

CLINICAL NETWORKS POLICY (v1.0)

Effective: 1 March 2006

- **Review:** This document will be reviewed annually.

Last Reviewed: 21 February 2006

Supersedes: No previous policy

Application: This policy applies to all aspects of health care in Queensland including public and private services, and across the continuum of care.

Objective: To improve the quality and efficiency of Queensland health services.

POLICY

Policy Statement:

Clinical networks will be established so that the knowledge and experience of clinicians can be used to improve the quality of care for patients and the efficiency and planning of Queensland's health services.

Policy intent:

1. *It is the aim of Queensland Health that clinical networks become a key component of planning and decision making for health services.*
2. *Clinical networks will be of different kinds and will be responding to different geographies and situations.*
3. *Networks will base their recommendations on high quality evidence.*
4. *Clinical networks will be resourced appropriately according to the level of responsibility assumed.*
5. *Networks will be subject to performance evaluation and be accountable for the advice and recommendations they provide.*

Definition:

A clinical network is defined as 'a formally recognised group, principally comprising clinicians, established to address problems in quality and/or efficiency of health care'

1. BACKGROUND

- 1.1. The Forster Report identified a number of weaknesses with the current management, planning and governance arrangements for Queensland Health. Amongst other things, the report identified a need to engage clinicians better in decision making processes and identified an unhealthy development of “silos” within the Queensland Health.
- 1.2. One of the solutions advocated by the Forster Report was the development of “clinical networks”, to have a broad range of functions including to:
 - Develop clinical service plans and targets for their specific areas within their funding allocation;
 - Develop models of care to improve services delivery, consistent with the Queensland Health Services Plan eg. Minimum amounts of funds to be allocated based on the model of care – prevention, primary/community care;
 - Allocate targeted funding to areas of highest need or potential health gain at the district level. The clinical networks may link the allocation of growth funding to quality and safety and practice improvements including implementation of clinical pathways;
 - Monitor the outcomes being achieved through the new resources, including reporting on the achievement of clinical performance targets.
- 1.3. The Action Plan for Health endorsed the concept of clinical networks with functions to:
 - Develop and implement statewide safety initiatives;
 - Improve clinical service planning;
 - Have a role in funds distribution processes to support improving clinical practice;
 - Develop and implement standard treatment processes targeting high volume services (where standardisation will improve safety and quality) with the support of the Patient Safety and Clinical Improvement Service;
 - Develop quality and safety benchmarking processes with the assistance of the Patient Safety and Clinical Improvement Service;
 - Involve local clinical teams in the discussion and interpretation of benchmarking data;
 - Undertake clinical audits in collaboration with clinicians and services.
- 1.4. Clinical networks have also been developed and used productively in other jurisdictions: see, for example, New South Wales (<http://www.health.nsw.gov.au/gmct/index.html>); and the United Kingdom (www.show.scot.nhs.uk/sehd/mels/1999_10.htm; <http://www.yorkshire-cancer-net.org.uk/html/links/networks.htm>). These sites also provide useful definitions.
- 1.5. This document outlines the Queensland Health policy on formation, operation and evaluation of clinical networks. Together with other policies (for example on Clinical Governance), it is part of Queensland Health’s endeavour to enhance opportunities for clinicians to engage in planning, priority setting and system improvement.

2. FUNCTIONS

- 2.1. Clinical networks could be tightly focussed addressing a single issue (eg. developing a clinical pathway) or could have a broad remit depending on the nature of the issue which stimulated the development of the network.
- 2.2. Networks are expected to address improving quality of care, safety for patients, more equitable access and patient outcomes, workforce issues and a more efficient health system. The priority accorded to each issue (and the way in which the issues manifest) will vary across networks.
- 2.3. In a constrained resource environment, a critical focus of clinical networks will be on innovation: identifying new ways for service improvement and to address current problems in service delivery, and ensuring that all services are aware of contemporary best practice.

