Standard Operating Procedure for the West Midlands Clinical Network Peer Review Process
For
Trauma, Adult Critical Care, Burn & Spinal Services

Network(s)
West Midlands Trauma, Adult Critical Care, Burn and Spinal Networks
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Revisions				
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1.0 BACKGROUND

Peer review is a method of evaluating services and providing a process through which we can learn from one another in order to improve.

2.0 PURPOSE

The overall intention should be that the peer review process provides a collective learning opportunity in a supportive non-threatening environment, enabling individuals and services to develop through self-reflection, peer support and the sharing of good practice.

Peer review should be an evolutionary process, which will demonstrate continued improvement in high quality care and related service outcomes.

The strengths of peer review include

- shared learning experience for both the service being reviewed and the visiting team
- the improved setting of organisational priorities within relevant managerial contexts
- improvements in the quality and standardisation of services, with reviews acting as catalysts for change
- improving relationships between commissioners and the services they commission
- helping to remove inter-professional barriers
- Improving collaboration across networks and beyond.

3.0 SCOPE

This SOP includes information about the peer review process for Major Trauma Services, Burns Services, Adult Critical Care Services and Spinal Services, whose network is managed by the West Midlands Network Manager.

4.0 RESPONSIBILITIES & PRINCIPLES

It is the responsibility of the Network Manager and Leads of each service to understand the requirements in this SOP and to lead the peer review process for their service or otherwise delegated appropriately. It is also their responsibility to ensure other staff members involved in the peer review process understand the information in this SOP.

4.1 Guiding Principles of Peer Review

- To be transparent in all processes

- To provide positive constructive feedback to services
- To provide development and learning for all involved
- To encourage the dissemination of good practice
- To support the improvement of quality and effectiveness of care
- To support improvement to the patient and carer experience
- To enable patients, carers and their families to be better informed about the services they can expect to receive
- To provide an independent review of service quality by groups of people who provide similar services
- To measure against national, regional and local clinical standards and guidelines
- To identify gaps and under resourcing
- To encourage service providers and commissioners to work together to improve service quality
- To inform commissioners regarding position against service specification and national standards and guidelines and wherever possible the standards should be used against and reflective of the information shown in the table appendix 1.

5.0 PEER REVIEW PROCESS

For those services where the Network undertakes their peer review there are 2 systems in place:

5.1 Self-Assessment Declaration Only

The Network can request its service to undertake a peer review self-assessment declaration, this may often be done in a year where no visits are taking place, or prior to a peer review visit. This will ensure that the information we have about the service is kept up to date.

- The Network office will circulate the peer review self-assessment declaration spreadsheet example appendix 2. to the Leads & Managers of the service for completion
- Upon receipt of the completed spreadsheet the Network office will analyse and validate progress against the standards and will provide a written report within 8 weeks for the service to share with their teams
- The Network office will continue to work with the Leads/Managers to ensure progress continues and that regular updates are made via the appropriate network meetings and dashboards
- The dashboards will be used to keep improvement / work plans up to date in order to meet areas of non-compliance.
- The Network office will report and escalate to NHSE / Integrated Care Boards on areas of significant concern or risk and of areas of significant improvement.

5.2 Peer Review Visits

The Network schedules the completion of peer review visits to all its services. The decision about who is visited and when will be at the discretion of the Network office using a 'weighting' process or following initial validation of a service self-assessment declaration.

Using the Network Peer Review Toolkit the Network office will assist Service Leads & Managers with the administration and preparation of the visit. Training sessions are offered to those who are being reviewed and who are instrumental in organising the visit for their service. This will provide them with a clear overview of the process, documentation and evidence requirements, timetables and the roles and responsibilities of those involved in the visit.

The Network Peer Review Toolkit is a standardised system used for peer review visits and can be used for each of our networks. The Toolkit includes notification letters and report templates, an administrative tasks/actions spreadsheet, reviewer contact details and a record of immediate risks/serious concerns.

