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# Trauma Handbook 2014



# Contents

## Page

1	<b>1. Introduction</b>
2	1.1 Background and Context
3	1.2 Aims and Outcomes of the National Peer Review Programme
3	1.3 Management of the National Peer Review Programme
5	1.4 Scope of Peer Review
6	<b>2. Overview of The National Peer Review Programme</b>
6	2.1 The Stages of the Peer Review Process for Trauma in 2015
7	<b>3. The Peer Review Timetable</b>
7	3.1 The Timetable for Peer Review Visits
8	<b>4. The Key Evidence Documents</b>
8	4.1 The Key Documents for Services
9	4.2 Key Network Documents
10	<b>5. The Trauma Quality Improvement Network System</b>
10	5.1 Principles for Uploading Evidence Documents to the TQIINS
11	<b>6. The Validated Self-Assessment Process</b>
11	6.1 Self-Assessment of Compliance and Writing of a Report
12	<b>7. Peer Review Visits</b>
13	7.1 Notification of Visits
14	7.2 Information for Reviewers
15	7.3 The Review Visit
16	7.4 Preparation of Visit Reports
17	<b>8. Identification of Concerns</b>
17	8.1 Management of Immediate Risks and Serious Concerns
18	8.2 Use of Risk Assessment Matrix
19	<b>9. Outcomes of the Peer Review Process</b>
19	9.1 Following Peer Review Visit
19	9.2 Annual Peer Review Reports
19	9.3 Joint Working between the Care Quality Commission (CQC) and the NPRP
20	<b>Appendix 1: Evidence Requirements for Peer Review Visits</b>
23	<b>Appendix 2: Reviewer Person Specifications</b>
24	<b>Appendix 3: Appeals and Complaints Policy</b>
26	<b>Appendix 4: Identification of Good Practice / Significant Achievements</b>

# 1. Introduction

This is the Handbook for the National Peer Review Programme (the Handbook), which will be used for trauma reviews taking place from 2015 onwards. The Handbook describes the method and procedures for carrying out the National Peer Review Programme (NPRP) for trauma networks, centres and units.

The programme will adhere to its founding principles and will continue to be:

- clinically led
- delivered consistently across the country
- focused on improvement
- focused on systems and services within and across organisations in clinical networks
- focused on the coordination of patient pathways
- peer on peer review
- integrated with other review systems
- based on patient and carer involvement.

The programme has developed and evolved to reflect events and changes in the NHS over the last ten years. In particular, the Francis Report on the public inquiry into the Mid Staffordshire NHS Foundation Trust published in February 2013 commented that peer review needs to be a key part of the

delivery and monitoring of any service or activity, and those involved need to demonstrate that this element of monitoring and learning is integral to the process of compliance with fundamental standards and improvement.

In developing the Handbook, as well as supporting the findings of the Francis Report and the Government's response to it, the challenges and objectives set out in a number of other strategic documents have been taken into account. These include 'Improving Outcomes: A Strategy for Cancer' published in January 2011 and the Health and Social Care Act (2012) which brought about the changes to the NHS since April 2013 in particular the introduction of new commissioning arrangements and the establishment of NHS England and the new Strategic Clinical Networks. The major trauma networks have delegated responsibility from the NHS England area teams and clinical commissioning groups to ensure that services are appropriately commissioned and have robust clinical governance processes.

In addition, the NHS has to increase efficiency year on year and therefore the peer review programme has been modified so that it remains sustainable and embedded in the service.

This has resulted in the following themes being used to inform the development of the revised process:

- ensuring the programme is suitable for a variety of clinical services, not just cancer services
- a greater emphasis on outcomes and patient safety
- having a programme that is proportionate but which can accommodate both targeted and comprehensive visits
- striking a balance between internal quality assurance and external review
- making the best use of resources in the service and in the peer review programme.

## 1.1 Background and Context

The NPRP started as a regional cancer programme in 2001 following the publication of the NHS Cancer Plan in 2000. The success of peer review in a number of regions led to a national programme, with services being assessed against measures based on the National Institute for Health and Care Excellence Improving Outcomes Guidance (IOG) and similar national documents. Reviews were originally undertaken based on the boundaries of the cancer networks but have since become a national programme which has extended to cover nearly all cancer services. With the changes to the NHS that came into effect in April 2013, the programme was initially hosted by NHS Improving Quality within NHS England before being adopted by the NHS England Medical Directorate in March 2014. At the same time, the programme

was commissioned to undertake a national review of paediatric diabetes services which demonstrated that the methodology is effective in clinical services other than cancer. Therefore whilst the programme has quality assured cancer services, it will include and support other services where it is invited and commissioned to do so. The initial round of peer review for Major Trauma Networks took place in 2012 and was procured by the Department of Health and subsequently transferred to NHS England. As part of the planned programme a second round of reviews took place in 2013/14 utilising the experience and knowledge gained through the NPRP.

Whilst the NPRP is focused on improving the quality and outcome of services, it also has responsibility to work

collaboratively with the Care Quality Commission (CQC) and information is shared between the two organisations. The peer review measures and process are mapped to the CQC domains: Safe; Effective; Caring; Responsive and Well-led. Immediate risks and serious concerns identified during peer review visits and the actions taken by trusts to address them are shared with commissioners. The NPRP is currently working with the United Kingdom Accreditation Service to consider becoming an accredited inspection service.

## 1.2 Aims and Outcomes of the National Peer Review Programme

The NPRP aims to improve the quality and outcome for patients and their families by:

- ensuring services are as safe as possible
- improving the quality and effectiveness of care
- improving the patient and carer experience
- undertaking independent, fair reviews of services
- providing development and learning for all involved
- encouraging the dissemination of good practice.

The outcomes of the NPRP are:

- confirmation of the quality of services in relation to national guidance or agreed measures
- speedy identification of major shortcomings in the quality or safety of services so that rectification can take place

- published reports that provide accessible public information about the quality of services
- timely information for local and specialised commissioners
- validated information which is available to other stakeholders.

The NPRP is conducted in a spirit of dialogue and co-operation between commissioners, clinical networks, trusts, their staff and the review teams. In order for the NPRP to meet its aims and outcomes, the peer review process is conducted following the principles of:

- openness - enabling concerns to be raised and disclosed freely without fear and for questions to be answered
- transparency - allowing true information about performance and outcomes

to be shared with staff, patients and the public

- candour - ensuring that any patients who may have been harmed by a healthcare service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it.

