Evaluation of the New Zealand Child and Youth Clinical Network Programme

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About the evaluation team

This evaluation was undertaken by Quigley and Watts in partnership with Anne Dowden (REWA). Quigley and Watts are specialists in public health research and evaluation and Anne Dowden is an independent specialist evaluation consultant. The work was undertaken by Carolyn Watts, Quigley and Watts and Anne Dowden, REWA.

Acknowledgements

The Paediatric Society of New Zealand (PSNZ) should be congratulated for their leadership and commitment to improving the health of children and young people in New Zealand.

Thank you to all those people who have contributed to this evaluation, leaders, facilitators and members of the Clinical Networks, the Ministry of Health, the Child and Youth Clinical Network Advisory Group and all the health professionals who generously shared their insights.

The Evaluation Steering Group was central to the direction of the evaluation. It was great to work with a professional and passionate group of people. Thank you to Denise Tringham and Kaleen Cooke from PSNZ for promptly responding to our queries and to Jo Johnson, Quigley and Watts for chasing up survey participants and ensuring we achieved a good response.

And last but certainly not least our thanks to Mollie Wilson who led this work on behalf of the Paediatric Society. Mollie has been pivotal to the success of this evaluation.
Executive Summary

Preface
This evaluation was commissioned by the Paediatric Society of New Zealand (PSNZ) as part of the Ministry of Health (MoH) contract to deliver the New Zealand Child and Youth Clinical Network (NZCYCN) Programme (the Programme).

The purpose of the evaluation was to understand how well the Programme is performing and to identify areas where it could be improved.

The Programme refers to the national support and leadership (via the PSNZ and the NZCYCN Advisory Group) for the development, implementation and ongoing maintenance of the Clinical Networks. The scope of the evaluation was primarily on the national process however aspects of impact reported about the Clinical Networks themselves has also been described. It should be noted a full evaluation of the Clinical Networks was beyond the scope of this work.

A logic model was developed to guide the evaluation. Evidence from interviews, workshops, documentary analysis and surveys was used to answer the evaluation questions. The findings were compiled by the evaluators and the evaluative conclusions made in collaboration with the Evaluation Steering Group.

Findings

1. How good is the design of the Programme?

The Programme is a component of the broader sector strategy required to meet medium and long term outcomes

The Programme is well designed to fulfil its contractual requirements and enable the short-term outcomes (implementation of the Clinical Networks) to be met. However, the logic model has identified gaps (outside of the contracted work) in the activities required to reach medium and long term outcomes. To meet medium term outcomes, such as the integration of Clinical Network principles into service commissioning, partnership and leadership is required from the organisations that commission, plan and fund services, the MoH and the District Health Boards (DHBs).

The Advisory Group provides multidisciplinary oversight

The Programme oversight is provided by the NZCYCN Advisory Group. The Advisory Group includes a range of health professionals carefully chosen for their expertise. Advisory Group members are generally representative of the sector – although there are challenges to maintaining such broad representation.

Strategic oversight at the national level requires the partnership of the Ministry of Health and District Health Boards

The leadership from the NZCYCN Advisory Group for the work contracted to PSNZ has been effective. Strategic oversight at the national level requires the partnership of the MoH and DHBs.

PSNZ Secretariat support is effective

The support from the Programme Secretariat is highly valued and is effective in providing practical guidance and support for establishing and operating the Clinical Networks. The Programme has established relationships with many key organisations (including NGOs) and professional groups. Partnership with the MoH and DHBs requires further work.
2. How effective is the communication about the Programme?

Communication about the Programme is reaching those directly engaged in secondary and tertiary level sub-specialty areas however is not as strong across the wider child and youth health sector.

Communication about the Programme and Clinical Networks is reaching members of PSNZ, secondary/tertiary level medical clinicians and health professionals in cities. The engagement with health professionals in primary care and more isolated communities is lower.

The information conveyed about the Programme is appropriate and valued by those it is reaching. 71% of people who have had some interaction with a Clinical Network say they have used information from the network in their own practice.

3. How effective is the implementation of the Programme?

Networks have engaged with a range of disciplines appropriate to the network.

All Clinical Networks have engaged with multidisciplinary professionals and organisations within their sector. In line with the resources available engagement is pragmatic, and to a large extent driven by who is on the CRG. This has led to some gaps in the range of multidisciplinary professionals and organisations some Clinical Networks have engaged with.

Networks support collaborative partnerships.

The Clinical Networks support a diverse range of collaborative partnerships which lead to increased opportunities to network and develop multidisciplinary approaches.

Networks have some but not all the infrastructural elements needed to be highly successful.

The Clinical Reference Group (CRG), along with the support from the PSNZ Secretariat were mentioned as two of the key elements of infrastructure by the Clinical Networks. In addition to clinical leadership CRG members highlighted the importance of an inclusive, non-hierarchical approach. The area that most limits Clinical Network progress is key CRG members having insufficient time to undertake the work. Other elements reported as missing were expertise in communication and evaluation.

4. How valuable is the Programme to the child health workforce?

The Programme and Clinical Networks are perceived positively by those who know about them.

Almost all health professionals, that are aware of the Programme and/or the Clinical Networks, feel it was valuable. Those involved in the Clinical Networks value them for guidance, collegial relationships, the focus on their own area of interest and the promotion of equity and improvement to clinical care.

Health professionals in the wider child and youth health sector who are not engaged with the Programme or the Clinical Networks are not aware of them.

5. Potential for the Programme

This Programme has the potential to be a highly effective component of a strategic approach to the planning and purchase of child and youth health services nationally.

The Programme was driven by the sector in response to a real need, articulated clearly over many years, and was based on sound evidence. However, in the absence of a national strategic approach to the provision of services for child and youth health it will be difficult for the Programme to move from improving the quality of services for those health professionals who choose to engage, to improving the delivery of consistent and equitable services nationally.
6. How could the Programme be improved?

To contribute effectively to medium and long term outcomes related to the national provision of equitable services leadership is required from the MoH and DHBs. A true partnership between the Programme, the Ministry and the DHBs is required to move from short term to long term outcomes. The diagram below in Figure 1 shows how the relationships (in red) and leadership (in green) are essential to the overall Programme outcomes.

**Figure 1: NZCYCN Programme logic model**

In the absence of a high-level partnership there are opportunities to strengthen the Programme, increasing its resources to enhance communication to the child and youth sector about the Programme and building the capacity of the CRGs. Specific actions include:

- Redefine the purpose of the Programme
- Create clear mechanisms to move clinical guidance into nationally consistent clinical delivery
- Build the partnership between the Programme and the system (planners and funders of services)
- Strengthen the Programme
  - Expand the communication about the Programme
  - Further develop key partnerships
- Increase the support for the CRGs
  - Provide adequate resources for CRG time
  - Provide support for monitoring and evaluation
  - Provide support for communication (strategy and channels)
Introduction

Who and what was the evaluation for?

This evaluation was commissioned by the Paediatric Society of New Zealand (PSNZ) as part of the Ministry of Health (MoH) contract to deliver the New Zealand Child and Youth Clinical Network (NZCYCN) Programme (the Programme).

The key users (and uses) of the evaluation included:

- **MoH** - accountability, inform planning and funding decisions
- **PSNZ** - quality improvement, accountability, feedback on achievements/gaps and challenges
- **Clinical Networks** - quality improvement, success factors, areas for improvement (in so far as these were assessed)
- **Wider child health sector** - information on Programme achievements and potential of the Programme and the Clinical Networks

The evaluation was overseen by a Project Steering Group chosen from members of the NZCYCN Advisory Group.

