

CHILD PROTECTION CLINICAL NETWORKS

Protecting Children, Supporting Clinicians

Foreword by Dr Sheila Shribman and Professor Terence Stephenson

The Department of Health (DH) and the Royal College of Paediatrics and Child Health (RCPCH) jointly commissioned this project in response to concerns about the contribution of health services in protecting children and young people from harm. While we recognise much excellent work and considerable progress in many places, a number of inquiries and reviews over the last ten years have shown that children and young people do not yet have equitable access to high quality care.

Recent failures highlight the critical importance of ensuring that clinicians have appropriate skills and competencies and work in a supportive environment with a clear governance framework.

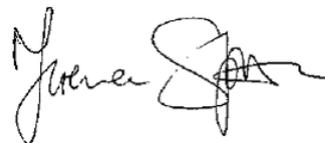
This project has demonstrated the unique potential of managed clinical networks (MCNs) to achieve this. MCNs provide the robust arrangements across organisations and the collective capacity and expertise to ensure equitable access to specialist advice, high quality training, development and support for clinicians, and to facilitate strategy development, governance, and quality improvement.

The health service plays a key role in protecting children and young people, and we are determined to ensure that all clinicians across the country are appropriately equipped, trained, and supported to carry this out.

Discussions with members of the Advisory Group and others formed a critical part of this project, and we would like to thank all those who shared their thoughts and experiences. Our intention now is to engage in further discussion with stakeholders on the implications for implementation and the next steps for the project.



Dr Sheila Shribman



Professor Terence Stephenson

Contents

| | Page |
|---|-------------|
| Executive summary | 2 |
| Introduction | 3 |
| Project aims, scope and definitions | 4 |
| Clinical networks to ensure equitable access to specialist clinical skills and experience | 8 |
| Problems | 8 |
| Proposals | 11 |

| | |
|--|----|
| Challenges | 16 |
| Regional or sub-regional over-arching multi-professional MCNs for child protection | 18 |
| The key features and functions of MCNs for child protection | 19 |
| Key considerations in developing MCNs | 23 |
| Challenges to the proposal for MCNs | 25 |
| Other proposals | 28 |
| Conclusions | 29 |
| References | 30 |
| Appendices | 32 |
| A. The prevalence of child maltreatment | 32 |
| B. Advisory Group Terms of Reference and involvement | 33 |
| C. Research methodology and limitations | 34 |
| D. Case studies | 35 |
| E. Key messages from the interviews and group discussions | 39 |

1. EXECUTIVE SUMMARY

- 1.1. The project aimed to establish the potential benefits and feasibility of developing clinical networks for child protection health services.
- 1.2. This paper provides background information on the project and on the concept of clinical networks. It then explores the problem of inequitable access to specialist clinical skills and experience for the provision of advice on complex presentations to local clinicians, and for conducting Child Sexual Abuse (CSA) assessments.
- 1.3. To address this, formally commissioned **specialist advice networks** are proposed, although the paper emphasises that local treating clinicians should retain responsibility for the clinical management of children and young people (C&YP). The paper also includes a discussion of the network approach to delivering CSA services, enabling scarce specialist skills and equipment to be pooled.
- 1.4. The paper then explores the potential of **over-arching managed clinical networks** (MCN) to provide population-based support to commissioners, and to lead on strategy development, governance and quality improvement, and professional training, development and support. To take on these roles, an MCN would require a network board, and management and leadership capacity.
- 1.5. The paper outlines a number of key considerations in developing MCNs, including the importance of avoiding tight control of member organisations, ensuring sufficient authority to influence change, and the need for clarity around role and remit, particularly in relation to clinical governance and accountability. Finally, the paper considers challenges to the development of

MCNs, most importantly the resource requirements and the question of whether an MCN is needed to achieve the desired ends.

2. INTRODUCTION

- 2.1. Following the tragic death of Baby Peter, Lord Laming published a Report (2009) which aimed to assess progress since his Inquiry into the death of Victoria Climbié (2003). This Report and others (CQC, 2009a; CQC 2009b) demonstrates that services still need to do more to protect C&YP from harm, and highlights inadequacies in the quality of health services and in the support available to clinicians.
- 2.2. To address these problems, existing legislation and guidance must be understood and implemented properly. However, there is also a need to ensure clear and effective *systems* for the delivery and development of services and the support and training of clinicians, with clear and robust governance and accountability arrangements.
- 2.3. The first half of this paper focuses on particular problems around the health assessment and management of C&YP who are suspected to be suffering or likely to suffer harm from carers. Every clinician should have the skills and competencies to identify C&YP who may have suffered harm. However, the assessment and management of C&YP with complex or infrequent presentations of maltreatment, and who may have experienced sexual violence or abuse, will require involvement from clinicians with extensive experience and with specific knowledge, skills and competencies. In many places, these clinicians are not available locally. As a result, specialist involvement may be absent or may be sought on an informal basis. Such arrangements are inadequate as they fail to ensure an equitable and high quality service for all C&YP.
- 2.4. The second half of the paper explores the inequities in access to high quality training, and opportunities for development and support for all clinicians involved in child protection.
- 2.5. In other areas of paediatrics, clinical networks have been developed to facilitate equitable access to safe and sustainable specialist services in appropriate settings and as close to home as possible, and to ensure high quality training, development and support for clinicians, thereby improving skills and competencies, as well as recruitment and retention.
- 2.6. The need for integrated and seamless services that are organised around the needs of patients is a key message of *NHS 2010-2015: from good to great* (DH, 2009c). Pathways in clinical networks for paediatric services are promoted in key policy documents by the Department of Health (DH) and the Royal College of Paediatrics and Child Health (RCPCH), including *Healthy Lives, Brighter Futures* (DH, 2009a) and *Modelling the Future III* (RCPCH, 2009)¹, and are regarded as a means of achieving Quality, Innovation, Productivity, and Prevention (QIPP) (DH, 2009b).

¹ Also in *A guide to understanding pathways and networks* (RCPCH, 2006), *Managed Clinical Networks in Child Protection, Child Protection Committee Proposals* (RCPCH Scotland, 2007), the forthcoming RCPCH guide to developing networks, and *A guide to promote a shared understanding of the benefits of managed local networks* (DH and DfES, 2005)

- 2.7. The DH and RCPCH therefore committed to work together to explore the potential benefits of developing clinical networks for child protection. As health policy is devolved to Scotland, Wales and Northern Ireland, the project focused specifically on English systems.
- 2.8. This paper aims to establish whether there are drivers and potential benefits to developing clinical networks for child protection, and to provide a clear picture of the range of available options.

3. PROJECT AIMS, SCOPE AND DEFINITIONS

Project aims

- 3.1. The project aimed:
 - To establish the potential benefits and feasibility of developing clinical networks for child protection
 - Subject to the above, to develop a proposed model for child protection clinical networks.

The services covered

- 3.2. The project focused on:
 - Health services rather than the whole multi-agency system. Nevertheless, a key consideration is how network arrangements would impact on and interface with multi-agency working and how they would link with Local Safeguarding Children Boards (LSCBs)
 - Child protection services, and not 'safeguarding children' (for full definitions see *Working Together to Safeguard Children*, HM Government, 2006 and the forthcoming 2010 update)
 - English structures and systems.

The definition of clinical networks

- 3.3. 'Clinical networks' is a broad term and encompasses a range of structures along a spectrum from very loose to much more formal.

Informational

- 3.4. At the loose end are informational networks - groups that correspond or meet to share best practice and explore issues of common interest. These are sustained through shared commitment and common bonds, and have a flat structure with no central authority. Such informally governed networks are commonplace within paediatrics (Cropper, et al., 2002).

Coordinated

- 3.5. Moving along the spectrum are more formal 'clinical fora' or 'coordinated networks'. These have a broader focus than just clinical topics and may develop shared clinical protocols and conduct joint audit. Nevertheless, the financial and clinical responsibilities of members remain separate, there is no

binding contract and these networks tend not to be involved in the coordination of professional training and development.

Managed

- 3.6. At the most formal end are managed clinical networks (MCNs) which are defined by the DH and DfES as including 'the function of a forum, has a formal management structure with defined governance arrangements and specific objectives linked to a formal strategy' (p11, 2005). MCNs tend to involve a degree of pooled finance to support the delivery of activities.
- 3.7. NHS Scotland explains:
- 'While it could be said that in some areas clinicians were already networking very effectively across boundaries, the main difference in MCNs is that the process is actively managed, with the system supporting the work – rather than the work happening in spite of the system' (p4, 2002a).
- 3.8. MCNs tend to have three core functions: addressing the operational delivery of services, such as the referrals and communication between different services along the pathway; the coordination of professional development, training and peer support; and finally, strategy development, the provision of population-based support to commissioners, and clinical governance.
- 3.9. This latter function may include the development and monitoring of standards, and challenging services that do not meet these. MCNs are therefore defined in the literature as a type of hierarchical network – they have an organisational core (often a steering group or board) which has authority to 'regulate' the work of members (Goodwin, et al., 2005).
- 3.10. Although the exact nature of an MCN will depend on its rationale and purpose, *A guide to promote a shared understanding of managed local networks* identifies a number of core activities:
- Regular informal meetings and/or correspondence
 - Regular formal meetings
 - Sharing audit
 - Agreed protocols, management structure and governance framework
 - Service improvement projects across the network
 - Organisational development/network meetings
 - Work plan (which would need to tie in with other relevant plans)
 - Review of data collection
 - Dedicated management team with identified programme lead
 - Network strategy, including: workforce development, finance and investment, baseline audits
 - Network quality and clinical governance plan
 - Sharing events
 - Performance monitoring using common dataset
 - Confirmed relationship with local commissioners (DH, p39, 2005).
- 3.11. MCNs also facilitate integration between different professions and a team approach to the delivery of care, and promote the idea that the competence, training and facilities to provide a service are more important than professional labels (NHS Scotland, 2002a). Another key feature is the involvement of patients in shaping the MCN itself and the delivery of care.

The benefits of clinical networks

- 3.12. Although a great deal of literature on networks has been generated, the majority of the discussion tends to be theoretical, and there is a lack of systematic review and evidence about the value of networks as a means of improving patient care (Greene, et al., 2009; Edwards, B., 2002; Cropper, et al., 2002; Miller, 2008).
- 3.13. There is no single network type that is better than all others – the features of each type have both advantages and disadvantages (Goodwin, et al., 2005). The general benefits that are discussed in the literature are listed below.

Outcomes and value

- Stimulate creativity and the spread of innovation (Goodwin, et al., 2005) by increasing opportunities for interaction between professionals from different disciplines and organisations (Edwards, N., 2002)
- Provide a means of accounting for service performance across health care organisations (Cropper, et al., 2002), reduces variation in service standards and improves safety (DH and DfES, 2005)
- Allow early detection of problems through improved performance monitoring (DH and DfES, 2005; Edwards, B., 2002)
- Facilitate the translation of evidence into practice (RCPCH, 2006)
- Facilitate continual quality improvement (RCPCH, 2006)
- Facilitate a rise in advice-giving between units in the network (CSIP, 2005).

