Clinical supervision and peer review for Community Paediatricians

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Background

BACCH Executive Committee considered the purpose and process of clinical supervision and peer review at the request of a number of members. Some services are now required to implement formal clinical supervision for community paediatricians, but there has not been a nationally recommended process in place. Discussion had taken place at EC between 2013 and 2014 and this paper has been approved by EC for publication as a policy document.

Purpose of clinical supervision and peer review

Clinical Supervision

The NHS Management Executive defined clinical supervision in 1993 as: '….a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations.'

Clinical supervision allows a practitioner to receive professional supervision in the workplace by a skilled supervisor. It allows practitioners to develop their skills and knowledge and helps them to improve patient/client care.

Peer review

Peer review promotes a proactive culture of learning about either general or specific areas of clinical practice e.g. safeguarding, autism spectrum disorder. As part of peer review, the procedures and processes as well as the evidence base underpinning clinical practice are usually covered. All participants in peer review benefit from the experience of others who are doing the same work as they provide advice regarding diagnoses and management. In community paediatrics, safeguarding peer reviews are already undertaken regularly in many services, and the RCPCH has published guidance on this:
http://www.rcpch.ac.uk/sites/default/files/page/Peer%20review%20final.pdf

Who is clinical supervision and peer review for?

Clinical supervision

Ideally, all trainees and SAS doctors should receive clinical supervision from senior medical colleagues. Consultants are expected to provide such supervision to both trainee doctors and SAS doctors. Some experienced SAS doctors are able to provide clinical supervision to less experienced SAS doctors.

Trainee doctors are required to satisfy a formal clinical supervision framework, undertaken by their clinical and educational supervisors at specific times with specific formats, and therefore do

not need additional recommendations. However, SAS doctors do not have such formal arrangements and will benefit from regular clinical supervision by their senior colleagues to support them in developing their skills/competences and to prepare them for progression through the two Thresholds and/or towards CESR. Some SAS doctors are highly experienced and are able to function independently in their area of expertise. Therefore, clinical supervision for SAS doctors needs to be provided according to their level of experience.

For consultants working as 'Named Doctor for Safeguarding', they should receive clinical supervision from the Designated Doctor for Safeguarding, on a one to one basis periodically.

Otherwise, consultants should be able to function as independent practitioners without additional supervision, and no further clinical supervision requirements will be recommended. For newly appointed consultants, it is beneficial to have a mentoring arrangement in place so that they are supported to settle into new roles e.g. leadership and management roles, but this is not the same as clinical supervision.

Peer review

Peer review for safeguarding has been established in many services. In some cases this is a commissioning requirement. All doctors involved in delivering safeguarding services should participate in regular peer review.

In some areas, 'Named Doctors for Safeguarding' from a number of different service providers meet periodically with the support of external facilitators, to discuss difficult cases and situations, and this is an additional peer review activity.

For other areas of clinical practice, there is greater variation. This could take the form of uni-professional meeting e.g. doctors only, or multi-professional for specific areas of clinical practice e.g. autism pathway reviews.

A well run peer review meeting should enable a team of people who understand the pressures and challenges of the particular clinical area/pathway to discuss the management of cases in a critical but supportive way. It is important that standards of clinical practice used in peer review are evidence based as far as possible.

How may this work in practice?

The following processes are proposed:

Scheduled one to one meeting, 30-45 minutes per month is the suggested length and frequency for a Specialty doctor new in post, gradually reducing as the doctor gains experience. Senior, experienced specialty doctors, particularly those who have passed through Threshold 2, may not need regular clinical supervision but should continue to be supported through the appraisal and management process. Clinical supervision should be a formative rather than a summative process.

The supervisee is to bring cases he/she had been involved in since the last supervision session for discussion. It may be helpful to set up some criteria or guidance on how cases are to be

prioritised. Some cases should also be chosen at random. The supervisor may also bring cases for discussion, if they are of educational value, or if the supervisor feels it would be beneficial to discuss.

Discussion should be documented briefly but to include any follow-up or agreed actions for review in future meetings. This documentation can be used as supporting evidence for appraisal and revalidation.

A clinician within the service should keep an overview of the process. This would include allocation of clinical supervisors, keeping track of supervision actually taking place, and addressing problems should they arise e.g. regular defaulting by a supervisor or supervisee. This activity should be acknowledged in the responsible clinician's job plan.

As for peer review, this may better be considered as pathway specific exercises. There are established models for safeguarding peer review. Similar processes could be considered for clinical conditions e.g. ADHD, ASD, or for specific pathways within a service e.g. general neurodevelopmental clinics, school medical clinics etc. The choice of which peer review to be set up will be a local decision, as there are likely to be numerous variations of service models.

It is recommended that specific amount of time should be allocated to clinical supervision and peer review within consultant and SAS doctor job plans, from SPAs.

Summary of recommendations

1. A system of clinical supervision for SAS doctors and medical trainees working in Community Child Health services, appropriate to individual level of experience and expertise, provided by Consultant Community Paediatricians and experienced SAS doctors, is recommended as good practice. In some organisations, this is a requirement.
2. Medical trainees should follow the formal clinical supervision framework as required by their training schemes
3. Named doctors for safeguarding should receive clinical supervision from Designated doctors for safeguarding
4. If implemented, clinical supervision meetings for SAS doctors should be documented with anonymised patient information. This documentation can be used as supporting evidence for appraisal and revalidation
5. In services with formal clinical supervision for SAS doctors, a clinician within the service should be tasked with keeping an overview of the process, and such activity should be acknowledged in the clinician's job plan
6. Peer review in safeguarding should take place in accordance with RCPCH recommendations
7. Time should be allocated from within consultant and SAS doctor job plans for clinical supervision and peer review activities if these are implemented.