The Programme refers to the national support and leadership (via the PSNZ and the NZCYCN Advisory Group) for the development, implementation and ongoing maintenance of the Clinical Networks. The scope of the evaluation was primarily on the national process however aspects of impact reported about the Clinical Networks themselves has also been described. It should be noted a full evaluation of the Clinical Networks was beyond the scope of this work.

The New Zealand Child and Youth Health (NZCYCN) Programme

The Programme is part of the solution to a much larger issue. The larger issue has been well documented over many years in the 1998 report *Through the Eyes of a Child* and more recently in the 2010 MoH review of health and disability services for children.

*the absence of a national overview to inform service planning, means paediatric sub-specialty services in New Zealand are vulnerable, and will continue to be so if nothing changes* (Ministry of Health 2010)

In 2010, the MoH recommended:

*That the National Health Board develop an overarching national plan for paediatric sub-specialty services in New Zealand, in consultation with clinicians, health managers and service users, and linked with the Long-Term Health Sector Plan to include:*

- referral/clinical pathways to ensure care is provided at the most appropriate level within the health and disability system
- service-wide standards,
- guidelines and protocols appropriate audit and review
- the provision of, and essential elements included in, outreach services
- how service provision will be managed to ensure continuity of care for individual children and young people and their families

It appears that no overarching plan was developed.

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In 2009 PSNZ put a proposal to the MoH \(^3\) to develop a partnership with the Ministry of Health, health providers, and other sectors responsible for the wellbeing of children and young people, to develop a joint work programme with a view to better integrating the available services for children and young people in New Zealand.

PSNZ emphasised in the covering letter sent with the proposal the aim of the proposal is to improve health outcomes for children and young people, through a framework that promotes safe high quality services at all levels of care, by improved Clinical Networks. To achieve this goal the development team will require significant ‘buy in’ from policy and senior staff at the Ministry and through District Health Boards.

What was contracted in 2010 was a part of the proposed solution only, the Clinical Networks. The Programme was initiated in 2010 to support the Government’s intention to develop Clinical Networks as a means of strengthening clinical leadership and engagement, supporting improved local, regional and national service and capacity planning and improved system performance\(^4\).

The current work of the Programme includes:

- a) Supporting existing networks and developing options for long term sustainability of the networks and
- b) Supporting and/or leading the implementation of additional prioritise service areas for the CN programme based on a robust prioritisation and planning process\(^4\).

The key participants in developing the NZCYCN Programme were the MoH, the PSNZ Executive, the Clinical Network National Secretariat (administrative, planning and reporting support) and the NZCYCN Advisory Group (strategic guidance to the Programme). The Clinical Networks have strong association/links with relevant Special Interest Groups (SIGs) that operate within PSNZ.

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What were we trying to find out?

Purpose
To understand how well the Programme is performing.

Objectives
1. To understand how effectively the Programme has been established
2. To understand how effectively the Programme is being implemented and managed
3. To understand the key features of the Programme, including those that are critical to its success and sustainability
4. To identify the areas that the Programme is working well and those that could be improved.

Key Evaluation Questions:

Evaluation Questions
How good is the design of the Programme?

Does it
- Use transparent appropriate methods
- Have effective support from PSNZ
- Have effective strategic national leadership

How sustainable is the overall design of the Programme?
How could the Programme design be improved?

How effective is the communication about the Programme?

How well has the Programme been promoted to engage the sector?
Is appropriate information about the Programme being conveyed effectively to the child and youth health workforce?
To what extent do the child and youth health workforce know of the Programme as well as the individual Clinical Networks?

How effective is the implementation of the Programme?

To what extent has the Programme engaged with multidisciplinary professionals within the sector (geographical spread, across settings including primary, secondary and tertiary care and in rural and urban communities)

To what extent do each of the CNs:
- Effectively support collaborative partnerships between multi members of the child and youth health sector?
- Have infrastructural elements (including clinical leadership) that will enable improvements in clinical practice?
- Have effective communication processes that inform the sector on local, regional and national network innovations and achievements?
- Have appropriate clinical Key Performance Indicator measures that are being adequately monitored?

How valuable is the Programme to the child health workforce?

How is the Programme perceived by child health workforce, both those who are actively engaged in the CNs and those who are not?
Why is the unengaged workforce not linking into the programme?
What aspects of the Programme are particularly valued? What aspects of the Programme are performing particularly poorly, or are of low value?
How much are the members/others using the CN resources? Do they value these resources?

**Improvements**
What areas does the sector believe the Programme (and the CNs) have been particularly strong or could be improved?
What are the suggestions for improvements?

**Potential of the Programme** (Clarifying the shared understanding of the programme intent and potential impacts)
What is the Programme striving to achieve?
What impacts has the Programme achieve to date?
What would assist the Programme to sustain its progress?

**Programme Logic**
A logic model (see Figure 2 on page 10) was developed to describe what the Programme is trying to achieve through its actions (joining up process and outcome). The logic model was developed in conjunction with the Evaluation Steering Group. It explains how the Programme works, why it is doing what it is doing, and how this is expected to achieve and contribute to certain outcomes. The shaded parts of the logic model indicate the outputs and outcomes that were included within the evaluation.
Figure 2: What is the Programme trying to achieve?

** Outputs

High quality Programme with:
- ✓ multidisciplinary strategic oversight with contributions from all relevant professional groups and is broadly representative of professional groups in the sector
- ✓ good communication with the child health sector
- ✓ transparent and accountable prioritisation methods that are accepted and viewed as effective for delivering optimum outcomes
- ✓ effective support from PSNZ

- Partnership established/strengthened between key providers

- Effective national leadership and communication with partners

** Short-Term

High quality Clinical Networks established with:
- ✓ Infrastructural elements that support improved clinical practice and service delivery
- ✓ effective communication processes that inform key stakeholders on local, regional and national network innovations and achievements
- ✓ clinical Key Performance Indicator measures are developed and routinely monitored

- Buy in from key providers
- Increased opportunities to network and develop multidisciplinary approaches

- DHBs and clinical paediatric partners understand and support project

** Intermediate

- Improved clinical practice\(^6\) that results in effective, efficient and safe service delivery
- Clinical Network principles are integrated into the commissioning of new services and renegotiating of existing service contacts by funders

- Service delivery partnerships emerge
- Agencies work at a highly collaborative level
- Network of learning across the country

- Strengthened national and regional leadership for quality child and youth services

** Long-Term

- Improved health outcomes for children and young people
- Service integration maximises effectiveness of services

- Increased understanding of quality child and youth services

- Sustainable national and regional collaborative leadership for quality child and youth services

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\(^5\) Providers refers to key providers of clinical child and youth services

\(^6\) For paediatric sub-speciality areas covered by clinical networks
What evidence did we use to answer the questions?

We used the following methods to collect the evidence:

Interviews and workshops

Workshops

Two workshops were held with the NZCYCN Programme Evaluation Steering Group. In the first workshop the Steering Group had input into the logic model and evaluation design. The second workshop focused on the preliminary findings. The Steering Group discussed the findings and assisted to make sense of the findings.

A workshop with the NZCYCN Programme Advisory Group and the clinical leaders and facilitators of all Clinical Networks was held as part of the National Meeting in November 2016. The workshop included an overview of the evaluation followed by small group discussions on the following questions:

What is the Programme trying to achieve (its purpose)?
What are the Clinical Networks trying to achieve (purpose)?
What are the key components of an effective national process?
What are the key components of an effective Clinical Network?
What is critical to the success and sustainability of the Programme and the Clinical Networks?

Discussions were recorded by each group and collated after the workshop.

