector and patient groups.

5.1 Proposed List of National Strategic Networks

The proposed list of national strategic networks is set out below.

- **Cancer**
- **Cardiovascular conditions**
- **Musculoskeletal and Orthopaedics**
- **Neurological Conditions**
- **Diabetes**
- **Respiratory Conditions**
- **Mental Health Conditions**
- **Neonatal/Maternity**
- **Infectious Disease**
- **Gastroenterology**
- **Women's Health**
- **Child Health**
- **Critical Care, Trauma & Emergency Medicine**

5.2 Drivers and considerations for determining the list of networks

We have taken an evidenced guided approach to determining what networks are needed to drive the priorities aligned to the NCF. A core challenge in dealing with the burden of disease is to ensure evidenced based interventions or best practice is being applied consistently across Wales.

There is intent in *A Healthier Wales* to develop a more 'upstream' approach to the way we deliver services. This provides a driver for those 'upstream' areas of the life course: prenatal, maternal and child health.

A further consideration informing the list is the service burden where demand or workforce challenges may be creating fragility. In some cases, there will be political imperatives, or other new service or public health issues arising that drive demand to establish new networks outside of the proposed list described in this paper. Therefore, this list must also be considered a starting point, but it will evolve and iterate as the drivers change.

5.2.1 Applying the Burden of Disease

The most recent Burden of Disease data (2016) included in the Public Health Wales 2018 Health and its Determinants report asserts that:

- Cancer now exceeds cardiovascular disease as the greatest cause of disease burden in Wales.
- Cancers, Cardiovascular disease (CVD) and MSK (Musculo Skeletal) disorders make up 48% of disability adjusted life years. (DALYs)
- DALYs caused by CVD and neonatal disorders has reduced, however the contribution of cirrhosis and liver disease have doubled.
- Influenza, Hepatitis C & C. difficile are the top three causes of DALYs for communicable diseases in Wales.

- By 2035 the proportion of adults living with a limiting long-term condition may increase by 22%, with greatest increases in stroke (33%), heart conditions (31%) and neurological conditions including dementia (72%).
- Past smoking most significant risk factor contribution.

The burden of disease cuts the burden by three key measures of assessing impact on population health. These are:

- **Disability Adjusted Life Years**

Mortality does not give a complete picture of the burden of disease borne by individuals in different populations. The overall burden of disease is assessed using the disability-adjusted life year (DALY), a time-based measure that combines years of life lost due to premature mortality (YLLs) and years of life lost due to time lived in states of less than full health, or years of healthy life lost due to disability (YLDs). One DALY represents the loss of the equivalent of one year of full health. Using DALYs, the burden of diseases that cause premature death but little disability (such as drowning or measles) can be compared to that of diseases that do not cause death but do cause disability (such as cataract causing blindness)

- **Years Lived with a Disability**

Years Lived with Disability (YLD) is a component of DALY and measures the burden of living with a disease or disability in the number of years. In the data, disabilities have different 'weights' that signify the severity of the disability (e.g., 0.061 for lower back pain, and 0.594 for blindness). YLD is determined by the number of years disabled times the duration of the disability

- **Years of Life Lost**

The total number of deaths from specific causes does not provide a good metric for informing public health priorities. Such a measure, for example, assigns the same weight to a death at age 80 as it does at age 30 or even at 1 year of age. Years of life lost (YLL) is a measure of premature mortality that considers both the frequency of deaths and the age at which it occurs

The following charts show the burden of disease conditions split by those three measures:

