Respiratory Clinical Networks Specification

NHS England and NHS Improvement

Background and context

Respiratory disease affects one in five people and is the third biggest cause of death in the England (after cancer and cardiovascular disease)[1]. Hospital admissions for lung disease have risen at three times the rate of all admissions generally and are a major factor in winter pressures faced by the NHS. Incidence and mortality rates from respiratory disease are higher in disadvantaged groups and areas of social deprivation[2]. The NHS Long Term Plan[3] committed to improving the treatment and support for those with respiratory disease, with an ambition to transform our outcomes to equal to, or better than, our international counterparts.

Since the publication of the NHS Long Term Plan the healthcare context has rapidly changed due to the global coronavirus (Covid-19) pandemic. The Covid-19 pandemic has significantly increased the numbers of patients that require acute and longer-term respiratory management, and there is now an immediate need for more strategic co-ordination of pathways of care for these patients; in addition to the clinical management of patients with other new and long-term respiratory diseases.

In order for our healthcare systems to best manage ongoing Covid-19 pressures, including its management as long term condition that will fall primarily to respiratory services, the establishment of respiratory clinical networks is proposed. The networks will help to reduce variation in delivery of care and support the sharing of best practice across regions and across the country. They will provide a strong foundation to manage the increase in need for respiratory services and reduce pressures on the healthcare system. The networks will also provide an opportunity to support implementation of the NHS Long Term Plan objectives including improving early and accurate diagnosis through the use of community based diagnostic hubs, promote prevention strategies and develop post Covid-19 recovery and rehabilitation pathways.

Clinical networks are already operating successfully in the NHS. They combine the experience of clinicians, multi-disciplinary working, the input of patients and clinical leadership to improve the delivery of care to patients in distinct areas, delivering true integration across primary, secondary and often tertiary care.

We have seen how stroke networks have transformed service delivery, similarly, cancer networks have raised standards, supported easier and faster access to services and encouraged the spread of best practice.

Respiratory medicine is a major contributor to hospital admissions and readmissions and is one of the most pressured specialities during winter. **The development of respiratory clinical networks will be vital in providing a strong infrastructure for an integrated model of respiratory services that are fit for the future.**

This document is a proposed specification for the establishment of respiratory clinical networks, the core functions and structure and the benefit this will bring to the sustainability of respiratory services.

[1] Public Health England, Respiratory disease: applying All Our Health, April 2015
https://www.gov.uk/government/publications/respiratory-disease-applying-all-our-health/respiratory-disease-applying-all-our-health
[2] Marmot M (2010) Fair society, Healthy lives: Strategic review of health inequalities in England, post 2010
[3] https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

Purpose of respiratory networks

Standardised functions

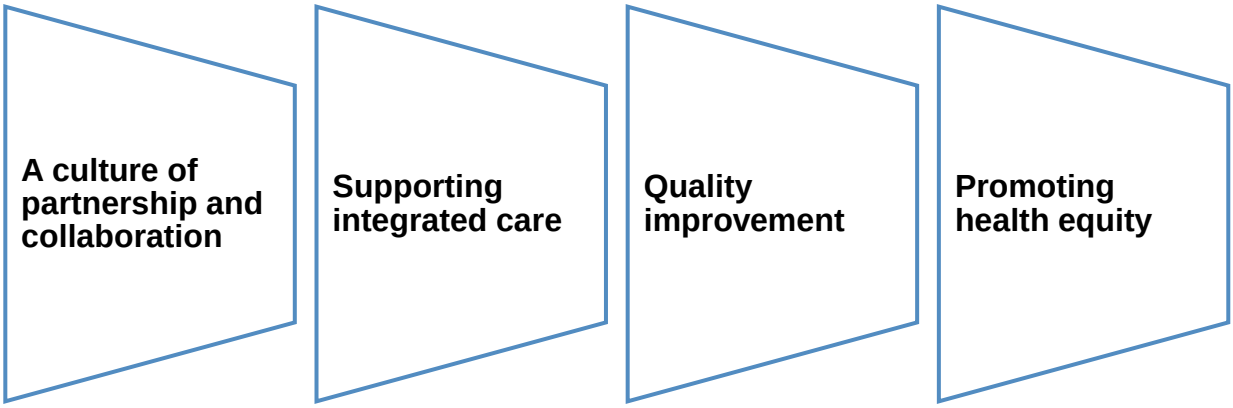
The networks will be central to the clinical leadership of respiratory services in managing the current and on-going demand posed by Covid-19, delivering the objectives of the NHS Long Term Plan and ensuring routine care for respiratory patients is of the highest quality.

