

CHILD PROTECTION PEER REVIEW FOR DOCTORS
WHO SAFEGUARD CHILDREN
RCPCH

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Purpose of document

The purpose of this paper is to define the principles and objectives of child protection peer review and to make recommendations to assist paediatricians in the UK to undertake this work in a consistent and systematic way.

Introduction

There is an expectation that doctors involved in child protection work will have access to support, peer review and clinical supervision in order to be confident and competent in this difficult area of work. The importance of these three areas as part of the clinical governance framework is described in a series of national documents including those from the GMC, the Department of Health and the RCPCH¹⁻⁷. However unlike the formal systems described for clinical supervision in nursing and other disciplines, the roles of 'peer review', 'support' and 'supervision' in relation to doctors have never been clearly defined. Pragmatically, the peer review process will encourage paediatricians to meet the accepted standards of our discipline and prevent practitioners working in isolation, in out of date practice with unacceptable interpretations, or restricted to personal views. Paediatricians that do not undergo peer review are likely to be regarded with concern by the courts, GMC, professional bodies and professionals.

Historically the purpose of peer review in the UK has been to assess the importance and quality of research submitted for publication in scientific journals; for the allocation of research funding and to assess the research rating of university departments⁸⁻¹⁰. In Child Protection the concept was expanded by groups of paediatricians following the Cleveland Inquiry¹¹ to provide support and an opportunity to receive feedback on physical signs particularly in sexual abuse through review of colposcopic photographs or other images taken in individual cases.

Nationally there is now considerable variation in the models of peer review ranging from local, regional and national meetings that include elements of support, clinical supervision and peer review. In addition there has been a considerable interest^{12,13} from the courts, the Police and the legal profession to ensure individual paediatricians giving evidence in court particularly in sexual abuse/assault cases have been 'peer reviewed'. The expectation being from the court that peer review reduces the risk of the 'maverick paediatrician' and provides a level of consistency and assurance that the evidence provided to the court has already met a measure of standard; the paediatrician has been judged by his/her peers; and both the evidence and the paediatrician are therefore more reliable. Anecdotal case reports have highlighted a growing concern that paediatricians participating in the peer review process yet not directly involved in the case, have become involved in court proceedings, carry a liability for any case that they have participated in peer review and an expectation that peer review will result in a consensus opinion. The importance of the process has been further highlighted in Bearing Good Witness¹⁴ as a way forward to the development

of local teams of expert witnesses providing a consensus expert opinion of cases to the courts.

There needs to be careful balances between ensuring paediatricians receive appropriate emotional support, advice, case management, supervision, education and training, and that practice is to the expected standards.

Peer review should not be regarded as a consensus opinion or be used by practitioners to name individuals in court as having provided them with a second opinion to provide credibility to their evidence.

Surprisingly there is little evidence on the effectiveness of peer review from formal studies although the process has now been adopted by professional bodies and is an expectation as part of good medical practice by professional bodies, the courts and the GMC. In general, peer review is held to be beneficial in the medical profession.

Peer Review for the purposes of this paper is defined as: *a person or persons of the same status or ability/expertise as another specified person or persons, providing an impartial evaluation of the work of the other/s.* (**Definitions Appendix 1**)

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."

Essentially, 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. Clinical supervision is a regular protected time for facilitated, in depth reflection on clinical practice. It aims to enable the supervisee to achieve, sustain and creatively develop a high quality of practice through the means of focused support and development¹⁵.

Clinical supervision enables practitioners to:

- * Identify solutions to problems
- * Increase understanding of professional issues
- * Improve standards of patient care
- * Further develop their skills and knowledge
- * Enhance their understanding of their own practice.

Clinical Supervision and Peer Review are differing forms of reflective practice and developmental activities that give practitioners the opportunity to learn from their experience and develop their expertise within clinical practice. Other forms of reflective practice include: coaching, action learning, and written reflective practice.