Patient experience

- Facilitate a more seamless patient journey (Goodwin, et al., 2005) and smoother service development through the increased integration and alignment to the patient pathway rather than to institutions or traditional professional fault lines (DH and DfES, 2005; Fraser and Edwards, 2001; NHS Scotland, 2002a; RCPCH, 2006; Wall and Boggust, 2003)
- Promote a focus on patient access and experience of care (Cropper, et al., 2002)
- Achieve shorter waiting times due to improved coordination and planning (DH and DfES, 2005)
- Ensure care is delivered as close to home/as locally as possible (CSIP, 2005; RCPCH, 2006)
- Facilitate service user involvement (DH and DfES, 2005; Lugon, 2003)
- Facilitate improved information for patients/parents (CSIP, 2005).

Equity

- Sustain vulnerable services and maintain access where the requirements of training and staff availability would otherwise have led to the closure of local services (DH and DfES, 2005; Edwards, B., 2002)
- Ensure equitable access to specialist services (including professionals and facilities) as these are designed across geographical, political and NHS boundaries (CSIP, 2005; NHS Scotland, 2002a)
- Once a user is identified at any point along the pathway, he/she can be pointed to all other parts of the service (DH and DfES, 2005)
- Increase the monitoring of service equity through governance arrangements (DH and DfES, 2005)

Staff experience

- Provide professionals with increased opportunities to shape services (DH and DfES, 2005)
- Facilitate a wider range of professional contacts and a greater understanding of the roles of colleagues (DH and DfES, 2005)
- Enable staff development, education and retention (DH and DfES, 2005), with opportunities for staff rotations within the network (CSIP, 2005; RCPCH, 2006)

Value for money and commissioning

- Optimise the use of resources (Edwards, B., 2002; Goodwin, et al., 2005) and facilitate sharing where resources are scarce (Cropper, et al., 2002; DH and DfES, 2005; Lugon, 2003) and iron out variations in demand (Edwards, N., 2002)
- Ensure resources are targeted at the parts of the pathways where investment is needed most (Edwards, B., 2002)
- Provide commissioners with a perspective from delivery agents (DH and DfES, 2005)
- Bring together multiple commissioners, providing opportunities for shared thinking (RCPCH, 2006).

Existing networks in child protection

- 3.14. The DH provided sponsorship for every SHA to establish networks of named and designated professionals with the aim of providing opportunities for peer support and review, and enabling members to discuss common issues and share best practice. These are informational or coordinated networks; they are not involved in the delivery of care; and their membership, formality, purpose and activities vary significantly.
- 3.15. In many places, there are other informational or coordinated professional support networks which have grown up organically according to local need and the enthusiasm of local individuals.
- 3.16. There is significant variation in service models for C&YP who may have experienced sexual violence or abuse. Some services are already delivered through clinical networks and elsewhere their development is under discussion.
- 3.17. In some places, a network approach to delivering Child Death Overview Panels is also already adopted. *Working Together to Safeguard Children* recognises that it may be appropriate for neighbouring LSCBs to share a Child Death Overview Panel, depending on the local configuration of services and the population served (HM Government, 2006). A small number of interviewees also referred to the possibility of developing collaborative teams across trusts for Rapid Response to Child Deaths.

4. CLINICAL NETWORKS TO ENSURE EQUITABLE ACCESS TO SPECIALIST CLINICAL SKILLS AND EXPERIENCE

Problems

Access to specialist clinical advice

- 4.1. All clinicians will on occasions reach the limits of their competence and confidence in assessing and managing a child or young person. In such situations, they must know whom to contact for further advice and support. This will be a specialist with skills and experience in the relevant area, based in a secondary or tertiary provider unit.
- 4.2. C&YP presenting with suspected maltreatment are no exception. All paediatricians should be competent to assess and manage the majority of C&YP, with named and designated professionals providing further advice as needed. However, the skills, experience and capacity of named and designated professionals are variable, and some complex presentations may be beyond their realms of experience and confidence.
- 4.3. All local services must have timely access to the full range of specialist skills and experience in order to offer a safe, equitable and high quality service to all C&YP. At present this is provided by doctors, but in the future, as nursing roles further expand and a team approach to the delivery of care is increasingly promoted, there is potential for nurses with specialist skills and experience in child protection to take on some of these roles.
- 4.4. In addition to paediatrics, advice may be required from specialists in specialties such as forensic medicine, paediatric radiology, neurology or ophthalmology². This may be sought directly by local doctors in these specialities, for example by radiologists in DGH settings, after first consulting their local paediatric child protection team.
- 4.5. Serious Case Reviews repeatedly highlight the importance of promoting a culture where respectful uncertainty, professional curiosity, and appropriate challenge is encouraged (Brandon, et al., 2009). In some instances, named and designated and other clinicians may need access to a specialist in order to discuss differing clinical views.
- 4.6. Occasions when specialist advice should be sought may include the assessment of C&YP with relatively infrequent presentations such as Fabricated or Induced Illness (FII), complex presentations where there is controversy around investigations, and some babies and children presenting with non-accidental head injury. Support may be needed to establish the appropriate investigations, to identify the clinical problem, to confirm and reassure that a diagnosis is correct, to advise on legal involvement, or to review a court report. Specific examples are provided below.

² Also including, for example: dermatology, paediatric dentistry, forensic odontology, genitor-urinary medicine, paediatric haematology, microbiology, nephrology, orthopaedics, pathology, psychiatry, surgery (including general paediatric surgery, maxillofacial, neuro-surgery, burns and plastics)

Examples where specialist advice may be required

A. Suspected non-accidental injury

A pre-school child presents with multiple fractures and a concerning history. The differential diagnosis includes non-accidental injury, but other causes of fractures must be excluded, including metabolic, genetic and nutritional disorders.

Advice and specialist investigations should be sought from those with specific knowledge and experience. X-rays and investigation results should be sent to specialists (including paediatric radiologists, geneticists, and nutritionists, as required), and telephone advice provided on further investigations, and to whom these should be sent.

B. FII

A child presents unwell and with significantly abnormal investigation results, and in particular, grossly deranged electrolytes. Investigations fail to demonstrate an obvious organic cause, and a differential diagnosis of salt poisoning is considered.

Telephone advice should be sought from specialists (such as renal and metabolic specialists, and paediatricians with extensive experience of FII) on what samples should be taken and to whom these should be sent.

C. Emotional abuse and neglect

A child presents with a long history of faltering growth, concerns about development, and worrying behaviour. The treating clinician is concerned that the child is being emotionally abused. Although they may have had conversations with the local CAMHS specialist, further advice may be required from a psychiatrist or psychologist with specialist experience about further assessments and how best to describe the emotional abuse.

- 4.7. Transfer of a child or young person to another unit is only required if there is a clinical need for specialist services, such as where there are concerns about FII and a definitive assessment is needed, or where a child or young person with a head and/or abdominal injury requires admission to PICU. For the majority of C&YP where maltreatment is suspected, what is required is not referral but specialist *advice and support* for the clinician, which can be provided by telephone (with images and local test results sent electronically for interpretation).
- 4.8. Formal arrangements currently exist between local and tertiary centres to allow the referral of C&YP with complex medical and surgical conditions, but such arrangements do not exist for the provision of specialist advice and support when there is a suspicion of maltreatment. As a result, this tends to be sought on an informal basis. Project interviewees, including paediatricians and other specialists, reported being approached on an informal basis for advice from clinicians in other trusts (see Appendices C and E).

The inadequacy of informal arrangements

Inequity

- 4.9. The key issue with informal arrangements is that they do not guarantee an equitable service. Some clinicians may not always recognise the need to seek advice; others lack networks of personal contacts; and some may feel uncomfortable asking for help in this way. Some specialists who are contacted for advice may also be reluctant to assist where the concern is

suspected abuse due to the time involved, the complexity of the work, the possibility of future legal involvement, and occasionally the view that it is not part of their contracted duties.

- 4.10. In some places second opinions on skeletal surveys are sought through informal networks of paediatric radiologists. These arrangements tend to break down at times of short staffing or annual leave. In other places semi-formal networks have been set up between trusts to provide a reporting service where this is not available locally. These tend to have better arrangements for annual leave cover but in many places lack the necessary resources to function optimally and some trusts have difficulty getting the local nearby paediatric radiologist to take on the work.
- 4.11. Failure to obtain specialist advice may lead to inaccurate diagnoses (both over and under-interpretation of physical findings) which ultimately places the child or young person, as well as the clinician at considerable risk. Failure to seek the necessary additional specialist advice is a contributory factor in the frequent challenge in the courts of opinions given by professional witnesses.
- 4.12. The risks are clearly illustrated in the Inquiry into the death of three-year old Kennedy McFarlane in 2000 from spinal injuries caused by her mother's boyfriend. Prior to her death, Kennedy was seen at the local DGH with a serious eye injury. The Inquiry identifies a failure to seek an opinion from a clinician with appropriate experience:
- ‘an ophthalmologist working in a DGH is unlikely to have much experience in the interpretation of non-accidental injury even in respect of eye injuries, and therefore the paediatrician with lead responsibility must take responsibility for ensuring that this medical information is fully evaluated, seeking expert opinion, forensic, paediatric and/or ophthalmological, from elsewhere as appropriate...’ (Hammond, 2000, p33).
- 4.13. The Inquiry recommends ‘a clinical network for paediatric, forensic and other specialty input, advice and peer support’ (p38).

Lack of sustainability and governance

- 4.14. Even if a clinician does succeed in obtaining specialist advice through an informal network, such arrangements are inadequate. By their very nature, informal networks are transient and dependent on individuals, and cannot therefore provide a robust, sustainable, and quality assured service. Seeking second opinions on skeletal surveys through informal networks, for example, can place an unsustainable level of pressure on the radiologist, and can also be difficult to audit.
- 4.15. Interviewees identified the following additional issues:
- The lack of clarity around the exact role of specialist clinicians, including involvement in legal processes and court work
 - The lack of clarity around the indemnity arrangements for those doctors advising on cases from other areas
 - The lack of forward planning when informal contacts are on leave and lack of succession planning for retirement or relocation
 - Resulting problems with workload and lack of allocation in job plans for specialists giving the advice (particularly given the potential for further work to be generated, such as court work)

- The lack of remuneration to trusts that employ specialists giving the advice.

