**Document control**

This document will be regularly updated to reflect the processes and procedures carried out by RCPCH in delivering the National Children and Young People’s Diabetes Quality Programme (NCYPDQP). Templates may be used with the permission of the RCPCH staff team.

The staff team will maintain a [webpage](mailto:diabetes.quality@rcpch.ac.uk) and documentation to accompany the process and are responsible for ensuring that all MDTs who are involved in the programme (including peer reviewers), have been asked to read them. Please let the team know of any amendments, inaccuracies or areas that you feel should be added to improve their usability, via diabetes.quality@rcpch.ac.uk

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
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<tr>
<td>1.1</td>
<td>19/07/18</td>
<td>SE</td>
<td>For pilot review visits</td>
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<td>2.1</td>
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<td>HC</td>
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<td>2.2</td>
<td>April 2019</td>
<td>HC</td>
<td>Cause for Concern Management Policy references added</td>
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1. Introduction

This Handbook has been prepared to support the National Children and Young People’s Diabetes Peer Review process as part of the National Children and Young People’s Diabetes Quality Programme (NCYPDQP). The Manual describes the method and procedures for carrying out the Peer Review Programme for Children and Young People’s (CYP) Diabetes Services in England and Wales.

The NCYPDQP is a three-year integrated programme, commencing in April 2018. It is designed to help multi-disciplinary teams (MDT’s) in Paediatric Diabetes Units (PDU’s) to transform the way they work to improve outcomes and deliver best practice care as efficiently as possible. The Programme is centrally managed by the RCPCH with the support of the 11 regional CYP Diabetes Networks, and will involve clinical teams across England and Wales.

The overarching ethos of the programme is to support networks, teams and individuals to work together to monitor and improve care and outcomes for patients by adopting a sustainable, efficient and integrated approach; it has been developed utilising the following principles:

- Clinically led
- User/carer involvement
- Consistency in delivery of the programme
- Developmental and not judgemental
- Focus on co-ordination within and across organisations
- Peer on peer
- Integration with other review systems

The Peer Review Programme will run alongside, but be managed separately from, the National Paediatric Diabetes Audit (NPDA) which is also hosted by the RCPCH. PDU’s will be encouraged to use their NPDA data and information gathered about their clinical service during Peer Review to drive improvements in care and outcomes.
1.1. Background and Context

To help continue the on-going improvement in paediatric diabetes outcomes in England and Wales, demonstrated over the last eight years, the National Children and Young People’s Diabetes Network, in partnership with the RCPCH, has established the NCYPD Quality Programme, comprising Self-Assessment, External Verification and Peer Review, in addition to a Quality Improvement Collaborative. The programme commenced from April 2018 and is wholly independently funded by participating Trusts and Health Boards.

The Peer Review Programme builds on the Department of Health’s ‘Diabetes Quality Improvement Network System’ (DQuINS) that was used to Peer Review 134 PDU’s in 2013/14. This was a popular and successful process amongst the clinical teams, requiring Self-Assessment against a set of standards, followed by a visiting team of diabetes professionals reviewing the individual units’ processes, team working, governance, outcomes and engagement with patients and families. In 2015, the programme was migrated to the Quality Surveillance Team (QST) within Specialised Commissioning, NHS England. A second round of Self-Assessment and External Verification took place 2015/16 but no review visits. In 2016 a decision was made by NHS England to no longer support Paediatric Diabetes due to funding demand from other programmes and the web portal access was removed.

The NCYPD Quality Programme will involve more of the MDT as Peer Reviewers and will expand the remit of the programme to include formalised Quality Improvement Collaboratives developed by the RCPCH, based on evidence of success from Sweden\(^1\), a country which has reduced its HbA1c levels markedly in recent years. A six-day pilot QI Collaborative, involving 10 whole MDTs over seven months was completed in July 2018 and demonstrated marked impact which is being collated and will be published later this year.

1.2. Aims and Benefits

The programme aims to support improvement in the care, experience and outcomes for Children and Young People with diabetes by:

- Inspiring teams and networks to work efficiently and effectively to reduce variation in outcomes
- Develop on-going clinical support for the Programme
- Benchmarking compliance with Standards and Best Practice Tariff criteria
- Fostering peer challenge, liaison, development and learning
- Identifying notable practice and projects for Quality Improvement

The anticipated benefits of the programme are:

For Everyone

- Single location for national disease specific data
- Minimum burden – data entered once and shared
- Centrally funded to minimise cost and bureaucracy
- RCPCH reputation for high quality projects
- Validated benchmarked data on individual teams
- Catalyst for change and service improvement
- Engagement with front line clinicians to help keep them up to date and share good practice
- Focus on improving patient experience and outcomes

For Commissioners and the National CYPD Quality Programme

- Guidance to support CCGs to manage payment of BPT and enable reduction of variation.
- An opportunity to benchmark PDU performance.
• Potential to demonstrate internationally a highly regarded integrated process. The International SWEET2 collaborative is in dialogue to use the Self-Assessment measures developed in England and Wales.