A peer review visit should be:

- a learning and sharing experience enabling both the peer review panel and the service to identify, develop and adopt good practice.
- provide a further external check on the robustness of internal quality assurance processes and identify how the ODN can support organisations for CQC visits and other quality inspections.
- allow discussion with the aim of determining compliance against the quality measures whilst identifying any issues concerned with the delivery of a quality and safe service in relation to patient experience and clinical outcomes.
- provide an opportunity for a team of peers to meet with members of the service being reviewed. Wherever possible a wide range of clinicians should be involved from the unit / service in order to obtain a breadth of understanding of the service.

For each visit a review panel is required, the Network office will seek multidisciplinary representation from:

- Clinicians
- Nurses
- AHP/HCS
- Management
- Commissioning
- Service Users

Each person will be offered peer review training ensuring they have the skills & information to enable them to contribute and participate as equal team members, that they understand the role they will play; how to review compliance and how to deal with any challenges.

Some people like to attend a visit before committing to a reviewer role therefore we offer the opportunity to attend visits in an 'observer' capacity.

Some of the many benefits of being a reviewer include:

- A shared learning experience
- An understanding of the improvements in the quality and standardisation of services, with reviews acting as catalysts for change
- Helping to remove inter-professional barriers
- Improving collaboration across networks and beyond.

When choosing reviewers we must take into consideration any conflict of interest. Impartiality and transparency is a key part of any successful visit therefore we will ask each reviewer to declare any potential conflict of interest from the outset and we will not allow individuals to review services that are part of their own shared pathways where possible; this will reduce any conflict of interest. On occasions we may request reviewers out with our own network region to assist us.

5.3 Visit Day Schedule

The example below is a typical schedule used for our visits giving the review panel the opportunity to walk around some of the service areas e.g. ED, Resus, Critical Care Unit, Burns Unit and talk with staff on duty.

Time is set aside to review each standard against any evidence provided by the service and also enables the formulation of any questions for the Q&A session and the final comments for the final report.

Part of the schedule includes a 30 minute service presentation; an overview of the service including their strengths, weaknesses, opportunities and threats.

09:00 – 09:15: Introductions with service peer review lead and executive representative
09:15 – 10:15: Unit Walk-Around - visit appropriate areas, talk with staff
10:15 – 13:00: Review standards against the evidence and dashboard. Reviewers only
13:00 – 13:15: Lunch Break
13:15 – 14:15: Service 30 min Presentation and interactive Q&A Session
14:15 – 15:15: Review panel prepare high level feedback
15:15 – 15:45: High Level Feedback with service representatives
15:45 - 16:30: Finalise comments for the report

5.4 Peer Review Reports

Following each visit a written report is prepared by the Network office within 10 weeks, however prior to the approval of the final report we ask the service to undertake a factual accuracy check of the information collected.

This process applies to the observations on the day of the visit and therefore the service must not include any improvements made or changes applied thereafter. The service must clearly state the inaccuracy which will be reviewed by the Network Manager and Regional Network Lead who will have the final say to any amendments.

Immediate Risks and Serious Concerns are dealt with through the CEO response and are not part of this process.

Following the factual accuracy check and any amendments the final report is approved and sent to the service Lead, the report will:-

- Provide feedback to the service in relation to the level of compliance against the peer review standards and any other measures set by the Network
- Identify positive developments and significant achievements
- Highlight any immediate risks, serious concerns and general concerns (please see section 6.0 for more information about risks) in relation to the delivery of a quality and safe service, patient experience and clinical outcomes

The service will use this report to agree the actions that need to be taken within agreed timescales, building on the strengths identified and address any aspects in need of improvement. Actions should be included in their Trust development programmes and the relevant team's/service's work plans.

Reports should be shared with:

- Lead Doctor and Nurse
- AHP Leads
- Service Manager and Divisional Manager
- Divisional Director and or Medical Director
- Executive responsible for the service
- Responsible Commissioner

Service progress will be monitored at Network board meetings and via the relevant dashboards which will be updated throughout the year to ensure its continued accuracy and ensure compliance is being achieved.

