

NHS Chief Executives

4 March 2009

Dear Colleague

FRAMEWORK FOR OBLIGATE NETWORKS

This letter provides guidance to NHS Boards in the establishment of Obligate Networks.

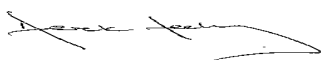
In May 2008, following an extensive and inclusive review, 'Delivering for Remote and Rural Healthcare' was published by the Cabinet Secretary, as Scottish Government policy. Within the detailed report the establishment of 'Obligate Networks' was identified as one of the key building blocks required to sustain local services and to ensure access to more specialist services that are not available locally. This concept builds on the well-established MCN approach that Scotland has pioneered but takes this a bit further and was identified as crucial to the sustaining access for those living in remote and rural communities by the Cabinet Secretary, when Delivering for Remote and Rural healthcare was published.

The term is used in Delivering for Remote and Rural Healthcare but is not defined in any detail and Annex 1 to this letter has been developed, by the Remote and Rural Implementation Group, to define the concept and provide guidance on where Obligate Networks will be required and, how these should be agreed between NHS Boards.

Obligate Networks should be established between NHS Boards to sustain core services and ensure access to four key specialist services not routinely available in Rural General Hospitals (RGHs), including Child Health, Mental Health, Radiology and Laboratories.

NHS Boards are asked to consider the proposed framework and report on plans, either in place or intended, on establishment of the proposed Obligate Networks and to identify other or future priorities to RRIG by email to nospgr@nhs.net no later than 31st **March 2009**.

Yours sincerely



Derek Feeley
Director
Healthcare Policy and Strategy
Directorate



Roger Gibbins
Chair,
Remote and Rural Implementation
Group

A Framework for Obligate Networks

This paper explores the concept of Obligate Networks and makes recommendations on the way forward. Consultation of the proposed framework has been wide and has included all Boards and regions across NHS Scotland.

Background

Throughout the engagement process, which preceded the publication of 'Delivering for Remote and Rural Healthcare'¹, a number of common requirements were identified by those working in remote and rural locations as necessary building blocks to ensure sustainability of local services and appropriate access to more specialist care for their communities. These common requirements included clinical decision support, education and training, quality assurance and standards, transport and formal support networks. Networks were seen clearly as the way forward but it was highlighted by a number of different practitioners, working in different areas of care, that a more formal approach would be required, agreed collectively between the remote and rural health system and those in the larger centres with access to more specialist services, if local access to was to be sustained. Delivering for Remote and Rural Healthcare highlighted that:

“Services must be planned and co-ordinated with a greater focus on more collective and collaborative responses within and across communities. **This will include the formalisation of networks to ensure that larger centres are obligated to support and sustain healthcare services in remote and rural areas.**”²

Two types of networks were envisaged: vertically, between specialist centres and remote and rural communities to support access to services and clinical expertise not available within the community; and lateral networks, between remote practices and RGHS to ensure common standards, protocols, training and development and to share good practice.

Networks within NHS Scotland

The network concept within NHS Scotland is not new. Although in existence as a model, before the Acute Services Review in 1998³, this far-reaching strategy identified clinical networks 'as arguably its most important recommendation'⁴ of the Review, with Managed Clinical Networks seen as offering:

“...the best prospect for delivering high quality services which make optimal use of resources and offer more uniform access to patients... Development of networks is not the same as centralisation and any need to concentrate high technology services will be balanced by increased outreach services for the population served.”⁵

¹ (2008) "Delivering for Remote and Rural Healthcare" May 2008, Scottish Government, Edinburgh. RR Donnelly B56045 05/08

² Ibid, p5 emphasis added.