Access to clinicians with specific paediatric and forensic competencies, and appropriate equipment and facilities for the assessment of C&YP who may have experienced sexual violence or abuse

- 4.16. All doctors must have the competencies and skills to manage the forensic aspects of any case of suspected maltreatment, including through appropriate record keeping, photo-documentation, and involvement in court proceedings. However, the assessment of C&YP who may have experienced sexual violence or abuse requires a particular set of forensic and paediatric skills (FFLM and RCPCH, 2007). Specific training and experience is therefore required.
- 4.17. At present, in many areas, there is a shortage of doctors with these skills. Interviewees attributed this to difficulties accessing training, the low volume of cases (which makes it difficult for skills to be maintained), and a lack of willingness to take on the work. The costs associated with commissioning a separate rota staffed by doctors with all the necessary core and case dependant skills (who are usually paediatricians or forensic physicians (FPs) (FFLM and RCPCH, 2007)) also has a bearing on their level of input into CSA examinations (Pillai and Paul, 2006).
- 4.18. In some places, therefore, it is difficult to find a willing doctor with appropriate skills to assess C&YP. When urgent cases arise in areas without full provision, interviewees referred to a tendency to rely on the 'good will' of non-rostered local doctors or of those from neighbouring areas, without any formal trust-to-trust arrangements.
- 4.19. This results in delays in examinations (Pillai and Paul, 2006) which are not only potentially emotionally harmful for the child or young person, but also reduce the likelihood of obtaining positive forensic evidence and therefore of making a conviction.
- 4.20. Many services also lack the appropriate facilities for photo-documentation and conduct examinations in environments which are not forensically approved, resulting in risks of DNA contamination (Pillai and Paul, 2006).

Proposals

Networks for specialist clinical advice

- 4.21. C&YP who present with signs of maltreatment should be assessed and managed by local paediatricians, working closely with multi-agency partners. However, as with all other areas of paediatrics, formal arrangements should be in place so that local clinicians have access to advice from those with more extensive experience and skill, and to all other specialists who may be

involved in assessing a child or young person with a complex presentation of child maltreatment³.

4.22. In relation to FII specifically, national guidance recommends:

‘Clinical medical directors of paediatric services should ensure robust arrangements are in place in their NHS Trusts, Foundation Trusts or PCTs to enable consultant paediatricians to have access to teams within their Trust and across to other clinical networks outside their organisations, to discuss clinical concerns about identification, diagnosis and clinical management of fabricated or induced illness cases’ (HM Government, 2008, p20).

4.23. *Delivering Quality Imaging Services for Children, A Report of the Paediatric Imaging Board* explores the shape of networks for paediatric radiology. It recommends three tiers of service, with local level 3 services operating as satellite units, closely linked to level 2 and 1 services for more specialist investigations, advice and opinions. All services will have image and report sharing facilities (DH, 2010).

4.24. A CSIP study (2005) of neonatal, paediatric intensive care and specialist paediatric networks identifies telephone advice-giving as an important component of networks (although this was often informal, attempts were being made to quantify it in terms of consultant times and outcomes).

4.25. To establish effective networks for access to specialist child protection advice, the informal arrangements which currently exist should be formalised by:

- Ensuring the identified specialists have sufficient capacity to provide the advice and for any subsequent discussions and legal involvement (by adjusting job plans, staffing levels, and commissioning arrangements as necessary), as well as arrangements for cover at times of leave
- Developing protocols and pathways (based on evidence-based national guidance) to aid decision-making about seeking advice, and clearly outlining roles and responsibilities.

4.26. The local treating clinician should retain responsibility for the clinical management of the child or young person. If the clinical needs of the child or young person require transfer to another unit, the local treating clinician should still retain responsibility for the safeguarding aspects of the case, including liaison with children’s social care and other agencies. There will however be some occasions where a child or young person is referred directly to a tertiary unit from primary care, and safeguarding concerns are then identified and managed by the tertiary unit (see *Delivering Quality Imaging Services for Children, A Report from the National Imaging Board*, DH, 2010, p.10).

4.27. All pathways and policies would be consistent with LSCB policies and managed in accordance with the multi-agency guidance in *Working Together*

³ Including, for example: dermatology, paediatric dentistry, forensic medicine, forensic odontology, genitor-urinary medicine, paediatric haematology, microbiology, nephrology, neurology, ophthalmology, orthopaedics, pathology, psychiatry radiology, surgery (including general paediatric surgery, maxillofacial, neuro-surgery, burns and plastics)

to *Safeguard Children* (HM Government, 2006, and forthcoming revision, 2010).

- 4.28. The range of specialist skills may be located in a number of different units within a region. Thus, a local service might be involved in a web of networking arrangements with a range of different services. For example, a local community paediatrician might access specialist advice on FII from a paediatrician working in a DGH in the neighbouring area; advice on long-term neglect from a paediatrician in a community service provided by another PCT; and paediatric radiology and haematology advice from the regional tertiary centre. In other places, all specialist paediatric advice may be received from just one experienced individual (one interviewee reported being employed by the SHA for 6PAs per week to provide regional support to local clinicians, including advice and peer review).
- 4.29. The formal arrangements between trusts would be flexible and would be likely to change over time as skills developed in different areas (however, clear pathways and clarity about accountability would always be required).

The impact on other stages of the pathway

- 4.30. Referral pathways from primary care and urgent care, and to services such as CAMHS, would remain unchanged as local paediatricians would continue to hold overall case responsibility.
- 4.31. While paediatricians would be most likely to use the specialist advice networks because of their role in assessing and managing C&YP who may have suffered maltreatment, all clinicians along the pathway would be able to access advice from specialists as needed.
- 4.32. Clinicians would continue to access support and advice on local child protection systems and processes from named and designated professionals (see *Working Together to Safeguard Children*, HM Government, 2006, and the forthcoming 2010 update).

Commissioning and finance

- 4.33. As described above, specialists would require an appropriate allocation in their job plan for the provision of specialist advice, and trusts employing these specialists would need to be remunerated for their work for other trusts.
- 4.34. Given the relatively small number of C&YP with complex presentations of suspected maltreatment requiring specialist advice, collaborative PCT commissioning would be the optimal approach. This would allow cases across a number of PCTs to be added together, making the necessary time allocation for a specialist easier to define in contractual arrangements. In addition, unlike specialised commissioning, collaborative PCT commissioning would retain the local multi-agency context.
- 4.35. Each PCT would conduct a needs assessment to obtain a clear understanding of the local demand for the service. Designated professionals would play a key role in assisting commissioners with this. The financial obligations of each PCT could be allocated on a population basis or by usage

of the specialist service (it may be possible to quantify this by recording advice-giving activity in the same way as new patient referrals).

- 4.36. The initial set-up and coordination of the commissioning arrangements would require short-term management support. A lead commissioner could be elected to take responsibility for managing the contract.

Recruitment of expert witnesses

- 4.37. Consideration should be given to bringing together the commissioning arrangements for specialist advice and expert witness activity. Expert witnesses play a crucial role in protecting children, and paediatrics is one of the key specialties from which expert witnesses are frequently required (in 2004, 10 per cent of the expert witnesses instructed in public law cases were paediatricians (DH, 2006a))
- 4.38. *Bearing Good Witness* identifies 'serious difficulties in maintaining an adequate supply of medical expert witnesses' for a range of reasons⁴ (p4, 2006a). It proposes that NHS trusts with substantial paediatric, child psychology and psychiatry services should provide medical expertise to the courts through forming teams of the same specialty or on a multi-disciplinary basis. These groups may include other specialists, such as radiologists, who are also frequently instructed as expert witnesses (DH, 2006a). The new commissioning arrangements for expert witnesses are being piloted in six sites, and the final evaluation report will be produced in 2011.

Clinical networks for child sexual abuse services

- 4.39. To ensure equitable and high quality services for C&YP who may have experienced sexual violence or abuse, the Child Sexual Abuse Sub-group of the Taskforce on the Health Aspects of Violence Against Women and Children (VAWC) recommends that PCTs must have multi-disciplinary therapeutic services and support for child victims and their families, and a Sexual Assault Referral Service (SARS). This may or may not include a Sexual Assault Referral Centre (SARC) - a holistic centre for victims of all ages (DH, Home Office and ACPO, 2009).
- 4.40. A SARS must include:
- Close links with local dedicated paediatric forensic medical services; staffed by doctors, nurses and counsellors, able to offer C&YP a choice of male or female doctor and counsellor
 - Specialist CAMHS post traumatic stress disorder services, group-work and psychiatric and psycho-therapeutic programmes

⁴ System being not well organised and dependent on multiple small agreements between individual doctors and solicitors; lack of succession planning; expert witness work concentrated in a small number of hands; few specialists nationally in some of the highly specialised disciplines required; too few doctors are encouraged or motivated to do the work (DH, 2006a)

- Access to specialist psychological support either in voluntary sector or embedded within health service and this should encompass counselling and clinical psychology specialist services
 - Specialist CAMHS support and consultation to those primary care and voluntary agencies supporting C&YP who have been abused (Taskforce on VAWC, CSA Sub-group, 2010).
- 4.41. Any child or young person who has experienced acute or long-term sexual abuse, or about whom there are concerns of sexual abuse, should receive this full range of services, where ever and when ever they present, in a setting that is appropriate to their age and that meets environmental and other standards (see DH, Home Office and ACPO, 2009, and RCPCH, 2010).
- 4.42. SARSs would be closely integrated with local services through defined patient pathways. C&YP would be able to self-refer to the service, and referrals could be received from a range of services including Police, primary care, and children’s social care. The Health Taskforce on VAWC CSA Sub-group has recommended the development of a national care pathway for C&YP who are victims of sexual violence which sets out the process from pre-disclosure, to disclosure/identification, suspected abuse in universal, targeted and specialist settings; through to medical examination, investigation, assessment, counselling/therapeutic intervention, witness experience (2010).
- 4.43. The Taskforce recommends that NHS commissioners should assess local needs and local services for victims of sexual violence and/or sexual abuse and ensure appropriate commissioning arrangements are in place. The Sexual Violence Against Women sub-group suggests that neighbouring PCTs consider working closely together when commissioning sexual violence and abuse services, and work towards collaborative commissioning of services at a regional level. This might be through Local Service Providers, the auspices of the SHA, a new or existing consortium or any other arrangements that work locally.
- 4.44. This reflects a move towards service delivery and planning through clinical networks. The development of SARS would enable local health services to pool clinicians, equipment and facilities, as well as financial resources, to deliver a joint high quality specialist service, rather than all local services attempting to deliver separate provision. There is also potential for the delivery of high quality training to trainee doctors as well as to expand the roles of nursing staff (see Case Study 1, Appendix D). All clinicians within the service would work to agreed standards and policies. The higher volume of cases would also enable clinicians to more effectively maintain their skills. Thus, the development of clinical networks would increase service quality and productivity.
- 4.45. As with the specialist advice service above, the initial set-up of a SARS would require some level of management support. The financial and management requirements are clearly laid out in the *Revised National Service Guide* (DH, Home Office, and ACPO, 2009).

Challenges

Loss of local skill

Concern

- 4.46. A number of interviewees expressed concerns that the development of a 'tiered' approach to child protection would result in child protection work being transferred to specialist centres, and this would go against the key principle that child protection is 'everybody's business'.
- 4.47. There were also concerns that those doctors who are already reluctant to engage in child protection would regard the introduction of network arrangements as an opportunity to refer all cases to specialist services, resulting in a loss of local skill, and ultimately risking failures to identify signs of maltreatment.

Response

- 4.48. Formal network arrangements for advice would involve minimal change to local practice and the local treating clinician would retain responsibility for case management. Formal network arrangements would not therefore result in a relocation of child protection activity or a de-skilling of the local workforce.
- 4.49. The establishment of specialist advice networks should actually help to increase local skill by providing local clinicians and trainees with the opportunity to discuss difficult cases with specialists with more extensive experience and skill.
- 4.50. A key aim of a network would be to ensure that service delivery can safely remain local by ensuring access to specialist advice when needed, rather than needing to *refer* cases to specialists.