Whilst some of the principles of clinical supervision and peer review are the same, the difference lies with the concept of the skilled supervisor providing a structured format for a supervisee to reflect and can be directed on clinical cases in the former and a group of peers, that may or may not have greater expertise, engaged in a discussion and providing an opinion on an individual's case that the individual can accept or reject but has the ultimate responsibility for providing their opinion in the latter.

Any one of the above reflective/developmental activities can be utilised within a clinical supervision session provided the participants identify the purpose of the session before it commences and it is practitioner focused, sensitive to the needs of practitioners, undertaken in the spirit of collaborative partnership and supports the learning and development of clinical staff.

Emotional support in child protection is the process in which peers, supervisors, other professionals or lay people help an individual deal with the emotions they experience during clinical practice in child protection and offer encouragement and comfort during difficult or stressful times. This type of support can be given within the peer review or clinical supervision setting but its importance as a separate element for the wellbeing of professionals in child protection is increasingly becoming recognised.

Principles of Peer Review^{16,17}

- Terms of reference for the peer review support group should be drawn up and agreed stating the purpose, objectives, membership and process for undertaking peer review (see Appendix 3)
- As a minimum attendance should be recorded with a signing in sheet. The activity will be recognised by the RCPCH for CPD points on application and providing the RCPCH criteria for CPD is met (attendance sheets kept for 18 months etc)
- The purpose of peer review is 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.
- A well run peer review should enable a team of people who understand the pressures and challenges of child protection to review the practices of colleagues in a challenging but supportive way.
- Each meeting should be facilitated by a Chair.
- Peer review should not be regarded as a second or consensus opinion. If this is a requirement of a particular case, agreement should be reached in advance by all involved parties on reporting arrangements and case leadership. Names of specific individual doctors should only 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 the report containing the opinion.
- As a minimum Photographs/video recordings should be available and reviewed prior to the case information being shared (to avoid bias in interpreting the findings). Where possible the case report or case records should be available.
- Cases should only be discussed when the examining doctor is present at the meeting.
- The lead consultant has the ultimate accountability/responsibility for the case. Individual actions related to cases to include changes of opinion should be the responsibility of the examining doctor under the supervision of the lead consultant

(where the examining doctor is not the lead consultant). Documentation of the actions should be in the individual patient's records.

- Whilst the peer review group should seek to achieve a consensus this may not be possible and the opinion and any documentation ultimately remains the lead consultant's responsibility.
- It is appropriate in the opening paragraph of court reports and witness statements to include a comment about regular attendance at peer review meetings. It is recommended however that the court report does not include a statement that the individual case has been peer reviewed. This implies a very different meaning especially to the legal profession who may mistakenly believe that an in depth review of the case has been undertaken and a further more expert opinion obtained.
- All paediatricians involved in child protection work should participate in peer review
- Appropriate time should be reflected in individual's job plans.
- Attendance and learning should be reviewed within individual's annual appraisal
- Peer review must be included in the tariff for Safeguarding Children.
- Consideration should be given to minuting meetings with documentation of generic learning points, actions identified, updating on LSCB issues or new research where peer review meetings incorporate wider Clinical Governance and Clinical Supervision purposes.

Objectives of Peer Review

- To provide Quality Improvement through developing and maintaining high clinical standards
- To provide training for junior or less experienced doctors.
- To provide support through the sharing of experiences of others
- To promote and achieve high reliability with forensically relevant documentation and interpretation of findings in cases brought for medical evaluation for suspected abuse.
- To provide time for discussion of difficult cases in a relaxed and non-threatening atmosphere.
- To view photo documentation accompanying the case presentation.
- To contribute to paediatricians' clinical supervision programme

Where peer review meetings are the only source of supervision and support:

- Provide opportunity for debriefing following involvement in difficult cases including those following court proceedings.

- To practice a high standard care of children who have been abused by ensuring complete evaluation of the child in relation to abuse.