Interviews

Interviews were undertaken 15 individuals:

Clinical Network leaders (n=2 paediatric specialist doctors)
Clinical Network facilitators (n=1 nurse, 1 NGO)
Clinical Network members n=2 (n=1 nurse, 1 NGO)
DHB Portfolio Managers for Child Health n=3
MoH staff n=2
Youth health sector health professionals (n=1 DHB community nurse, 1 Youth One Stop Shop GP)
Regional Child Health Alliance project manager n=1
PSNZ Society project manager n=1

Interviews were undertaken by phone or in person. Interviewees were sent an interview schedule and background information prior to the interview (Appendix 1). Interviews were recorded and transcribed.

Online surveys

Two online surveys:

1. Clinical leaders and facilitators of the Clinical Networks

An online survey of all Clinical Network leaders and facilitators was undertaken in January 2017. An invitation was sent to all leaders and facilitators n = 20 followed by two reminder emails. The survey was completed by 19 of the 20 leaders or facilitators.

2. Health professionals working with children and young people
An online survey of the child and youth health sector was carried out to gather the opinions of health professionals with a focus (solely or partially) on healthcare of children and young people. An invitation letter from Dr Pat Tuohy (Chief Advisor - Child and Youth Health, MoH) was sent out with an explanatory email to a wide range of health professionals via the following networks (recipients were also encouraged to share the invitation with colleagues who may not have received the email):

- PSNZ Listserv members.
- Child Health Regional Alliances member lists (Northern, Midland and Southern, and key contacts in Central area as it does not have a child health alliance); and their contacts including some individual GPs and paediatricians.
- Society of Youth Health Professionals Aotearoa New Zealand (SYHPANZ) member list.

A reminder email was sent one week later. A total of n = 212 were received. About a third were primary care sector (29%) and half were secondary/tertiary sector (46%). Half were members of PSNZ.

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Documentation and literature

A wide range of documentation was reviewed including:

- Documentation about the establishment of the Programme (proposal, contract, reports that informed the rationale)
- Documentation about the operation of the Programme (compendium of operational processes, reports from Clinical Networks)
- Documentation on Clinical Network work programmes
- International and national literature on Clinical Networks

How did we determine ‘how good is good’?

Evidence was brought together from the different information sources to answer each evaluation question. The findings were discussed by the Steering Group who assisted to interpret the answers bringing background context to the judgements of relative value or merit.
Findings

1. How good is the design of the Programme?

Is the Programme designed to achieve its intended outcomes?

The Programme is well designed to fulfil its contractual requirements and enable the short-term outcomes (implementation of the Clinical Networks) to be met. However, the logic model has identified gaps (outside of the contracted work) in the activities required to reach medium and long term outcomes. To meet medium term outcomes, such as the integration of Clinical Network principles into service commissioning, partnership and leadership is required from the organisations that commission, plan and fund services, the MoH and the DHBs.

The Programme, as contracted, is a component of the approach recommended by PSNZ. The original intent was to provide Clinical Networks as a component of an overarching strategic framework for the delivery of paediatric specialty services. This intent was supported by the national and international evidence base, that Clinical Networks can have valuable impacts on strengthening clinical leadership in service planning leading to improved system performance and ultimately, health outcomes for children and young people. PSNZ emphasised the requirement to work in partnership with the MoH and the DHBs to achieve the intent.

The Programme is a component of the broader sector strategy required to meet medium and long term outcomes

The original intent of the PSNZ proposal (2009) and national reports (HFA/PSNZ 1998 and Ministry of Health 2010) was to provide Clinical Networks as a component of an overarching strategic framework for the delivery of paediatric specialty services.

PSNZ emphasised the importance of a partnership approach

*The aim of the proposal is to improve health outcomes for children and young people, through a framework that promotes safe high quality services at all levels of care, by improved Clinical Networks. To achieve this goal the development team will require significant ‘buy in’ from policy and senior staff at the Ministry and through District Health Boards (PSNZ, 2009)*

The final contracted work, this Programme, is a component of the recommended approach. However, the Programme is not linked to a broader strategic framework or strategic leadership that would enable the Programme achievements to contribute directly into the medium and long term outcomes of the recommended approach.

The purpose of the contract is

*To work in partnership with the Ministry of Health, health providers and other sectors responsible for the wellbeing of children and young people to develop and provide ongoing leadership and support for paediatric specialist Clinical Networks (MoH contract for services with PSNZ, 2014).*

Evidence base recognises the potential of Clinical Networks

The Programme documentation includes a substantial evidence base outlining the potential for Clinical Networks to have a positive impact on the overall quality of care, access and equity of service provision and the effectiveness of services, at all levels over the long term.
The needs of children, young people and their families for care and support along a continuum can be achieved more easily than from isolated services. Networks protect families from gaps between services (NZNYCN website)

There is a shared understanding among the Advisory Group and leads within the Clinical Networks of how the Programme and Clinical Networks can contribute towards a long-term improvement in health outcomes in the health sector. However, how this potential could be realised in the New Zealand context is not fully articulated. The logic model has identified gaps (outside of the contracted work) in the activities required to reach medium and long term outcomes. There is no strategy for how initial actions (outputs and short term outcomes) by the Programme and Clinical Networks will be integrated into the commissioning of services, or renegotiating of existing services, in the New Zealand health system.

I would hope there would be some conduit from local or regional level up to the Paediatric Clinical Network up to the Ministry to prompt for targeted focus (DHB Portfolio Manager)

The difficulty is you’re working with a network but you’re sort of separate to DHB funding so the direct course into implementation becomes difficult depending on people’s good will to do this stuff and it’s sort of separate to service (CN Leader)

Logic model summary

To document this shared understanding of Programme intent, a logic model for the Programme (outlining the outputs, and the short, medium and long term outcomes of the Programme and the Clinical Networks) was agreed at the outset of this evaluation in collaboration with the Evaluation Steering Group, and in consultation with the Clinical Network leads. (See the logic, Page 10)

Once the Clinical Networks are established, the medium-term outcomes include:

- Improved clinical practice that results in effective, efficient and safe service delivery
- Clinical Network principles are integrated into the commissioning of new services and renegotiating of existing service contacts by funders
- Service delivery partnerships emerge
- Agencies work at a highly collaborative level
- Network of learning across the country
- Strengthened national and regional leadership for quality child and youth services

And related to these, the long-term outcomes include:

- Improved health outcomes for children and young people
- Service integration maximises effectiveness of services
- Increased understanding of quality child and youth services
- Sustainable national and regional collaborative leadership for quality child and youth services
Does the Programme use transparent, appropriate methods?

The criteria for a high quality programme included:

1. Multidisciplinary strategic oversight with contributions from all relevant professional groups and is broadly representative of professional groups in the sector
2. Transparent and accountable prioritisation methods that are accepted and viewed as effective for delivering optimum outcomes

**Multidisciplinary oversight:** The Programme oversight is provided by the NZCYCN Advisory Group. The Advisory Group includes a range of health professionals carefully chosen for their expertise. Advisory Group members are generally representative of the sector – although there are challenges to maintaining such broad representation.

**Strategic oversight:** The leadership from the NZCYCN Advisory Group for the work contracted to PSNZ has been effective. Oversight is focused more on the operational (i.e. the activities of the Programme) and short to medium term outcomes rather than strategic or long-term outcomes. Strategic oversight at the national level requires the partnership of the MoH and DHBs. Leadership has been hampered by the lack of an overarching strategy for child and youth health and the autonomy of DHB planning and purchasing decisions.

**Transparent prioritisation:** The process to set up Clinical Networks is extensively documented. However, the decision-making process to prioritise which Clinical Network is set up is not fully transparent. In practice, a nuanced process occurs that takes into account a range of factors (beyond those stated). Furthermore, on occasion, requests from Government are received that override the documented selection process.