Loss of links with local multi-agency partners

Concern

- 4.51. There may also be concerns that the involvement of specialists on a regional or sub-regional basis, would result in a loss of crucial links with local multi-agency partners.

Response

- 4.52. As described, when advice is sought from specialists, the local treating clinician would still retain responsibility for managing safeguarding concerns, including liaison with children's social care and other agencies.
- 4.53. Sufficient capacity would need to be allocated in the job plans of those clinicians delivering CSA services through networks to enable them to develop effective relationships with the different children's social care services and other agencies within the network area.

Identifying sufficient capacity to provide specialist services

Concern

- 4.54. There may be concerns about identifying sufficient capacity to free-up specialists to provide the specialist advice and to staff SARS, particularly

given the current difficulties in engaging clinicians to take on child protection work.

Response

4.55. Further scoping work would be needed on a regional basis to identify the extent of this issue. However, in the long-term, introducing systems which provide appropriate specialist support should increase confidence and therefore positively impact on recruitment and retention.

Concerns about the provision of advice leading to involvement in legal proceedings

Concern

4.56. Interviewees gave anecdotal reports of paediatricians and other medical specialists becoming involved in court work after informal advice to colleagues had been passed on to children's social care, and for this reason some may be reluctant to take on the role of providing specialist advice. Anecdotal evidence suggests that for some radiologists the potential for involvement in court proceedings is a key deterrent from reporting on examinations where non-accidental injury is suspected.

Response

4.57. This concern emphasises the critical importance of ensuring that all clinicians are clear about the remit and purpose of a specialist's role, and that there are clear guidelines around documentation. There would need to be sufficient allocations in specialists' job plans for any legal involvement.

Clinicians may prefer to rely on informal arrangements rather than formal routes for advice

Concern

4.58. There may be concerns that local clinicians would prefer to rely on informal networks for specialist advice rather than formal systems. Several interviewees referred to the effectiveness of personal relationships for seeking advice and described informal networking as an essential part of the culture of paediatrics.

Response

4.59. In designing network arrangements, it would be important to work with local clinicians to identify the informal networks which currently exist. This would ensure that any networks that are developed formalise and clarify already effective relationships.

CSA networks will involve a requirement to travel

Concern

4.60. Unlike the network for specialist advice, the development of SARSs will involve a requirement for C&YP to travel to specialist units to receive services, as well as a requirement for specialists to travel to deliver the services.

Response

4.61. This concern highlights the need to take travel implications for C&YP, their families, and also clinicians, into careful consideration when planning SARS.

The relevant factor would be the time taken to reach the service rather than the distance covered.

Governance arrangements within specialist advice networks

Concern

4.62. There may be concerns about how specialists will know that their advice has been acted upon, and what action would be taken if a treating clinician continually fails to take the advice of a specialist.

Response

4.63. As described above, the role of the specialist would be to offer advice, but responsibility and accountability would remain with the local treating clinician. Concerns about the practice of a clinician would be managed by employing organisations in the normal way.

Financial implications of developing advice networks

Concern

4.64. The development of specialist advice networks would require PCTs to establish commissioning arrangements for new activity or for activity that was previously provided on an informal basis. There may be concerns that PCTs will have difficulties meeting these costs given the current financial climate.

Response

4.65. Improving the quality of care and reducing errors in diagnosis, will result in long-term, sustainable financial savings not only for the NHS, but also for the courts, and for society as a whole (see Gilbert, et al., 2009, for information on the long-term impact of child maltreatment).

5. REGIONAL OR SUB-REGIONAL OVER-ARCHING MULTI-PROFESSIONAL MCNS FOR CHILD PROTECTION

5.1. The proposals described above involve the development of a range of network arrangements to ensure access to specialist clinical skills and experience but fall short of recommending over-arching regional or sub-regional multi-professional managed clinical networks for child protection which would have a far wider remit (see the definition in 3.6-3.11).

5.2. *A guide to promote a shared understanding of managed local networks* identifies the symptoms that may indicate the need for managed networks. A number of these apply to child protection health services in some areas, including: problems with staff recruitment, retention, and training; poor outcomes; poor quality of care; high inequalities; poor performance management; poor commissioning; low staff morale; and problems with the sustainability of services (DH and DfES, 2005, p38).

5.3. The additional features of an MCN for child protection are described below.

The key features and functions of MCNs for child protection

Support to commissioners and strategy development

- 5.4. MCNs for child protection would have a key role in providing clinical advice and support to commissioners and in the strategic development of services. These activities tend not to fall within the day-to-day mind-set of clinicians. However, with leadership through an MCN, the aggregate of expert knowledge could be brought to bear on commissioning issues.
- 5.5. Clinical leadership and engagement in commissioning is a core principle of world class commissioning (DH, 2009c). Clinicians are best placed to advise on the services that should be commissioned, on likely future demand, as well as on the standards and activity measures that could usefully feed into the performance management of commissioning contracts. An MCN approach to this would ensure that the needs of the whole population, rather than of individual institutions, were taken into account, and that consideration was given to the competing demands of different specialties in a resource-constrained environment.
- 5.6. The inclusion of commissioning representation on the MCN board (see 5.12 below) would help to facilitate this role, enabling clinicians and commissioners to share ideas and adopt a joined-up approach to reforming services.

Governance and quality improvement

- 5.7. Over-arching regional or sub-regional MCNs would also have a key role in clinical governance and quality improvement.
- 5.8. Member organisations would define the optimal patient pathway and standards along this pathway (based on national statutory and professional guidance, and consistent with LSCB policies). These would extend beyond process and efficiency and would also incorporate patient experience, safety and effectiveness of care (RCPCH, 2006).
- 5.9. The MCN would take a lead in ensuring that any new evidence was translated into standards, policies and practice (the development of a National Knowledge Service, as proposed in *Bearing Good Witness*, would help to facilitate this (DH, 2006a, p43)).
- 5.10. MCNs would facilitate regular audit against standards, would provide feedback on performance and benchmarking between services (and also between networks). There would need to be agreement about the data to be collected, and this could then be used to also inform commissioning and service development.
- 5.11. An MCN would also provide the opportunity to compare practice and protocols, and to share learning, for example from Serious Case Reviews and Child Death Overview Panels, as well as to share best practice. The aim would be to develop 'learning organisations' and to promote feedback, reflection, learning, innovation, and continuous improvement.

- 5.12. To take on these roles, an MCN would require an 'organisational core' with authority and credibility, to which all member organisations were accountable. Goodwin et al. refer to the need for 'a position of centrality from which to exert leverage' (2005, p7). This could consist of a multi-professional (and potentially multi-agency) network board or steering group with responsibility for approving standards, for identifying poor practice, and for sitting alongside commissioners to challenge services that do not meet these standards. In joining the MCN, member organisations would agree to recognise the authority of the MCN board.
- 5.13. Joint information technology systems, such as an intranet, would provide an effective way of sharing network information and documentation, including MCN policies, standards, new evidence, and performance data.

Training, development and support

- 5.14. Lord Laming's Progress Report recognises the need to improve the skills, understanding and support for a range of children's health professionals (2009). The Report also identifies the current shortage of health visitors, the reluctance of paediatricians to become involved in child protection work, and the difficulties recruiting to named and designated roles. Project interviewees also raised concerns about recruitment and succession planning.
- 5.15. A key aim of an MCN would be to ensure access to high quality training, support and opportunities for development, thereby attracting clinicians into child protection work and improving retention.

Training

- 5.16. The recent Care Quality Commission (CQC) Review found significant inadequacies in the safeguarding training received by NHS staff (2009a). A stocktake of current training programmes conducted by the DH identified a range of barriers to training: lack of resources (including the capacity of clinicians to attend training and to deliver training); lack of prioritisation on an organisational and individual level; limited availability of programmes; and the timing and location of programmes. There were found to be particular issues around advanced level training for named and designated professionals, and training for GPs and independent contractors.
- 5.17. Child protection training covers a broad range of staff and subjects, and local organisations are responsible for ensuring that staff receive the appropriate training through working in close partnership with LSCBs. To achieve greater standardisation, over-arching regional or sub-regional MCNs could play a role in monitoring training against LSCB and national standards.
- 5.18. The MCN would also take on a role in coordinating the delivery of more specialist training, enabling trusts to share training costs and to pool trainers with specialist knowledge. Specialist clinicians within an MCN would have an appropriate allocation in their job plan not only for the provision of specialist advice, but also for the delivery of specialist training and developmental opportunities (and this would be reflected in the collaborative PCT commissioning arrangements described in 4.33 – 4.36).
- 5.19. This would apply not only to paediatrics but to all specialties required in assessing cases of suspected abuse. *Delivering Quality Imaging Services for*

Children, A Report from the National Imaging Board recommends that *level 1 units* would act as the centre for training and provide CPD for all staff in the network. Child protection MCNs would play a role in coordinating the safeguarding elements of this training (for training content see the Safeguarding Training Matrix in *Delivering Quality Imaging Services for Children, A Report from the National Imaging Board*, DH, 2010).

Reflective practice

- 5.20. To ensure high quality, evidence-based services, it is recommended that clinicians engage in reflective practice with other clinicians, for example through supervision, peer review, and mentoring.
- 5.21. The need to improve access to high quality supervision was a key theme in the DH training stocktake and is frequently highlighted in Serious Case Reviews (Brandon, et al., 2009). There are also inadequacies in the provision of peer review for paediatricians. Models currently vary significantly in terms of frequency, formality and perceived purpose. In some small or remote units there are too few paediatricians involved in child protection work to run local group meetings.
- 5.22. To help address these issues, an over-arching regional or sub-regional MCN would monitor access to, and quality of opportunities for reflective practice across services. An MCN could also coordinate joint peer review meetings between different services, such as between SARS (potentially through telemedicine facilities). The RCPCH is currently developing guidance on the key principles and best practice in running peer review meetings for doctors (2010, DRAFT). In addition to the existing regional designated professionals networks, the MCN could facilitate the development of other peer networks as needed (for example, one interviewee commented on the need for a network of named mental health professionals).
- 5.23. The MCN could also organise mentoring schemes to enable local clinicians to develop their skills and expertise in particular fields. This would enable a proactive and collaborative approach to workforce planning as the skill-base could be developed in identified areas of current or forthcoming shortage.

Psychological support

- 5.24. Studies show high rates of depression, anxiety and substance misuse in health professionals, especially doctors from a range of specialities (Practitioner Health Programme, 2010). The NHS Practitioner Health Programme, a service being piloted in London that provides support, diagnosis and access to treatment for doctors and dentists with mental health concerns, has received a relatively large number of presentations from paediatricians (Practitioner Health Programme, 2010). Particular concerns relating to medical staff include the poor management of conditions, failure to seek appropriate assistance, and the ability to disguise illness from others through self-prescription (DH, 2006b).
- 5.25. Given the nature of the work, access to psychological support is particularly important for those working in child protection. Clinicians need access to ongoing preventative psychological support, as well as to timely acute support. For some, this is currently not available locally. Others may be reluctant to seek support from a team in their local hospital with whom they already work.

