NHS
Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
PEER REVIEWS

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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*June 2018*	*New SOP*
1.1	*July 2020*	*Review of SOP via new Peer Review Subgroup (AEG)* *Process updated in line with MyAssurance audits*
1.2	*Sept 2020*	*Review of SOP via new Peer Review Subgroup (AEG) in line with changes from subgroup meetings.* *Approved AEG 23-Sept-2020*
1.3	*March 2022*	*Minor amends. Change in cycle to Q1 and Q2. Peer reviews changed to every other year. Reference to the generic peer review templates. Approved at QPaS and AEG April 2022*
1.4	*April 2023*	*Minor amends to align with new CQC Quality Statements and closed cultures metrics. Addition of Patient Safety Partners. Approved at Audit and Effectiveness Group (5th April 2023).*
1.5	*May 2024*	*Annual review. Minor changes. Added InPhase and removed MyAssurance. Approved at Peer Review Subgroup (AEG) on 8 May 2024.*

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1. INTRODUCTION

Humber Teaching NHS Foundation Trust is committed to a culture of continuous learning and improvement across services. Peer reviews were established in 2018 to enable teams to share good practice and identify areas for quality improvements. The peer review process, supported by a review of relevant performance data, should enable teams to determine their level of compliance with the CQC Quality Statements. They should support improvement plans at a local team level and also highlight trust wide themes with shared learning and good practice identified. Peer reviews can also increase the quality of information available to provide the board with assurance or identify risks, and the outcomes can be shared with patients, regulators and commissioners. The standard operating procedure is designed to support peer reviews that will be undertaken across the services.

2. SCOPE

This SOP is applicable to all Humber Teaching NHS Foundation Trust services and provides a framework to guide the review.

3. DUTIES AND RESPONSIBILITIES

3.1. Divisions

Each divisional group will ensure that peer reviews are undertaken in accordance with the SOP. There will be a peer review cycle each year and teams/services will be expected to carry out a peer review once every other cycle. The clinical network groups' leads are responsible for submitting a proposed schedule for peer reviews to be completed. The schedule will be monitored through the clinical network groups with the assistance of the Governance and Patient Safety Team (Clinical Audit).

3.2. Matrons/Service Managers/Team Leaders/Charge Nurses/Clinical Leads

- Are responsible for ensuring that peer reviews are co-ordinated across their areas of responsibility.
- Will ensure that any issues identified in the peer reviews are addressed in a timely manner, leading to an improvement in the quality and safety of services within their sphere of responsibility.
- Will take an active part in the implementation of peer reviews across the services.

3.3. Team Leaders and Charge Nurses

Will co-ordinate and support the implementation of peer reviews across the Trust.

3.4. Safeguarding Team

Will support the implementation of the peer reviews across the Trust.

3.5. AHP Representatives

Will form part of the peer review teams and support the implementation of the peer reviews across the Trust.

3.6. Pharmacy Team

Will support the implementation of the peer reviews across the Trust.

3.7. Patient Safety Partners

With support and oversight from the Governance and Patient Safety Team the Patient Safety Partners will actively participate in peer reviews.

3.8. Patients and Carers

Patients and carers will contribute to the peer review process. Patients and carers will be invited to participate through informal interview and the completion of the patient and carer questionnaires.

3.9. Volunteers

Volunteers will contribute to the peer review process. The volunteers will be invited to participate in one of the elements of the peer review.

4. PROCEDURES/PROCESS

The Trust's Peer Review Programme aims to improve care for the people we serve by:

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

4.1. Peer Review Process

Peer Review Schedule

In Q4 each division will generate a peer review schedule for the coming peer review cycle. This will be agreed through the clinical network groups.

Each peer review cycle will commence 1st April and run throughout Q1 and Q2 ending on 30 September. Services will then enter a rolling peer review programme.

The divisions will prioritise their schedule based upon the latest CQC inspection outcomes, Datix incidents and themes, complaints, IIRs, sickness rates and safer staffing numbers.

The schedule will identify the date and time of the peer review will take place and appoint a lead reviewer. The support reviewers will also be identified on the schedule.

Frequency

The divisional leads will determine within their services /teams the number of peer reviews that need to take place. The minimum requirement is that each service undertakes at least one peer review every two years. If following a peer review a team/service is identified as requiring significant improvement actions or there are concerns relating to patient safety, then peer reviews should take place annually. This will be monitored through the Audit and Effectiveness group.

Peer Review Team

There will be a lead reviewer for each peer review team they will co-ordinate and assemble the peer review team. The lead reviewer should be a band 7 or above. Peer reviews must be led by a reviewer who has experience of undertaking the peer review process and has the skills to give feedback sensitively and appropriately. They will also provide feedback on good practice, as well as areas for improvement.

The team will comprise of at least one representative from the division being reviewed but should not be someone directly linked to the service.

In addition, there will be a minimum of two other people from different disciplines from the list below:

- Nursing
- Medical
- Psychology
- Occupational Therapy
- Pharmacy
- Mental Health Legislation
- Social Work
- Speech and Language Therapy
- Physiotherapy
- Safeguarding
- Patient and Carer by Experience
- Patient Safety Partners
- Volunteers

Each member of the peer review team will be allocated a specific area to review, relevant to their knowledge and expertise.