Disability-adjusted life years (DALYs) by cause, Wales

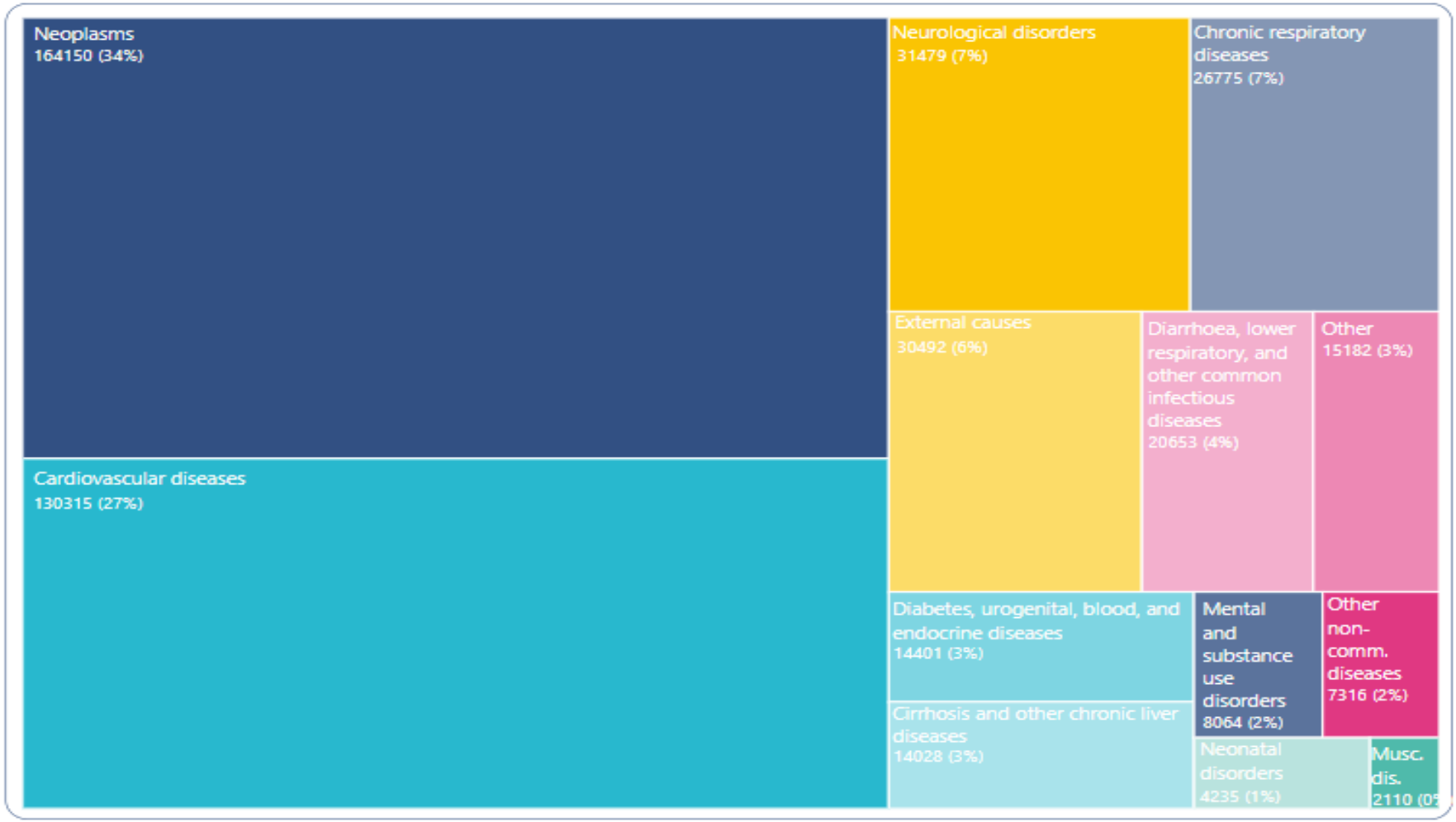
Data from *Health and its determinants in Wales* report produced by PHW Observatory (2017)

Years Lived with disability (YLD) by cause, Wales

Data from *Health and its determinants in Wales* report produced by PHW Observatory (2017)

Years of life lost (YLL) by cause, Wales

Data from *Health and its determinants in Wales* report produced by PHW Observatory (2017)



This work has identified that there are further proposed strategic networks driven by wider system, service and life-course priorities as referenced above. These are derived from extensive discussions and engagement with Welsh Government policy leads, clinicians, and clinical leads across Wales, as well as the existing networks and wider National Programmes themselves.