It is equally important that peer review is undertaken with proper regard to issues of equality and diversity, including the needs and interests of people with disabilities and from black and minority ethnic communities.

These principles will be emphasised during each of the peer review training sessions.

## 1.3 Management of the National Peer Review Programme

The NPRP is led by a small national team. The National Programme Director for the NPRP provides strategic leadership and direction to ensure the implementation of an effective and efficient quality assurance process which meets the needs of key stakeholders. The National Programme Director is supported by a Deputy National Programme Director who manages national operational functions, including the development of the peer review measures and responsibility for the team that manages aspects of the process relating to reviewers and provides central

administrative support for the organisation.

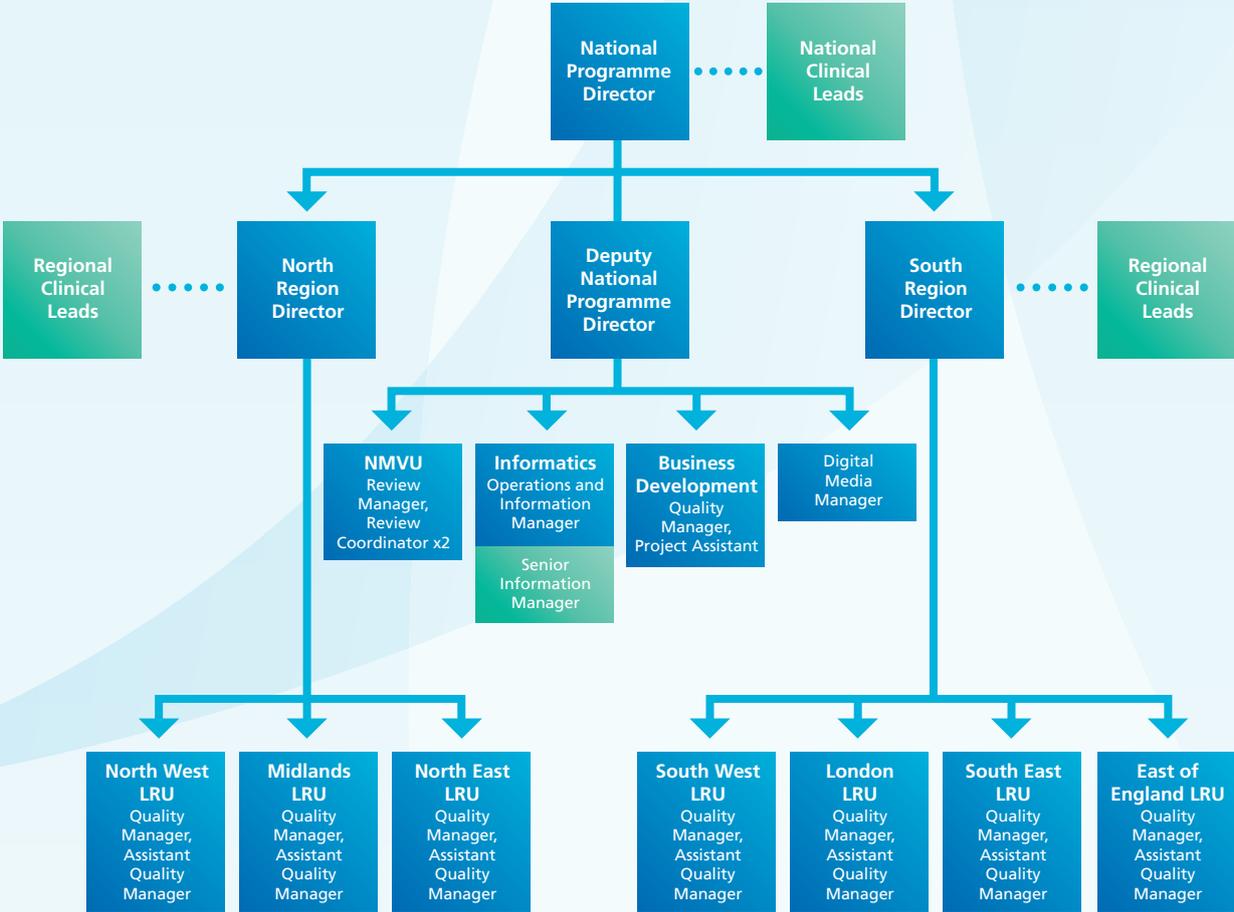
There are two regional teams, one for the north and one for the south, each led by a Quality Director. The quality directors ensure the NPRP is implemented effectively and provide strategic links to key stakeholders in their region. They also provide leadership to seven local review units (LRUs) and have a strategic role in supporting the national team in service with regards to design and development. Each LRU is made up of a Quality Manager and an Assistant Quality Manager who are responsible for local

implementation of the NPRP.

Clinical advisors to the NPRP include national clinical leads for adult and paediatric services and clinical leads for the two regions. These individuals provide advice and guidance on a daily basis and may attend some external reviews. The National Clinical Director for Major Trauma will provide specific advice with regard to the major trauma review programme. This ensures that the programme of peer review is clinically led.

The structure of the programme is summarised in Diagram 1.

Diagram 1 - The Management Structure of the National Peer Review Programme



The NPRP is funded and hosted by NHS England under the leadership of the Clinical Director of Specialised Services, within the Medical Directorate.

The governance of NPRP is through the Specialised Commissioning Oversight Group (SCOG) and decisions regarding the strategic direction, funding, selection and introduction of new clinical services will be subject to SCOG approval.

The NPRP does not employ its reviewers, rather, NHS trusts and other healthcare organisations release their staff to be trained and to undertake reviews.

Having completed a review, the staff return to their organisation with the experience and learning from seeing another service in detail. NPRP is committed to having service user or lay person involvement in the reviews, and patients, carers or parents are regularly

members of the review teams. For the trauma reviews in 2015, a different model is required to obtain a lay view on services.

## 1.4 Scope of Peer Review

The NPRP has reviewed the majority of cancer services and other clinical services including paediatric diabetes services and major trauma. It reviews the quality of services rather than the practice or conduct of individuals, although on occasion reviewers may need to draw observations relating to an individual to the attention of the organisation being reviewed. The programme assesses compliance with measures for the services included in the programme. It also reviews services' positions in relation to clinical indicators and the qualitative assessment of a broad set of objectives for the delivery of services which encompass the whole system of quality and safety in relation to

patient experience and clinical outcomes.

