

It is a core competency for all clinical staff working with children to undertake regularly documented reviews of practice¹, including peer review. It is a component of the Clinical Governance Framework and is expected by the judiciary, GMC and professional bodies.

Definition

Peer review: person(s) of the same ability or expertise providing an impartial evaluation of the work of others.

Peer review is a form of reflective practice, as is clinical supervision. Clinical supervision usually involves a senior supervisor providing a structured format in a one-to-one setting and involves both reflection and direction. Peer review involves a group of peers discussing and providing opinions which the individual can accept or reject.

Purpose of peer review

- To provide a proactive culture of learning, professional development and support, education and training, case supervision, service improvement and improvement of multiagency processes.
- To provide support in a non-hierarchical environment, decrease professional isolation, sharing of best practice and understand the complexities of common but uncertain situations.
- Peer review provides assurance that the case findings and report meet a measure of standard and are more reliable.

Principles

Terms of Reference should be produced, including purpose, objectives, process, membership, chairing arrangements and frequency of meetings. Attendance should be recorded, with signatures. Regular attendance should be expected.

Aims and objectives

- To retrospectively review cases, photo-documentation, the medical report and multiagency process/working/communication.
- To provide quality improvement, maintain high clinical standards, provide training and support, to provide time for discussion in a suitable environment and to debrief following difficult cases.

Process

Cases should only be discussed when the examining doctor is present and photographs should be reviewed prior to the case information. The lead consultant retains accountability, with this applying to any subsequent document changes. Discussions should refer to relevant evidence bases and the environment should be challenging yet supportive. Any requests for second or consensus opinions should be agreed in advance. Minutes should be

¹ http://www.rcpch.ac.uk/sites/default/files/Safeguarding%20Children%20and%20Young%20people%202010%20final_v2.pdf

kept; documenting learning points, actions and research updates (as well as attendance) but should be anonymous and non-attributable.

Pitfalls

You should not use a colleague's opinion without consent or use the names of colleagues as second opinions when appearing in court.

Using a circle of close colleagues may lead to a lack of challenge, and bias towards the views of the most experienced can lead to inappropriate dominance. Atmospheres in which colleagues feel reticent to challenge must be avoided. Failure to regularly attend and failure to produce all evidence may indicate poor practice.

Positive outcomes

Peer review can reinforce child protection clinical networks, enhance understanding of when to refer a case to children's social care, increase individual confidence, allow for identification of and support for clinicians in difficulty, allow professionals to ask questions without embarrassment, decrease isolation and ultimately increase standards.

GOOD PRACTICE RECOMMENDATIONS

1. All relevant organisations should formally establish peer review processes for safeguarding
2. All paediatricians should participate in safeguarding peer review
3. All paediatricians should attend peer review meetings at least monthly
4. All paediatricians should engage regularly with other forms of reflective practice, including clinical supervision
5. Detailed Terms of References should be produced and agreed; outlining membership and frequency of meetings
6. Minutes should be kept; documenting attendance and non-attributable learning points and actions
7. The examining doctor must be present when cases are discussed, unless agreed in advance
8. The lead consultant always retains accountability and responsibility for any subsequent document changes
9. All participants must ensure a challenging yet supportive environment
10. Colleagues' names or opinions should not be used without consent
11. All participants must ensure that all forms of bias are avoided
12. Participants must produce all the evidence when presenting a case
13. Peer review should form part of the evidence for both annual appraisal and subsequent revalidation
14. Peer review should be adequately reflected in job plans

Every organisation employing paediatricians working in child protection should establish peer review processes in line with the recommendations and standards contained within this document.

Further reading

A Thomas, A Mott. Short report: 'Child Protection Peer Review for Paediatricians', *Child Abuse Review* (2012), wileyonlinelibrary.com, DOI: 10.1002/car.2201

Appendix 1 – Example of Child Protection Peer Review Terms of Reference

Purpose:

To develop a proactive culture of learning about procedures, process and evidence base underpinning diagnosis and in so doing provide support regarding opinions reached and benefit from the experience of peers who are doing the same work.

Objectives:

- To provide time for discussion of difficult cases in a relaxed, non threatening atmosphere
- To provide support through the sharing of experiences of others
- To review cases seen to ensure appropriate evidence based management
- To view photo documentation accompanying the case presentation
- To provide opportunity for emotional support
- To provide training for inexperienced paediatricians

Membership:

All paediatricians conducting child protection examinations

Process:

- The Chair will be drawn from amongst the group and should rotate
- The peer review should meet a minimum of once a month
- Attendances should be recorded on a sign in sheet kept within the department for 18 months
- Where possible the group will seek consensus in forming a view on the case and it is the lead consultant for each case who is responsible for ensuring any actions, changes of opinions and recording related to case management
- Individuals will keep a log of their attendance/certificates to present in their annual appraisal
- Where the process is the only method of clinical supervision in cases more detailed documentation of case management and self reflection will be required as well as consideration of production of minutes of the meeting
- If a case is presented for second opinion/expert opinion purposes, agreement should be reached in advance by all involved parties on reporting arrangements and case leadership. Names of specific individual doctors should be recorded in the file or in any subsequent reports derived wherefrom with the permission of that individual only after she/he has seen the notes and agreed the content of the opinion and report
- Examining doctors should be present for the discussion of their case
- All photographic evidence should be produced
- Photographic evidence should be reviewed prior to case information being shared (to avoid bias in interpreting the findings)