We propose the following additional networks will therefore be established:

- **Gastrointestinal**
- **Women's Health**
- **Infectious Disease**
- **Critical Care, Trauma & Emergency Medicine**
- **Child Health**

5.3 Managing Interfaces

A key design principle running through the establishment of a refreshed set of networks is to ensure there is a clear strategy guiding their work.

It follows that we avoid creating implementation networks, operational delivery networks or communities of practice which are 'orphaned.' A link to an umbrella structure must be in place to ensure activities are aligned to the national priorities and to ensure that we are not duplicating efforts or establishing programmes of works that could have unintended consequences, waste resources, or introduce unwarranted variation.

There may be instances where there is no natural strategic umbrella. In those cases, there will still be a need for a strategic steering body to guide the implementation network, operational delivery network or community of practice.

We have tried to achieve a consistency, and a taxonomy that is clear and makes sense. This desire for clarity must be balanced against the reality that healthcare services are heterogeneous, and there is no 'one size fits all' arrangement. Any attempt to produce this will be an approximation and a compromise. Rather than asking if we have achieved perfection, we have asked 'is this better than the status quo. Managing interfaces and interdependencies is also equally important to be able to separate strategic activities from operational delivery activities and ensure there is appropriate capacity established to execute with a clear and consistent approach to the delegation of activities across the networks (including working with National Programmes). This approach will prevent strategic networks getting embroiled in operational issues and will ensure that operationally focussed delivery groups are not creating national strategies.

There will be interdependencies and relationships with other national programmes of work. For example, there are several strategic networks whose services are also involved in or impacted by, the scheduled and unscheduled care programmes, national diagnostics programme as examples. Likewise, there may be nationally directed activities identified as a priority which require a response or input from networks.

The infrastructure that will be developed to enable the distinct types of networks to fully succeed in the aims and objectives as set out in the National Clinical Framework will be developed and set

out in the scope of 'Product 4' together with consideration and proposals on how to manage these interfaces, as well as supporting challenges and maximising opportunities around co/multi-morbidities.

5.3.1 Illustrative example of configuration

Strategic Networks will be supported to have facilitated conversations as part of an ongoing planning cycle. These conversations will inform and shape the views of each Strategic Network in terms of the required infrastructure and linked groups required to deliver improvement in outcomes. The table below illustrates potential examples for how this might be organised, but will be used as a basis for discussion with the strategic networks, and with existing networks to agree the most appropriate 'strategic homes':

Strategic Network	Implementation Network	Operational Delivery Network	Community of Practice
Cancer	Single Cancer Pathway		
	Rapid Diagnostics services for Cancer		
Cardiovascular	Heart Failure Pathways		
	Acute Coronary Syndrome Pathway	Vascular ODN	
	Comprehensive Regional Stroke Services	Stroke ODN	
Musculoskeletal	Orthopaedic Surgery Persistent Pain	Orthopaedic ODN	
Neurological Conditions			
Diabetes			
Respiratory			
Mental Health Conditions			
Neonatal and Maternity		Neonatal Service	
Infectious Disease			
Gastrointestinal	Liver Disease		
	Inflammatory bowel disease		
Critical Care, Trauma and Emergency Medicine		Major Trauma	
	Critical Care		

Strategic Network	Implementation Network	Operational Delivery Network	Community of Practice
Women's Health			
Child Health	Rare Diseases		

The Rare Diseases Implementation Group is in the process of taking forward a range of initiatives important to the many patients who suffer from such conditions. There is no obvious strategic home for this group, but we will develop it as an implementation network. Their strategic steer will be expected to take their strategic guidance from the UK Rare Diseases Framework.