The NPRP will visit providers of services and networking groups. The review of the network group can take place at the same time as a visit to a major trauma centre. In order to establish if they are compliant with the measures services need to provide evidence demonstrating compliance by uploading it to the relevant peer review web based network system, in this case the Trauma Quality Improvement Network System (TQuINS). The review of clinical services will help to establish if they have appropriate engagement with networking groups.

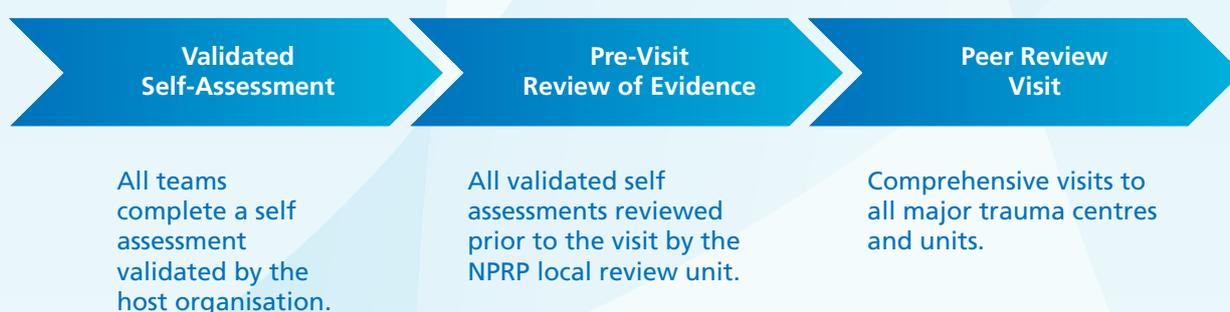
Where ambulance services provide pre-hospital care to more than one major trauma network the ambulance service will be required to submit only one set of evidence and will participate in one review. This should be the network for which the ambulance service is a major provider of pre-hospital care, and that is reviewed earliest in the cycle. The information will be shared with subsequent reviews for networks which the ambulance service covers. This will be agreed prior to the commencement of the review cycle.

## 2. Overview of The National Peer Review Programme

### 2.1 The Stages of the Peer Review Process for Trauma in 2015

The peer review programme consists of three stages as illustrated in Diagram 2.

Diagram 2: The Key Stages of the Peer Review Programme



#### a) Validated Self-Assessment

A self-assessment will be undertaken by the team that delivers the service. This comprises an assessment and commentary against the measures and comments on clinical indicators / outcomes (see section 2.2 below). The self-assessment should be checked by the trust and endorsed by the Chief Executive Officer (CEO) as being an accurate assessment. Self-assessments must be conducted in line with the principles of openness, transparency and candour (see section 1.2 above). Deficiencies

in services identified at self-assessment should, in the interests of patient safety and the quality of care, be resolved or mitigated by the trust in advance of the peer review visit.

#### b) Pre-Visit Review of Evidence

The peer review local review unit will undertake a desktop exercise comparing the evidence with the validated self-assessment prior to the visit which will be shared with the trust and the review team prior to the visit.

#### c) Peer Review Visits

All major trauma centres and units will be visited as part of a comprehensive visit programme.

## 3. The Peer Review Timetable

### 3.1 The Timetable for Peer Review Visits

Peer review visits will take place from January to March 2015. Table 1 (below) provides an indicative timetable of when major trauma centres, and their associated trauma units, are likely to be visited. Table 1 also

shows which NPRP local review unit will co-ordinate the reviews within each network.

Trusts will be informed by their NPRP local review unit of the exact date of their review and date by which they will have to

upload their evidence to TQuINS. More details of the notification process may be found in Section 8 (below).

Table 1: Indicative Trauma Review Schedule (January to March 2015)

MTC	12 - Jan	19 - Jan	26 - Jan	2 - Feb	9 - Feb	16 - Feb	23 - Feb	02 - Mar	09 - Mar	16 - Mar	23 - Mar	30 - Mar	NPRP LRU
Queen's Medical Centre, Nottingham													Midlands
Cheshire and Merseyside Collaborative MTC													North West
King's College Hospital London													London
Addenbrooke's Hospital Cambridge													East
University Hospital, Coventry													Midlands
Hull Royal Infirmary													North East
John Radcliffe Hospital Oxford													South West
Northern General Hospital, Sheffield													North West
University Hospital of North Staffordshire, Stoke-on-Trent													Midlands
Southampton General Hospital													South East
Royal Victoria Infirmary, Newcastle													North East
Royal London Hospital													London
Sheffield Children's Hospital													North West
Queen Elizabeth Hospital, Birmingham													Midlands
Derriford Hospital Plymouth													South West
Royal Sussex Country Hospital Brighton													South East
Birmingham Children's Hospital													Midlands
Royal Preston Hospital													North West
St Mary's Hospital London													London
James Cook University Hospital, Middlesbrough													North East
Frenchay Hospital Bristol													South West
Leeds General Infirmary													North East
Greater Manchester Major Trauma Centre Collaborative													North West
St George's Hospital London													London
North West Children's Major Trauma Network													North West

## 4. The Key Evidence Documents

### 4.1 The Key Documents for Services

In order to demonstrate compliance with the measures, all teams are required to provide three key documents; an operational policy, an annual report and a work programme. It is expected that these will be working documents of the service rather than documents that have been produced solely to support the peer review process. These documents will be uploaded to the relevant peer review web based network system e.g. TQuINS, as evidence for the validated self-assessment and for peer review visits. More detailed guidance on the evidence requirements for the different stages of the peer review process can be found in Appendix 1, however the general contents of the key documents are described below:

#### a) Operational Policy

The operational policy should include:

- a description of how the service is structured, how it functions and how care is delivered across the patient pathways
- an outline of policies and procedures that ensure safe, high quality care
- agreement to, and demonstration of, the clinical guidelines and treatment protocols for the service.

The operational policy should be checked to ensure it remains an accurate description of the service and how it functions, ensuring key personnel, pathways and references to guidelines are up to date.

