Peer review

New model proposal to reflect the NHS vision for new ways of working

The current QRS peer review model is based on a successful and well proven framework which includes pre visit preparation, a structured review day timetable and a robust post review process to ensure that the quality of the final report is robust and accurately reflects the findings of the review team.

In addition, the credibility of the model is dependent on the use of specialist clinical and patient peer reviewers who are experts in the pathway being reviewed.

Consideration now needs to be given as to how the peer review process can be conducted in a different way. This is to reflect the changes that have been enforced, in the short and medium term, as a result of the COVID-19 pandemic, but also to reflect that, in the long term, new technology and ways of working will need to be reflected in the QRS approach. Organisations and potential reviewers will expect it.

The purpose of this paper is to consider how the existing peer review model can be adapted to respond to the new vision for the NHS, expectations of organisations and national guidelines on working in a different, but safe and equally efficient way.

Current principles, and recommendations for new ways of working, are presented based on the existing framework of:

1. Pre visit
2. Review day - in three distinct stages:
    a. Evidence
    b. 1:1 interaction
    c. Review discussion
3. Post review

1. Pre visit

As has already been demonstrated, much of the existing preparatory work can already be undertaken remotely and the impact on this stage of the process is therefore limited.

a. Initial scoping of the review – meetings with the service to be reviewed to agree the scope of the review and draft timetable. This also helps to determine the size and skill mix of the team required.

Recommend *–increased use video conference[1] to conduct meetings, in order to reduce the need for face to face contact. QRS to consider developing a video to be sent to teams in advance, explaining the review process, preparing for a review and expectations.*

b. General preparation – including:

- development of the timetable, sourcing the team, Caldicott approval
- training

[1] The recommended CSU and NHSE/I software is MS Teams®. Zoom is not recommended.

- preparation of packs etc.

Recommend *– most of this stage is already completed remotely; training has been completed online for some time now removing the need for travel to the QRS office for face to face training. On-line should now be the standard approach to training.*

The exception to travel to the office is for review packs which are currently printed for all reviewers. QRS to consider alternative options for providing evidence for reviewers (e.g. electronically on tablets) – removing the need for printing.

c. Background report and self-assessment - in preparation for a review, the host organisation is asked to prepare a background information and self-assessment (for standards based reviews). This provides an introduction to the service which is then provided to reviewers in preparation for the review.

Recommend *– no change. This is already developed and circulated remotely.*

2. Review day

The current review day is based on a structured timetable and the current model requires face to face contact (see 2e below for the benefits of face to face discussion). This part of the peer review process will potentially need to change significantly. Whilst some elements could conceivably be achieved remotely, it is anticipated that some elements will still need to be conducted face to face – albeit within new national guidelines on social distancing and infection control2 – and not least to reduce the direct impact on the service being reviewed.

As part of the planning and preparation, the Director of Infection Prevention and Control (DIPC) for the host organisation should confirm the requirements for the visit that the host organisation will expect from the review team.

Note: the first part of this section assumes that the review teams will be of a similar size and composition as is currently in place. The second half of this section addresses the challenges of team size and skill mix.

The current review day timetable includes:

a. Review team introduction and briefing – this allows the team to meet each other, QRS to reiterate its key messages to reviewers (including infection control, impartiality and confidentiality etc) and also provides the opportunity to give any further context to the service being reviewed.

Recommend *– subject to new social distancing and infection control guidelines, this could continue to be undertaken face to face, on site. However, this aspect of the review day could easily be conducted, via videoconference, prior to any on site activity. Suggest one week before – so that any immediate questions can be addressed between reviewers, or with the host organisation, prior to any onsite elements (if applicable). It is acknowledged that a brief introductory meeting will still need to take place prior to any on site activity.*

[2] This section makes several references to Social distancing. It is recognised that this will not always be possible and a short risk assessment will therefore need to be conducted during the preparation phase of the review, and on the day, where this is not possible – to ensure that working practices continue to be safe. This will include working with the host organisation to ensure that rooms of an appropriate size are available for the course of the review, to ensure that guidelines can be followed as far as possible. Where appropriate, reviewers will also be advised to wear PPE – in line with local and national guidance.

b. Presentation from the host organisation – this is an opportunity for the host team and review team to meet, provide additional context to the service and for the review team to ask any questions of clarification, based on the pre visit information.

Recommend *– subject to new social distancing and infection control guidelines, this could continue to be undertaken face to face, on site. However, this aspect of the review day could also easily be conducted, via videoconference, prior to any on site activity. It could take place immediately after the review team introductory call (see above) – in order to save on time and multiple virtual meetings.*

c. Review of evidence – the current review day allocates an early portion of time to the review of evidence provided by the organisation, set against the standards being used. It is an important part of preparing the service and the review team and identifying key questions and areas of further attention. It is worth noting that some reviewers have (in their post review evaluations) identified that one hour to review all of the evidence is insufficient and more time before hand to review evidence before attending would be helpful. In addition, feedback suggests that this is not helpful when all the evidence is electronic, as this compounds the impact on time available to review thoroughly. In light of these comments, and also in response to new ways of working, there are a number of potential options:

i. Continue as now – on site review of evidence with the whole team, subject to appropriate social distancing and other national requirements regarding safe work processes.