It will be obvious that in some cases there will be an initial need for an Implementation Network, and, as it progresses a programme a work to address a problem or support the meeting of expected service standards, that this will create a series of ODNs (e.g., Stroke services)

Some operational delivery networks are already being developed before a strategic umbrella network exists, but that can be mitigated by creating an initial strategic structure. An example current at the time of writing is where a National Strategic Network for Vascular Services is being established to provide the strategic guidance and co-ordination for regional Vascular Surgery ODNs. In due course, such a strategic network may form part of a Cardiovascular Strategic Network.

5.4 Recommendation

Proposals will be developed for the supporting infrastructure, governance, and resources (product 4) and an implementation plan (product 5).

It is recognised that implementation will need to happen in a phased manner so as not to destabilise the wider system, and to enable enough focus and central managerial and clinical resource to be effectively deployed. As work to establish further detail is undertaken, a suite of supporting implementation networks and links to existing national programmes (e.g., the diagnostics portfolio) will be further mapped out.

It is also recognised that the proposed configuration of Strategic Networks will impact on staff working within existing national clinical networks within the NHS Wales Health Collaborative and that changes will be required in some existing roles as part of a move from existing national networks and major conditions implementation groups to the new configuration of Strategic Networks. This change will need to be managed sensitively and carefully, in line with relevant applicable policies and procedures.

The National Clinical Framework Steering Board is asked to approve the proposals for the set of national strategic networks as set out in this paper.

6 Product 4: Proposed Core Infrastructure

This section sets out the specification for Product four, as set out in the Workstream Initiation Document (WID):

Product Four: A specification of the minimum core clinical, managerial, and administrative infrastructure required to establish, support, sustain and develop a national strategic network

Networks will be set up with a federated and enabling ethos. The federated approach means they will be established and adhere to core remit and principles, but they will, as they mature, need to establish their own broader infrastructure as necessary to fulfil their roles as set out in product document 2. Networks will need to determine their required infrastructure to support the delivery of service and system level change.

A framework structure is suggested here:

- **A leadership group**
- **Informed by a very broad base of clinical reference groups (clinical meaning the service, not the background of everyone in the group)**
- **A selection of task and finish groups, 'scrums' and 'rolling mauls' brought into being to deliver the work**

Maintaining clarity of function is important, and the groups should be sized appropriately. As a rule of thumb, when Leadership Groups or T&F groups meet, it should be possible to feed

them with two pizzas. If not, they are probably too big and will lose focus. Reference groups, on the other hand, will need a buffet.

6.1 Establishing a Leadership Group and Model of Clinical Leadership

This section describes the leadership group that will be required to run each of the national strategic networks.

The key leadership component of each network will be the Network Director and the Clinical Lead. These individuals will work side by side to build and lead the network structures and engagement processes and will be expected to ensure a broad base of knowledge from across primary and secondary care, across the full range of health and care professionals. They will also be expected to ensure the perspective of patients informs their work and to engage with the range of capabilities that third sector organisations can bring to service design.

Clinical leadership roles are not the preserve of any one professional group. What is important is that the lead clinician ensures that they build a truly multi-disciplinary and multi-professional structure that provides credibility with the range of staff providing the services, and the patients in receipt of them.

It has been a deliberate decision not to prescribe a 'triumvirate' leadership structure traditional in many health boards as this only involves two clinical professions: nurses and doctors. There are many other clinical and professional disciplines in health that are equally important to involve in leadership roles.

It is also a deliberate decision to insist on one clear clinical lead. This makes communication and liaison between other clinical networks, the National Programmes and the broader NHS Executive easier, and encourages a sense of responsibility and ownership for those assuming the role. The clinical leads will be selected, and held to account, on their ability to bring colleagues with them and shape consensus.

Populating the teams that will constitute required 'Implementation Networks,' or 'Operational Delivery Networks' will be driven by each Strategic Network, supported by the wider capabilities that will be available through the new NHS Wales Executive (financial, performance management, planning, programme management, quality improvement).

