The Office *of the* Committee *for* Health & Social Care

Code Of Practice For Healthcare Professionals When Service Users, Who Are Minors, Or Their Guardians On Their Behalf, Wish To Explore A Professional Off-Island Opinion.

In the interest of clarity, this document refers to the specific circumstances of clients, who are minors, referring themselves (if Gillick competent) or who have had such arrangements made by parents or guardians, for further opinion off-island (from a practitioner registered with an appropriate professional body) outside standard referral patterns.

This Code of Practice relates to the care of children and young people only.

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1. Medically Unexplained Symptoms (MUS), Perplexing Presentations (PP) and Fabricated or Induced Illness (FII), are conditions defined by the Royal College of Paediatrics and Child Health (RCPCH), and for the sake of brevity in this guideline, will be generically referred to as Complex Medical Conditions (CMC). FII is fortunately rare, however, MUS and PP may form a continuum. The management of CMC is nationally recognised to be a challenge and is resource intensive. Clinician/parent/child relationships can be put under strain, and further opinions frequently sought. Outside of standard referral patterns, such opinions can be obtained independently and without formal referral, and as such potentially lead to a dispute with local provision. In an attempt to avoid such outcomes, this guideline (Code of Practice, COP), has been formulated to address concerns raised in the report entitled, 'learning following a local investigation into complaints from families about the use of safeguarding processes'. The COP is the outcome of a co-production' exercise involving all interested parties, including a group of parents.

   In the case of CMC, a Multi-Disciplinary Team (MDT) will normally be convened. The Convening Clinician (CC) could be the lead local clinician involved (from Primary Care, Secondary Care, Child Psychiatry or Community Services), or a member of the local safeguarding team. MDTs in these circumstances are referred to as Professionals Meetings (PM) and are convened on an individual basis to include all health professionals working with the child/children involved. The local Named Doctor for Child Safeguarding (NDCS) should be the first line of safeguarding contact into the PM, unless conflicted, in which case the Designated Doctor for Child Safeguarding (DDCS) advice and input would be involved.

   In the 'peculiar circumstances' of Guernsey (isolated small population, limited local paediatric resources, potential for conflict of interest between NDCS and lead clinician roles) the DDCS (who is an off-island resource) will have a low threshold for involvement in any CMC. This is because they can play an important role in advising the professional meeting, and early engagement can help assure that safeguarding concerns are properly and appropriately addressed. In particular, that concern about missing a medical diagnosis does not lead to medical abuse of a child, and that anxiety about safeguarding does not prevent valid diagnostic processes from being carried out.

2. It remains the right of any client (or for the parents, on behalf of a minor) to seek a second opinion should they so choose. (As outlined within the Guernsey provision under the Secondary Healthcare Contract)

3. Such a wish should be respected by the responsible clinician(s) locally. The contract between MSG/HSC would indicate a local second opinion should be sought first, and indeed such an extra view may well prove helpful. However, in the complex area of CMC an off-island specialist opinion is likely to be sought. Policy G1033, Priority Setting in Health and Social Care, applies, but if the locally sought second opinion, in agreement with the lead clinician, feels that an off-island opinion is required then that can go ahead through an HSC preferred supplier. An alternative route to such a second opinion could be through the professional meeting. A request for a further opinion off-island to 'satisfy a patient request because they did not like the local opinion' would almost certainly not be approved (a private opinion could then be sought if required).

4. The most effective use of a second opinion is whereby this is sought in cooperation with the family with discussion and agreement as to the route to be taken. In circumstances where a cooperative approach has been taken, there will be ample scope for appropriate multi-disciplinary talks/planning of therapy to be actioned, with a resultant best likely outcome for the child.

5. Occasions may arise, where in a locally organised and agreed action plan, the patient and/or the parents may not wish to pursue a specific part of this plan, be it diagnostic or therapeutic. To avoid an impasse developing, policy G107, Dealing with Complaints has been changed and now includes the possibility of appointing a mediator. In particular, the following information has been added to the policy. 'An independent mediator may also be sought by HSC in cases where a family and those healthcare professionals providing care to the child are unable to agree on components of care, as part of addressing the issue'.

6. Seeking multiple further opinions should be discouraged unless the local healthcare team, in consultation with the parents, agrees this is an appropriate action.