**The Advisory Group provides multidisciplinary oversight**

The Programme oversight is provided by the NZCYCN Advisory Group. The Advisory Group includes a range of health professionals carefully chosen for their expertise.

In the past, the Group has had representation from relevant professional groups however it has proved difficult to maintain such a range of representation. Members are reimbursed for transport costs and can receive the Ministry of Health standing committee fees. Lack of reimbursement for actual costs (e.g. a day of income for GPs) and the demand on individuals, are two reasons for turnover of group members and difficulty in attracting replacement members.

**Strategic oversight at the national level requires the partnership of the MoH and DHBs**

The Advisory Group focuses on the outcomes of the Programme in the medium term, of three to five years. This is consistent with the services that are contracted (the contract has a three-year term). A longer term, strategic, focus (as outlined in the introduction to the contract service specification but not specifically in the contract outputs) would be ideal.

Currently, the Advisory Group considers that its ability to make progress towards long term outcomes of the Clinical Networks is severely restricted because progress is closely tied to the strategic direction and progress made by the entire sector, of which it has limited ability to impact.

That said, a longer-term focus may help the Advisory Group to identify those (likely few) areas that it can provide support for the Clinical Networks to influence the improvements in clinical practice and the purchase and delivery of services and thus contribute to longer term outcomes of the sector.
Prioritisation decisions to set up Clinical Network are not fully transparent

The process for becoming a Clinical Network is well documented. There is a large compendium of resources used in the development of the Clinical Networks. This includes several steps to becoming a network including completing templates, questionnaires and a business case. The stated aim of these resources is to ensure a consistent approach to the development of Clinical Networks, and frequent mention is made to the need to be ‘transparent and objective’.

The documentation includes for example, a ‘Network Assessment Template’ with nine key indicators or themes (e.g. problem, population, quality improvement/health gain, feasibility and so on). However, the assessment is not transparent. No details are included on what constitutes ‘good’ (or poor). Operationally, a detailed and nuanced decision-making process occurs that is not overt in the documentation.

Furthermore, other factors effect whether a Clinical Network is given a higher or lower priority. These include:

- The vulnerability of the specialty area; those areas that are more vulnerable are given higher priority, and
- Requests from Government to establish Clinical Networks (such requests can override the prioritisation processes and a request acts as an alternate pathway to setting up a Clinical Network).

Does the Programme have effective support from PSNZ?

The support from the Programme Secretariat is highly valued and is effective in providing practical guidance and support for establishing the Clinical Networks. There is extensive documentation about the operation of the Programme (such as templates, use of logos and sign off procedure for guidelines). These are highly valued by the Clinical Networks leaders and facilitators.

PSNZ Secretariat support is effective

The Programme has a comprehensive suite of operational procedures to support establishment and management of a Clinical Network.

The key elements of the support identified by the Clinical Networks were administrative support for meetings, structure and process for developing the network, frameworks for developing the key performance indicators (KPIs), technical and strategic advice including engaging with the MoH, access to well established lines of communication, the Starship website, frameworks with clearly defined expectations based on outcomes, templates, terms of reference, consistency and experience.

The Clinical Network facilitators and leaders said they could not function without the advice, clear processes and administrative support of the Secretariat.

We could not have done it if it wasn’t without the support of Mollie and Kaleen, honestly, they are both outstanding (CN facilitator)

It’s been hugely important. I think without it, the network wouldn’t exist because there is a substantial amount of workload reduction by having a secretariat to deal with the stuff that takes a lot of time and a lot of the co-ordination that pretty much would just eat into our clinical day to such a level it would just be saying this is not worth it (CN leader)
In the survey of facilitators and leaders most said the national process had been very effective (15 of 18 surveyed). One person said it had been 'somewhat effective'. Two people felt that they were too new in their role to comment.

*Guidance and ongoing support has been enormously helpful from a strategic and operational perspective as well as structure and process for developing and continuing the Clinical Network. I cannot speak highly enough of the leadership and support provided by Mollie Wilson and the real assistance from Kaleen in so many aspects* (survey participant)

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**Has the Programme established/strengthened partnership with key providers**

The Programme has established relationships with many key organisations (including NGOs) and professional groups. Partnership with the MoH and DHBs requires further work.

Relationships with some key organisations and professional groups have been established but tend to be child and disease-specific in focus. Relationship with NGOs are valuable conduits to families and patients.

There is a good partnership with some key individuals at the MoH. However, relationships do not appear to extend across the MoH to key policy people, portfolio managers or the Office of the Chief Nurse.

There are no formal links with the DHBs into the planning, funding or delivery of services.

**Key organisations and professional groups**

Relationships have existed at times with key professional groups such as the Society of Youth Health Professionals Aotearoa New Zealand (SYPHANZ) and the Royal College of New Zealand General Practitioners (RNZCGP). These relationships have been difficult to maintain over time and representation on the Advisory Group has been patchy.

**NGOs important conduit to patients and families**

NGOs that were involved in Clinical Networks value their involvement and the work of the Clinical Networks highly. Excellent relationships exist between NGOs and Clinical Networks, which provide an important link between patient and family support, as well as advocacy and treatment.

**Relationship with the MoH**

There is a good relationship with parts of the MoH. The relationship with the MoH is largely with Service Commissioning, and Office of the Chief Medical Officer. Relationships do not currently extend to policy or the Office of the Chief Nurse. In the absence of a specific Child Health Strategy the Programme is not linked into any strategic policy at the Ministry level.

*I think from a Ministry perspective this is our only investment in this area and if that’s all that we invest in I don’t know if the mix is right. I don’t think the mix is right personally and the other perspective I’m voicing is in name essentially, it’s a child and youth Clinical Network but I think from a youth health perspective, if we thought about what is needed for youth in a Clinical Network it’s not currently seen in this mix* (Advisor child and youth health)

**DHB relationships**

Attempts by the Advisory Group to engage with the DHB Chief Executive forum have been largely unsuccessful. DHBs focus on the priorities set out in national guidance, the Minister’s letter of expectation, national health targets and Better Public Services targets for children and young people (immunisation and rheumatic fever). While DHBs strive to provide the best possible access to clinical
services, efforts to improve health are driven by the burden of ill health at a population level. In the absence of a national directive to consider or follow the advice of the Clinical Networks, DHBs report change would need to be driven by senior clinical staff. Success would depend on the forums and processes at each DHB for clinician involvement in the funding and planning of DHB child and youth services.

the next step is saying how do we ensure that [CN guidelines] gets distributed and implemented at a local DHB level too because I entirely agree with what the Clinical Networks are working towards and trying to achieve. I think it’s just in terms of that next step and how do we embed it locally so I think there’s definitely great value and as I mentioned the paediatric team in our local DHB sings the praises of the guidelines that are coming out at a national level (DHB Portfolio Manager)
2. How effective is the communication about the Programme?

How well has the Programme been promoted to engage the sector?

Communication about the Programme and Clinical Networks is reaching members of PSNZ, secondary/tertiary level medical clinicians and health professionals in cities. The engagement with health professionals in primary care and more isolated communities is lower.

Communication about the Programme is reaching those directly engaged in secondary and tertiary level sub-speciality areas however is not as strong across the wider child and youth health sector.

About half the wider child and youth sector health professionals surveyed were aware of the Programme (49%). Note that some that are unaware of the Programme are aware of individual Clinical Networks (especially networks for Child Protection, Eczema and to a lesser extent Diabetes).

It should be noted that primary care may not be an appropriate focus area for some Clinical Networks and therefore lower awareness would be expected.

