Child protection clinical networks project, CPSIG meeting November 09

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What are clinical networks?

- Clinical networks already DH policy – promoted in Child Health Strategy
- *'Linked groups of professionals and organisations from primary, secondary and tertiary care,* ***working in a co-ordinated manner, unconstrained by existing professional and (organisational) boundaries****, to ensure equitable provision of high quality clinically effective services…'*(Scottish Department of Health, 1999)
- *'Networks can be viewed as* ***a framework within which services are developed and delivered in a coordinated and integrated fashion****'* (C Ewing and H Edwards, RCPCH, 2009, DRAFT)

What are clinical networks?

- **Learning / informational network**
  - Association - informal group that corresponds or meets to consider specific topics, best practice and areas of common interest
  - Forum – more formal group that meets regularly, has an agenda that focuses on specific topics, develops shared protocols
  - Classified as 'enclave' networks - weak regulation / strong integration

What are clinical networks?

- **Developmental network**
  - Forum with a broader focus than purely topic-based issues
  - Develops new forms of integration / operation between professionals and organisations, often based on care pathways
  - Compliance is voluntary, no binding contract, financial and clinical responsibilities remain separate

What are clinical networks?

- **Managed clinical network (MCNs)**
  - Key feature: clear governance and accountability
  - A type of 'hierarchical' network – strongly regulated and strongly integrated with authority and influence
  - Common features of such networks include: joint provision of a defined package of services; regulation; pooled finances

(Typologies based on: 'Development of Networks', C Ewing and H Edwards, RCPCH, 2009, DRAFT; and 'Guide to Promote Shared Understanding of the Benefits of Managed Local Networks', DH, 2005)

What are clinical networks?

- **Networks and child protection**
  - We know that learning and informational networks exist across the country e.g. designated professionals' networks
  - The aim of this project is to consider whether more formalised networks (which already exist in some places e.g. Northumbria Paediatric Forensic Network) could help to address the variability in practice and ensure greater governance and accountability

The benefits of clinical networks

- Increases the **coordination / integration** of services, and therefore the patient experience
- Facilitates the **sharing of best practice**, knowledge and experience, and **stimulates creativity**
- Motivates local **improvement** through audit and benchmarking
- Ensures **equity and consistency** in service quality
- Provides access to **expertise**
- Enables **comprehensive local services** through pooling scarce resources
- Enables staff **development** and **support,** for example through joint peer review

Aim of project

1. To establish the potential **benefits and feasibility** of developing child protection clinical networks, including impact on:
   - Service quality, such as access to specialist advice, clinical governance
   - Staff experience and competence, such as peer review, supervision, training, recruitment
   - Other factors, such as workforce planning, service user involvement, research

Aim of project

2. Subject to this, to develop **proposed models** for child protection clinical networks, including consideration of:
   - Commissioning, regulation and links with LSCBs
   - Financial arrangements and implications
   - Management arrangements
   - Impact of local demography and geography on the optimal shape of the network

Scope

- Child protection rather than safeguarding as a whole
- Enabling NHS to fulfil responsibilities for child protection rather than entire child protection system
- English structures and systems, although key messages about networks should be applicable to all UK

Output

- Recommendations on clinical networks for child protection to DH and RCPCH (not a strategy for implementation at this stage) by end 2009 / early 2010

Methodology

Key questions to answer

- What are the key standards that child protection services should meet? – what are we aiming for?
- What's working well and less well in child protection health services?
- What role could clinical networks play in addressing any issues?
  - Is there best practice that can be shared?
  - Can we learn from networks in other service areas?
  - Can we draw any international comparisons?

Methodology

- **Literature review**
- **Interviews, service visits, discussion forums**
  - Multi-disciplinary health professions
  - Commissioning, service management
  - Range of settings – urban, rural; community, acute, tertiary
  - Child protection networks already in existence / development – Scotland
  - Clinical networks in other service areas – cancer and neonatal
- **Multi-agency, multi-disciplinary Project Advisory Group**

Key problems

1. **Variations in service quality**
- Clear evidence of significant variations in service delivery and quality (2006 survey of forensic services by Pillai and Paul; my visits across country; interviewees' expert witness work; CQC review, 2009)

a) Variations in availability of high quality CSA services
- Areas without 24/7 cover due to lack of professionals with sufficient competencies and experience, low volume of cases and specialised equipment required
- Gaps in rota dealt with in adhoc way without formal referral / funding arrangements

Key problems

b) Variations in access to specialist opinions / investigations
- Evidence-base not well developed, increasing need for specialist advice on complex cases
- Variations in investigations conducted, and in consultation with experienced professionals to interpret results
- Specialists in child protection contacted on ad hoc basis to give advice on complex cases, resulting in concerns about:
  - Funding and capacity to deliver the advice
  - Whether professionals are indemnified for advice given
  - Lack of governance arrangements
  - Lack of forward planning for retirement / movement of skilled professionals
- When child admitted to tertiary centre, a few interviewees reported insufficient information reported back, lack of clarity about roles and responsibilities

Key problems

2. Variations in access to support and development for professionals
- Professionals working with children often feel undervalued, unsupported and at risk (Lord Laming, 2009)
- In some places regular local review of all cases; elsewhere more ad hoc
- Workload / capacity issues can prevent attendance at joint peer review meetings
- Insufficient advanced level child protection training
- Likely to be contributing to reluctance to take on child protection work among professionals in some places

Options for the way forward?

- Is there a case for developing more formal networks to address some of the issues identified?
- Key principle that services **delivered locally as far as possible** to maintain skill and ensure links with multi-agency partners
- But where insufficient capacity or specialist experience, could services be delivered through network arrangements between organisations?
- What might these specialist services include?:
  - CSA
  - Formal advice on the most complex cases
  - Comprehensive range of specialist investigations by other disciplines (paediatric haematology, radiology, ophthalmology etc)
  - Advanced level training and peer review

Options for the way forward?

- A number of different networking arrangements depending on where the skills are
- Focus on developing local experience through advice and peer review rather than keeping specialist knowledge in the centres
- All services supported by agreed pathways, policies, and standards, with regular audit

Challenges?

- What would be the optimal **commissioning arrangements**, especially since within a region child protection expertise is not located in one centre?
- What should be the **governance arrangements / accountability** for joint peer review?
- What **management / leadership capacity** is required to make it happen? – to plan pathways, set standards and audit?
  - What is the role of the designated professionals networks, commissioners, and SHA safeguarding leads?
- How ensure designated **specialist providers have sufficient capacity** to deliver opinion and advice to local services?

Challenges?

- Where children do need to be referred, e.g. for CSA examination, what are the factors that determine the **appropriate size for the network**?
  - Balance between sufficient cases to make service delivery affordable and to maintain skills, while avoiding excessive travel and maintaining links with multi-agency partners
- How ensure local professionals do not refer all patients where child abuse suspected, resulting in **loss of local skill and links with local services?**
- Would network arrangements involve **motivating professionals** to adopt new ways of working, or is it about formalising what is already happening?
- How ensure network arrangements clarify processes, roles and responsibilities, rather than adding **another layer of organisational complexity / bureaucratic burden** that detracts from clinical work?

Your views and advice?

1. Have we correctly identified the issues?
   - Have you experienced these problems?
   - Have we missed anything?

2. What are your ideas for the way forward?
   - What are your views on the idea of developing specialist centres for advice on the most complex cases, for peer review, training etc?
   - How different is this to what is already happening?
   - Are there other solutions?

3. How do we get there?
   - What are the challenges / barriers to moving forward, and how do we address these?