ii. Host organisation upload evidence prior to the review onto the QRS portal. Evidence is then allocated to review team members to review in advance of any on site visit. This could be specific groups of evidence, according to their area of specialism, rather than every reviewer reviewing every piece of evidence. Consideration would need to be given to the technical and information governance requirements of this option.

iii. Host organisation upload evidence prior to the review on to the QRS portal. Evidence is reviewed by QRS Director / Assistant Directors only - who then draft the self-assessment response and provide a draft briefing for reviewers which outlines any specific areas needing clarification – for reviewers to raise directly with the service. This will also include reference to any standards where the QRS team are unable to give a definitive assessment of compliance. This will therefore require reviewers to look at specific evidence and discuss in more detail with the host team.

iv. QRS team to visit the organisation, prior to the 'review day' and undertake a table top review of evidence. A draft self-assessment and briefing would be provided to reviewers, outlining any specific areas needing clarification – for reviewers to raise directly with the service.

d. Review of premises / facilities and environment – in order to assess standards applicable to the environment. This is the one element of the current review process which cannot be conducted remotely. This also offer the opportunity for reviewers to have 'informal' conversations with the host team, review clinical notes (where appropriate) and observe interactions between team members and colleagues in other settings.

Recommend *– This element could be undertaken by QRS representatives only – or with one or two reviewers (rather than the whole team). Either of these two options would require clear consideration of appropriate social distancing guidance and infection control guidelines.*

e. Meetings with host team members and other stakeholders – one of the most important elements of the review day. Whilst there will be some additional risk if this element continues to be face to face, this is the opportunity for team members to meet their peers, discuss the service and get clarification on any concerns. Whilst these discussions are generally led by the content of the standards, it is a vital source of other intelligence, whereby team members can speak freely within their own professional

group. It also provides the opportunity for reviewers to pick up on any 'nonverbal' intelligence. On this basis, every effort will be taken to keep this element as face to face, recognising that suitable precautions will be required.

***Recommend** – ideally, this should continue to be face to face (subject to restrictions previously identified). However, as individuals have been required to work remotely, the technology, operational knowledge and willingness is now far more widely available to allow these meetings to be conducted remotely.*

f. Review team meeting to discuss findings – this enables all the intelligence gathered prior to and during the course of the review day, to be brought together in order for the review team to draw their conclusions. This enables the assessment against each of the standards to be completed as well as identifying the high level narrative – for feedback to the host team as well as the forming the outline draft of the review report.

***Recommend** - ideally, this should continue to be face to face (subject to restrictions previously identified). However, as individuals have been required to work remotely, the technology, operational knowledge and willingness it now far more widely available to allow these meetings to be conducted remotely.*

g. Feedback to the host team

***Recommend** - ideally, this should continue to be face to face (subject to restrictions previously identified). However, again these meetings could be conducted remotely. Consideration should also be given to how many people need to attend this – both from the host team and the review team.*

Based on the above, it is conceivable that a review could be undertaken in its entirety almost remotely, with the exception of the review of facilities. However, this is not ideal – and it is recommended that a blended approach of remote and onsite working is adopted, which reflects the service being reviewed, and the requirements of the review team.

Review team members

Quite simply, the quality of QRS reviews is entirely dependent upon the expert reviewers and patients who give their time and share their expertise as peer reviewers.

The impact of the COVID-19 pandemic provides a significant challenge to QRS' ability to source reviewers. This may be due to reviewer reluctance (understandably) to visit other services and organisations, based on their own preferences or personal restrictions. This may be particularly significant for our patient reviewers. However, perhaps more significant will be the willingness of NHS organisations to allow reviewers time off for reviews – as services are under pressure to return to business as usual.

***Recommend** – consider new ways of working (outlined above) so that NHS reviewers can undertake more aspects of the review remotely – reducing travel time and time away from their own organisations. Also consider using smaller teams to undertake reviews. Update the QRS risk register in relation to availability of reviewers to reflect that the pool or reviewers who will potentially now be available (particularly patient reviewers) will be significantly smaller as a result of the pandemic.*

***Recommend** – update communications with all reviewers to ensure that QRS are explicit regarding need to wear PPE, IPC, social distancing and any other requirements as specified by QRS or the host organisation.*

3. Post review

Much of the existing post review work is already undertaken remotely and impact on this stage of the process is therefore limited.

a. Preparation of the draft report – for circulation to reviewers and the clinical service reviewed

Recommend – no change. Already completed remotely, via email.

b. Collation of comments received and updating of drafts

Recommend *– no change. Already completed remotely, via email.*

c. Presentation of draft report to QAG – for final discussion and sign off. Currently this QAG meetings are face to face, with an option of teleconference.

Recommend *– QAG meetings to be conducted via videoconference rather than face to face. This has already been started and is easily achieved.*

d. Final updates and publication of final report

Recommend *– no change. Already can completed remotely by email.*

Conclusion

The COVID-19 pandemic, and new vision for the NHS, has provided a significant challenge to QRS and its ability to continue providing peer reviews to organisations. However, it is hoped that this paper provides sufficient insight to demonstrate that some of the challenges presented are surmountable. By being creative, working more flexibly and adopting the new technology that is now more widely accessible, peer review could continue and therefore provide the benefits and outcomes to NHS organisations that it has done over many years.

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