The term 'clinical' is descriptive of the problems and challenges that network are brought together to address. Many of the people comprising each proposed type of network will be 'clinical' in the sense of being nurses, doctors, or other clinical professionals, but many will be from different professions or roles, such as managerial, informatics and digital, data science, together with involvement from outside the NHS, including social care, the third sector and patient groups.

For the totality to be coherently directed and managed, the networks require a consistent structure (given that the purpose and function of strategic networks is set and this workstream is seeking to brigade and manage networks in a more cohesive and consistent way).

The Leadership Group (National Strategic Networks):

- **Network Clinical Lead**
- **Network Director/Manager**
- **Additional clinical members – minimum two other, to ensure multi-professional knowledge**
- **Network Co-ordinator/ Dedicated administrative support**
- **Analysis/data science**
- **Planning/programme management**

Some of the above roles may be shared across more than one strategic network and some functions (e.g., planning and programme management and analysis/data science) will be provided through centrally organised teams.

Wider network membership will be determined by each network with advice from the central leadership team, and will reflect key service elements (e.g., of pathway specific roles or services). This core structure should not be taken to imply that each network will have sole 'ownership' of a professional occupying each of these roles. It is likely that for most networks, the individuals will be shared with other networks or other service areas. The workload for each network will vary, so no 'one size fits all' prescription will be given.

Networks will move away from an executive led model of working and transition to a clinically led model as described in this document. This means that networks will not be chaired by executive leads, nor will there be an expectation for peer group representatives on every group

6.2 Supporting/Enabling Functions

All networks will require access to additional skills and capabilities in addition to those available in the core team. Networks which establish 'Implementation Networks' will be responsible for effectively managing a supporting portfolio of work that will be supporting or leading Health Board services or, where appropriate, ODNs (Operational Delivery Networks) on practical pathway/service level changes. To successfully deliver the stated aims of improving outcomes and developing sustainable service models, networks will require engagement with services, patients, and citizens, need to access high quality planning, programme, and project management.

They will require support in navigating the emerging digital landscape, be able to access health intelligence capabilities and, in a managed way, commission work packages from other national statutory organisations (Health Education Improvement Wales, Digital Health and Care Wales).

It is the role of networks to develop their position as drivers of the strategic direction of the service. Their engagement, collectively through the NHS Executive, will inform the engagement with the two most fundamental enablers for the service: workforce and digital technology. This will increasingly mean that the requirements that emerge from clinical

networks (and national programmes) will inform what HEIW and DHCW are commissioned to deliver for the health and care system in Wales.

The existing NHS Wales Health Collaborative has developed a central health intelligence function together with planning, finance, and business management teams. These teams will continue to develop an approach to supporting the work of Strategic Networks, their subsequent Implementation Networks and Operational Delivery Networks, but as part of a broader team within the NHS Executive.

6.3 Clinical Reference Groups

Clinical reference groups are the engine-room of the Clinical Networks. They form the broad base of each network, ensuring wide engagement at the delivery end of the service. Clinical Reference groups are sometimes designed to be at the decision and strategy-setting level in governance structure. In the landscape described here, that is unnecessary: the *de facto* 'board' of each network will include many clinicians and will be informed by that much broader base.

To maintain active engagement with services, to maximise best use of scarce clinical time and to be able to successfully maintain focused and manageable membership of networks, clinical reference groups will be necessary to inform direction, sense check thinking and provide consensus view where there may be strong divergence of view in terms of what needs to be done about a particular issue.