#### b) Annual Report

The annual report should include:

- a summary of any changes to the service and the challenges and achievements in the previous year
- information on clinical outcomes, including results from participation in national, local and network audits, research programmes, specified clinical indicators and service profiles where applicable. Services should review their clinical outcomes in comparison to other services across England
- service workload and activity data, Trauma Audit Research Network (TARN) national audit results (including information relating to the clinical indicators and outcomes), patient feedback, trial recruitment and work programme updates.

The annual report should be written, ensuring key achievements and challenges, are included.

#### c) Work Programme

The work programme should include:

- how the service is planning to address any challenges and concerns, minimise risk and address non-compliance with the measures
- an outline of the service's plans for service improvement and development over the coming two years
- planned participation in audit, patient feedback exercises and

clinical trials.

To support services in the preparation of their key documents, the measures incorporate guidance on which of the three documents should contain evidence to demonstrate compliance. Should any further supporting documentary evidence be required, it is expected that services will make use of documents that already exist or information that is currently being collected for the effective functioning of that service.

All these documents should be agreed by the lead clinician and the team. Appendix 1 provides further guidance on the evidence for validated self-assessment.

It should be noted that these are the documents that will be made available to the reviewers in advance, and that additional documents provided on the day should be kept to a minimum and may not be considered by the reviewers.

## 4.2 Key Network Documents

The network should have a constitution that sets out the configuration of the services in the network. The constitution should show the membership of the group, its terms of reference and how it is governed. The document should also name the clinical guidelines for the

services in the network along with the diagnostic, referral and treatment pathways. These guidelines and pathways must have demonstrated agreement from all constituent organisations. The actual guidelines may be in a separate document.

The annual report and work programme should provide an overview of the network and its constituent services.

## 5. The Trauma Quality Improvement Network System

The peer review programme has developed a web based network system for each of the specialities covered in the peer review programme. In trauma, this is the Trauma Quality Improvement Network System (TQuINS) and may be found at [www.tquins.nhs.uk](http://www.tquins.nhs.uk). The system is a secure web based database that supports each stage of the peer review process. It enables clinical teams to attach documents to their records to support the evidence of their organisation's compliance with the measures.

The system:

- gives teams an interactive tool to manage quality and improvements
  - allows assessments and supporting evidence to be kept together
  - provides online paperless access to those validating and verifying evidence
  - facilitates the transfer of good practice between organisations by allowing other users to access documents for use in their own organisations
- provides information for national analysis and reporting
  - provides information to patient websites such as NHS Choices.

### 5.1 Principles for Uploading Evidence Documents to the TQuINS

No uploaded documents should contain patient identifiable information. In addition, organisations should not upload documents that have patient identifiable data that has been anonymised by using a marker pen or any other correction type substances, as the text underneath is often visible once scanned.

The format for uploaded documents is Portable Document Format (PDF) as this will enable maximum functionality of the database.

The size of the documentation should be kept to a minimum. Only information required as evidence should be included as additional evidence not only adds burden to the service being

reviewed, but also wastes the time of the reviewers. It will not necessarily follow that services that submit many additional documents will be judged to be of a higher quality.

In general:

- most documents should not be more than 1Mb in size
- documents of more than 4Mb should not be uploaded except in very exceptional circumstances
- scanned documents should be avoided, however should one need to be uploaded, it should be saved either in PDF or in Jpeg (.jpg) format at 70% quality. A scanned sheet of A4 will generally occupy no more than 500Kb while remaining legible.

It should also be noted that papers that are 'embedded' into the documents and uploaded will not normally be accessible to other readers and therefore this practice should be avoided.

## 6. The Validated Self-Assessment Process

As described in Section 2, all services are required to undertake a validated self-assessment before the peer review visit.

The stages of the validated self-assessment process are:

- uploading of the three key documents to TQuINS and, if required, assembly of any additional supporting evidence
- completion of the self-assessment report including compliance against the measures together with a written commentary on each of the sets of measures.
- validation or checking of the self-assessment through an internal governance processes of the trust and endorsement by the chief executive
- publication of the report on TQuINS

### 6.1 Self-Assessment of Compliance and Writing of a Report

An honest self-assessment of compliance with each of the measures, ensuring that all aspects of each measure has been met, should be recorded on TQuINS.

The measures have been grouped into a number of areas such as pre-hospital care and reception and resuscitation to assist teams to make an assessment as to whether the service is meeting the measures. The measures also provide a broad set of objectives for the delivery of a quality and safe service in relation to clinical outcomes and the patient experience.

The lead clinician should complete a short self-assessment report about their service for each group of measures. As the report will provide up to date information for commissioners, CQC, patients and the public, it should meet the principles of openness, transparency and candour (see section 1.2).

The report should address areas of non-compliance, giving the reasons and any plans or actions towards achieving compliance.

The validated self-assessment report provides the opportunity for the team to identify areas of good practice / significant

achievements and any immediate risks or serious concerns.

On completion of the validation of the self-assessment, the report must be endorsed by the CEO (or equivalent) of the trust. This endorsement must be recorded on TQuINS. If a validated assessment or the evidence it is based on is found to be dishonest, this information may be published and the organisation referred to the CQC.

## 7. Peer Review Visits

The purpose of a peer review visit is to provide an opportunity for a team of peers to meet with members of the service being reviewed. The peer review visit will allow discussion and questioning with the aim of determining compliance against the quality measures and identifying a broader set of issues concerned with the delivery of a quality and safe service in relation to patient experience and clinical outcomes. In addition, the visit will provide a further external check on the robustness of internal quality assurance processes.

The NPRP invites nominations for reviewers from service providers, area teams and commissioners. Service providers have a responsibility to nominate an appropriate

number of reviewers against the person specification (see Appendix 2). In the first round of visits to trauma units, non-executive directors will provide a lay input to reviews.

Suitable nominees are trained and if successful, they are then added to the reviewer database. Visiting teams will be made up of a multi-disciplinary group of clinicians, managers and lay people with appropriate skills and training. As often as possible, 'peers' will be people who are trained and working in the same service as the people they are reviewing. The views of all team members from all backgrounds will be respected. Should a reviewer be selected for a review and have a conflict of interest, the reviewer must bring this to the attention of the NPRP without delay.

Trusts will be notified in advance of the members of the expected peer review team, however this may be subject to change without notice.