³ (1998) "Acute Services Review" May 1998, Scottish Office, HMSO

⁴ Ibid, p135

⁵ Ibid, p135

The concept of Managed Clinical Networks was accepted as extant health policy and the first guidance was issued in February 1999⁶, defining MCNs as:

“...linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, unconstrained by existing professional or Health Board boundaries, to ensure equitable provision of high quality clinically effective services throughout Scotland.”⁷

This initial guidance identified a role for MCNs in supporting remote and rural communities ‘concerned with a number of specialities rather than one single speciality or disease’ (para 4), and established a number of core principles for MCNs (Appendix 1). These principles have remained largely unchanged in later guidance^{8 9}, although the most recent guidance has removed the reference to the role of networks in development of the intermediate specialist, referring instead to the development of new or extended roles^{10 11 12}, which perhaps reflects the evolving nature of healthcare over the last decade. The support for remote and rural health services has been seen but has tended concentrate on speciality specific support.

One of the identified strengths of MCNs is their flexibility, built on a democratic consensual style¹³, and the concentration on clinical outcome and service improvement, with achievement of standardisation through the development of shared protocols, but without direct accountability for service delivery. In terms of delivering for remote and rural areas, the attendant lack of formality can also be a weakness.

HDL (2007) 21 also provided guidance on regional and national MCNs. This reproduced at Appendix 2, for ease of reference, however the role envisaged for these MCNs:

“1. ...to clarify and support the development of patient pathways across Board areas when the service cannot be provided in one Board area alone. They are therefore **focused on common protocols, training and audit**¹⁴.”

“4. It is important to emphasise, particularly in the regional and national contexts, that MCNs should not be viewed as a means of filling a funding gap in existing services. However, they **can** exert influence through their integration into regional planning processes and through their role as vehicles for developing an evidence base to support quality improvement and service developments.”

and perhaps more importantly the role that they are excluded from highlights the gap that the obligate network will need to resolve.

‘Better Health, Better Care’¹⁵, published in December 2007, reaffirmed the importance of networks within NHS Scotland, positioning them as an organisational expression of the values of cooperation and collaboration that lie at the heart of Scotland’s mutual approach to health services. It went on to identify the need for the traditional MCN model to be strengthened in some circumstances, to address particular service planning challenges,

⁶ NHS MEL (1999) 10 “Introduction of Managed Clinical Networks within NHS in Scotland” 9th February 1999, Scottish Office.

⁷ Ibid, para 3

⁸ NHS HDL (2002)69 “Promoting the development of MCNs in the NHS In Scotland” 18th Sept 2002, Scottish Executive

⁹ NHS HDL (2007) 21 “Strengthening the Role of Managed Clinical Networks” 27th March 2007, Scottish Executive

¹⁰ MEL (1999)10 para 8.9

¹¹ HDL (2002) 69 para 11.9

¹² HDL (2007) 21 para 10.5

¹³ Ibid, para 23

¹⁴ Emphasis added

¹⁵ (2007) “Better Health, Better Care” December 2007, Scottish Government, Edinburgh. RR Donnelley B53881 12/07

such as, in the provision of neurosurgery and specialist children's services. Work has been taking place on both these issues since the publication of Better Health Better Care and a proposal to establish a Managed Service Network for Neurosurgery was accepted by the Cabinet Secretary for Health and Wellbeing in January 2008.¹⁶

At the National Directors of Planning Business Meeting on 5th August 2008, a paper¹⁷ was presented which outlined a number of overarching principles, identified by the Neurosciences Working Group, as necessary for the establishment of an MSN. Whilst clearly developed for a different purpose, these overarching principles of coherence, consistency, sustainability and redesign are helpful in refining the obligate network concept further. It is suggested however, that whilst the seven key criteria may have applicability for obligate networks, the underpinning detail may be different.

Delivering for Remote and Rural Healthcare

Delivering for Remote and Rural Healthcare, the final report of the remote and rural work stream established following the publication of the 'National Framework for Service Change'¹⁸ was accepted by the Scottish Government in spring 2008. The Report identified the importance of a network approach to sustain **core services** in **medicine, surgery and anaesthesia** and identified **four** more specialist areas for the development of networks as a priority, including: **Child Health, Mental Health, Radiology, Laboratories**. Since publication, work has been ongoing to further determine the detail in respect of both the core services and these specialty areas.

The service models and care pathways group are developing care pathways for the most common conditions and these pathways are built on a clear expectation that whilst many of the services will be available locally, these services will, for some patients, network with another centre, where a wider range of diagnostics and treatments are available. These relationships require to be defined.