- 2.4. The precise range of functions will be clearly articulated in the network's Terms of Reference but all networks will be expected, in the first instance, to address specific opportunities for improvement in patient outcomes in Queensland and establish measurable outcomes to track performance against this goal.
- 2.5. Characteristics of all networks will be an emphasis on evidence-based decision making, collaboration and multi-disciplinarity, involvement across the continuum of care and a focus on service improvement and innovation.
- 2.6. In terms of *quality*, networks might be involved in:
 - 2.6.1. Development of clinical pathways, development and dissemination of guidelines;
 - 2.6.2. Development of integrated referral paths to promote access to expertise and to facilitate effective referral back to, and ongoing treatment by, local services;
 - 2.6.3. Development of performance measures and clinical indicators for clinical services and comparison of Queensland performance with best practice nationally and internationally;
 - 2.6.4. Priority setting to ensure equitable access for patients across Queensland (including development of priority setting tools);
 - 2.6.5. Stimulating the development of specialised equipment and, in more mature networks, assuming responsibilities for its governance;
 - 2.6.6. Assessing the nature of the volume-outcome relationship encompassed within the network's purview and developing strategies to optimise the location of service provision;
 - 2.6.7. Monitoring the application of the Service Capability Framework in a specialty and associated minimum safe staffing standards;
 - 2.6.8. Development and/or implementation of information packages to assist patients to make informed choices about assessing risks and benefits of treatments;
 - 2.6.9. Development of credentialing framework for specialties;
 - 2.6.10. Ensuring that all services in Queensland are providing treatment (and psycho-social support) in line with contemporary best practice yielding the best possible outcomes for patients;
 - 2.6.11. Conduct of clinical audits and feedback to clinicians.
- 2.7. The *efficiency* mandate of clinical networks should be interpreted very broadly and could include:
 - 2.7.1. Production *efficiency*: facilitating arrangements to ensure that clinical services are efficiently provided (including in terms of site of care).
 - 2.7.2. Clinical *efficiency*: ensuring that the mix of services provided in the remit of the clinical network should produce the greatest possible clinical benefit. In this regard clinical networks should ensure that the balance of preventive, primary care, acute and rehabilitative services is most appropriate and that additional enhancements are recommended at the right point of the intervention spectrum.
 - 2.7.3. Distributional *efficiency*: ensuring that access to service for patients is as equitable as possible across Queensland.
 - 2.7.4. *Dynamic efficiency*: ensuring clinical services are positioned well for technological change; that Queensland Health's research base is maintained and strengthened; that well founded scientific advances are implemented for to Queensland in a cost effective way and that the skills necessary for meeting health needs in the future are available.
- 2.8. Clinical networks should contribute to the planning and priority setting processes of Areas (including development/expansion of specialties within the Area) and to the development of clinical training and research (including development/enhancement of training networks for Registrars).
- 2.9. Areas, as part of their planning processes, will identify priorities for service improvement and networks may also assist in identifying priorities within any funding envelope identified for the relevant service.

- 2.10. Cross-area networks could prove particularly useful in the management and development of quaternary services and to provide a co-ordination mechanism for addressing the same issue where clinical networks have been established in each of the Areas. Networks with a Statewide coordination function would normally include the chairs of the relevant single Area networks.

3. TYPES OF CLINICAL NETWORKS

- 3.1. In line with the Policy Intent, clinical networks will vary along a number of dimensions including their formality and responsibility; focus; and area served.
- 3.2. In terms of *formality and responsibility*, networks will vary along a spectrum from groups similar to the current collaboratives which are characterised by a strong emphasis on shared learning and problem solving; through to groups which function as coordinating committees or clinical taskforces, addressing any or all of the functions identified below; to groups which function as the board of management of an integrated clinical service with direct management responsibility for provision of clinical services.
- 3.3. Networks could be established with either a time-limited life specified in their charter or as ongoing. If ongoing, there should be rigorous review of the network after three years.
- 3.4. The broadly-based clinical networks that may look similar to the current collaborative will tend to be developed and initiated by clinicians themselves to respond to specific problems identified by the relevant group and to provide opportunities for development of collaborative quality improvement strategies. They would also tend to be larger than other types of networks, aiming to be very inclusive in keeping with their shared learning objective. Most specialist clinicians would be linked to at least one of these networks as a means of participating in processes to improve quality and patient care.
- 3.5. Networks may evolve in terms of formality and responsibility: more mature networks could be expected to exercise greater direct budget, management or fundholder responsibilities.
- 3.6. Clinical networks could be established to *focus* on a particular disease (eg. diabetes); a particular intervention mechanism or specialty (cardiac intervention or cardiology); more broadly in terms of disease/illness (chronic disease or cancer) or on a process such as patient flow or clinician-management relationships. Networks could be established to focus on services provided by Queensland Health or to stimulate service improvement in both the public and private sectors.
- 3.7. In terms of *geography*, it is anticipated that most clinical networks will be established within a single Area. Although post-Forster, Districts remain the key building blocks of the Queensland Health organisational structure, Forster also identified an unhealthy development of "silos". This suggests the need for a greater level of co-ordination across Districts to facilitate referrals and efficient delivery of services. Clinical networks may also be established where District boundaries inhibit provision of efficient and high quality services. Such clinical networks might evolve to provide the management of integrated clinical services.
- 3.8. It will be appropriate to establish some clinical networks serving South East Queensland (Central and Southern Areas), networks to co-ordinate services for Brisbane and the North (Central and Northern Areas) or for improving clinical services across Queensland (Statewide services).

4. ESTABLISHING CLINICAL NETWORKS

- 4.1. Administrative responsibility for establishing and/or endorsing clinical networks rests with Area General Managers (for single area networks) and the Queensland Health Executive Management Team (for networks involving more than one Area).
- 4.2. Clinical networks will normally be initiated through interaction between District/Area Managers and clinicians, jointly identifying problems that need to be addressed. Statewide

networks could also be established following discussion with any member of the Executive Management Team or the Director of the Clinical Practice Improvement Centre.

- 4.3. Clinicians interested in establishing a network should discuss their proposal with the Area General Manager or relevant contact person with the Area Office. Proposals for multi-area networks could also be raised with the Director, Clinical Practice Improvement Centre.