Clinical leadership will be essential in developing a strong foundation for effective functioning of the networks. This leadership will be critical in responding to the rapidly developing evidence base on Covid-19 and harnessing the workforce and agencies to respond. The networks will support the planning for increased demand of services, especially during winter and future potential surges of Covid-19.

Respiratory clinical networks will be responsible for design, guidance and promotion of optimal respiratory care pathways, including those for Covid-19, which will ensure more people who are diagnosed with a respiratory condition receive high-quality care from diagnosis to acute care, rehabilitation and beyond, building on the priority areas of the NHS Long Term Plan for respiratory disease.

Respiratory clinical networks will cover a sub-regional footprint, facilitating cross-sector and agency working to ensure all systems deliver optimal respiratory care in line with current clinical guidance and best practice standards. Networks are a prime opportunity to support integrated working across institutional and organisational boundaries, allowing knowledge to flow between individuals and organisations and support the on-going digital transformation of healthcare delivery.

All networks will have a responsibility to ensure that they address health inequalities and promote health equity across all services and pathways. Respiratory networks will champion the role of integrated care to enable delivery of specialist care closer to home, that is personalised and has the patient voice at the core.



Respiratory clinical networks core objectives

All respiratory networks will have the following core objectives in addition to responding to local needs. How these are implemented will be the decision of local systems in collaboration with the network.

Supporting organisations in developing systems and processes for:

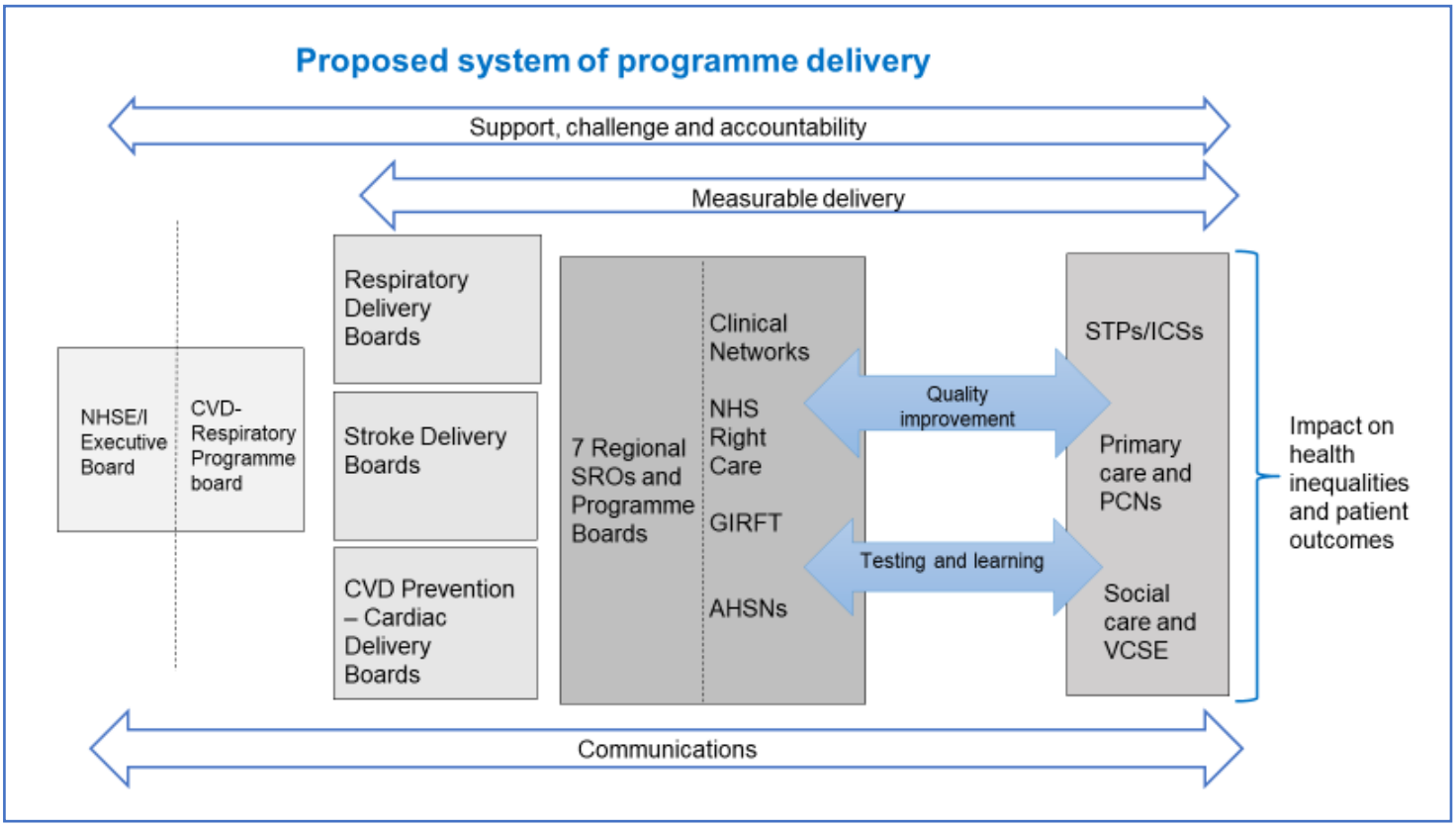
1. **Acute management of Covid-19 patients and planning for future surges.**
2. **Follow-up and rehabilitation for post-Covid-19 survivors (including virtual rehab).**
3. **Restoration of respiratory services based on the NHS Long Term Plan priorities for early and accurate diagnosis, medicines optimisations, community acquired pneumonia and pulmonary rehabilitation – adapted to the Covid-19 environment for remote monitoring and care closer to home.**
4. **Target interventions in areas of high deprivation, lower socioeconomic groups and those with complex health needs, with an aim to reduce health inequalities.**