Within the more specialist service networks, perhaps the furthest advanced work is in relation to the development of a Managed Care Network for Mental Health between NHS Grampian and NHS Orkney and NHS Shetland. This network will not be a single entity but a collaboration of the four main sub-specialty areas that make up main stream mental health services, including adult mental health, older people (mental health), Learning disability, and Child and Adolescent Mental Health Services, coming together under the umbrella of one obligate network.

It is intended that some specialist services for children may also be sustained through a networking approach. In relation to children's cancer, a permissive network¹⁹, has been proposed. No further guidance is currently available, although work is ongoing at this time.

Obligate Networks

The aim of 'Delivering for Remote and Rural Healthcare' is to provide a framework to ensure sustainability of, or access to, services. Obligate Networks were identified by that report as key building blocks of this framework. These may be Vertical Obligate Networks to support

¹⁶ (2008) "Neuroscience Implementation Group: Report to Cabinet Secretary for Health and Wellbeing" Jan 2008. unpublished

¹⁷ Feeley D (2008) 'Managed Service Networks (MSNs)' BP 27 (08), unpublished

¹⁸ (2005) "National Framework for Service Change" May 2005, Scottish Executive (2005) "Delivering for Health" November 2005, Scottish Executive

¹⁹ (2007) "National Steering Group for Specialist Children's Services: Report on Children's Cancer Services in Scotland: Option Appraisal – Children's Cancer" p 7, Nov 2007, Scottish Government.

access to services and specialist expertise; or they may be Lateral Obligate Networks that ensure common standards of care.

It is likely that Vertical Obligate Networks that sustain clinical services will be the most prevalent type of Obligate Network. Delivering for Remote and Rural Healthcare identified only one Lateral Obligate Network that needed to be established, a network between the RGHs. It is recommended that RRIG should undertake this function in the initial stages of implementation and ensure that there are robust ongoing arrangements for the future, once the role of RRIG is concluded.

Obligate networks will require a degree of formality, often missing from the traditional MCN approach, if services in remote and rural areas are to be sustained for the long term. The way in which this will be achieved is summarised in the Framework below. A comparison of the requirements from the different networking vehicles and the additional requirements from Obligate Networks is provided at Appendix 4.