Those least likely to be aware of the Programme are:

- Based in small towns of rural areas (28% are aware of the Programme) compared to about half (50% to 52%) for those on Regional cities, Large cities, or Auckland metropolitan area.
- Those that are less likely to be aware include GPs (26% aware) and nurses in primary care (14% aware); in contrast secondary/tertiary medical clinicians\(^7\) (80% aware) are most likely to be aware.

Those most likely to be aware of the Programme are:

- Members of PSNZ (71% of those reporting they are members are aware of the Programme).
- Some regions have low awareness of the Programme, compared to others: Northland (27% aware), Tairawhiti (16% aware), and Wairarapa (16%); while Auckland and Hawke’s Bay have higher awareness (50% aware).

There is little difference in awareness levels between those with and without a specific child/youth health focus

Those that only focus on children and young people in their practice (55% aware) have similar awareness of the Programme as those working with people of all ages (59% aware) or those who mainly work with children and young people (43% aware).

Lower awareness of the Programme appears to impact on perceptions of the individual networks, where respondents had some involvement with these

Not being aware of the Programme correlated with feeling less informed about the Clinical Network they had most contact with as well as being less likely to refer others to that network, being less likely to think the Clinical Network supported collaboration or prompted better clinical practice.

\(^7\) Note we are unable to differentiate vocationally registered paediatricians and resident medical officers (including Paediatric Advanced Trainees, Paediatric Basic Trainees and general junior Paediatric doctors) from the survey results
Is appropriate information about the Programme being conveyed?

The information conveyed about the Programme is appropriate and valued by those it is reaching. Information is available about the Programme on the PSNZ website and on the Starship website. The Starship website has information about the Programme generally and each of the Clinical Networks have their own page. The NZCYCN website received over 160,000 hits in 2016. PSNZ produces the CYNet newsletter biannually which is distributed widely through the following channels with an invitation to forward on to interested parties:

- the PSNZ List Serve
- Separately to all the Clinical Network leaders and CRG members
- DHB Paediatric Clinical Director groups
- DHB Child Health Manager Group
- As many DHB portfolio managers that PSNZ is aware of
- Plunket national contact
- The NZCN Advisory Group
- Contacts within MoH
- Contacts within regional child health alliance groups

The Clinical Networks (facilitators and leaders) value the website and newsletters as an important mechanism for communicating their work to the wider sector.

In the survey of the wider child and youth sector, for those that had interacted with one of the networks, 71% said they had used information from the network in their own practice, 59% have referred colleagues to the information and 57% have directed families to the information.
3. How effective is the implementation of the Programme?

To what extent have the Clinical Networks engaged with multidisciplinary professionals within the sector (geographical spread, across settings including primary, secondary and tertiary care and in rural and urban communities)?

All Clinical Networks have engaged with multidisciplinary professionals and organisations within their sector. In line with the resources available engagement is pragmatic, and to a large extent driven by who is on the CRG. This has led to some gaps in the range of multidisciplinary professionals and organisations some Clinical Networks have engaged with.

Networks have engaged with a range of disciplines appropriate to the network

This can be seen both in the makeup of the CRG and the members of the wider network. Some networks have undertaken stakeholder analysis and purposely identified and sought representation from NGOs, consumers, geographical regions (including rural areas) and types of health professionals to ensure a diverse CRG and network.

There are strengths and limitations with using the PSNZ email list for expressions of interest in CRG membership

The PSNZ email list reaches health professionals with experience and knowledge in paediatrics however many allied health professionals and nurses are not members of PSNZ so may not receive information about the Clinical Networks.

The only reason we knew about it our team, was because one of our doctors was one of the founding members (CN facilitator)

Some respondents report that engagement and communication by Clinical Networks is somewhat ad hoc and is does not include a broad enough dissemination of information.

No clear dissemination to wider GP community except to shoulder-tapped individuals (Sector survey respondent)

Engagement with DHBs is through interested clinicians rather than any formal links, or agreements, with DHB planning, funding or service management

Most networks have also attempted to engage with clinicians at DHBs.

I think by year 3, 18 of the 20 DHBs had representation, but there have been 2 DHBs no matter how much I’ve tried, I’ve yet to get somebody from those DHBs (CN leader)

Representatives are finding replacements for the network when they move on to another role in the DHB

... I think that’s a positive sign of the value they find from it (CN leader)

Engagement is highest for specialist physicians and secondary and tertiary nurses and lowest for primary care, allied health, parents and young people

The survey of Clinical Network leaders and facilitators showed most networks aimed to engage with parents (and young people to a lesser extent), GPs, primary, secondary and tertiary care nurses, specialists and allied health professionals. The highest levels of engagement to date have been with specialist physicians and secondary and tertiary care nurses. Most networks reported parents, young people, primary care nurses and allied health professionals as groups they have not yet fully engaged with.
This is supported by the survey of the wider child and youth health sector showing varied awareness of the Programme from tertiary/secondary care (where there is higher awareness) to primary care (with low awareness).

Primary care was noted as a part of the sector more difficult to engage directly although some networks have wide membership including GPs and practice nurses.

Paediatric allied health professionals are less represented on some networks. A possible reason for lower representation is a smaller workforce that is less able to commit time to individual specialist areas (unless in a main centre). It should be noted that allied health professional representation is not appropriate for all networks.

Some networks have established formal MoUs with other organisations. This is valuable as it ensures engagement is more likely to be sustained rather than relying on individuals.

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**To what extent do the Clinical Networks effectively support collaborative partnerships between multidisciplinary members of the child and youth health sector?**

The Clinical Networks support a diverse range of collaborative partnerships which lead to increased opportunities to network and develop multidisciplinary approaches.

**Networks support collaborative partnerships**

Network members value the opportunity to develop and enhance relationships with colleagues across the country and learn from what is working well without “reinventing the wheel”.

The survey of sector health professionals suggests that this extends beyond those closely involved in the networks into the wider sector.

Most health professionals that are aware of the Programme (49%), reported that it was supporting collaborative partnerships:

- The Programme is supporting collaborative partnerships between health professionals across the child and youth health sector (86% agreed or strongly agreed)
- Most health professionals that had an interaction with one or more Clinical Network report that the Clinical Network they interact with is supporting collaborative partnerships between health professionals across the child and youth health sector (65% agreed or strongly agreed).

**Collaborative partnerships are enabling multidisciplinary approaches**

A range of multidisciplinary approaches are being reported. Several Clinical Networks described how they were able to showcase innovative service provision using a multidisciplinary approach that was then picked up by other parts of the country.

- The Eczema Clinical Network report the example of a secondary level nurse-led clinic being run in primary care setting to maximise access to care. The Eczema Clinical Network has been able to support and mentor nurses in other regions wanting to set up a similar approach.
- Another example in the Palliative Care Clinical Network was a DHB and Hospice sharing expertise to improve care for children and families.
- Work demonstrating the cost-effectiveness of services is being shared by Clinical Networks across the country.
If they don’t have management support, they’re not going to get anywhere and sometimes it’s even advice around how to actually work with management to get their support and how they can demonstrate that this is of benefit and not just clinically but financially (CN facilitator).

To what extent do the Clinical Networks have infrastructural elements (including clinical leadership) that will enable improvements in clinical practice?

The CRG, along with the support from the Secretariat were mentioned as two of the key elements of infrastructure by the Clinical Networks. In addition to clinical leadership CRG members highlighted the importance of an inclusive, non-hierarchical approach.

The area that most limits Clinical Network progress is key CRG members having insufficient time to undertake the work. Other elements reported as missing were expertise in communication and evaluation.

The time and mechanisms to influence DHB funding and planning (as discussed in the previous two sections) was also mentioned by networks as an element blocking improvements in clinical practice.

The support from the Secretariat is a key infrastructural element (as discussed in section one).