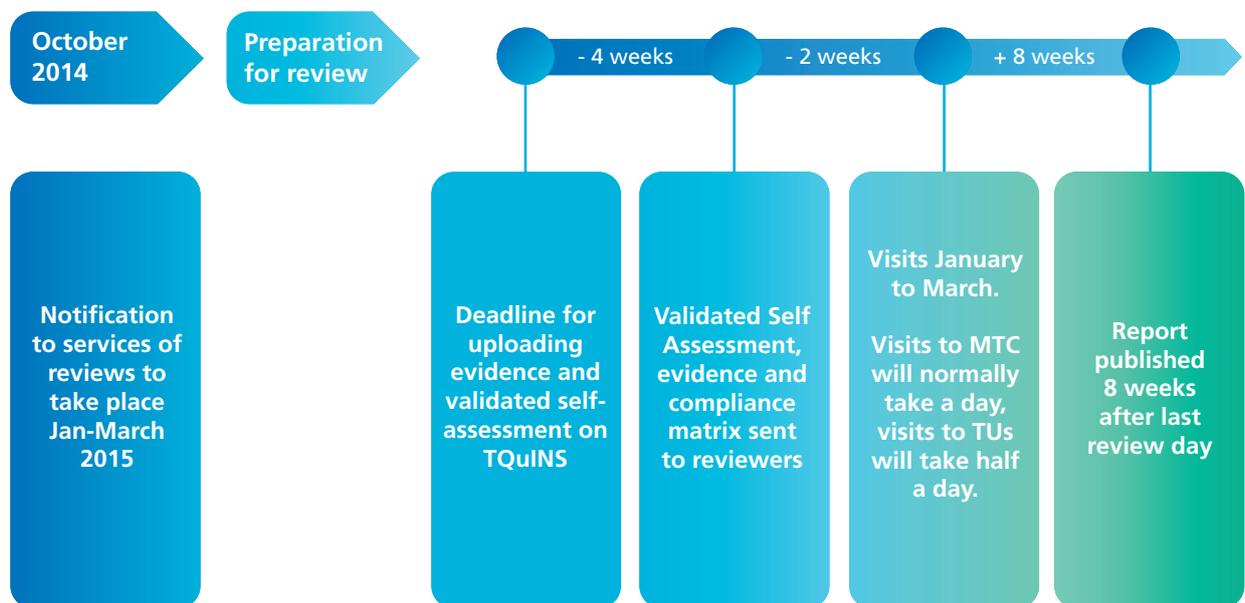
Reviewers have a collective responsibility for examining and considering information that enables them to reach robust conclusions about compliance with the national measures and about the quality of services. While undertaking a review, reviewers are acting on behalf of the NPRP and should not pursue any individual or organisational interests.

## 7.1 Notification of Visits

Services will be formally notified in October 2014 of the visit that is to take place in 2015.

Diagram 3 illustrates the different stages of the visit process:

Diagram 3: The Peer Review Visit Process



## 7.2 Information for Reviewers

Two weeks before the visit, reviewers will be able to access the Visit Information Management System (VIMS) to obtain and download the following information:

- the three key documents uploaded to TQuINS
- information for agreed clinical indicators
- the team's validated self-assessment report
- A matrix showing the team's self assessment of compliance
- logistical information.

At the visit, the team being reviewed should provide one hard copy of the three key documents and the self-assessment documentation. Additional supporting evidence provided on the day should only be that which could not be readily uploaded to TQuINS e.g. patient information. The reviewers will have limited time in which to review evidence that was not uploaded in advance and provided on the day.

### 7.3 The Review Visit

One or more reviews may take place on the same day and on occasions it may be necessary to spread visits to an organisation

over more than one day. In general, trauma unit visits will take approximately half a day, whilst reviews of trauma centres

will take a whole day. Examples of typical review day schedules are shown below.

Table 2: Review Timetable

MTC	TU
Review Team Arrival	Review Team Arrival
Review Team Evidence Review (1.5 hrs)	Review Team Evidence Review (1hr)
Review Team Tour of Facilities (45mins)	Review Meeting (1hr) <i>Review team meet with the team</i> <i>NB presentations should be kept brief to allow for discussion between reviewers and teams.</i>
Presentations and Review Meeting (2hrs) <i>Review team meet with</i> <ul style="list-style-type: none"> <li>• Network</li> <li>• Ambulance Services</li> <li>• MTC</li> </ul> <i>NB presentations should be kept brief to allow for discussion between reviewers and teams.</i>	Reviewer Preparation of Feedback
Lunch	Feedback to the Team (20mins)
Reviewer Preparation of Feedback (30mins)	Report Writing (1hr)
Feedback to the Teams (45mins)	
Report Writing (2hrs)	

Whilst the reviewers will concentrate on the compliance with the measures and evidence relating to patient experience and clinical outcomes, as reviewers with professional or personal experience of services elsewhere, they may comment

and raise concerns about any relevant aspect of the service as they understand and observe it on the day of the review.

It is essential that peer review visits are undertaken in a spirit of openness, transparency and

candour and that proper regard is given to issues of equality and diversity, including the needs and interests of people with disabilities and from black and minority ethnic communities.

## 7.4 Preparation of Visit Reports

The reviewers will prepare a draft report on the day of the review and any subsequent amendments will be sent to the reviewers prior to the report being signed off by the Quality Director. Trusts will be given the opportunity to comment on the factual accuracy of the report before it is made publicly available. Any comments relating to the factual accuracy of the draft report should be submitted in writing to the LRU within two weeks of receipt. In the first instance, any queries will be resolved locally with the LRU in consultation with the relevant Quality Director if necessary. The LRU will consider issues raised about factual accuracy with reference to the evidence that was uploaded onto TQuINS in advance of the visit and any records made of

any additional evidence that was available on the day. However, it should be noted that it is the uploaded evidence that is the main source of written evidence for the review. Any unresolved queries will be referred by the LRU to the NPRP national team. Issues in the report relating to the views of the review team will not be changed.

The circumstances where an appeal against the contents of a report will be considered are where either:

- the reviewers have concluded that a service gives cause for serious concern / immediate risk, or
- the reviewers have concluded that the service's performance in complying with the measures is unsatisfactory.

These are the only circumstances in which an appeal can be submitted against the conclusions of reviewers. Should a team, or a reviewer, consider that an aspect of the review was conducted inappropriately, then this may be raised as a complaint. The appeals and complaints policy is shown in Appendix 3.