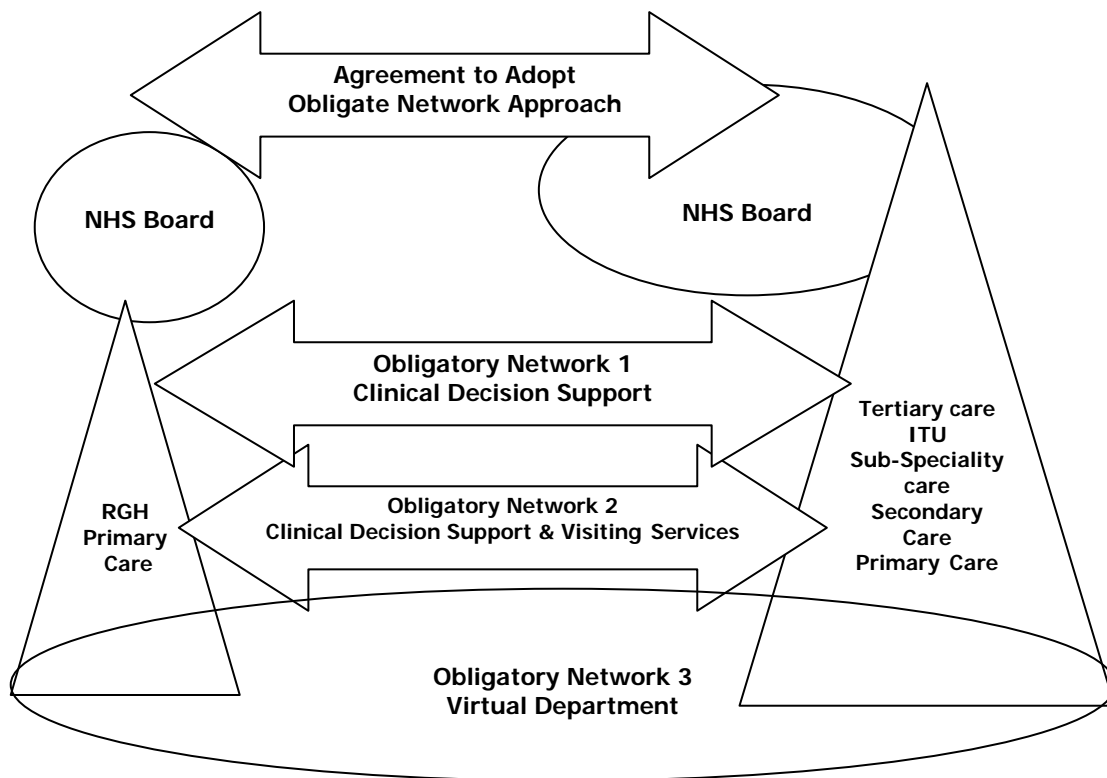
Defining an Obligate Network

An Obligate Network is a formalised arrangement between two or more healthcare organisations that secures access to sustainable services for the whole population served by these organisations. Obligate Networks may be strategic between NHS Boards, who will agree a basket of services to be provided within that arrangement, or they may be at an operational service level between a specialist service and a more generally based service. These networks will provide:

- Access to expert opinion to inform and support local decision making, which may be 24/7;
- Development of shared protocols and pathways;
- Improved discharge planning;
- Transfer Debriefs;
- Peer Group support, training and education; and
- Rotation for Skills update and maintenance, this may include joint appointments.

Whilst aimed at clinical service sustainability, obligate networks may also provide benefits for non-clinical services.

The obligation arrangements may differ between services, the obligation may be limited to ensuring clear pathways of care, where more specialist diagnostics or treatments are not locally available, this may be supported by a visiting service and limited clinical decision support, or it may be more far reaching, with the creation of a virtual department, with joint appointments. The specific arrangements will need to be agreed on a speciality specific basis and may require larger departments to make significant changes to current working arrangements. The following graphic describes the model:



It is recognised that whilst there may be existing arrangements between NHS Boards, in order to maximise the available capacity across Scotland, Obligate Networks, particularly, although not exclusively, for clinical decision-making, could be provided by an NHS Board, not normally linked with the more remote Board.

It has also been recognised that obligate networks for clinical support services may differ for individual clinical pathways. For example, patients from the Western Isles are currently transferred to Raigmore for ENT surgery. NHS Western Isles could enter into an obligate network with NHS Greater Glasgow & Clyde for radiology services. This should not be seen as a reason to change the definitive patient pathway, but, there will need to be arrangements in place to ensure that this does not add to the steps within the pathway and arrangements between clinicians will be required to ensure appropriate communication.

Framework to Develop Obligate Networks

The comparison of the different network vehicles provides a number of steps towards the establishment of Obligate Networks.

1. Establish heads of agreement at regional or Board level to the principle of an obligate approach to service delivery and sustainability. This must be written and must clearly define the nature of the obligation. Whilst many boards will currently have agreements in place, in relation to a number of services, through Service Level Agreements, the underpinning philosophy of an Obligate Network is different, based on partnership and mutuality of responsibility, rather than buying of a service. It is about dual responsibility and accountability for the service.

2. Ensure Chief Executive Leadership, supported by appropriate Medical Director and functional Executive support. The appropriate Regional Planning Group may undertake this function for arrangements between NHS Boards.
3. Agree a work programme for the services to be included within the Obligate network and identify priorities for development.