Clinical Networks must have the right people, with the right leadership styles, on the CRG

By having the right people on the network, those respected in their area, the Clinical Network becomes a powerful influencer clinically.

The CN is again far more powerful than what we do individually (CRG member)

Having the right people on the CRG is critical to all other aspects of a network’s success, communication, engagement with the sector and choosing KPIs that are relevant to multiple stakeholders.

The reference group is all important. As long as you’ve got a reference group of people who are prepared to participate in the work programme then it’s going to be successful (CN Leader)

CRG leadership needs to be strategic non-hierarchical and welcoming. Joint medical and nursing leadership has worked well for one network allowing greater reach, relevance and sustainability for the CRG. The CRG requires time to form. The first year is about building strong relationships within the CRG, getting to know the strengths and experience of different members.

Creating strategic partnerships via the CRG membership (with support and professional organisations) to leverage the influence and communication of the network has proved effective.

Inadequate resources for CRG time

The area most frequently highlighted as missing in terms of support was funding to allow facilitators and leaders to commit time to the CRG.

I think the ministry perspective, is well eventually this will be business as usual what they need to understand, is this is well and above what is our business as usual (CN Leader)

Lack of support for evaluation

The networks interviewed reported needing additional guidance or skills to evaluate the impact of their work.
We wanted to include the evaluation and we have not found an easy simple way to actually do that (CRG member)

Lack of support for communications
See discussion below.

Lack of strategic leadership and a mechanism for Clinical Networks to contribute to DHB planning and funding processes

CRGs and others involved in the Clinical Networks report a growing frustration with the lack of integration of their work (such as published clinical guidelines) into decisions about funding and planning of health services. Many consider that such integration would be achieved through the strategic leadership role they expect of the MoH.

There are clear examples where Clinical Networks have developed clinical guidelines, but implementation of the guidelines has stalled. There appears to be no consistent commitment or plan for implementation from the MoH or DHBs. When such clinical guidance is not implemented, it has a negative impact not only on the long-term outcomes of service integration but also on the momentum and sustainability of the Clinical Network effected and other Networks observing the situation.

The network has come to a cross-roads. It has established a Ministry published document that outlines an implementation plan for a comprehensive, cost-effective Clinical Network to improve delivery of care throughout NZ. However, the implementation has only been partially completed with significant and longstanding gaps still impacting on the care of children. Unfortunately, Ministry engagement for implementation has ceased. What is required is sustained advocacy and lobbying from the national leadership of the Ministry and DHB NZ for this work to be completed! Further, as a result of the loss of momentum I have a sense that the involvement of people in the network is dissipating (CN Leader)

To what extent do the Clinical Networks have effective communication processes that inform the sector on local, regional and national network innovations and achievements?

Networks have a range of communication processes that inform the sector on local, regional and national network innovations and achievements. Communication reaches many but not all health professionals.

Improving communication requires more administrative support and expert communications input.

Communications are sent through a range of clinical channels relevant to each network

These include:

- The CYNET newsletter is sent to a wide distribution list.
- The NZCYCN website (hosted by Starship) received over 160,000 hits in 2016.
- Relevant organisation communications BPAC, PHARMAC, and DermNet.
- Formal relationships with other organisations such as consumer support or professional bodies, enables wider communication, which is more efficient (in terms of CRG time).
- Regular emails out to the network.

I often either get comments back directly saying this is really helpful thank you or they’ve got questions that they want to make contact with somebody or it reminds them about the network (CN Leader).
• Networks are generally not set up to communicate directly with parents, although many create resources they share via other organisations and websites including KidsHealth.
• Communication into DHBs tends to be network dependent via clinical individuals. Information about the Clinical Networks individually is not reaching funding and planning managers in the DHBs.
• CRG members also disseminate information via their own networks.

Communication about the Clinical Networks activities is not reaching all health professionals

Over half of health professionals that had an interaction with one or more Clinical Network report that they were well informed about that Clinical Network’s activities (58% agreed or strongly agreed).

Health professionals are not communications experts

Several CRG members note that written communications are not their area of expertise. They lack the skills to write for different audiences (i.e. for health professionals, managers and families) as well as the knowledge of how, and who, to disseminating information to.

To what extent do the Clinical Networks have appropriate clinical KPIs that are developed and adequately monitored?

Clinical Networks have an extensive range of clinical KPIs. The KPIs do appear appropriate, however a full assessment (of both the KPIs and KPI monitoring) was beyond the scope of this evaluation.

The monitoring that has been observed is limited. It is unlikely to provide robust data on progress towards Programme and Clinical Networks’ outcomes. Monitoring tends to be at the output level rather than outcome level. For example, Guideline uptake is tracked by the number of website hits (i.e. downloads of the Guidelines), rather than measuring a change in behaviours (such as use of the Guidelines) that said, some Clinical Networks are assessing uptake of guidelines directly, which is a complex and requires significant resources. Monitoring and evaluation support to strengthen KPI monitoring and to measure KPI contribution towards medium and long term outcomes would be beneficial.

Clinical KPIs are considered valuable and provide a useful focus

Clinical Networks have an extensive range of KPI and the CRGs appreciate the focus the KPIs bring to their Clinical Networks. The KPIs have supported the CRG to achieve a lot.

Clinical KPIs appear to be appropriate

There are a wide range of KPIs across the networks all of which appear clinically important and in line with the purpose of being a Clinical Network. Examples include:

• Models of care/clinical guidelines - all networks have developed best practice guidelines (or in one case have promoted national guidelines). These are often one of the first work streams for a CRG and are seen as highly valuable by CRG members and wider network members.

  We started with the model of care and I think that that’s been critical, it’s kind of like the base plate of where we are all working from, and again we’ve had positive feedback from people who have had nothing to do with the network and who I’ve shared it with and who
have come back and shared really positive feedback saying that’s make a lot of sense because again it’s about encompassing all services (CN Leader)

- Teaching/dissemination of clinical best practice
  Networks take on the dissemination of clinical best practice through teaching, some offering significant sector workforce development, for example:
    - Monthly teaching sessions that all DHBs can link into by videoconference
    - Sponsored nurse meetings

One of the key factors of our work is a significant, huge amount of teaching that, definitely that’s from CRG members but I know that also our wider members do this as well (CN Leader)
4. How valuable is the Programme to the child health workforce?

How is the Programme perceived by child health workforce, both those who are actively engaged in the Clinical Networks and those who are not?

The Programme and Clinical Networks are perceived positively by those who know about them.

I think that it’s an absolutely invaluable opportunity for the organisation to be part of it … if the CRG keeps moving forward which I hope it will and I hope it gets the support to do that, then I can see huge potential to change the experiences that people with CF (CN CRG member)

Almost all health professionals, that are aware of the Programme and/or the Clinical Networks, feel it was valuable.

- Health professionals agreed the Programme is a valuable approach to supporting the development of Clinical Networks (92% agree or strongly agree).
- All but one health professional that had an interaction with one or more Clinical Network agreed or strongly agreed that the Programme is a valuable approach to supporting the development of Clinical Networks.

Those not engaged with the Programme, or whose work focuses in areas other than those covered by the Clinical Networks, have a lack of awareness, rather than a negative opinion, of the Programme or the Clinical Networks.

Why is the unengaged workforce not linking into the Programme?

Health professionals in the wider child and youth health sector who are not engaged with the Programme or the Clinical Networks are not aware of them.

About half the wider child and youth sector surveyed are aware of the Programme (49%).

The most common reason for not interacting with a Clinical Network was that they did not know of the Clinical Networks (over 50% of those surveyed who had not interacted with a Clinical Network said this). A third (36%) indicated that had heard of Clinical Networks but they didn’t know what Clinical Networks did. And nearly one in five (18%) people said they could not easily access the information.