- 5.26. An MCN would help to address these issues by providing opportunities for peer support, and signposting clinicians to appropriate services for psychological support.

Additional roles as required

- 5.27. In addition to the key features described above, an MCN could take on additional roles in order to meet local and regional needs as required. This might include the coordination of joint Rapid Response to Child Death teams, and the health input into Child Death Overview Panels. An MCN could also play a role in coordinating the recruitment of expert witnesses, and the provision of peer review and support for clinicians involved in this⁵.

Management and leadership requirements

- 5.28. To coordinate the range of functions described above, an MCN would need leadership and management. The literature identifies that enthusiastic and committed clinical leadership is key to the effectiveness of an MCN (Goodwin, et al., 2005; Greene, et al., 2009; NHS Scotland, 2009b). A clinical lead should be identified at an early stage to champion the network and lead the development process (NHS Scotland, 2009b), engage other professionals (Goodwin, et al., 2005), and then take ongoing responsibility (NHS Scotland, 2009b). The lead should be someone who is respected by peers, with extensive experience in child protection, strong leadership skills, charisma (Goodwin, et al., 2005), enthusiasm, and commitment to collaboration (Greene, et al., 2009).
- 5.29. Goodwin, et al. warn against 'network capture' by a particular professional elite, or by a particular organisation (2005). To avoid this, consideration could be given to shared leadership between specialist and local professionals (Greene, et al., 2009) and to alternating the professional background of the clinical lead.
- 5.30. The literature also emphasises the importance of management and administrative support (Edwards, B., 2002; Gorman, et al., 2003; NHS Scotland, 2009b). Edwards and Fraser describe the management role as one of architect (supporting the design of the network); operator (connecting individuals and pieces of the network); and caretaker (to enable monitoring, learning and support within and outside the network) (2001).
- 5.31. The extent of management and leadership support required would depend on the size and complexity of the network, and the scope of network activities. The management team of a cancer network in London, for example, includes a full-time manager, a nurse director and a medical director. Meanwhile, the West of Scotland MCN for Child Protection is clinically led by an experienced Lead Clinician with dedicated sessions, is managed by an MCN manager, and supported by a part-time administrator.

⁵ *Bearing Good Witness* recognises that 'in time, such groups or teams in adjacent NHS organisations may form managed local networks to enhance the viability of their services, specialisation and spread of expertise, and to share their resources and training more effectively' (2006, p5)

- 5.32. The clinical lead, manager and/or administrator of a child protection MCN would need to be hosted by a member organisation (this could be rotated) or by the SHA. NHS West Midlands employs a Clinical Engagement Lead for Safeguarding Children for two PAs (a paediatrician), who works closely with designated professionals and is leading a number of service development activities including an audit of local services against standards for CSA.

Finance

- 5.33. *A guide to promote a shared understanding of the benefits of managed local networks* recognises that the cost or burden to individual organisations within a network will depend on: 'the type of managed local network, who is involved, what services are being provided, what the situation is now, how partners already work together and what cultural, organisational and budgetary boundaries exist' (2005, p39).
- 5.34. MCNs would require financial support for MCN management resource for initial set-up and on an ongoing basis. This would need to be jointly provided by member organisations or by the SHA.
- 5.35. As described above, specialists would be likely to be involved not just in the provision of advice but also in delivering specialist training and reflective practice, and this would need to be reflected in job plans and commissioning arrangements.

Key considerations in developing MCNs

- 5.36. The development and implementation of MCNs would require careful planning (there are a range of documents that provide useful information on this⁶). A number of key lessons from the literature are explored below.

Establishing the appropriate size of the MCN

- 5.37. An early and potentially recurring decision will concern the appropriate boundaries for a network (Cropper, et al., 2002). While the literature emphasises the importance of inclusiveness, evidence also suggests that very large networks tend to incur high administration costs and lead to inertia (Goodwin, et al., 2005). Careful consideration would need to be given to ensuring that the network board or steering group achieved appropriate representation, without being so large as to jeopardise decision-making.

Avoiding tight control and mandation

- 5.38. Goodwin, et al. emphasise the importance of member organisations allowing their activities to be managed and governed, and for this reason do not recommend mandated MCNs (2005).

⁶ See *Managed Clinical Networks, A Guide to Implementation* (NHS Scotland, 2002b), *A guide to understanding pathways and networks* (RCPCH, 2006), *Key lessons for network management in healthcare* (Goodwin et al., 2005), the series of Scottish Executive HDLs (latest – NHS HDL (2007) 21), and the forthcoming RCPCH guide to developing networks

- 5.39. Tight control of member organisations and excessive bureaucracy should also be avoided as this risks disharmony and demotivation, and can limit local innovation (Goodwin, et al., 2005). There is a need to ensure some degree of formality, without networks 'losing their spark' (Edwards, N., 2002). MCNs should be bottom-up, participative and allow high levels of initiative and autonomy (Fraser and Edwards, 2001). Local clinicians should be fully involved in network development - for example, governance systems and quality measures should be useful to members. A self-assessment approach to audit could be considered or a peer review approach (as used in cancer networks).

Ensuring sufficient authority to influence change

- 5.40. While tight control of members should be avoided, MCNs need the authority and credibility to influence change. Marlow and Gill identify this as a key challenge and for this reason recognise the value of convening an MCN under the aegis of a commissioning body which can effect authority through the commissioning and contracting process (2007). The authority of cancer networks is partly achieved through the representation on the network board of all chief executives of provider and commissioning organisations and service users. Meanwhile, the West of Scotland MCN for Child Protection multi-agency Steering Group includes representation from all NHS Boards in the Region⁷, child health commissioners, Police, Forensic Medical Examiners (Child Examiners), Social Work and the voluntary sector. Representation from the Young Persons Group of the Network is also welcomed.

Ensuring networks engage rather than dis-empower local clinicians

- 5.41. As has already been discussed in relation to the specialist advice network, there may be concerns that the development of an MCN would result in local clinicians shifting their responsibilities for child protection to the network or feeling disempowered. Measures would need to be taken, including through training programmes, to ensure that all clinicians properly understood the role of the MCN and recognised that child protection was still 'everybody's business'.

Ensuring meaningful lay involvement

- 5.42. The literature identifies the critical importance of patient/lay involvement in the development and running of MCNs. However, it also recognises the challenge of identifying individuals who are willing to engage and of ensuring their meaningful involvement. Training may help to equip C&YP and parents with the skills to play a substantive and important role.

The relationship between MCNs and other organisations

- 5.43. A key challenge in developing MCNs is the sheer complexity of provision, and the need to ensure effective links with the wide range of related organisations (RCPCH, 2006) including networks that currently exist or are proposed (such as SARS, paediatric radiology networks, arrangements for

⁷ This also includes Executive Directors for Child Protection, Lead/Link Clinicians for Child Protection, and Nurse Consultants for Vulnerable Children

the recruitment of expert witnesses, and any additional regional Practitioner Health Programmes).

- 5.44. A key consideration will also be how the MCN relates to members' organisational strategies and activities, including those of LSCBs. An MCN should aim to align local strategies rather than 'hand down' policies and plans (Connor, 2001), and should be in keeping with local priorities and processes. There should also be absolute clarity about the roles and responsibilities of local organisations and of an MCN.

Achieving clarity about governance and accountability

- 5.45. While a defining feature of an MCN is its clear governance and accountability arrangements, the literature identifies that achieving this is also a key challenge (NHS Scotland, 2002b; Goodwin, et al., 2005). The whole basis of clinical governance is that NHS boards are made accountable for the quality of care provided in their organisations, but since MCNs function across organisational boundaries, there are questions about who should be responsible if things go wrong (NHS Scotland, 2002b).
- 5.46. Individual organisations' duties under Section 11 of the Children Act 2004 to safeguard and protect the welfare of children are wider than those outlined in this paper, and it would be critically important that MCNs did not detract, but instead helped to support this activity. Individual organisations would still be responsible for the quality of care that they deliver, and this would be monitored, in part, by the MCN board.
- 5.47. As described above, concerns about the practice of individual clinicians would still be managed in the normal way, although the development of an MCN should provide a formal structure and route for escalating any concerns to the employing organisation.

Challenges to the proposal for MCNs

- 5.48. In addition to the considerations described above, there are a number of more significant challenges to developing child protection MCNs.

Competing organisational priorities and market-orientated policies

Concern

- 5.49. A key challenge will be how to develop and sustain effective partnership working and collaboration between organisations with different and potentially incompatible organisational cultures and objectives (Fraser and Edwards, 2001). This is a particular concern given the current policy direction towards plurality of provision (including delivery by independent organisations) and market-orientated approaches to the delivery of care.

Response

- 5.50. Poor collaboration is one of the very problems that MCNs are aiming to overcome. MCNs could play an important role in ensuring that the increasing complexity of provision does not result in C&YP falling through the net. The MCN clinical lead would play a key role in developing network relations. In addition, the increasing shift towards outcome-orientated measures and the

focus on patient safety and experience has the potential to reward collaborative working. *NHS 2010-2015: from good to great* emphasises: 'a high-quality and productive NHS will need provider services organised around the needs of people. Now is not the time for NHS organisations to patrol their own boundaries' (2009c, p.58) and proposes to 'look at what more needs to be done to align incentives, so that organisations work more effectively together in the interests of patients' (p.59).

The resources required and the lack of firm evidence for positive outcomes

Concern

5.51. The literature demonstrates that developing and maintaining MCNs tends to be time-consuming and resource intensive (Miller, 2008). There is also a lack of firm evidence for the impact of MCNs, positive outcomes are likely to take time to become apparent (Miller, 2008), and direct benefits will not necessarily flow to every member in equal measure or reflect particular contributions (Cropper, et al., 2002).

Response

5.52. The lack of firm evidence does not mean that MCNs do not have a positive impact. As with any policy intervention, the particular impact of an MCN would be difficult to demonstrate.

5.53. Cropper et al. propose that a long-term and 'rounded' view of investment is required (2002). Although some pooled resource will undoubtedly be needed to provide the necessary management support, this need not be particularly extensive, particularly compared to cancer networks for example, which are involved in rigorous monitoring against national targets.

Is an MCN needed to achieve the desired ends?

5.54. The literature repeatedly refers to the importance of clarifying the purpose and mission of an MCN before embarking on development (Fraser and Edwards, 2001; Gorman, et al., 2003; Goodwin, et al., 2006):

'Before establishing a new network, key stakeholders need to identify a number of key questions to be asked: why is the network needed?; what the network can do that individual parts of the network, in their own organisations, cannot do?; what is the network trying to achieve and how will it know it has achieved it?' (Conner, 2001).

5.55. The proposed added value of a regional or sub-regional child protection MCN would be the collective capacity, expertise and influence to provide population-based support to commissioners, to take a lead on clinical governance and quality improvement, and to monitor and coordinate training, development and support.