For each Specialist Service where an Obligate Network is to be established:

4. Define the range of service provision required/included (e.g. specialist input - visiting or telemedicine clinics, MHO cover etc). This must be written and clearly define the nature of the obligation.
5. Structural arrangements for the Obligatory network should be clear, with clear identification of the Lead Clinician and Lead Service Manager at specialist service level. Arrangements for administrative and data collection support must also be clear.
6. A Network steering group should be established with multi-professional/multi-disciplinary representation from each participating service/organisation. In some areas it may be possible to combine this role across disciplines e.g. between an RGH and a centre that has sub-specialist surgical services, one Steering group may be more appropriate.
7. The network may consider that a co-chairing arrangement or joint clinical leads is an appropriate model to cover boundaries. These posts should be from different organisations.
8. Service users and/or carers and representatives of the voluntary sector should be members of the obligate network. In some circumstances, it may be more appropriate to engage with service users and carers in a different way, it is important however, that their views can influence the design of services.
9. Map current service provision by specialist service and identify the gap between current and future services. This should include ensuring meeting NHS targets and improvement to services and may require redesign.
10. Agreement in principle establishment of network and formal Board sign-off in each Board will be required.
11. Develop a Project Plan for development of Network to include key elements, including:
 - Identified range of service provision;
 - Common care pathways, protocols and standards;
 - Established e-health links, including tele-health opportunities and web design;
 - Integrated approach to workforce planning;
 - Programme of training and education;
 - Plan for communication and stakeholder engagement;
 - Data Collection/Analysis, including ensuring that services are supported by an appropriate evidential base;
 - Agreement of key performance indicators and plan to implement and monitor these;
 - Arrangements for the management of risk;

- Programme of audit and framework for clinical governance and quality improvement; and
 - Service user and carer input.
12. Establish appropriate governance arrangements for the Obligate Network. Where the Network expands beyond Board boundaries specific arrangements will be required to ensure that each Board is assured that appropriate standards of clinical, corporate and staff governance are met. These arrangements should link with the governance arrangements in place at regional level.
13. All workplans should be approved by the accountable body(ies). This may be a Board or may be through the Regional Planning Structures established by Boards. Each network should provide an annual report on progress and service improvement.

Appendix 5 provides a standard template for use when proposing the establishment of an Obligate Network.

Conclusions

An Obligate Network, as envisaged by Delivering for Remote and Rural Healthcare is something more than the traditional MCN approach in place in Scotland. It will require a degree of formality, excluded from these arrangements and it may be required to fill a gap in service delivery. This is particularly relevant for the vertical networks identified in the report.

RRIG will establish arrangements to establish a lateral Obligate Network between the Rural General Hospitals and the relevant NHS Boards.

To sustain services in remote and rural areas there will need to be a formal agreement between Boards, in the North this may be part of the recently announced Island Partnership approach²⁰, part of the regional planning structures, or it may be something more than that. It will also, however, require agreement at speciality level. In terms of speciality level, there is an urgent need to establish obligate networks to sustain core services and to address the four specialist service priorities identified: Child Health, Mental Health, Laboratories and Diagnostics.

Agreement of a definition is however only the first step. This paper identifies a process to progress the development of this concept, both between organisations and at speciality specific level. To date, there has been an ‘in principle’ acceptance of this approach as a vehicle to sustain services, it is now time to test the approach and move from concept to reality.

Next Steps

As noted above, the priority areas for action have been identified as: sustaining core services and developing networks to ensure access to four key specialist services not routinely available in RGHS, including Child Health, Mental Health, Radiology and Laboratories. These priority areas are not an exhaustive list, however, further priorities will be for NHS Boards to determine.

²⁰ (2008) Letter from Colin Cook to Chairs and Chief Executives of NHS Grampian, Highland, Orkney, Shetland & Western Isles. 8th July 2008

NHS Boards should consider the Framework for Obligate Networks and report on plans, either in place or intended, on establishment of the proposed networks. RRIG will offer to facilitate and support the establishment of Obligate Networks, where Boards request this support.

Extract from HDL (2007) 21: Strengthening the Role of Managed Clinical Networks

“Core Principles

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

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

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

10.3 Each Network must have an annual work plan, setting out, with the agreement of those responsible for delivering services, the intended service improvements, and, where possible, quantifying the benefits to service users and their families.

10.4 Each Network must use a documented evidence base, such as SIGN Guidelines where these are available, and should draw on expansions of the evidence base arising through audit and relevant research and development. All the professionals who work in the Network must practice in accordance with the evidence base and the general principles governing Networks.