Very few people gave responses that indicated the Clinical Networks were not valuable to their work.

What aspects of the Programme are particularly valued?

Those involved in the Clinical Networks value them for guidance, collegial relationships, the focus on their own area of interest and the promotion of equity and improvement to clinical care.

Those involved in the Clinical Networks indicated that they particularly value the following about the Clinical Network they were most involved with:
- The guidance the Clinical Networks provide. This is described in a range of ways including published guidelines, training/education sessions and clinical updates – such as dissemination of recent research articles, as well as guidance and expertise gathered from networking sessions or collegial conversations about cases.
- The collegial relationships and networking opportunities.
- The inclusion of a primary care focus; involving primary care in guideline development promoting/enabling high quality primary care.
- The youth health care focus.
- The multi-disciplinary focus.
- The improvement in clinical care.
- The promotion of equitable service delivery.

How much are the members/others using the CN resources? Do they value these resources?

The Clinical Network resources are being used by those who are aware of them.

Most health professionals surveyed that have some interaction with a Clinical Network have used information from the Clinical Network to inform their work in the past year (71%). Furthermore, over half have referred their colleagues (59%) or their patients and families (57%) to information produced by the Clinical Network.
5. Potential for the Programme

What is the Programme striving to achieve?

In the long-term the Programme is striving to contribute to improved health outcomes for children and young people (see Figure 3 below). It aims to do this through clinical leadership and improved clinical practice supported by service integration that is linked to funding and planning decisions. The Programme requires strong supportive relationships and national strategic leadership (depicted in green and red in the figure below) to make and maintain these changes in a nationally consistent, sustainable way.

Figure 3: Logic model for the NZCYCN Programme

What impacts has the Programme achieved to date?

The Programme has many achievements to date including the development of national clinical leadership, clinical guidance, dissemination of guidance and workforce development leading to improved clinical practice.

Development of clinical leadership

The networks enable access to specialist knowledge (particularly for those in smaller centres) by identifying clinical ‘go to’ people.
Development of clinical guidelines/best practice guidance
All Clinical Networks have created clinical guidelines/models of care/best practice.

Dissemination and use of clinical guidelines/ best practice guidance
Networks take on the dissemination of clinical best practice through teaching, some offering significant levels of sector workforce development.

Input to regional clinical pathway development
Clinical Networks have been able to influence the development of regional clinical pathways by sharing those already developed through the network. This has meant pathways across the country are more consistent and work that has already been done is not being repeated.

Improved clinical practice

There was broad agreement that the Programme and Clinical Networks can improve clinical practice
Most health professionals surveyed, that are aware of the Programme, felt it was promoting better clinical practice in New Zealand (83%).
Most health professionals that had an interaction with one or more Clinical Network report that their Clinical Network they interact with is promoting better clinical practice within its area of focus (77% agreed or strongly agreed).

There are many examples of Clinical Networks activities improving clinical practice.
For some networks, which do not require highly specialised clinical treatment approaches, a bottom up approach is used to influence clinical practice. For example, the nurse-led clinics for eczema delivered in primary care by secondary care nurses.
For those requiring highly specialised care which may not be available in smaller population centres. Clinical Networks have raised awareness of the need for this care and how to access it, for example:

Have I got direct evidence for it, no but the perception is yes it has improved care. Definitely the phone calls that I get from around the country which has always been the case since I’ve been here, the level of question it’s different. It’s like a different level of care they’re asking, and the fact that they’re asking about this child, there’s no dispute that this child can benefit from palliative care which 10 years ago would have been a question of do you think this child would benefit from palliative care... now they’re asking questions at a different level of care requirement (CN Leader)

What would assist the Programme to sustain its progress?

The Programme sustainability is at risk for two reasons:

1. The mechanism required to integrate the work of the Programme into DHB planning and funding is missing.
Those involved in the Clinical Networks described the purpose of the Programme and the individual Clinical Networks in terms of their contribution to the long-term outcomes for the health sector (i.e. of improved health outcomes for children and young people through improved clinical practices and integration of services).
2. There is no sector strategy for this Programme to connect any progress made by the Programme and the Clinical Networks into wider sector progress towards improved health outcomes.

The lack of an overarching strategy for the child and youth health diminishes the potential of the Programme and individual Clinical Networks to make an impact.

In terms of sector strategy or child health strategy, our child health strategy is 1998 and our youth health plan of action is 2002 so we are essentially working without clear child and youth health strategy (Advisor, Child and Youth Health)
6. How could the Programme be improved?

To contribute effectively to medium and long term outcomes related to the national provision of equitable services leadership is required from the MoH and DHBs. A true partnership between the Programme, the Ministry and the DHBs is required to move from short term to long term outcomes.

In the absence of a high-level partnership there are opportunities to strengthen the Programme, increasing its resources to enhance communication to the child and youth sector about the Programme and building the capacity of the CRGs.

Redefine the Programme purpose

In the absence of a national strategy the Programme purpose is unrealistically broad in scope. The purpose does not match the content of the contracted outputs. A lack of clear purpose has led to stakeholders with different expectations about what the Programme can and should deliver.

The purpose of the Programme needs to be clearly articulated and shared with all stakeholders to ensure everyone committing time to Clinical Networks understands the scope and intent. Frustration and disillusionment that the work of the Clinical Networks is not being used to improve service planning and delivery is already apparent in some networks.

Review information about the Programme (for example on the Starship website) to ensure it clearly describes what is on offer rather than a theoretical description of what Clinical Networks could achieve (if it were part of a wider strategy for planning, purchasing and delivering health services).

Define what is meant by ‘youth’ within NZCYCN

There was discussion particularly from those involved in youth health about the appropriateness of the focus of the networks. The key concerns raised were the focus on specific diseases that did not represent the key areas of concern in youth health or the holistic person-centred approach used by youth health services.

From the perspective of PSNZ, young people are included (where appropriate) within each network as they transition to adult services.

Clear mechanisms to move clinical guidance into nationally consistent clinical delivery are required

To date leadership for the Programme has been provided by the Advisory Group on behalf of the sector. In the absence of effective national leadership from the MoH or engagement and support from the DHBs the Programme will struggle to move the clinical guidance into nationally consistent clinical delivery. It is not reasonable to expect a largely voluntary group of clinicians to negotiate with 20 DHBs to bring about the system changes required for equitable high quality services. Figure 4 below shows how this leadership is vital to achieving Programme outcomes.

It’s ad hoc, it purely is dependent on those involved [in the Clinical Networks] (CN Leader)

If there’s some mandate from the ministry that this is actually important, of value and is to be supported, that would I’m sure assist. Because even the national group, they don’t even have that mandate, they can suggest it to the DHB but they can still ignore completely what they are saying (CN CRG member)

The value of the Clinical Networks is it provides a formal environment to actually move forward this important work which is across the board. If it’s left to the individual DHBs it’s always going to be ad hoc and you’re always going to get a disparity in what is provided and the level of service as well as quality and this is a way to actually improve this (CN facilitator)

Suggestions to have an impact on improved clinical practice include:
The regional health alliances and clinical pathways projects regionally are potentially a mechanism to support changes recommended by the Clinical Networks.

Agreement on clinical outcomes/indicators that could be factored into the purchase of services at a DHB level.

**Build the partnership between the Programme and the system**

The Programme was always intended as a partnership between the MoH, PSNZ, DHBs and other health providers committed to improving wellbeing for children and young people. The partnership has not occurred leaving the Programme largely as a devolution of responsibility by the Ministry of Health with little buy-in from the DHBs. Partnership involves all parties coming to the table to contribute to mutually beneficial outcomes. Figure 4 below shows how these relationships are critical to the achieving Programme outcomes.