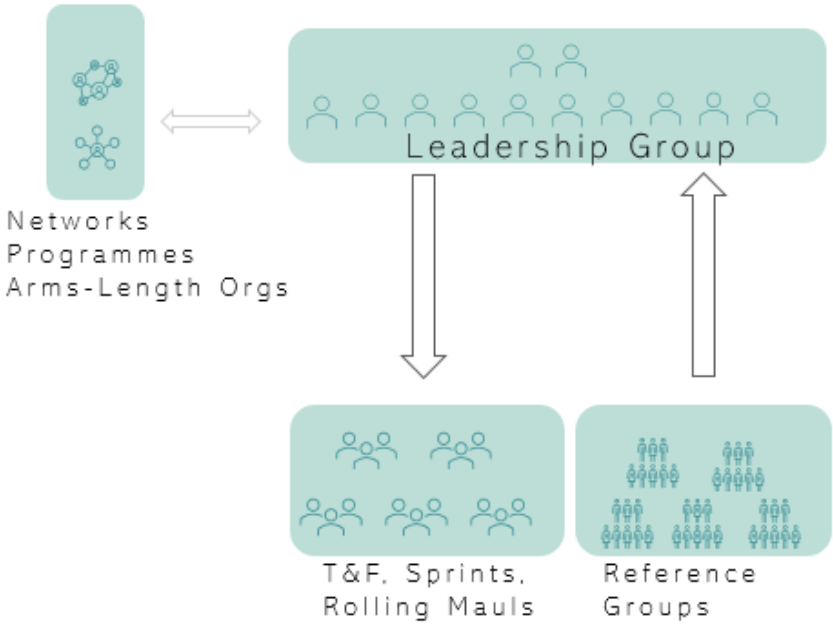
Clinical reference groups can come together virtually where input may be required in real time, but all networks will be encouraged to physically bring their clinical reference groups together at points in the year to give protected time to developing the cohesion of the network.

Memberships of clinical reference groups is not prescriptive, but they should seek to be inclusive, have broad health board and specialty representation and have a clearly articulated purpose and remit. They could represent the clinical pathway or elements of the pathway, or organised around subspecialties e.g., in the case of a Musculoskeletal and Orthopaedics network, clinical reference groups could be formed around Spinal Surgery, Hip, Shoulder, Hand etc. These reference groups provide subject matter expertise and support the network in distilling priorities and areas for action.

6.4 Role of the patient voice – Citizens' voice

Community Health Councils (CHCs) have a statutory role in Wales to represent and advocate on behalf of the public and patients who use NHS services. The CHCs are undergoing a refresh which will lead to the establishment of 'Citizen's Voice.' Whist the Strategic Networks will principally be concerned with setting national direction, parameters for delivery, standards, and measures, ensuring that the needs of patients are met through engagement and involvement will be key to success. Active discussions are happening between the programme team taking forward the establishment and refresh of national networks to ensure that the interaction with the groups responsible for patient advocacy is co-ordinated and prioritised.

4 Product Four: The core clinical and managerial infrastructure of the networks



Broad based.

Clinical means: doctors, nurses, AHPs, operational managers, local authority, third sector and involve cross-boundary (primary care, secondary care, Public Health, WAST). They also involve the people who will use the services.

Networks are constituted around broad categories, so need a broad base.

A broad base will encourage an 'upstream' focus.

These are networks, not lobbying organisations – Prudent Healthcare principles apply

Broadly constituted networks will start to inform thinking and conversations to developed 'pooled budgets' to foster a truly cross-sector integrated approach.

This approach needs organisational support and investment in 'clinical time'.

6.5 Recommendation

Proposals will be developed for the implementation of the set of networks are described in Product 5.

It is recognised that implementation will need to happen in a phased manner so as not to destabilise the wider system, the existing delivery of work commitments, and to enable enough focus and central managerial and clinical resource to be effectively deployed.

It is also recognised that the proposed configuration of Strategic Networks will impact on staff working within existing national clinical networks within the NHS Wales Health Collaborative and that changes will be required in some existing roles as part of a move from existing national networks and major conditions implementation groups to the new configuration of Strategic Networks. This change will need to be managed sensitively and carefully, in line with relevant applicable policies and procedures.

As work to establish further detail is undertaken, a suite of supporting implementation networks and links to existing national programmes (e.g., the diagnostics portfolio) will be further mapped out.