Benefits of respiratory clinical networks

- Systems will have access to expert advice, co-ordination and support planning for the immediate and further Covid-19 surges and to establish recovery and rehabilitation pathways for this new group of patients.
- Networks can quickly share and adopt models of care and innovations from a single organisation across the network, and through links with the national clinical director to spread innovation nationally.
- Services will benefit from a quality improvement focus, using data for improvement and implementing the learning from *Getting It Right First Time* (GIRFT) respiratory reviews to streamline provision potentially reducing the burden on acute services. .
- A networked approach in conjunction with primary care and community services can be used to manage new and longstanding non-Covid-19 respiratory patients' diagnosis and treatment to reduce the impact of winter pressures on acute providers.

Governance

This is the first time NHS England and NHS Improvement has invested in national respiratory clinical networks. Successful establishment and effectiveness will be overseen through the existing system of governance of the Cardiovascular (CVD)-respiratory national programme via the CVD-respiratory programme regional senior responsible officers (SROs).



The governance will encompass and support the post Covid-19 restoration and recovery work in addition to the subsequent focus on the NHS Long Term Plan objectives. It is anticipated that the respiratory networks will continue to support and lead improvement in respiratory outcomes after the immediacy of managing respiratory issues arising from Covid-19 subsides.

Role of the central team

- Identifying and allocating network funding resource.
- Defining the national policy objectives for respiratory disease as in the NHS Long Term Plan.
- Undertake initiatives that need to be done once on a national footprint; working collegiately with national organisations and programmes to develop and implement national respiratory standards and guidelines (such as NICE) particularly for new and emerging management of patients post Covid-19.
- Supporting robust network clinical leadership through the national clinical director and GIRFT lead for respiratory disease.
- Sharing best practice nationally

Role of the regional team

- Enabling and facilitation of collaboration across systems working with STP/ICS and other system partners to develop a strategic approach to patient diagnosis, treatment, self-management and rehabilitation.
- Ensuring robust clinical leadership and clinical collaboration for the network.
- Ensuring engagement with national Healthcare Quality Improvement Partnership asthma and COPD audit programme (NACAP) and long term plan metrics for respiratory ambitions, and a focus on quality improvement.

Role of the respiratory clinical network

- In the development and formation phase, the network will take a whole system working approach (as outlined in the NHS Long Term Plan) and ensure robust consultation and agreement with local STP/ICS leads.
- The network will operate in agreement with the local systems (STP/ICS across the region) supported by the Regional Medical Directors.
- Co-ordination and improvement of pathways of diagnosis and management of patients with respiratory disease from prevention, self-management, acute care and rehabilitation and long term support. This should include acute care for Covid-19 patients, planning for future surges and follow-up respiratory related rehabilitation for post Covid-19 survivors.
- Restoration of respiratory services based on the NHS Long Term Plan priorities for early and accurate diagnosis, medicines optimisations and pulmonary rehabilitation – adapted to the Covid-19 environment for remote monitoring and care closer to home.
- Support local systems to target interventions in areas of high deprivation, lower socioeconomic groups and those with complex health needs, with an aim to reduce health inequalities.