## 8. Identification of Concerns

Reviewing services either during the validated self-assessment or a planned visit may identify concerns. There will be occasions when these concerns are more serious and pose an immediate risk to patient safety or clinical outcomes. The following guidelines provide a framework for organisations involved in validating self-assessments and for members of review visit teams to identify and manage the different levels of concern.

In the peer review process there are three categories of concern,

all of which require action to be taken, however timescales and management will vary:

### a) Immediate Risk

An “immediate risk” is an issue that is likely to result in significant harm to patients or staff or have a direct serious adverse impact on clinical outcomes and therefore requires immediate action.

### b) Serious Concern

A “serious concern” is an issue that, whilst not presenting an

immediate risk to patient or staff safety, is likely to seriously compromise the quality of patient care, and therefore requires urgent action to resolve.

### c) Concern

A concern is an issue that is affecting the delivery or quality of the service that does not require immediate action, but can be addressed through the work programmes of the services.

### 8.1 Management of Immediate Risks and Serious Concerns

#### a) Immediate Risks and Serious Concerns Identified at Peer Review Visit

Where an immediate risk or serious concern is identified by the review team at a visit:

- the LRU will notify the organisation on the day of the review
- the Quality Director will then email a formal letter to organisation’s CEO or equivalent, within five working days of the visit, copying in:
  - National Programme Director for peer review
  - The Accountable Officer of the host CCG
  - The Specialised Commissioners
  - The Medical and Nurse Directors of the host AT
  - The Medical and Nurse Directors of the AT that hosts the specialised commissioners or AT, if appropriate.
- for immediate risks, the formal response from the organisation is required within 10 working days of the email

to the organisation’s CEO or equivalent; for serious concerns the response is required within 20 working days

- there may be occasions when the action required to fully address the problem cannot be achieved immediately, however it is expected that interim actions be taken to reduce the risk and for the organisation to submit a credible action plan with milestone dates
- where the Quality Director (in consultation with the review team if appropriate) considers the response from the organisation to adequately address the immediate risk or serious concern, the Quality Director will email the organisation CEO or equivalent to acknowledge the letter and its contents and make reference to further updates and progress on the actions identified, copying in other agencies as for the letter in the second bullet point above

- where no response is received, or the response is deemed inadequate to address the immediate risk or serious concern, after 10 working days for an immediate risk or 20 working days for a serious concern, this will be followed up by the Quality Director
- where the Quality Director continues to receive what they consider to be an inadequate response from the organisation, they will escalate the matter to the Area Team Director or appropriate Specialised Commissioner, and the Care Quality Commission.

The Francis Report commented on the lack of clarity as to who is responsible for following up the findings of peer review reports. The CEOs of trusts and other organisations are accountable for the actions in response to immediate risks and serious concerns brought to their attention by peer review teams.

## 8.2 Use of Risk Assessment Matrix

In most cases it will be clear whether an issue is a concern, serious concern or immediate risk. However there will be issues in which circumstances may vary significantly and would need to be taken into account when assessing the risk.

In assessing the risk it is important to identify the actual risk to patients. Further

questions should then be asked to determine the impact of the risk, the likelihood of this happening and whether any action has been taken to remedy or ameliorate the situation.

Having determined the exact nature of the risk it is recommended that a risk scoring matrix is used to identify the

appropriate category as shown below in Diagram 4.

Diagram 4: Risk Assessment Matrix

Likelihood		Consequence				
		Insignificant	Minor	Moderate	Major	Catastrophic
		1	2	3	4	5
Rare	1	1	2	3	4	5
Unlikely	2	2	4	6	8	10
Possible	3	3	6	9	12	15
Likely	4	4	8	12	16	20
Almost certain	5	5	10	15	20	25

 Concern

 Serious Concern

 Immediate Risk

### Consequence descriptor

Insignificant	Minor	Moderate	Major	Catastrophic
Reduced quality of patient care	Unsatisfactory quality of care	Mismanagement of patient care	Minor harm to patient or staff	Fatal / Major harm to patient or staff

For the purpose of The National Peer Review Programme these guidelines have focussed on safety and quality of patient care.

## 9. Outcomes of the Peer Review Process

The implementation and follow up of actions resulting from the peer review process is primarily the responsibility of the

organisation reviewed and not a function of peer review. Responsibility for ensuring the implementation and follow up

of actions within appropriate timescales rests with the commissioners and the host area teams.

### 9.1 Following Peer Review Visit

Following a peer review visit an individual report for each team/service, prepared by the visiting review team, will normally be available on the relevant TQIINS web-site eight weeks after the completion of the visit. This will provide external feedback to the teams/services, will confirm the level of compliance with the measures, and comment on a broader set of issues concerned

with the delivery of a quality and safe service in relation to patient experience and clinical outcomes.

Following the publication of any of the above on the TQIINS web-site the organisation should agree the actions that need to be taken within agreed timescales, building on the strengths identified and

addressing any aspects in need of improvement. Actions should be included in strategic development plans and the relevant team's/service's work programme.

### 9.2 Annual Peer Review Reports

Following the completion of every peer review cycle the National Programme Director will produce a national report which will include an overall analysis from all the published reports, including a focus on individual conditions and cross cutting services. The reports will appear on the publically available pages of TQIINS. The identification of good practice/significant

achievements for later dissemination and recommendation is an important component of the review process and therefore will be reflected in reports.

The following will be notified when the above reports are available: service providers, area teams, strategic clinical networks, local and specialised

commissioners, the Care Quality Commission, appropriate national clinical directors.

### 9.3 Joint Working between the Care Quality Commission (CQC) and the NPRP

CQC and NPRP collaborate to promote the delivery of high quality care in England specifically in relation to the delivery and quality assurance of services subject to peer review. A statement of joint working is being agreed between the two organisations.

The outcomes of this work to date includes:

- Immediate risks and serious concerns are reported to CQC;
- The teams/services with poor performance are shared with CQC;

- Partnership working with CQC visits in relation to services.

## Appendix 1

# Evidence Requirements for Peer Review Visits

A full copy of all evidence uploaded onto TQuINS must be available to reviewers on the peer review visit. This can be either hard copy or electronic. If the evidence is only available electronically, the host organisation must ensure the peer reviewers have appropriate access to electronic evidence in the location the review is taking place. This evidence should be available for each individual review team. Additional evidence on top of that included in the three key documents and uploaded onto TQuINS should be kept to a minimum.