5.56. The key question for consideration therefore is whether an MCN is needed to achieve these ends. Could they be achieved by individual member organisations without an MCN? (in other words, we need to consider 'why the whole is greater than the sum of the parts' (Miller, 2008)). Could they be achieved by any other mechanisms that already exist?

5.57. To explore this concern further and to reflect the complexity of the debate, a number of alternative approaches to MCNs are discussed below.

Regional or sub-regional coordination is not required

Concern

5.58. It could be argued that local designated professionals already provide support and advice to commissioners, and that clinical governance and quality improvement should be the responsibility of local organisations, with any higher-level regulation led by the Care Quality Commission (CQC). It could also be argued that regional or sub-regional oversight of professional training and development is not required - LSCBs already play a key role in developing training policies, and the DH and national professional bodies are in the process of developing guidance to improve consistency and quality.

Response

5.59. A key benefit of an MCN is the collective expertise to provide *population-based* advice to commissioners. Network governance would aim to complement, rather than replace local governance systems, and the MCN would provide the collective management capacity for more extensive activities such as audit and benchmarking. An MCN would also play a key role in ensuring that LSCB policies and national guidance on training and professional development and support were translated into practice, and by pooling specialist trainers, access and overall productivity would be improved.

Regional coordination by SHAs without the need for an MCN

Concern

5.60. SHAs already work closely with named and designated professionals to manage the performance of local organisations, and some also take on a role in coordinating the delivery of specialist training (see Case Study 2, Appendix D) - it could therefore be argued that further regional governance is not required.

Response

5.61. The clinical leadership of MCNs should result in governance being regarded as not just about performance but also quality (thereby achieving clinical engagement and more sustainable and far-reaching improvement). As described, this clinical leadership would also facilitate advice and support to commissioners, as well as providing career development opportunities for the clinicians taking on these roles. Although some SHAs play a key role in delivering specific specialist training courses, an MCN would have the capacity to monitor and coordinate training, development and support across the board on an ongoing basis.

Regional coordination by designated professionals networks without the need for an MCN

Concern

5.62. If clinical leadership and engagement are the key requirement, then it could be argued that the existing coordinated designated professionals networks could achieve the desired ends without the need for an MCN.

Response

- 5.63. The interviews suggest that in order to take on a wider range of activities, the existing networks would require additional management and leadership capacity. Without management support, it is unclear how specialist training, development opportunities and support could be coordinated, or how access and quality could be monitored on an ongoing basis.
- 5.64. The literature also emphasises the importance of network inclusiveness, and it could therefore be argued that the membership of designated professionals networks is not sufficiently broad. An MCN board, on the other hand, would include representation from the range of professional groups and specialties involved in the patient pathway, as well as commissioners, service users, and potentially multi-agency partners.
- 5.65. There may also be concerns about whether designated networks would have the authority to influence real improvement. MCNs would have leadership capacity, high-level backing from member organisations (through virtue of being jointly funded) and agreement from all members to adhere to the network board.

6. OTHER PROPOSALS

Specific and separate commissioning

- 6.1. Effective commissioning is central to the delivery of high quality and productive services. At present however, commissioning arrangements for services that assess and manage C&YP who are identified as being at risk of maltreatment are underdeveloped.
- 6.2. Commissioning tends to be focused around individual organisations rather than based on the patient pathway and the needs of C&YP. In addition, services that assess and manage C&YP are rarely commissioned as specific or separate components within the broad area of children's services. This results in:
 - A lack of performance management, and a lack of systematic monitoring of service activity and quality
 - Insufficient time and capacity allocated for child protection work - by the nature of the conditions, child protection tends to be more time-consuming than other areas of paediatrics (due to the multi-agency working and involvement in legal proceedings), as well as often being unanticipated and requiring urgent attention.
- 6.3. To address these issues, specific, separate and comprehensive service commissioning arrangements should be in place for the assessment and management of C&YP who are identified as being at risk of maltreatment. Designated professionals should have a role in advising on this. Further consideration needs to be given to explore whether these problems also need addressing at other stages of the patient pathway.

Management support

- 6.4. Interviewees for this project, as well as respondents to the DH training stocktake, repeatedly described issues around workload and capacity. This has a bearing on ability and willingness to engage in child protection activities, particularly peer review and court work.
- 6.5. In addition to effective commissioning arrangements, appropriate management support is needed to ensure that clinicians have sufficient capacity in their job plans to carry out child protection work and to engage in appropriate training and reflective practice.

7. CONCLUSIONS

- 7.1. All C&YP who are identified as being or likely to be maltreated must receive timely and high quality health assessments. These are key to informing multi-agency child protection assessments. To achieve this, clinicians must have access to the full range of specialist skills and experience that may be required in assessing complex presentations of maltreatment.
- 7.2. Robust network arrangements must therefore be developed between local services and units that employ the appropriate specialists. There must be clear pathways and protocols for accessing specialist advice, and sufficient capacity in job plans to provide this.
- 7.3. To ensure equitable access to doctors with the forensic and paediatric skills to assess C&YP who may have experienced sexual abuse or violence, PCTs should work closely with neighbouring PCTs when commissioning SARs. Network arrangements would enable scarce skills, facilities and equipment to be shared.
- 7.4. There is also potential to develop over-arching multi-professional MCNs on a regional or sub-regional basis. The key benefit would be the collective capacity and influence to provide population-based support to commissioners, to lead on strategic development and clinical governance, and to coordinate consistent high quality training, development and support for the range of clinicians, with the potential to improve recruitment and retention.
- 7.5. The development of MCNs for child protection would take careful planning. In particular, consideration would need to be given to avoiding tight control of member organisations, ensuring sufficient authority to influence change, and ensuring clarity about the roles and responsibilities of an MCN and of the member organisations, particularly around clinical governance.
- 7.6. Most importantly, there is a need for absolute clarity about an MCN's intended purpose and the specific added value that it will bring. This may vary on a local and regional basis depending on the nature and extent of existing problems, and the effectiveness of other mechanisms that already exist, including other networks and the SHA.

- 7.7. Where a clear need for the development of MCNs is identified, this is likely to involve the employment of a clinical lead, manager and/or administrator by an SHA or jointly by member organisations, who would work closely with a network board with recognised authority, and with existing designated professional networks and all other health professionals involved in child protection.

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9. APPENDICES

A. The prevalence of child maltreatment

‘Child maltreatment remains a major public-health and social-welfare problem in high-income countries... Child maltreatment substantially contributes to child mortality and morbidity and has long-lasting effects on mental health, drug and alcohol misuse (especially in girls), risky sexual behaviour, obesity, and criminal behaviour, which persist into adulthood’ (Gilbert, et al., 2008).

A study by the NSPCC which directly surveyed young adults in the UK (18-24 years old) found that as many as 16 per cent had experienced serious maltreatment by parents during their childhood (Cawson, 2002). In addition:

- Seven per cent experienced serious physical abuse at the hands of their parents or carers
- Six per cent experienced serious absence of care at home, and five per cent serious absence of supervision
- Six per cent experienced frequent and severe emotional maltreatment
- One per cent of children aged under 16 experienced sexual abuse by a parent or carer and a further three per cent by another relative; 11 per cent experienced sexual abuse by people known but unrelated to them; five per cent experienced sexual abuse by an adult stranger or someone they had just met (Cawson, 2000).

In high-income countries 4-16 per cent of children are physically abused, one in ten is neglected or emotionally abused, and 5-10 per cent of girls and up to five per cent of boys are exposed to penetrative sexual abuse (Gilbert, et al., 2008).

In 2008, 34,000 children in the UK became the subject of a child protection plan (this represents 27 children per 10,000 of the population aged under 18). Of these, 45 per cent became the subject of a plan under the category of neglect, 25 per cent under emotional abuse, and 15 per cent under physical abuse (DCSF, 2008).

However, few children who are maltreated ever receive official attention - studies that link self-reports to official statistics for child protection provide direct evidence of under-reporting

to agencies (Gilbert et al., 2008). One study found that only five per cent of children who were physically abused and eight per cent of children who were sexually abused had contact with child-protection services (MacMillan et al., 2003, cited in Gilbert et al., 2008).

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B. Advisory Group Terms of Reference and involvement

Terms of Reference

Purpose

The purpose of the Advisory Group is to:

- Provide clinical, management and other expertise and experience
- Ensure engagement of and consultation with relevant stakeholders
- Review and challenge project recommendations.

Frequency of meetings

The Group will conduct the majority of its work electronically, and will meet physically on a maximum of two occasions.

Membership

Members will be invited to join the group on the basis of their individual expertise or to represent a specific group of stakeholders.

Members will provide a two-way communication channel with their wider network/constituents. If members are unable to attend meeting(s), they will nominate an individual with expertise in the same field to attend in their place.

Advisory Group involvement

A meeting of the Advisory Group was held in October 2009⁸ which included a presentation of emerging project findings, and group discussions on the potential of clinical networks to address current problems in child protection health services. Following the meeting, members were asked to submit written thoughts on the proposal to develop clinical networks for child protection. A draft of the report was circulated for feedback in February 2010.

⁸Attended by representatives with expertise in: commissioning, emergency medicine, forensic medicine, general practice, health service management, health visiting, midwifery, nursing, ophthalmology, paediatrics, public health, radiology

C. Research methodology and limitations

Literature review

Although the project time-scales and limited capacity did not allow a systematic review, a range of literature (identified through popular search engines and recommended by interviewees) on both clinical networks and child protection health services was reviewed, analysed thematically, and then used to inform the paper.

A number of other documents also informed the paper, including: the annual reports of existing networks; other papers proposing the development of clinical networks (the RCPCH Scotland Child Protection Committee report, and a business case for a CSA network in one region); and a review of the safeguarding services provided in one local area and the related service specification.

Interviews and group discussions

The project manager held individual discussions with at least forty professionals. These varied significantly in content, length, and formality, according to the background of the individual, the time available, and the stage of the project:

- Some took the form of semi-structured interviews, while others were informal discussions (although all are referred to as 'interviews' in this paper)
- Early discussions tended to focus more on current problems with child protection services, while latter discussions also tested out emerging themes and network models
- Some were conducted by telephone, and others face-to-face
- Written notes were taken and some were also recorded on tape.

In addition to the input from the Advisory Group (see footnote on pg 33), discussions were held with professionals from children's social care, commissioning, emergency medicine, general practice, genitor-urinary medicine, haematology, nursing, management, mental health, midwifery, and radiology. Paediatricians formed the largest group of interviewees as the issues that were identified at the start of the project as key drivers for networks related largely to the *assessment* of C&YP. Care was taken to ensure that interviewees were from a range of settings (including urban and rural; tertiary, acute, and community) and from different regions of the country.

To learn lessons from existing networks, the project manager visited the West of Scotland Child Protection Managed Clinical Network and the Northumbria Paediatric Forensic Network. Meetings were also held with a paediatrician who is developing a network in the South East of Scotland, and with the nurse director of a London cancer network.

Some interviewees were identified by the RCPCH and DH project leads; others were themselves Advisory Group members or recommended by Advisory Group members; and some were recommended by other interviewees. Information about the project and a request for ideas and best practice was sent via the email bulletins of the DH Children, Families and Maternity Branch and the British Association of General Paediatrics.