5. COMPOSITION

- 5.1. The composition of a network must include members with expertise in all relevant disciplines and with experience in different locations of practice and so, in that sense, the collective membership should be representative. However, individual appointments to clinical networks should be on the basis of expertise and interest not representation. Members of clinical networks should act to promote optimal health care for Queensland rather than the interests of one service location.
- 5.2. Clinical networks should be chaired by a clinician. The Chair (or co-chairs) for the clinical network should have the respect of his/her clinical peers, the support of other members of the networks and would be able to have access to and be listened to by relevant senior staff. The other members of the clinical network should be chosen based on expertise to contribute to the problem being addressed but generally should involve people, actively involved in patient care, from an appropriate range of disciplines (medicine, nursing, allied health), subspecialties, and practice settings, together with others with relevant expertise (e.g. in epidemiology, public health) and appropriate managers.
- 5.3. Clinical networks should also include consumer/carers members and, where appropriate, people from relevant non-government providers of care. Networks focussing across the continuum of care will include members with expertise in primary health care and general practice.
- 5.4. In line with the policy intent, clinical networks should principally be comprised of clinicians and the leadership of the network should have the confidence of the members of the networks and the broader clinical community. There may be members of the network occupying administrative roles (e.g. District Managers) to bring expertise in operational and implementation issues.
- 5.5. Where co-chairs are appointed, they should normally come from different disciplines. Larger networks should have an executive to share leadership tasks and to drive the agenda for the network. Again, the executive should comprise people from a range of different disciplines and locations.
- 5.6. Networks may establish 'sub-networks', subcommittees or time-limited taskforces to deal with specific issues or subspecialty areas.
- 5.7. The Charter establishing the networks should normally specify an 'executive sponsor' within the Area (who may or may not be a member of the network) to function as a conduit into decision making processes.

6. SUPPORT

- 6.1. Clinical networks will be supported through the Area offices of Queensland Health but normally located with, and accountable to, the chair of the relevant network. Clinical networks which have cross area functions will be supported through the most appropriate Area office.
- 6.2. The support for clinical networks will include funding to ensure time release of the Chair of the clinical network, a Project Officer and running costs to support the network and allow some project and/or information systems development funding. A Service Level Agreement between the Clinical Practice Improvement Centre and Areas will provide funding of around \$1M per annum to each Area to facilitate support for within-area networks and up to an additional \$150,000 for each cross area network (both amounts to be indexed with inflation).

More mature networks, exercising broader functions, would be expected to require greater levels of resourcing.

- 6.3. Networks will also have access to a pool of funds to establish pilot projects or undertake research where the evidence base for recommendations is unclear.
- 6.4. The Clinical Practice Improvement Centre will provide training for Chairs of clinical networks and project officers to ensure they are aware of:
 - Appropriate techniques which could facilitate network operation;
 - Data availability, and how to develop data specifications for additional clinical data that might be required by the networks;
 - Information dissemination and consultation strategies; and
 - Team and group processes.
- 6.5. The Clinical Practice Improvement Centre will also assist networks to access routine data sets held by Queensland Health.
- 6.6. The Clinical Practice Improvement Centre will convene a meeting of Chairs and project staff of networks annually. This will be designed to:
 - Facilitate coordination of networks
 - Provide an update on policy developments
 - Provide for exchange of learnings and
 - Provide for staff development.
- 6.7. The Queensland Consumer Health Council, in conjunction with the Clinical Practice Improvement Centre will provide training and support to consumer members of clinical networks.
- 6.8. Areas should establish clinical advisory committees or meetings of networks chairs to provide oversight of the clinical networks established within their Area, to receive reports from the clinical networks and to advise on budget priorities for recommendations from the networks. Reports from cross area networks will be considered by the Director General's Clinical Advisory Group.

7. EVALUATION

- 7.1. Clinical networks should evaluate their own performance annually against their work plan and by using a standardised questionnaire provided by the Clinical Practice Improvement Centre to ensure that the participants in the network continue to regard the investment of their time as appropriate.
- 7.2. Networks should also review their Terms of Reference and composition annually to ensure that they continue to reflect contemporary needs, the work plan and capacity. Changes to the Terms of Reference or composition need to be endorsed by the commissioning body (Area or Executive Management Team). Each network should also explicitly review each year areas where its work might impinge on other networks (or where other networks might be formed) and highlight this through the relevant Area office.
- 7.3. In addition, the Clinical Practice Improvement Centre will conduct a formal process and outcome evaluation of the established clinical networks i.a. assessing the levels of evidence used in network recommendations, changes in clinical practice and resource allocation, including how any enhancement funding recommended by networks has actually been expended, and the metrics specified in each network's Charter. The annual review will also consider issues of overlap and coordination between networks.

- 7.4. In addition to consideration by the Queensland Health Executive Management Team, the evaluation report will be provided to the Director General's Clinical Advisory Group and to Area Clinical Advisory Committee for their information and/or consideration.
- 7.5. There should be an external evaluation of the implementation of the clinical networks policy in late 2009.

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