7 Product 5: Implementation and Transition Arrangements

This section sets out the specification for Product Five, as set out in the Workstream Initiation Document (WID):

Product Five: Actions required to move from the current portfolio of clinical networks and implementation groups to the recommended new configuration of strategic national clinical networks within the supporting functions of the Executive

This is an intentionally high-level document. It describes the approach, outline timeframes and the management of change. A more detailed implementation plan will be produced in advance of the mobilisation of resources. This document does not describe a formal organisational change process, such a process can only be defined and implemented following the final approval of products one to four from this workstream.

7.1 Establishing an Implementation Team

The Team constituted to produce the documents and products to set out the scope, remit, list of networks, supporting arrangements and implementation plan will continue to be the focussed resource, however, recognising that moving from planning to implementation requires additional resources and skills, the existing programme team will be supplemented by:

- HR and OD support (provided by Public Health Wales/external additional if required)
- Financial and business support (provided by the existing Collaborative Director of Resources)

- Communication

In addition to this, the existing national network leads will be brought together with this team on a frequent basis to support the implementation.

7.1.1 Staff engagement, consultation, and involvement

The existing NHS Wales Health Collaborative has established a series of mechanisms that will be important to ensuring that all staff are afforded an open opportunity to engage with and be involved in the programme of change. Mechanisms like regular e-bulletins, directors update will provide a written update that reaches all staff, whilst the established Staff Forum will be used to channel more focussed discussions with staff as required. Engagement with current network clinical leads and managers will continue and open discussions to help inform and further shape the overall implementation and transition plan will be arranged on an ongoing basis. Any formal organisational change process resulting from this work will include full staff consultation.

7.2 Working Assumptions

The following working assumptions are informing the planning of implementation:

1. The scope of funding available is the existing budget provided to the Collaborative to fund Networks and Implementation Groups and that the infrastructure described will aim to be delivered within that envelope
2. The NHS Executive will go live on 1 April 2023
3. No additional networks will be added to the list as issued for engagement (described in Product 3)
4. The current programme team will remain in place until implementation is complete and post implementation arrangements have been reviewed and recorded.

7.3 Approach

Change can be unsettling for all who experience it, but it can also be a positive force for improvement, particularly where staff and stakeholders are effectively engaged in it. All staff will receive regular communications and be provided the opportunity for dedicated 1-1 meetings with line management to support them through the process.

The implementation will follow the Public Health Wales Organisational Change Policy in order to ensure that best practice is followed but (and perhaps more importantly), this process will be supplemented by an open and transparent approach that ensures negative impacts are minimised as far as possible, and that opportunities, when they emerge are made accessible in a fair and equitable way.

A post implementation report will be produced identifying any legacy issues which may require transferring to a different body (e.g., any matters previously specific to Collaborative Executive Group that may need to be transferred as legacy issues).

7.3.1 Managing stakeholders

Stakeholders are split into two distinct and separate groups, essentially internal and external. Internal references employees of the collaborative, along with clinical leads undertaking a sessional commitment.

External Stakeholders refers to the wider NHS and 3rd sector organisations (of which many of the proposed disease condition networks will have or need to establish relationships with).

The established stakeholder groups used to date in the process of engagement and consultation will continue to be updated on progress of implementation with regular update reports.

8 Recommendation and next steps

It is recognised that implementation will need to happen in a phased manner so as not to destabilise the wider system, and to enable enough focus and central managerial and clinical resource to be effectively deployed. As work to establish further detail is undertaken, a suite of supporting implementation networks and links to existing national programmes (e.g., the diagnostics portfolio) will be further mapped out.

9 Engagement and Feedback

All products were circulated to key stakeholders for comment via MS Forms. This comprised of the:

- Collaborative Executive Group
- Welsh Government Policy Leads
- NHS Wales Collaborative Staff
- NHS Executive Programme and National Clinical Leads.

Feedback was collated, and common themes identified and summarised, these will be shared alongside this document.