Workstreams and projects identified from the peer review visits will be managed using the network planner and linked to the wider network work programme.

Commissioners of the service will take forward any actions to support the service and will work with the service and the network to ensure timely resolution or mitigation is put in place.

6.0 MANAGEMENT OF RISKS AND CONCERNS

As part of the peer review process there are three categories of concern, all of which require action to be taken, however timescales and management will vary. Risks and concerns can be identified during the receipt of a self-assessment declaration or during a peer review visit.

The risk and concerns are described as:

6.1 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.

A formal response from the organisation is required within 10 working days of the notification to the organisation’s Chief Executive or equivalent / Medical Director / Service Lead.

6.2 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.

A formal response from the organisation is required within 20 working days of the notification to the organisation’s Chief Executive or equivalent / Medical Director / Service Lead.

6.3 General Concern

A “general 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. These may also include the standards that are not currently being achieved/met by the service.

6.4 Risk Management Process

The following guiding principles provide a framework for Networks involved in validating self-assessments and for review panels to identify and manage the different levels of concern or risk. The review panel should make recommendations for areas of quality improvement or to address concerns or gaps in service, based upon local or national evidence, knowledge and/or experience.

Upon identification of any risks and/or serious concerns:

- Verbal notification is given to the Service Lead and Management/Exec Teams on the day of the visit during the high level feedback session using a proforma, appendix 3
- The Network Manager & Regional Lead(s) will email a formal letter to the services' Chief Executive / Medical Director / Service Lead within five working days of the visit, copying in the Accountable Officer of the relevant commissioning body.
- The service will need to ensure that both Trust Level and Division Level Risk Registers are updated.
- The Network will use its 'Risk Oversight Framework' to score each risk against a score matrix, appendix 4 supplied by NHS England ensuring a level of confidence and a consistent rationale that supports the judgements and views made by the review panel. A score over 12 will be escalated to the Acute Specialised Commissioning Team who will identify key stakeholders to manage the issue and where there is a service not achieving at least a 50% total achievement rating this should be escalated to relevant ICB's, Regional Quality Leads to provide support and leadership to the service.
- The Network Manager will report as required to the National Medical Lead / National Lead Directors.
- Concerns can be addressed through services work plans which should be monitored by the service and Network quarterly
- When actions required to fully address a risk/concern cannot be achieved immediately, interim actions must be taken to reduce the risk and a credible action plan with milestone dates submitted to the Network office for monitoring
- Where the Network Manager considers the response from the service to be inadequate to address a risk/serious concern, he/she will email the services' executive team to acknowledge the letter and its contents and make reference to further updates and progress on the actions identified, copying in other relevant agencies.
- Where no response is received by the service this will be followed up by the Network Manager and Network Regional Lead(s).
- Where there continues to be what is considered an inadequate response from the organisation, the Network Manager & Network Regional Lead will inform the relevant Commissioning Lead and the Care Quality Commission. If the concerns relate to or

impacts on doctors in training a formal letter will be sent to the Training Programme Director (TPD) and Regional Advisor (RA) of the relevant speciality.

7.0 Outcomes of the Peer Review Process

Any actions resulting from the peer review self-assessment or visit is primarily the responsibility of the service reviewed and not a function of the peer review panel. Responsibility for ensuring the implementation and follow up of actions within appropriate timescales rests with the Network.

8.0 Appeals and Complaints Policy

A distinction should be 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.

8.1 Appeals

An appeal should only be considered, where reviewers have concluded that a service gives cause for a serious concern or immediate risk or the reviewers have concluded that the service compliance with the measures assessed is deemed to be unsatisfactory.

Any such appeal should be submitted by the Trust Chief Executive to the Network Manager and must be submitted within four weeks of the publication of the peer review report.

Any appeal received should be considered initially by the Network Manager and relevant Network Regional Lead, who may then convene a subgroup to investigate. The membership of the subgroup will be determined on a case by case basis and 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 panel and the conclusions it drew and in doing so, it will examine whether, in light of the points made in the statement of appeal the review panel’s conclusions were reached reasonably and fair.