4.2. Peer Review Templates

Generic peer review templates have been built into the Audit Plus app on InPhase. The templates have been developed using the CQC Quality Statements and Closed cultures metrics. The peer review templates will be subject to annual review following feedback at the end of the peer review cycle. The peer review template will be reviewed and approved through the Peer Review Sub-Group in Q3/Q4.

4.3. Before the Peer Review

Each lead reviewer must undertake the peer review training located on ESR prior to becoming a lead reviewer. The training will support us in providing a consistent standard of what is required to undertake a peer review, and aid us towards moving to a local peer review accreditation program.

In preparing to carry out a peer review the Governance and Patient Safety team will supply the peer review leads with the following information about the service:

- Closed culture metrics
- Statutory/Mandatory training compliance
- Safer staffing dashboard
- Patient feedback (patient survey results, compliments, etc.)
- CQC open action plans
- Level 3 performance report
- Record Keeping audits
- Any patient safety reviews or investigation (PSIAs and PSIIs) reports submitted in the previous 12 months

- Peer Review Top tips document
- Peer review questions and guidance for Audit Plus app on InPhase

The lead reviewer will inform the team/service ideally **two months** before their review is due to taking place and **again two days before**. This is particularly important if the review team wishes to go out into the clinical area. Patient and carer involvement is important, so before the review takes place, the service /unit should contact the patients/carers (where this is appropriate to do so) and provide every opportunity for carers to be involved in the process. The service/unit should make arrangements with the patients/carers so that the peer review team can contact them on the day. This may be face to face if appropriate, or over MS Teams or the telephone.

4.4. **Preparing the Peer Review Team**

The lead reviewer should organise a meeting one week prior to the peer review. The peer review team should meet to cover introductions, gain clarity on the review purpose, ensure the peer reviewers can access the InPhase app to undertake the review, and cover any practicalities, i.e., where to meet and to arrange any follow up time that the lead coordinator may require.

4.5. **Process on the day of the Peer Review**

The peer review team will agree who goes, where and when within the timeframe, thus can capture different aspects i.e., an early shift, night shift or in the community different clinics etc. The peer review team will review the data list above, and to agree their roles for the day. This could also be done on the day with a tabletop discussion, before beginning the review. Remember as well that first impressions of the service are important, what do patients and visitors see? Is it clean?

The peer review team will undertake the reviews using the templates on Audit Plus app on InPhase and complete the comment and action section to support findings and results. On the day of the peer review, the team will meet at the review area, and go through the structure and format of the day with the staff. This will cover the reason for the peer review, what to expect, and the feedback process once the review has been completed.

The Clinical Audit Facilitator will provide support where needed to ensure the process runs smoothly and staff are able to access and complete the templates on InPhase.

4.6. **On Arrival at the Service**

On arrival, the peer review team should be wearing their ID badges and are to make themselves, known at the reception/intercom/office. They will be required to discuss with the person in charge the requirements for wearing of PPE.

All peer review visits will be planned and known about in advance; on arrival the reviewer should ask for the person who is expecting them.

The peer review team should explain who they are and what you will be doing.

Depending on the service being visited, the peer review team should ask about:

- Any security or personal safety precautions you need to be aware of on the unit (do you need a personal alarm, how does it work, etc.)
- Facilities and if there is a room you can use during the visit

- How many staff are on duty, vacancies, sickness, etc.
- How many service users the service has and if there are any you are unable to speak with that day
- Timings during the day, e.g., handover, visiting hours, protected mealtimes, meetings, etc.
- Any clinic/therapy sessions/patient activities that day which could be observed

4.7. Evidence required on the day to be reviewed by the peer review team

The peer review team will be allowed access to review the following:

- Training compliance from ESR
- Team/business meeting minutes
- Carers' pack
- Staff induction pack
- Welcome pack
- e-Roster

4.8. Completing the peer review templates during the visit

The templates are there to guide the reviewing team as to what type of things to observe, and to what to talk to staff about.

Additional information obtained from staff and service users can be added to the comments section in the templates. Notes should be made by each member of the peer review team, and then at an agreed time the team should come back together to share their findings on the specific areas they have been reviewing.

It is important that the recommendation boxes are completed in the template as these aid in the production of the report.

4.9. Identify actions and next steps

The peer review report will be generated through the information created from the Audit Plus app. The peer review team will share their initial findings with the team and discuss the actions remembering that the peer review process is to drive continuous quality improvement. The Peer review process is not an inspection; it is also not just about trying to fix problems. It is about using 'critical friends' to give assurance for identifying and sharing good practice and suggesting areas for improvement. Good practice may be practice that is undertaken very well and can be share with others to aid their learning.

The peer review should provide a positive developmental experience for all those involved. Reviewers can learn as much as those being reviewed and are then able to take back relevant learning to their own teams and services.