Additional evidence that may be provided on the day include patient information and guidelines (see other sections of this appendix). Whilst reviewers may consider any additional evidence presented on the day, should there be a dispute after the review relating to any such documents, this will be resolved based on the evidence uploaded onto TQuINS prior to the visit.

### Types of Evidence

#### Three Key Documents

Chapter 4 of the Handbook sets out the three key evidence documents for peer review. Ideally, these should be operational documents that represent good management practice and not produced solely to meet the requirements of

peer review. Most of the evidence required to meet the measures can be presented in these three key documents with additional documents kept to a minimum. As these documents are uploaded onto TQuINS, these form the 'official' evidence of the team and should there be a dispute about the outcome of a review or assessment, it is the uploaded evidence that will be considered in the first instance, rather than any off-line evidence that may have been presented separately.

#### Information for Patients

It is not necessary to include patient leaflets or other information in the key documents or to upload it onto TQuINS. This should be made available and seen as part of the peer review visit. This will ensure that any materials used meet the measures include appropriate local information for patients.

#### Maintaining Confidentiality

##### Patient Identifiable Information

It is essential that no identifiable patient data, including hospital number, is uploaded in the three key documents or any other documents uploaded onto TQuINS. Particular care should be taken when documents are scanned as the scanner may pick up details that cannot be seen

on the hard copy, for example when using a black marker pen to anonymise documents. Copies of actual patient letters should not be uploaded; it is sufficient to make a statement, for example describing how patients receive a permanent record of a consultation, or to show a template.

#### Staff Information

The personal details of members of staff, such as certificates or job plans, should not be uploaded onto TQuINS.

#### Other Key Points

##### Agreement to Documents

The front cover of all documents uploaded should show the period it relates to, the author and the date and possibly version number. It must say the date it was agreed and the name and role of the person who has agreed it. If that person has a delegated role and is agreeing to a document on behalf of others, this should be clearly recorded. Where an operational policy includes a number of policies, guidelines etc., the measures identify specific requirements for agreement to these. The names and roles of the people agreeing these, as well as the date agreed, must also be shown either at the front of the document or in the section relating to these documents.

Where documents have been agreed at a particular meeting, the details of this meeting should be recorded.

### Attendance Records / Meeting Dates

Records of attendance and meeting dates are required against a number of measures. A summary only of attendance at a multi-disciplinary team (MDT) meeting is not acceptable. Attendance should be shown on a meeting by meeting basis so that the personal attendance by individuals can be quantified, as well as highlighting any meetings where whole specialties have not been represented.

This can often be satisfied by one clear piece of evidence showing:

- dates of the meetings
- name, role and organisation represented of those who have attended each meeting

The validated self-assessment report form should comment about any roles not covered or attending appropriately.

### Audit

Audits should be clinical rather than performance i.e. not two week waits. National audits are acceptable as a network audit, but outcomes against a national audit should be demonstrated.

Dates of the meetings where audits have been presented must be clearly shown in the key documents as should any outcomes.

### Configuration of the Network

The configuration of the network is essential to the review of a particular tumour site and ensuring compliance against the IOG. Details of the referral pathway and populations are essential. This should be included in the constitution of the networking group.

### Distribution Lists

A copy of the distribution list is sufficient for self-assessment. It is not necessary to see proof of distribution but a team should confirm if they have distributed a document or policy.

### Hyperlinks and Embedded Documents

It is acceptable to include internet hyperlinks in documents but these links must have open access and not be on the closed section of the organisation intranet system. If a document is converted to PDF format the hyperlinks may not function and hard copies have to be provided for validated self-assessment or a peer review visit. Similarly 'embedding'

documents in evidence is acceptable so long as when the documents are subsequently downloaded the embedded documents can be opened.

### Membership

When a measure asks for the membership of a group then the name, role and organisation the individual represents should be described on the evidence. The role indicated should be specific, for example, being clear if someone is a medical or clinical oncologist. Information should also be clear as to whether they are a core, extended or cover member of a team. Where a particular member is not in place, then the mechanism used to ensure a role's particular input should be clearly indicated in the evidence.

### Patient Experience Exercise

For both peer review and validated self assessment, a copy of the patient exercise should be seen. The National Cancer Patient Experience Survey is acceptable for this measure. Where there are insufficient responses to the National Survey for the speciality to have its own results, teams should supplement this with a local survey.

### Policies / Guidelines / Pathways

The date and version should be shown on all policies / guidelines / pathways. These may be included in the operational policy as an appendix, or provided as an internet hyperlink. Where the policy / guideline / pathway is not included, the full name of the document and its date and version number should be included. Where national guidelines have been adopted, the local context must be described unless the measure indicates this is not required. Flow charts are an acceptable means to explain details within pathways and guidelines. If it is

unclear that a meeting has taken place, reviewers on a peer review visit may ask for minutes of the meeting.

### Qualifications / Certificates / Job Plans / Timetables

Copies of qualifications, certificates and job plans should not be included in the key documents or uploaded onto TQuINS. Instead the details of the document should be included in the appropriate key document. Details of qualifications would be the name of the course completed, the awarding institution and the date awarded. In the case of job plans / timetables, a statement

should be made in the key document to confirm that a particular requirement is contained in a job plan / timetable and this has been checked.

It is not practical to be explicit about the evidence required for every measure but it is hoped this appendix sets out the broad principles and give specific examples which can be applied to most of the measures. If you are unsure as to what evidence is required then please do ask for advice from your LRU.

## Appendix 2

# Reviewer Person Specifications

### Healthcare Worker Reviewer Person Specification

#### Experience

- At least two years working in the role they will be undertaking during the visit
- Working at a senior / expert level within the context of the condition / service (as clinician [including non-medical clinician], manager, commissioner).