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.

The decision of the subgroup will be the final with no further stage of appeal and whenever possible, the result of an appeal will be made known no longer than eight weeks from the date the appeal was submitted.

8.2 Complaints

The vast majority of reviews will be carried out successfully and without incident. However it is recognised that sometimes there may be issues or concerns about aspects of the review process.

Services have the opportunity to agree the details of the preparations for a peer review. Any complaints, for example about dates, timings etc. should be made in the first instance to the Network office e.g. Network Manager, Regional Lead.

Complaints about the conduct of a review should be made to the Network Manager at the time, or where this is not possible, immediately after the review.

Complaints about the conduct of the peer review panel or panel member should be addressed in the first instance to the Network Manager.

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 initially with the Network Manager, the normal procedures for checking factual accuracy of draft reports lies with the organisation.

If there is a disagreement regarding factual accuracy and resolution not achieved, then the complaint should be addressed to the Network Manager.

9.0 ABBREVIATIONS

SOP:	Standard Operating Procedure
TPD:	Training Programme Director
RA:	Regional Advisor

10.0 REFERENCES

National Critical Care ODN Peer Review Process documentation

11.0 APPENDICES

APPENDIX 1 – Service Specification, National and Local Guidelines

Critical Care Services	• ICNARC data • SSQD dashboard • CQC reports • Compliance against NHSE / CCG service specifications • Compliance against relevant national standards and guidelines, e.g.NICE, FICM, Intensive Care Society, GPICS, EPRR, Current 7 day service standards where applicable, NCEPOD • Compliance against relevant network guidelines & pathways • Patient feedback • Staff safety culture reports • Staff wellbeing reports • GIRFT reports
Trauma Units & Major Trauma Centres	• Data – new system to be confirmed • Compliance against NHSE / CCG / service specifications • Compliance against relevant national standards and guidelines, e.g. NICE, BOAST • Compliance against relevant network guidelines & pathways • Compliance of training requirements e.g. ATLS, APLS, TNCC • Patient feedback • Staff wellbeing reports • Datix reports • GIRFT reports
Burns Services	• iBID data • Compliance against NHSE / CCG / service specifications • Compliance against relevant national standards and guidelines, e.g. NICE, British Burn Association • Patient feedback • Staff safety culture reports • Staff wellbeing reports • GIRFT reports
Spines Services	• TARN • Compliance against NHSE / CCG / service specifications • Compliance against relevant national standards and guidelines, e.g. NICE, FICM, Intensive Care Society, National Spinal Cord Injury Association • Patient feedback • Staff safety culture reports • Staff wellbeing reports • GIRFT reports

Major Trauma Centres via Specialised Commissioning	Specialised Commissioning have resumed mandatory collection of SSQD information from Q1 2022/23 and will be working with providers to support a resumption of collection of information and a renewal in how this information is reported for quality assurance and commissioning purposes. Acute service providers: Highly specialised services will be required to submit their annual outcome data for 2022/23 through the SSQDs. This collection will begin in April 2023. NHS England and NHS Improvement • The SSQD submission process will be made mandatory for Q1 2022/23. Information on the submission timetable will be posted on the Quality Collection and Reporting System FutureNHS page by 14 March 2022

APPENDIX 2 – Self-Assessment Declaration Spreadsheet

Ref No.	Descriptor	Criteria for 'Met'	Criteria for 'Partially Met'	Criteria for 'Unmet'	Self-Assessment	Figure Achieved	Supporting Comments e.g. work in progress information	Evidence location e.g. work plan, annual report, Operational Policy or during visit
1.1	The provider must implement a standardised approach to the detection and response to deteriorating health on general wards with reference to NICE 50	Provider has a standardised approach to the detection and response to deteriorating health on general wards		Does not meet 'Met' criteria				
1.2	Admission to Critical Care must be timely and meet the needs of the patient. Admission must be within 4 hours from the decision to admit (unscheduled admissions).	98% of patients are admitted within 4 hours of decision to admit	90%-98% of patients are admitted within 4 hours of decision to admit	< 90% of patients are admitted within 4 hours of decision to admit				