More clarity is required about the nature of these mutually beneficial outcomes and constructive collaboration to achieve them. Without all partners involved, the Programme can only realistically be expected to deliver short term changes.

First steps would include:

- Clear communication about the nature of the partnership the challenges/barriers with the MoH about next levels of outcomes.
- Strengthen links with child health decision makers across the 20 DHBs.
- Enhance relationships with strategic partners, for example RNZCGP, Well Child providers, and consumer groups.
- Increase communication across the child and youth sector about the networks generally.

*Figure 4: Logic model for the NZCYCN Programme*
**Strengthen the Programme**

There are areas of the Programme that would benefit from additional resources and strengthening.

**Communication, awareness raising and partnerships**

Expand the communication about the Programme to raise awareness and increase the visibility and understanding about the Programme and the Clinical Networks. It is important the child and youth health sector health professionals who may rarely need to access information know it exists and how to find it when they need it.

The Programme could expand the range of breadth of partnerships to better communicate with generalist paediatricians, primary and community care providers. Because these health professionals deal with a wide range of issues the most effective channel of communication is likely to be via their own generalist networks and existing professional development pathways, for example, RNZCGP, SYPHANZ.

- Confirm, clarify and communicate what the Programme (and Clinical Networks) aims to achieve; and how it will do this.
- Confirm and communicate what the Programme is less likely to be able to influence; such as whether it aims to directly deliver or indirectly contribute to the medium-term outcomes.
- Promote and disseminate CN published guidelines.

**Increase the support for CRGs**

CRGs are well supported in terms of administration. The key areas requiring further support are:

1. Adequate resources for CRG time.
2. Support for monitoring and evaluation (including evaluative thinking to support a focus on medium terms outcomes - not only the short-term outcomes e.g. not only the production of clinical guidelines, but also sector wide use of them).
3. Support for communications (writing and dissemination).
4. Succession planning (this is critical to sustainability of the CRG, particularly the leaders’ and facilitators’ roles, because of the work involved.

*If it comes to the point that only a couple of people are the ones doing the work then I think you have a time limited network. Because I know from experience that it can only be sustained for so long and when clinical work increases, that kind of network group work, gets put as a lower priority and it stalls and loses momentum* (CN leader)
Conclusion

This Programme has the potential to be a highly effective component of a strategic approach to the planning and purchase of child and youth health services nationally.

The Programme was driven by the sector in response to a real need, articulated clearly over many years, and was based on sound evidence.

However, in the absence of a national strategic approach to the provision of services for child and youth health it will be difficult for the Programme to move from improving the quality of services for those health professionals who choose to engage to improving the delivery of consistent and equitable services nationally.
### Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tr>
<td>BPAC</td>
<td>Best Practice Advisory Centre, an independent, not-for-profit organization offering educational and continuing professional development programmes to medical practitioners and other health professional groups throughout New Zealand</td>
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<td>CN</td>
<td>Clinical Network</td>
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<td>CRG</td>
<td>Clinical Reference Group, responsible for the operation of the Clinical Network</td>
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<td>DHB</td>
<td>District Health Board</td>
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<td>KPI</td>
<td>Key performance indicator</td>
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<td>NZCYCN</td>
<td>New Zealand Child and Youth Clinical Network programme</td>
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<tr>
<td>PHARMAC</td>
<td>PHARMAC is the New Zealand government agency that decides which pharmaceuticals to publicly fund in New Zealand</td>
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<tr>
<td>PSNZ</td>
<td>Paediatric Society of New Zealand</td>
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<td>RNZCGP</td>
<td>Royal New Zealand College of General Practitioners</td>
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<tr>
<td>Starship</td>
<td>Starship Child Health is a dedicated paediatric healthcare service and major teaching centre, providing family centred care to children and young people throughout New Zealand and the South Pacific</td>
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<td>SYPHANZ</td>
<td>Society of Youth Health Professionals Aotearoa New Zealand</td>
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<tr>
<td>Well Child</td>
<td>The Well Child programme is a package of universal health services offered free to all New Zealand families/whānau for children from birth to 5 years.</td>
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<tr>
<td>Youth One Stop Shop</td>
<td>Primary health care (including drop-in services) plus a range of other services for young people</td>
</tr>
</tbody>
</table>
Appendix 1

Evaluation of the Child and Youth Clinical Network (NZCYCN) Programme

Information sheet for interview participants

You have been asked to participate in an interview about the NZCYCN Programme because we are interested in including your views about the Programme in the evaluation. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

The project

The NZCYCN Programme was set up in 2010 to link groups of professionals and organisations to sustain and improve the quality of services for children and young people in New Zealand. We are interested in your views on the Programme.

The evaluation

The evaluation is being undertaken by Quigley and Watts and Rewa. Several methods are being used to collect information to inform the evaluation including interviews.

The scope of the evaluation is primarily on the national process (i.e. national support and leadership via the PSNZ and the New Zealand Child and Youth Clinical Network Advisory Group) for the development, implementation and ongoing maintenance of the Clinical Networks however we will also record aspects of impact reported about the Clinical Networks, that is ‘what difference they are making’.

Should you agree to take part in this project, you will be asked to:

1. Agree to an interview by telephone at a time that is convenient to you.
2. The questions we would like to ask you are included in this document.
3. The interview will be recorded, however if you do not agree to this the interviewer will only take notes.
4. The interview will take about 45 minutes.

You may withdraw from participation in the research at any time prior to the analysis of the data and without any disadvantage to yourself of any kind.

If you have any questions about our project, either now or in the future, please feel free to contact:

Carolyn Watts (Project Manager)
carolyn@quigleyandwatts.co.nz
021 828 055
Consent Form for Participants

I have read and understood the information sheet explaining this research.

- I have had the opportunity to talk about the research and ask questions. I am satisfied with the answers I have been given.
- I understand that my participation is voluntary and that I can withdraw from this research at any time prior to the analysis of the data.
- I know whom to contact if I have any questions about this research.
- I agree to the use of anonymous quotes being used and I understand that while my name will not be used because of the nature of my role it may be possible to identify the information I have provided.

I agree to take part in this research (you will be asked for verbal consent at the interview).

I agree to allow the interview to be tape-recorded (you will be asked for verbal consent at the interview).

Questions

Your role

1. Can you give me a brief overview of your role please?

Your views

We are interested in your views on how well the Clinical Network you are involved with is working:

2. How successfully has your Clinical Network engaged professionals from across the sector you work in?

3. Do you think your Clinical Network has the right people on it?
   a. Do you have the leadership, capability, capacity you need?

4. How well has your Clinical Network supported collaborative work between members of the child and youth sector?

5. How has your Clinical Network focused on improving service delivery?

6. Does your Clinical Network have good communication processes to inform the sector about its work? How do you think this could be improved?
7. How well has your Clinical Network been able to tackle the objectives/piece of work it committed to doing? What has helped/hindered?

**Sustainability of the Clinical Networks**

8. How sustainable are the Clinical Networks going forward – with/without national support?
   b. What is needed to sustain the Clinical Networks?

**Communication about the Clinical Networks**

9. In your opinion does the wider sector know about the Programme and the individual Clinical Networks?
10. How effective has the promotion of the Programme been – has it reached all the right people across the child and youth sector? Who is it NOT reaching?
11. Has the right information been made available about the Programme?

**Value of the Clinical Networks**

12. How valuable do you think the Clinical Networks are to the sector?
13. What do you value most about them?
14. How could they be improved?
   
   Do you have any questions or any final comments?

   Thank you for your time today.