#### Skills

##### Communication

- Presents own viewpoint clearly and concisely
- Actively listens to others
- Reflects back own understanding others' contribution
- Tactful and sensitive to others' verbal / nonverbal reactions
- Accurately records and reports on findings
- Diplomatic
- Confidential

##### Team orientation

- Actively seeks views from other team members
- Demonstrates respect for others' viewpoints

- Adapts own behaviour to suit situation
- Demonstrates ability to work within a multi-disciplinary team

##### Analysis & problem solving

- Bases judgement on an unbiased logical approach
- Asks probing questions
- Searches for evidence on which to base judgements
- Carefully uses observation as a source of evidence

##### Task oriented

- Prepares fully
- Focuses on achieving an outcome
- Takes personal responsibility for delivering results
- Completes required tasks

##### Resilience

- Maintains and projects enthusiasm despite pressure
- Can adapt to a variety of situations

##### Organisational awareness

- Able to identify the essentials
- Considers individual events within the context of the wider system

Knowledge, understanding and commitment to:

- Principles of the cancer peer review programme
- Principles and implementation of IOG
- Multi-disciplinary approaches to care
- Patient / carer involvement in service delivery and service improvement
- Modernisation of cancer services and implementation of the National Cancer Plan

Peer reviewers will undergo mandatory training and should be able to commit to undertaking peer review visits over the period of the national programme.

## Appendix 3

# Appeals and Complaints Policy

A distinction is drawn between complaints and appeals. Complaints are concerned with the processes and conduct of peer review, while appeals are challenges to the conclusions drawn by reviewers in specific circumstances.

### Appeals

The circumstances where an appeal will be considered are where reviewers have concluded that a network / trust gives cause for a serious concern or immediate risk or the reviewers have concluded that the network / trust performance in complying with the measures is assessed as being unsatisfactory. These are the only circumstances in which an appeal can be submitted against the conclusions of reviewers.

Any such appeal should be submitted by the Chief Executive of the trust / organisation or by the Network Director. The appeal must be submitted within four weeks of the publication of the peer review report.

Any appeal received will be considered initially by the Executive Group of the National Peer Review Programme who may then convene a subgroup to investigate. The membership of the subgroup will be determined on a case by case basis by the Chair of the Executive Group, but may include a representative from Care Quality Commission and a patient / carer representative.

No member of the subgroup will have had any prior involvement in the review at issue.

The subgroup will review the methodology and process used by the review team and the conclusions it drew. In doing so, it will examine whether, in light of the points made in the statement of appeal the team's conclusions were reached reasonably and fairly. The subgroup will consider whether the team's conclusions were unreasonable or disproportionate in the light of the available evidence. Reasonableness may be called into question if irrelevant matters are taken into account, or relevant matters not taken into account.

The subgroup will consider whether there was evidence within the appeal statement which might lead to different conclusions being reached from those contained within the report. Any such evidence must have been submitted during the period of the review.

The decision of the subgroup of the Executive Group for the National Peer Review Programme will be the final with no further stage of appeal. Whenever possible, the result of an appeal will be made known no longer than eight weeks from the date the appeal was submitted.

Administrative and clinical support to the subgroup will be provided by members of the National Peer Review Programme.

### Complaints

The vast majority of reviews will be carried out successfully and without incident. However it is recognised that sometimes a Strategic Clinical Network or their constituent elements will be unhappy about aspects of the review process. The opportunities for making complaints and the process for dealing with those complaints is set out below.

Networks and trusts have the opportunity to agree with their LRU, the details of the preparations for a review. Any complaints, for example about dates, timings etc. should be made in the first instance to the Quality Manager with lead responsibility for the review. Complaints about the conduct of a review should be made to the Quality Director of the LRU during, or, where this is not possible, immediately after the review.

Complaints about the conduct of a team, or a team member, or a member of the LRU should be addressed in the first instance to the Quality Director of the LRU. N.B. Complaints about the way teams and individuals have carried out their role are an entirely legitimate area of complaint. However, complaints

about a person, as distinct from that person's conduct of their role and responsibilities, are not acceptable.

Complaints about the drafting of the peer review report should be resolved with the Quality Director for the LRU through the normal procedures for checking factual accuracy of draft reports with the organisation. If no resolution is achieved, the complaint should be addressed to the National Programme Director of the National Peer Review Programme.

In general, any complaints that cannot be resolved with the Quality Director will be referred

to the National Programme Director of the National Peer Review Programme. who in turn will refer the matter to the Executive Group for the National Peer Review Programme.

Complaints concerning the peer review process must be submitted prior to the publication of the final peer review report.

#### Complaint from a Reviewer

There may be an occasion when a complaint is received from a reviewer, perhaps about the conduct or outcome of the peer review process, about the behaviour of other team

members, or the way an individual reviewer feels they have been treated.

In such circumstances it is hoped that the matter can be resolved locally and the complaint should be made in the first instance to the Quality Director responsible for the review team. If this is not appropriate, because the complaint concerns one of the Quality Directors, then the complaint should be made to the National Programme Director.

## Appendix 4

# Identification of Good Practice / Significant

### Achievements

At all levels of the programme, review teams have the opportunity to identify good practice / significant achievements in any of the settings under scrutiny. The good practice / significant achievements:

- should be directly linked to the services under scrutiny
- may be of an innovative nature but may also be common practice that is undertaken very well or under particularly challenging circumstances.

Those undertaking validated self assessments and review visits should ensure that there is robust evidence for the identification of good practice / significant achievements. Good practice / significant achievements should be commented on in the summary of the reports.

The identification of good practice / significant achievements for later dissemination and recommendation is an important component of

the review process.

Fraser (2002)<sup>1</sup> states: – *“In healthcare the number of variables that are constantly adapting and changing makes scientific analysis very difficult and time-consuming. The adoption of potential improvements may be delayed whilst large and often inconclusive studies are conducted to identify ‘best practice’... The term ‘good practice’ is used to cover any substantiated practice that has delivered positive results elsewhere.”*

Areas that may be identified by the reviewers as examples of ‘good practice’ will be based on their personal opinions. These practices may be being undertaken elsewhere in other trusts or networks.

1 It is suggested the following definition is used:

Good practice: practice that has delivered or has the potential to deliver positive improvements in care elsewhere.

2 Good practice may have:

- contributed to the delivery of safe, high quality patient centred services
- successfully integrated services through constraining / complex circumstances
- facilitated improved compliance with the measures
- improved the patient and carer experience
- improved outcomes of care for patients
- improved teamwork within the service
- improved the efficiency of service organisation.

3 Areas of good practice will be agreed by the validation and verification panels or the visiting team when they are drawing their conclusions. Areas identified as ‘good practice’ will be identified within the reports.

<sup>1</sup>Sarah W Fraser. (2002) Accelerating the Spread of Good Practice - A Workbook for Healthcare. Kingsham Press