- Connecting and working with other regional networks such as cardiovascular, diabetes and cancer to ensure the respiratory network can collaborate on joint areas such as rehabilitation, and not operate in isolation of other long term conditions.

- Identify and connect with specialised commissioning networks for respiratory such as: severe asthma and interstitial lung disease; and with other local networks such as tuberculosis in conjunction with Public Health England.

- Networks will ensure the patient focus is central in the development of local and regional pathways and interventions – in line with the Clinical Commissioning Groups and NHS England's statutory duties[4].

[4] Section 14U of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) specifically states that CCGs must promote involvement of each individual, their carer and (should there be any) their representatives in decisions relating to the prevention or diagnosis of illness, or their care or treatment.

Section 14V states that CCGs must, in the exercise of their functions, act with a view to enabling individuals to make choices with respect to aspects of health services provided to them.

Network structure

It is proposed that 13 networks will be funded; these footprints have been defined by regions as being consistent with other clinical networks and based on discussions with regional medical directors.

Initial funding for establishing and developing respiratory networks will be through the national respiratory programme; throughout the lifetime of the NHS Long Term Plan this will transition to business as usual working.

Each respiratory network will be centrally funded for clinical lead and management time:
The funding for 2020-21 has been agreed at £200,000 per network to cover:

- Clinical lead time, *shared across primary and secondary care* (minimum of 0.5 WTE)
- Network manager
- Dedicated administrative support

Local discretion can be applied for the allocation of funding to these roles and how the staffing to manage the network is organised on a local level.

The membership of networks should comprise people from the whole pathway and from a range of professions to bring perspectives on:

Acute care
Children and young people
Community services
Diagnostics
Digital and technology
Health Education England
Integrated care
Local authority
Medicines (including community pharmacy)
Patient representatives
Prevention (including: tobacco control, flu/pneumococcal vaccines and infection control)
Primary care
Public Health England
Secondary care
Social care
Specialised commissioned services
Third sector

It is expected that membership will represent multi-disciplinary working across the network.

Timeframe
It is expected that the central team will confirm funding arrangements in July. Local systems are encouraged to recruit the key leads for the network in particular clinical leads through July/August 2020, with the ambition that all regions will have a network in place by September/October 2020.

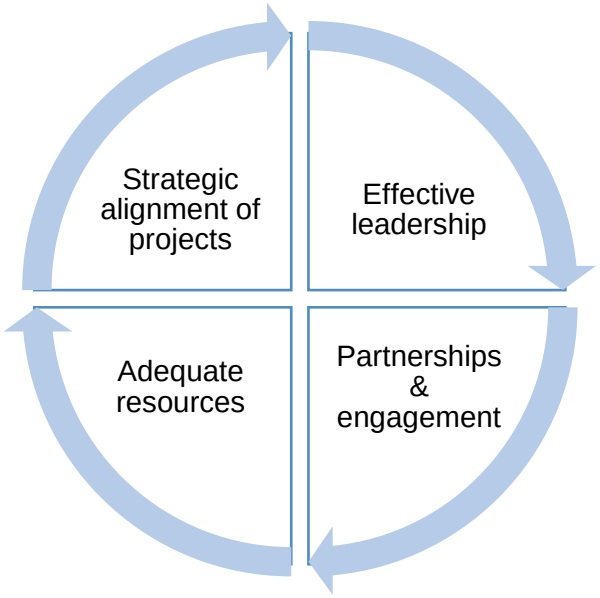
The network would then be encouraged to agree a terms of reference (ToR) and confirm the membership of the network.

Evaluation

Clinical networks have shown to be an effective conduit for quality improvement in service delivery and improving patient outcomes across clinical disciplines[5].

Qualitative studies have synthesised the key domains to successful networks that are also enablers for change. The domains have been seen across successful networks in both the UK and internationally[6] - these will provide the basis for qualitative analysis on the effectiveness of the networks.

The key domains of effective networks include[7]:



In order to measure the effectiveness of respiratory clinical networks across England, a qualitative method will be employed to evaluate the networks.

In consultation with network leaders a qualitative survey will be distributed at six months and one year following the establishment of the network.

The findings will be used to support networks in areas of improvement and share successful practices across the networks.

[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5018194/
[6] **Development and validation of a survey to measure features of clinical networks**, Brown et al. (2016) BMC Health Services Research https://core.ac.uk/download/pdf/81752087.pdf
[7] **Clinical networks: enablers of health system change,** Manns B.J, Wasylak T (2019) CMAJ November 25, 2019 191 (47) https://www.cmaj.ca/content/191/47/E1299