An email was also sent to all SHA children's leads informing them about the project, and requesting the opportunity to attend designated professionals network meetings. A total of three designated professionals network meetings were attended.

The early emerging project findings were presented and discussed at a number of meetings, including an SHA designated professionals network meeting, an annual meeting of the Child Protection Special Interest Group, and a DH meeting of child protection stakeholders.

Data limitations

While the interviews and discussions provide valuable anecdotal information, it was not possible to obtain views from a representative sample of stakeholders due to the project timescales and limited capacity.

The interviews highlighted some common themes, such as the shortage of appropriately skilled clinicians to conduct CSA examinations, and the high workload and limited capacity of named and designated professionals. However, on other topics, interviewees' experiences varied - problems discussed by some, were not identified by others.

Many of the interviewees were experts in the field of child protection. It proved challenging finding less experienced professionals to interview. This made it difficult to get a first-hand picture of some of the reported problems, in particular, access to specialist advice. In addition, it should be recognised that there are limitations to interviewing as a research method for identifying problems with service quality.

Obtaining and comparing interviewees' opinions on the proposal to develop clinical networks was challenging. Interviewees' interpretation and understanding of the term 'network' varied widely. Many had a clear view of the need for CSA networks, but opinions on the need for networks for other types of abuse were varied and often unformed. Many could see arguments both for and against, and did not have a clear view about what a child protection network should look like.

As a result of these limitations, while the interviews provided some valuable information about current problems, discussions with the RCPCH and DH project leads (who have extensive experience of child protection services across the country) also played a key role in informing the paper. Similarly, because a clear network model did not emerge from the interviews, the literature and follow-up discussions with experts in particular fields (such as commissioning) played a crucial role in informing the network models presented.

D. Case Studies

Case study 1 - Northumbria Paediatric Forensic Network

The Northumbria Paediatric Forensic Network provides assessment for all C&YP under the age of 16 years who report an incident of sexual abuse occurring within the past seven days. The network serves approximately 1.5 million people, with around 110 new patients each year and 150 follow-up patients.

Prior to the development of the network, there was no dedicated acute service - referrals for CSA examinations were fitted in at the end of clinics, resulting in delays in examinations. Out-of-hours examinations were conducted by paediatricians on a voluntary basis (with remuneration by the Police). There were often gaps in the rota and concerns among paediatricians about indemnity and working in isolation.

There were also concerns that few clinicians had the required knowledge, skills and competencies to provide an appropriate and holistic assessment service in any given locality. The relatively small number of C&YP requiring the service and the need for high quality facilities and equipment also made it difficult to provide on a local basis.

A six-month scoping project, led by the SHA, explored the feasibility of establishing an MCN, and developed a network model through close working with clinicians and the Police. The

MCN was established in 2003, with funding from Northumbria Police and the local PCTs (with contributions based on population size).

The network is staffed by six consultant paediatricians from five different trusts, as well as a Clinical Director, a Lead Nurse, and a coordinator (0.6 WTE).

North of Tyne PCT is the nominated Lead Commissioner with responsibility for managing the contract. Newcastle Hospitals NHS Foundation Trust is the lead provider, employing professionals through honorary contracts to ensure clear accountability and professional indemnity.

A daily clinic slot is allocated for initial assessments and follow-up appointments, and there is a fully staffed out-of-hours rota. Paediatricians, supported by specialist nurses, conduct all assessments, and all professionals are appropriately trained. The nursing role is being expanded to include the provision of follow-up support, advice and STI screening, and the potential for developing the role of Paediatric Forensic Nurse Examiner is being explored.

Consultations, reports and statements follow a standardised process and format, in line with RCPCH guidance. There are quarterly clinical governance meetings and regular audits against service standards.

The MCN team meets on a monthly basis with a representative from Northumbria Police to ensure effective communication between the two agencies.

One PA is allocated in each professional's job plan for weekly group supervision and peer review, and there are regular away days to explore practice development. A psychologist is also employed by the network and offers sessions to health, counselling and administrative members of the team.

Recent service improvements include the introduction of a text messaging reminder system for follow up appointments and a formalised care pathway incorporating early post-assault support to families. Future plans include the development of a system for reviewing all new research literature and an audit of service users' views.

Case Study 2. – NHS West Midlands training programmes

NHS West Midlands is currently working in partnership with Warwick University to deliver a number of training programmes on a regional basis. This is regarded as key to ensuring that there are sufficient professionals trained as both generalists and specialists to support children, young people, parents and staff around the safeguarding agenda.

Child death review training

A range of multi-agency training on Child Death Review processes were supported on a regional basis including workshops on the new processes, a supplementary training the trainer course, and workshops on 'Running an effective Child Death Overview Panel' and 'Responding to an Unexpected Child Death'.

Courses to increase medical skills

In response to paediatricians' concerns about giving evidence in court, NHS West Midlands commissioned a Court Skills in Child Protection training course, in partnership with the Warwickshire Family Justice Council, the Royal College of Paediatrics and Child Health (RCPCH) and the University of Warwick. The course covers evidence-gathering, receiving instructions, report writing and preparing for court. The course includes presentations from

experts in the legal and health fields and provides an opportunity to take part in a mock court exercise led by senior barristers. Following a successful pilot, three further courses are planned for delivery.

Interpreting the physical signs of child sexual abuse and colposcopy training for paediatricians have also been identified as training needs. NHS West Midlands have commissioned Partners in Paediatrics to develop training to support the recently developed child sexual abuse care pathway.

In addition, it has just started a third cohort of the Leadership for Influence: Safeguarding Children Practice Programme, and continues to have a mixed composition of Designated and Named professionals.

To identify any further gaps in the training available, NHS West Midlands are analysing the responses from within their region to the DH Named and Designated professionals' survey on safeguarding training. Ongoing areas of work include adapting the safeguarding leadership programme for Health Visitors and School Nurses, developing an e-learning module for doctors in training, and looking at the skills and competencies of the specialist nurse in the Child Death Fast Response Team.

Case Study 3 - West of Scotland Managed Clinical Network for Child Protection

During 2001, in light of the Hammond Report⁹, the West of Scotland Regional Planning Group (a group of high-level leads representing all Health Boards within the West of Scotland) commissioned a feasibility report on the development of a Managed Clinical Network (MCN) for Child Protection.

Following this, the Regional Planning Group designated the development and establishment of the MCN. Funding (top-sliced from all Health Boards in the Region) was allocated for a Lead Clinician, a Network Manager and Administrator.

The Network aims to improve the quality of child protection services throughout the region. Since its inception, it has expanded from having a medical focus to being truly multi-disciplinary. The Network works primarily to improve the Health input to the child protection process, but includes representation from other agencies. The Network has a variety of sub-groups and working groups, including groups on Training, Nursing, and Young People.

The Network developed a Quality Assurance Framework (QAF) – a set of quality standards and performance indicators against which it conducts audits, based on self-assessment by Boards. These audits have developed into a full benchmarking framework, which Boards are asked to complete and submit for analysis.

Best practice procedures have been developed in a number of areas including radiological investigations and non-accidental head injury. The MCN has also developed a standardised proforma and core dataset for comprehensive health assessments, and a care pathway to facilitate access to health services by Social Work and Police. Guidelines are currently being developed for emotional abuse and anogenital warts.

A new patient information leaflet 'All you need to know about a Forensic Medical' was recently developed by the Network with its Young People's Group, and has been approved by all partner bodies. The Young People's Group is made up of children and young people

⁹ Hammond, H. 2000. *Child protection inquiry into the circumstances surrounding the death of Kennedy McFarlane*. Edinburgh

who have been through the Child Protection system, and includes a core group and a wider consultation group.

The Network has delivered a number of national conferences on specialist child protection topics (Neglect (2006), Emotional Abuse (2007), Sexual Abuse (2008) and Abuse of Infants (2009)), and has developed a DVD on Infant Abuse which is used as part of consultant Tier 3 training. The MCN aims to provide and facilitate training that cannot be offered by individual Boards.

The Network is currently developing a new mentoring scheme to grow 'tertiary level consultants' across the region. These clinicians would advise colleagues in their local Board areas, and would also jointly staff a regional rota for 24/7 on-call advice. Funding has been secured from the Scottish Government's *National Delivery Plan for Children and Young People's Specialist Services*¹⁰ for back-fill while the designated professionals are on mentoring placements.

¹⁰ See <http://www.scotland.gov.uk/Publications/2008/02/25093458/0>

E. Key messages from the interviews and group discussions

The key comments made in interviews and group discussions are listed in the table below

| Theme | Comments |
|---|--|
| Variable quality of services | <ul style="list-style-type: none"> • In some places there is poor clinical practice in conducting haematology investigations (including cursory investigations, poor practice in recording examinations, and failures to consult with a paediatric haematologist on the interpretation of results) • In one tertiary centre, presentations of FII are identified that should have been spotted earlier |
| Access to specialist clinical skills and experience | <ul style="list-style-type: none"> • Some presentations of suspected maltreatment are beyond the realms of experience and competence of local named and designated professionals: <ul style="list-style-type: none"> ○ Named and designated professionals are not experts in all types of abuse ○ The experience of named and designated professionals is variable – and those in remote and/or rural places may see a low volume of cases ○ Named and designated do not receive any specific training but learn ‘on the job’ ○ Named and designated professionals have limited capacity for giving clinical advice, and should instead be focused on organisational strategy • There can be difficulties accessing appropriate specialist experience: <ul style="list-style-type: none"> ○ In one place, there is a reliance on an ‘informal grapevine’ for advice on cases of FII as no local clinician has the appropriate experience ○ In some places there are delays or difficulties in obtaining second opinions from paediatric radiologists ○ In certain specialist fields, there is only a small number of specialists, and these are unevenly distributed across the country • Some clinicians give advice to those from other trusts on the basis of ‘good will’ without any formal arrangements (including paediatricians and professionals from other specialties, such as paediatric radiology, GU medicine, forensic odontology) • Problems with informal arrangements include: <ul style="list-style-type: none"> ○ Informal networks take time to develop, and new and less experienced named and designated professionals may not have personal contacts to rely on ○ Capacity issues – the provision of advice is not included in job plans or formally commissioned ○ Lack of clarity around role and remit of the adviser (e.g. the potential to become involved in legal proceedings; giving advice without seeing all the notes or knowing what action has been taken) ○ Concerns about indemnity of those professionals giving advice ○ The lack of succession planning and arrangements for annual leave ○ The lack of standards to support the giving of advice |