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

10.6 Each Network should include representation by service users and the voluntary sector in its management arrangements, and must provide them with suitable support in discharging that function. Each Network should develop mechanisms for capturing service users’ and carers’ views, and have clear policies on improving access to services, the dissemination of information to service users and carers, and on the nature of that information.

10.7 Each Network must have a quality assurance programme which has been developed in accordance with the arrangements set out by NHS Quality Improvement Scotland. The social work Performance Improvement Framework (PIF) and developing work on joint inspection will be relevant to multi-agency Managed Care Networks.

10.8 Networks’ educational and training potential should be used to the full, in particular through exchanges between those working in the community and primary care and those working in hospitals or specialist centres. All Networks should ensure that professionals involved in the Network are participating in appropriate appraisal systems which assess

competence to carry out functions delivered on behalf of the Network, and that the participating clinicians are involved in a programme of continuous professional development.

10.9 There must be evidence that the potential for Networks to generate better value for money has been explored.”

Extract from Annex to HDL (2007) 21: Strengthening the Role of Managed Clinical Networks

Regional MCNs

1. The aim of all Regional Networks is to clarify and support the development of patient pathways across Board areas when the service cannot be provided in one Board area alone. They are therefore focused on common protocols, training and audit.
2. Generally, the arrangements which are being put in place by the 3 Regional Planning Groups relate to the assessment of applications to become a regional MCN to ensure that there is clarity about the benefits to be gained through the development of the Network, as well as clarity about the management and clinical lead arrangements, and any costs involved.
3. There is also an important role for inter-regional MCNs. These may cover 2 or more regions, and in some cases which would not meet the criteria for designation as a national MCN, may need a Scotland-wide scope through a co-ordinated approach by all 3 Regional Planning Groups.
4. It is important to emphasise, particularly in the regional and national contexts, that MCNs should not be viewed as a means of filling a funding gap in existing services. However, they **can** exert influence through their integration into regional planning processes and through their role as vehicles for developing an evidence base to support quality improvement and service developments.
5. Each MCN must have clarity about its accountability and governance arrangements, and differentiate between governance, accountability, performance management and accreditation. The core principles set out in paragraph 10 of the main HDL apply to regional MCNs.

MANAGED SERVICE NETWORKS (MSNs)

The following is a summary of the paper presented to the National Directors of Planning Group in August 2008.

1. Overarching principles

MSNs should enable:

- Coherence
- Consistency
- Sustainability
- Redesign

2. Any proposal to develop an MSN should be tested against **seven key criteria**:

(a) Ownership/Leadership

MSNs must be owned by Boards. They should be chaired by 'honest broker' at CEO (by CEO who was not from 'provider' Board). It was recognised that Clinical Leadership was vital and should be provided by a Medical Director. MSNs also need a Director who would be a senior person from a Board. The CEO, Medical Director and Director should each come from a different Board.

(b) Commissioner/Provider Relationship

The underpinning philosophy was to keep things together as much as possible; i.e.

- MCN a subset of the MSN
- Links to National Planning Forum would be important
- Standards and transparency should guide the design and specification of services

(c) Infrastructure

A number of key infrastructure requirements were identified:

- eHealth should prioritise MSN requirements, including telehealth
- ISD to form data consultancy
- a managerial infrastructure would be necessary
- audit/data infrastructure would be crucial

(d) Governance/Accountability Authority

The governing principle should be that MSNs needed to work within existing governance and accountability arrangements. It was recognised that:

- an escalation process was required
- IST & QIS might have a role

(e) Funding

There was a strong preference that resources should be **pooled** not top-sliced and vested in statutory authorities.

(f) Quality Improvement

It was agreed that MSNs should be vehicles for improvement and should pursue sustainability and redesign through standards.