7. It has to be recognised that seeking multiple unsanctioned further opinions, and /or not cooperating with a treatment action plan set out by an MDT or PM may raise concerns regarding whether the best interests of the child or young person is being considered and this could potentially lead to a safeguarding referral to avoid the possibility (albeit very rare) of missing Fabricated or Induced Illnesses (FIIs). However, any such safeguarding referral should be discussed with the family ahead of time unless it's been assessed that doing so could potentially harm a child or young person.

8. In the circumstances of a privately obtained, self-sought second (or more) opinion, any investigation/treatment plan proposed with 'local delivery' must be subject to professional meeting discussion with the active participation of the external clinician(s) referred to.

9. Where further opinions have been sought (and obtained) by self-referral (most likely in the private sector) without the cooperation of the local health team, it is entirely appropriate that both the Primary Care Practitioner (PCP) and the local lead clinician, relays all appropriate information both to the off-island independent clinician(s), and back to the local secondary healthcare team (via the professional meeting). This latter action is to ensure local health providers are informed of diagnostic tests and therapeutic actions in the event of further healthcare issues arising whilst the patient is resident on-island, and that the off-island clinician(s) is fully informed. If the patient has not been discharged from care, then it seems appropriate for all pertinent information to be made available to all parties. It may be that it is never right for a patient with CMC to be discharged from local care. Withholding details of care undertaken off-island, by either the parents/guardians of the child, or the off-island clinician(s), could raise safeguarding concerns, if such actions impact negatively upon the health and wellbeing of a child or young person.

10. Local clinicians cannot be compelled to or expected to action investigations or treatment plans obtained in a non-sanctioned way and without recourse to professional meeting discussion, if they believe such recommendations not to be in the best interests of the child, or where such recommendations do not conform with national guidance, or are outside of local policy.

11. But also, local secondary healthcare teams cannot abrogate all responsibility for children whose guardians/parents choose to take their child down non-mandated routes. Local secondary healthcare teams retain a duty of care to all children resident on island, and it may be right, as discussed in paragraph 9 above, that patients with CMC are not discharged from local care. In these potential difficult scenarios, the DDCS and the NDCS retain a fundamental role in ensuring the child's healthcare needs remain met as far as possible.

12. However, where an impasse develops, and a proposed course of investigation/treatment cannot / will not be delivered locally then should the parents / child still wish to have recourse to this plan, responsibility for delivering and supervising such care remains in the hands of those recommending it. This does mean that such intervention is likely to take place off-island, and unless agreed to by HSC, will not be covered by the Secondary Healthcare Contract.

13. In the circumstances described in paragraph 10 above, a PCP may be asked to action diagnostic tests and therapeutic measures, which they feel they cannot comply with. It may be that such requests do not follow national guidelines, or involve prescription of medication/diagnostic tests, with which the PCP is not familiar, or deem to be beyond their scope of practice. In this scenario, the PCP should seek support and advice through the professional meeting and specifically from the DDCS.

14. Switching local lead consultants is often not unreasonable and may be by mutual consent. Withdrawing from all contact with the local healthcare teams, however, should be discouraged. A fundamental role of the PCP should be to ensure continuity of care such that the patient 'does not fall between stools'. The help and advice of the NDCS and/or DDCS in these circumstances may be essential since the PCP could be placed in an invidious situation with no source of local advice available to them. Intercurrent illnesses could arise, which could be handled locally.

15. In the case where a patient is receiving unsanctioned care off-island (see paragraphs 7, 8, 9, and 10 above), it would be for the PCP to remind the administering healthcare team to

keep the local healthcare team fully informed of actions taken and investigations, and therapies proposed (as per GMC guidance). This does not however imply that the local healthcare team will participate in this programme, unless such a programme has been agreed in an appropriately constituted professional meeting.

16. It is good practice to copy in the clinical correspondence to all relevant professionals, and to the patient/parents of minors, unless such an action is thought to incur risk to the child, or in the case of exceptionally delicate and difficult consultation with colleagues.

References

RCPCH 02/03/21 - New guidance on perplexing presentations

RCPCH 05/22 - External second opinions in Paediatrics

Heyman et al Arch did Child 104 2019 (12)1127-8 - avoidance of psychological diagnoses in PPS

Burger et al 2020 PMC7347190 - Outcome of multiple further opinions in adulthood

Greenfield et al BMJ Open 2021 e044033 - Value of second opinions in defined conditions