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|------------------------------------|---|
| | <ul style="list-style-type: none"> ○ There may be questions about the impartiality of personal contacts and whether they are indeed the expert in a particular field ● The potential benefits of establishing more formalised arrangements/networks for accessing specialist advice include the sharing of expertise, clearer pathways and governance, and sign-posting to specialists. There is also the potential to develop an 'on-call' rota for specialist advice through a network ● Key considerations in developing networks for specialist advice include: <ul style="list-style-type: none"> ○ The aim would be to grow local expertise and skill through network arrangements rather than keeping this in a centre (i.e. not a hub and spoke model) ○ C&YP would normally not need to be transferred to another unit and the principle should remain that C&YP are treated as close to home as possible ○ Analogies can be drawn with other complex diagnoses, such as cystic fibrosis ○ A 'tiered' model is already recognised – a network would aim to formalise existing arrangements ○ Proper commissioning would ensure that specialists had the capacity to provide advice and should include governance arrangements ○ Commissioning arrangements could be based on the likely number of cases requiring specialist advice for each trust ○ Guidance about when specialist advice should be sought should not be too prescriptive - this should be down to professional judgement ○ Networks would take the form of a 'net', as specialists in child protection are not located in one tertiary centre but instead across a range of different units ○ There would be a need to ensure that cases were still managed locally to retain effective links with local multi-agency partners and to maintain local skill (particularly given that safeguarding should be 'everybody's business') ○ There may be problems identifying and sustaining sufficient specialists to provide the specialist advice ○ There would obviously be cost implications to developing networks ● However, in some areas it was felt that appropriate specialist skills and experience is already accessible without formal network arrangements: <ul style="list-style-type: none"> ○ Timely specialist advice is available locally, including through colleagues, local named and designated professionals or a nearby tertiary centre ○ Informal networking arrangements are effective and valuable for obtaining advice, and an essential part of the culture of paediatrics ○ There should already be commissioning arrangements with specialists at tertiary centres ○ Specialist advice from professionals outside of a local area is only required very rarely and there would be difficulties establishing commissioning arrangements for such small numbers |
| Access to clinicians with specific | <ul style="list-style-type: none"> ● In many places there are gaps in CSA rotas and difficulties providing an out-of-hours service, and there is a lack of willing and appropriately skilled and experienced clinicians to conduct CSA examinations, due to: <ul style="list-style-type: none"> ○ The low volume of cases making it difficult to develop and maintain skills |

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|---|---|
| <p>paediatric and forensic competencies and appropriate equipment and facilities for the assessment of C&YP who may have experienced sexual violence or abuse</p> | <ul style="list-style-type: none"> ○ A reluctance to engage in the work due to fear of the court processes, the disruption to clinical work, and reluctance to take on out-of-hours work (however in one place local trainees are keen to develop skills in CSA but the small number of cases prevents this) ● Funding may also be a barrier to developing an out-of-hours rota, particularly given the low volume of acute case – FPs may be regarded by commissioners as a more cost effective way of delivering the service ● The lack of provision can result in a 'haphazard' approach to urgent presentations, and a reliance on the 'good will' of doctors from neighbouring areas to conduct urgent examinations without formal arrangements. This can lead to: <ul style="list-style-type: none"> ○ C&YP who present out-of-hours having to wait until the morning for an examination ○ Lack of sustainability and succession planning ○ Capacity issues for those conducting the examinations ○ Issues around roles and responsibilities for follow-up work including attendance at case conferences, liaison with local agencies, and court work ○ A reduction in recognition and referral rates (i.e. it was felt that if a higher quality of service were delivered, a greater number of cases would be uncovered) ● In one place there was also a lack of access to a DNA-free environment for conducting examinations ● A small number have concerns that FPs may lack paediatric skills and may not adopt a holistic approach to assessment, but another questioned whether it is necessary or realistic for paediatricians to always conduct out-of-hours examinations ● In some areas CSA networks are already being developed or consideration is being given to this. Perceived benefits include: <ul style="list-style-type: none"> ○ Pooling available expertise ○ Providing peer support and review for those conducting the examinations ○ Facilitating high quality training ○ The potential to engage FPs in joint meetings ● Specific considerations in developing CSA networks include: <ul style="list-style-type: none"> ○ The need for not only a shared rota but also consistent protocols and standards (and audit against these), as well as joint peer support and review ○ The need to work closely with the Police and other agencies in developing the service, and the importance of joint funding ○ The need to carefully consider travel requirements for C&YP and professionals (some emphasised that C&YP and families would be prepared to travel for a high quality service) ○ The importance of not separating CSA from other types of abuse ○ The potential to expand the roles of nurses in delivering the service ○ The important role of play specialists ○ The potential for a shortage of competent clinicians to staff the rota initially, but in the medium term the network should |
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|---|---|
| | <p>help to address this</p> <ul style="list-style-type: none"> ○ The need for management/administrative support to scope, set up, and maintain the service ○ The challenge of delivering a cost effective service, given the low volume of cases ○ The need to ensure that those delivering the service have the capacity to develop close links with the other agencies in each of the localities served by the network ○ The possibility of combining the out-of-hours CSA rota with Rapid Response to Child Death |
| <p>Links between tertiary and local services when C&YP are admitted</p> | <ul style="list-style-type: none"> ● In some places, there is effective working between tertiary units and local services when C&YP are admitted – this is attributed to good communication ● In one place there was on occasion a lack of clarity about roles and responsibilities for managing safeguarding concerns (including liaison with children's social care and attendance at case conferences), and in another there were delays in pulling together comprehensive reports with input from all the specialists involved ● In one tertiary centre, when C&YP were admitted with concerns about maltreatment, the named professionals ended up managing the safeguarding concerns without appropriate commissioning for this or arrangements for peer support |
| <p>Professional training, development and support</p> | <ul style="list-style-type: none"> ● There are a range of different peer review models of varying frequency and geographical scope (including weekly local meetings and quarterly regional meetings); in some places every case is 'peer reviewed' while elsewhere there are informal discussions between colleagues rather than scheduled meetings; there are variations in peer review protocols (including variations in note-taking and whether the treating clinician is always present when their cases are discussed) as well as perceived purpose ● In one place it is not possible to run local group meetings because there are only two local doctors involved in child protection work ● A key benefit of joint peer review meetings across different areas is the opportunity to share expertise, particularly with smaller units (tele/video-conferencing is a means of facilitating this) ● Workload can be a barrier to attending regional peer review meetings, and there is a need to ensure that an allocation for peer review is included in job plans and built into the commissioning costs ● There are difficulties in ensuring clear governance and accountability arrangements for joint peer review – in particular, how should disagreements and concerns about individual practice be managed? ● There can be difficulties in providing supervision for designated professionals, and there is a need for peer supervision across trusts; there may be difficulties in ensuring clear governance and accountability arrangements and there are questions about how this would feed into organisational appraisals and revalidation (as with joint peer review) ● There is a need for ring-fenced budgets for child protection training |

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| | <ul style="list-style-type: none"> • In some places, specialist training courses are already delivered across a number of trusts or on a regional basis • Mentoring/buddying schemes could help support new named and/or designated professionals in their roles • Joint peer support, review and training could be a key function of a network |
| The development of consistent policies and protocols | <ul style="list-style-type: none"> • The development of consistent policies and protocols is also a driver for establishing networks, and could result in the following benefits: <ul style="list-style-type: none"> ○ Avoiding duplication of effort ○ Preventing trainees from having to learn new policies each time they move to a new organisation ○ Addressing the challenge for tertiary centres of working with a number of local services each with different policies and protocols ○ Ensuring that equivalent neighbouring services are developed and enabling practice to be compared and best practice to be shared ○ Ensuring there is capacity in specialists' job plans for the development of joint policies and protocols (in some places this is currently done in personal time) |
| Capacity and workload | <ul style="list-style-type: none"> • Current problems around workload and capacity of named and designated professionals include: <ul style="list-style-type: none"> ○ Roles having expanded without an increase in capacity ○ An increase in C&YP on child protection plans ○ Difficulties attending peer review and other meetings because of workload ○ Lack of capacity as a barrier to service development (including the development of networks) |
| Recruitment and retention | <ul style="list-style-type: none"> • In some places there are difficulties recruiting to child protection work (particularly named and designated posts) and there is a lack of succession planning • In some places, there is a reluctance to engage in child protection work due to fears about the complexity of the work, the potential for involvement in court work, and the time-consuming nature of the work • Effective training is key to recruitment and retention, as is consultants having the capacity to support and develop trainees (in one place, the paediatricians who move into child protection are often those who have completed a Masters course in child health) • Including an element of child protection in every job plan can be a means to ensuring the engagement of all clinicians • In the longer term, networks should increase recruitment and retention as professionals should feel more supported, and networks can also facilitate workforce planning • There are questions around how involved general paediatricians should be in child protection – whether cases should be immediately referred to the community team or whether this results in de-skilling |
| Audit, clinical governance and | <ul style="list-style-type: none"> • There are benefits of conducting joint audit across organisations |

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| quality improvement | <ul style="list-style-type: none"> • There is a need for additional capacity to coordinate audits • There is a need to ensure that audit results in action and improvement • Some named doctors need greater support with the quality control aspect their role (it was felt that a network could help facilitate this) • There is a need for national standards |
| Additional comments on network models and development | <ul style="list-style-type: none"> • There are already a range of existing professional support networks, some of which have grown up organically through strong leadership • If more formal networks are to be developed, the models will vary from place to place depending on need • There is a need for a network of named mental health professionals to provide peer support and to enable policies and protocols to be shared • It is critically important that clinicians are involved in establishing networks; personal relationships between clinicians are what works best and networks should build on these • A network would require management and leadership capacity in order to coordinate training, peer review, governance and other activities; existing designated professionals networks have limited management and administrative support • Lessons learnt from existing networks include: <ul style="list-style-type: none"> ○ The importance of sign-up from chief executives to ensure that a network has sufficient 'clout' ○ The need to think in advance about what will be the measure of success for a network ○ The difficulty of isolating and demonstrating the definite impact of a network (although it is felt that networks bring people, projects and ideas together, motivate action and the sharing of ideas, and ensure appropriate professional support and development) ○ The importance of ascertaining from members what network activities would be useful (what they are already doing locally, and where the network can add value) • There is potential to deliver Rapid Response to Child Deaths and Child Death Overviews through network arrangements across trusts |
| Concerns and key considerations in developing networks | <ul style="list-style-type: none"> • Key concerns and considerations include: <ul style="list-style-type: none"> ○ Ensuring absolute clarity about roles and responsibilities within networks ○ Ensuring networks do not add another layer of organisational complexity ○ The time involved in running networks ○ How networks will be funded |

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| | <ul style="list-style-type: none"> ○ The fact that the current policy focus on a market-orientated approach to service delivery goes against the notion of collaborative working and networking ○ The need to ensure that networks do not dis-empower local professionals ○ The need to ensure that networks do not lead to silo working by separating health from other agencies |
| Other general points/problems | <ul style="list-style-type: none"> ● Other general problems and concerns raised include: <ul style="list-style-type: none"> ○ Difficulties for designated nurses in getting access to trust boards ○ The need to better engage general practice in child protection, for example through training ○ The need for child protection services to be separately commissioned from general paediatrics (partly to ensure effective processes for monitoring quality), and the need for a tariff that appropriately reflects the time-consuming nature of the work (including liaison with other agencies and court work) ○ The need for specialist training in child protection, including court skills and CSA ○ The need for clearer pathways and links with CAMHS, YOTs/the criminal justice system, and the need for earlier recognition and intervention ○ Some adult mental health teams may not regard safeguarding children as part of their role ○ The value of including safeguarding standards in commissioning contracts with all provider organisations |