(g) Workforce/Staffing

Key requirements include:

- clarity about roles
- job planning important
- workforce planning and development sitting alongside service
- planning in the MSN

3. In comparing the outline models against the above criteria, the clear preference was for a **consortium approach** with the following key features:

- A single Consortium (i.e. including providers and purchasers)
- Chaired by Non-Provider
- Large and small boards involved
- All provider boards as members
- Service Leaders at the table (and linking to the MCN)
- Patient/public reps important
- National Planning read across to be considered as this work develops

Comparison of the Requirements from Different Networking Vehicles

MCN Criteria	MSN Criteria	Underlying Principle	Obligate Network
		Aim	Sustain service delivery either through local access or clinical decision support
Management Arrangements Lead clinician/officer Accountability Network manager Annual Report	Ownership/Leadership CEO/MD/Lead Director Managerial infrastructure Governance and accountability	Management Arrangements	Once structure (next) agreed, clear management arrangements to: Progress individual service agreements, within context of wider agreement. Must involve local lead clinicians, managers, with finance and planning support
Defined structure Relations to planning functions	Commissioner/provider relationship Infrastructure to support, including eHealth	Structure	Services included agreed strategically between Boards, involving Chief Executive, Director of Finance and/or Planning and MD. May be convened regionally. Clear identification of services to be included. Detail agreed at service level.
Workplan for Service Improvement		Performance management	Agreed workplan within strategic context to agree which services. Each service produce a workplan with KPIs. Priority to standards & protocols
Documented evidence base & agreement to practice in accordance with evidence. Audit	Audit	Standards/Evidence base	Services should be planned and delivered in accordance with the evidence base. Audit support should be provided.
Multi-disciplinary/multi-professional New roles	Workforce/staffing	workforce	Multi-disciplinary/multi-professional engagement in network. Engagement of wider community partners necessary in some networks e.g. mental health

			Detailed workforce planning for the multi-professional/multi-disciplinary team undertake within context of network.
Service user/voluntary sector involvement	Patient/public reps	PFPI	PFPI engagement in speciality specific networks.
Quality Assurance Programmes	Quality Improvement	Quality Assurance	Quality Assurance Programmes
Education and Training Appraisal & CPD		Education & training	Key aspect of obligate network. Training & education plans to be developed within workplan.
Value for money	Funding should be pooled	Performance management	Service meets key NHSS targets including 18 week RTT.

1. Obligate Network – Standard Assessment Framework

This paper outlines in a standard proforma the basic information that should be expected to be described before approval to establish an Obligate Network is made by NHS Boards. NHS Boards may also require additional information.

It is accepted that some of the elements may not be available at an early stage but will be required to be addressed over time by the Obligate Network and would provide, in the early stages a reporting template.

Obligate Network Criteria	1.1.1 Obligate Network Response
Proposed Obligate Network	[Insert overall service title]
Participating NHS Boards	[insert names of all participating NHS Boards]
Aim of Network	[insert brief description of the aims of the network including detailed explanation of services to be included]
Organisation: Management Arrangements and Accountability	Identify lead executive in each NHS Board overseeing obligate network
Lead Clinician	Insert name Note: it may be appropriate to have joint clinical leads.
Lead Service Manager(s)	Insert name and designation
Identified lead in each participating NHS Board	Insert names and designation
Network Steering Group	Explain organisational arrangements in place to oversee network between NHS Boards, including accountabilities
Chair of Steering Group	Insert name and designation. Note: it may be appropriate to have co-chairs. These should come from different organisations.
Members of Steering Group	List names of others not identified above.

Service User, Carer, Voluntary sector representatives	List names/organisations
Evidence to support establishment of network	Brief description of population need, service deficits.
Expected outcomes	Brief description of improvements sought by approach.
Resource Requirements	Identify capital and revenue resource requirements and funding sources.
Project Plan (may include one or more of these elements)	<ul style="list-style-type: none"> • Identified range of service provision; • Common care pathways, protocols and standards; • Established e-health links, including tele-health opportunities and web design; • Integrated approach to workforce planning; • Programme of training and education; • Plan for communication and stakeholder engagement; • Data Collection/Analysis, including ensuring that services are supported by an appropriate evidential base; • Agreement of key performance indicators and plan to implement and monitor these; • Programme of audit and framework for clinical governance and quality improvement; and • Service user and carer input.
Governance and Risk Arrangements	Identify Governance arrangements: corporate, clinical and staff and identify reporting arrangements to each participating NHS Board. Management of risk should be explicit, including where the risk is carried when the service is unavailable.
Diversity & Equality Assessment	
Other Information	

March 2009