Pitfalls of the Peer Review Process

Peer review relies on mutual trust and honesty. Practitioners need to be aware of the potential limitations and pitfalls. The responsibility for ensuring the process serves its purpose should lie with the Designated/ Named Doctor and ultimately the Chief Executive of each Trust. Pitfalls to be avoided include:

- Use of another colleague's opinion without their consent.
- Misuse of the peer review using names of peers in the court system where they may or may not have been present at the meeting and are unaware they have been offered as a second opinion.
- Emergence of self serving cliques of peers
- Bias in favour of the assumed/ self appointed/ most experienced expert
- Teams that work towards a "cosy consensus", restricting scope for divergences of view or opinion – and perhaps putting pressure on junior team members to adopt the views of the team leader;
- Favour towards minimising poor practice and lack of sufficient challenge
- Avoidance of meetings to avoid the challenge of peers.
- Failure to produce all the evidence i.e. the full complement of photographs
- Inefficiency where the purpose of the group moves into an emotional support process
- Bias produced by discussing the history prior to reviewing the photographic evidence.
- Delay in discussing cases waiting for peer review meeting. Where practitioners have concerns about a case which needs quick resolution, advice and supervision should be sought as soon as possible.

Recommendations

1. Each Trust/organisation employing paediatricians working in Child protection should establish a peer review meeting according to good practice standards described above.
2. Terms of reference should be drawn up based on the best practice example (**Appendix 2**)

3. Audit to be undertaken by Trusts/organisations to establish whether provision complies with the good practice standards.

Conclusion

Peer review and clinical supervision are part of the clinical governance framework to which all doctors must comply. Peer review has a role to play in maintaining public and court confidence. Courts and multi-agency meetings require assurance that medical staff have discussed their current cases and particularly any issues where views on causation of harm to the child may differ and that work by junior members of the team is supervised and corrected as necessary by someone who is more senior and experienced in expert witness work.

Although Peer Review is the best available system for assessing the quality of child protection cases, it is not perfect. Increased efforts are being made to improve the efficiency and transparency of the peer review process

Potential areas of development include:

- Telemedicine
- Anonymous presentation of evidence at Peer review
- Managed Local Networks
- Development of local teams of experts providing consensus opinion in line with Bearing Good Witness

References

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APPENDIX 1

Definitions

Peer Review: A person or persons of the same status or ability/expertise as another specified person or persons, providing an impartial evaluation of the work of the other/s.

Consensus Medical Opinion in Child Protection: Evidence provided to the court or multi-agency meeting is based on the opinion or position reached by a group of medical staff as a whole on the significance of the findings, diagnosis and case management of a particular case.

Clinical supervision: Clinical Supervision is a structured, formal process through which staff can have regular protected time for facilitated, in depth reflection on clinical practice, continually improve their clinical practice, develop professional skills, maintain and safeguard standards of practice.

A medical expert witness is a qualified doctor who produces a report (based on assessment of the evidence and often of the child or other individuals involved) and may then appear in court to give evidence and be cross-examined.

Second Medical Opinion in Child Protection: A second opinion is the process of seeking an evaluation by another doctor to confirm the diagnosis and treatment plan of the primary doctor, or to offer an alternative diagnosis and/or treatment approach.

Many doctors who act as witnesses in court do so as ‘witnesses of fact’, in other words they are the doctor who has treated the child. Others are external to the care of the child or the family concerned

Managed local networks are linked groups of health professionals within and across NHS provider organisations who work together in a co-ordinated manner to deliver specialised services. They differ from other types of partnerships in having clear clinical governance and accountability arrangements. Other benefits of such networks include working to common standards across organisations, thereby reducing variation in services and providing a single point of access to a wider range of expertise.

Emotional support in Child Protection is the process in which peers, supervisors, other professionals or lay people help an individual deal with the emotions they experience during clinical practice in child protection and offer encouragement and comfort during difficult or stressful times.

APPENDIX 2

EXAMPLE

TERMS OF REFERENCE FOR CHILD PROTECTION PEER REVIEW

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)