APPENDIX 3 – High Level Feedback - Peer Review High Level Feedback Form

Outline the feedback session and what to expect following the visit • High level feedback • Factual Accuracy Checking • Initial draft report • Following up on any evidence • Final written report within 8 weeks.
Immediate Risk - Escalation may be required on the day to Trust exec's or NHSE/ICS. "An issue that is likely to result in significant harm to patients or staff or have a direct serious adverse impact on clinical outcomes & therefore requires immediate action" **Serious Concerns** "Whilst not presenting an immediate risk to patient or staff safety it is likely to seriously compromise the quality of patient care, and therefore requires urgent action to resolve"

Standards Ref number	IR or SC?	IR/SC details	Risk Score & Impact Descriptor (see below risk score matrix)

Areas of significant improvement and good practice

APPENDIX 4 - Risk Score Matrix

Impact Score	Hazard Impact Descriptors	Likelihood Score	Likelihood Descriptor
1	**Negligible** - Minor poor experience of patient(s) - Occasional complaints of poor patient experience - No serious Incidents - No or minimal breech of guidance, standards and/or policies - L1 Routine monitoring (MH) – Managerial/Operational Issue with low level short term risk	1	Likely (>50% chance) to be less than one year/no or minimal mitigations required
2	**Minor** - Minor physical or psychological harm/injury (recoverable) to patients, - Multiple formal complaints of poor patient experience - Service Loss / interruption > 8 hours, including ongoing low staffing level reducing service quality - Limited evidence of non compliance with guidance, standards and/or policies - Local media coverage – short-term reduction in public confidence in part of system organisation/pathways - L2 Routine Monitoring (MH) - Managerial/Operational issues with low level risk	2	Likely (>50% chance) to be at least once a year / short term mitigations identified and in place
3	**Moderate** - Single significant physical or psychological harm, or permanent injury - Single serious complaint (including concerns raised by healthcare staff) that requires reporting to or investigation by regulators - Service loss / interruption > 24 hours, including ongoing unsafe staffing - Reduced CQC rating/ recommendations. - Single non-compliance with guidance, core standards and/or policies - Local media coverage – loss of public confidence in a system organisation/pathway (short/ medium term) - L3 Enhanced Monitoring (MH) - Safeguarding concerns; Never Event with moderate impact	3	Likely (>50% chance) to be at least every six months / mitigation plan in place and on track
4	**Serious** - Multiple significant physical or psychological harm/injury (<10), - Multiple serious complaints (including concerns raised by staff) that requires reporting to or investigation by regulators - Service loss / interruption > 48 hrs including uncertain delivery of service due to lack of staff. - Reduced CQC rating/Challenging recommendations. - Evidence of non-compliance with core standards and/or policies - Local media coverage. Significant loss of public confidence in a system organisation or pathway (long term) - L3 Enhanced monitoring (MH) - Multiple safeguarding concerns; Never Events with moderate impact	4	Likely (>50% chance) to be at least quarterly / mitigations unlikely to prevent risk within next quarter
5	**Severe** - 1 avoidable/unexpected death or multiple significant physical or psychological harm/injury (>10) - Service loss / suspension / interruption > 1 week, including due to lack of staff - CQC enforcement action/Critical report and low rating. - Major non-compliance with core standards and/or policies - National media involvement likely. Significant loss of public confidence in a system organisation or pathway (long term)	5	Likely (>50% chance) to be monthly / insufficient mitigations in place and/or significantly off track.
6	**Critical** - 2 or more avoidable/unexpected deaths - Permanent loss of service/facility, including non- delivery of service due to lack of staff. - Prosecution / Severely critical report by regulator - Significant and immediate infringement of process/systems which results in loss of critical service and/or risk to service users - National media coverage inevitable. Total loss of public confidence in system organisations and/or pathways.	6	Likely (>50% chance) to be daily / insufficient mitigations identified and minimal reduction in risk impact expected