Feedback to the team on the same day is vital. The review team will ensure the lead of the service hears the team's comments as soon as possible. Feedback will be given verbally and it will be agreed if further written information would be helpful, and who would provide this.

An action plan will have been mutually agreed prior to submitting to the 'Audit and Effectiveness' group for oversight.

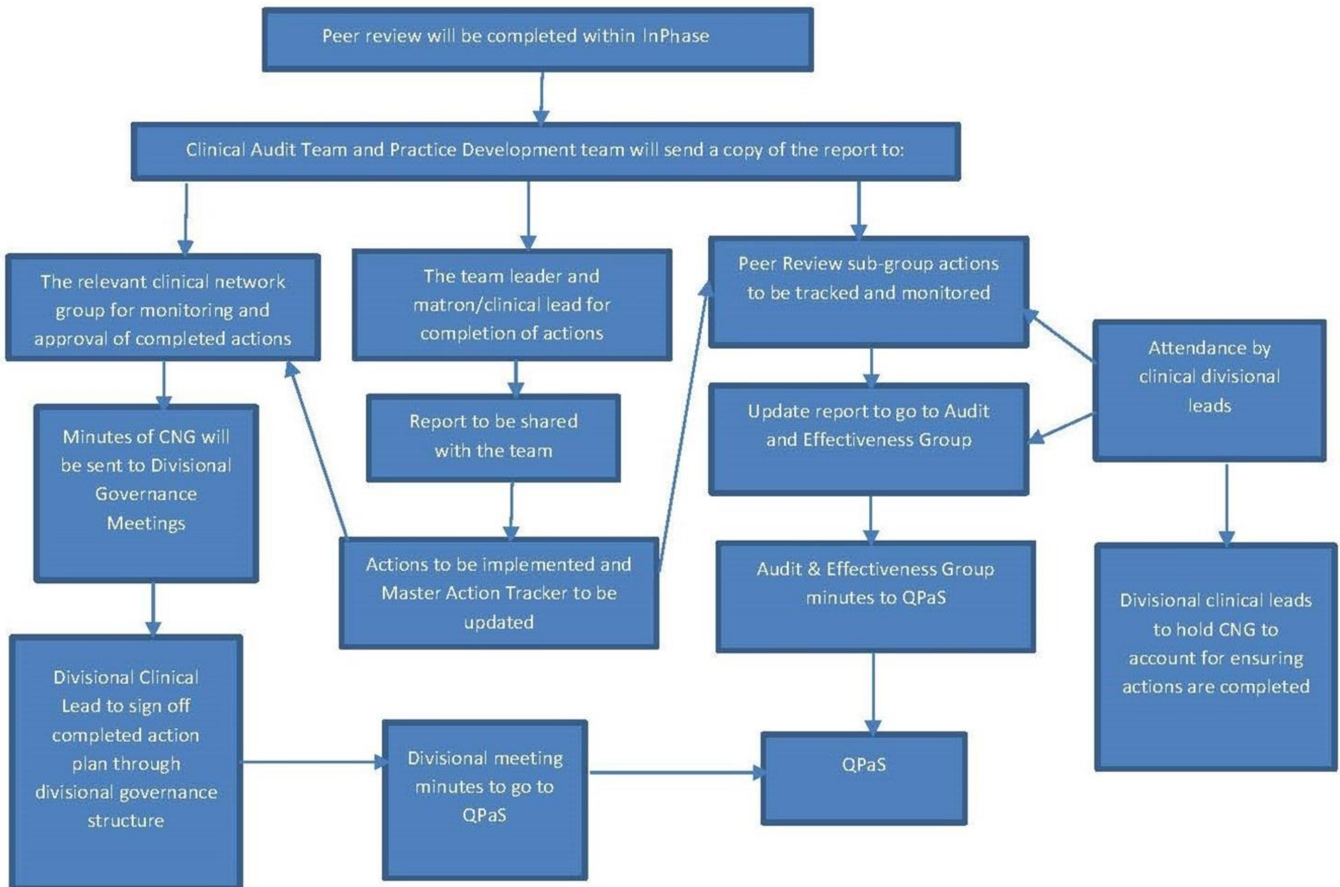
Having this information in InPhase will enable the tracking of themes and the sharing of good practice across teams.

***4.10.* Feedback and improving the process**

Feedback should be sought from all those involved in the peer review process to enable the improvement of future peer reviews.

A completed feedback form will be submitted to the clinical audit team following the completion of each peer review (can be found in the peer review documentation pack).

***4.11.* Report and Actions Process**



***4.12.* Governance**

The finalised reports will be reviewed /approved by the relevant clinical network and taken to the Peer Review Subgroup for overview. An update report from each meeting will be taken to the Audit and Effectiveness Group (AEG) and will provide assurance to QPaS via the AEG minutes showing actions arising from the review are being appropriately tracked and implemented. Peer review themes will be reported to QPaS. The Peer Review Report will be submitted to QPaS bi-monthly.

5. REFERENCES

- Single assessment framework - Care Quality Commission (cqc.org.uk)
- Care Quality Commission (2019) Identifying and responding to closed cultures.