• For diabetes services commissioned by NHS England, Specialised Commissioning, the NHSE Quality Surveillance Team, may use Self-Assessment data in their initial assessments and may utilise the RCPCH Peer Review programme for any required visits to individual Trusts.

For Trusts and Health Boards

• Better evidence to monitor improvement and efficiency
• Access to continued BPT funding by assuring compliance with BPT specification
• The opportunity to improve expertise, reputation and skills of the PDU team members
• Potential for ‘trickledown’ of funded training in Peer Review techniques
• Encouragement about progress and celebration of achievement

For MDTs

• The opportunity to work together better with a shared purpose
• Development of QI skills amongst MDT members applicable in other work
• Provision of improved data to inform development and requests for resources
• Opportunity for CPD and recognition of progress
• Incentive to resolve gaps and reduce variation in service provision
• Improved awareness by senior managers of the needs/achievements of PDUs
• Data is entered once and shared widely to reduce burden
• Links with other data sources and information in public and professional domains.
• A focus on patient outcomes and the factors impeding their improvement
• The opportunity to visit and learn from other units and teams
• Enables networks to benchmark with each other

2 ‘SWEET’ is an acronym derived from ‘Better control in Paediatric and Adolescent diabetes: Working to create Centres of Reference’
For Patients, Parents and Carers

- Improved safety – links to CQC
- Better experience – live life to the full
- Long term benefit – keep well longer
- Better information and support
- Reduced inequity – high quality care wherever they live
- National data and evidence to support choice
- Involvement in service improvement

The Peer Review Programme should be conducted in a spirit of dialogue and co-operation between the Networks, Trusts, their staff and the review teams. The regional CYP diabetes networks have delegated responsibility from the providers and commissioners to ensure that services are appropriately commissioned and have robust clinical governance processes. It is expected that the programme will also have dialogue and co-operation with the commissioners of the services.

It is essential that the process is undertaken with proper regard to issues of equality and diversity, including the needs and interests of people with disabilities and black and minority ethnic communities. This principle should be emphasised during each of the Peer Review training sessions.

1.3. Management of the Programme

This programme was set up by a project Steering Group, on behalf of the National CYPD Network, comprising the National Network Clinical Lead and representative regional network Clinical Leads and Managers. From July 2018 operational delivery and planning for the programme will be...
overseen by a National CYP Diabetes Quality Programme (NCYPDQP) Board, meeting approximately every six weeks and functionally separate from the National CYP Diabetes Network. A National Clinical Adviser provides clinical input to the Board and Programme and both are supported by an expert reference group, including wider representation from clinical specialties, the National Network (Managers and Chairs) and external stakeholders, meeting 3-4 times a year.

The NCYPDQP will be hosted by the RCPCH and managed by a team of staff led by the Diabetes Programme Manager. There will be strong operational and communication links between the Programme team at the RCPCH and the 11 regional CYP diabetes networks.

1.4. Scope of Peer Review

It is intended that the Quality Programme will ultimately cover all children and young people’s diabetes services within England and Wales. Each regional CYP Diabetes network, health organisation and multidisciplinary team (MDT) will be invited to complete an online annual Self-Assessment against published measures, which will be moderated, benchmarked, Externally Verified and reported locally and nationally to stimulate enquiry, learning, spread of good practice and celebration. There will be a robust, proportionate process for External Verification including challenge to ensure that the resultant PDU scores are clear, consistent and fair.

The process of Peer Review is concerned not only with the review of an organisation’s compliance against measures, but also with the qualitative assessment of a broad set of objectives for the delivery of services. It is not ‘competitive’ but will seek evidence to validate the Self-Assessment, explore the barriers to improvement as well as identifying positive practice examples. The interaction at the visit and the resulting report and recommendations will provide teams with the tools and evidence to plan their improvement, supplemented by the opportunity of the Quality Improvement Collaboratives within the overall programme. Peer review reports will be shared by the RCPCH with medical directors and followed up to monitor implementation of the recommendations.
Accreditation

The framework for Self-Assessment and Peer Review will be compatible with future migration to a CSAA-approved accreditation scheme in England and align with the NHS Wales Peer Review Framework, taking into account their different funding and geographic challenges. However wherever possible the arrangements will be consistent for all participating units.

1.5. How data from the programme will be used

Data from the Self-Assessment process, once Externally Verified, will in due course be published in a national report and units will receive local reports showing how their team compared with other similar sized services. In future years the information may be offered to the Care Quality Commission (CQC) for its intelligent monitoring service, and may contribute from 2019 towards the NHS England Clinical Service Quality Measures (CSQM).

The Self-Assessment data and the supporting evidence gathered by units can help to streamline contractual conversations with NHS Trust managers and CCGs when negotiating the Best Practice Tariff (BPT) Criteria. Whilst this does not directly exist in Wales the data can inform Network and Health Board monitoring.

Peer review reports will be narrative, not scored or rated but will cover a consistent set of themes. They will be shared with Medical Directors and highlight areas of concern (including safety) and/or notable practice. The RCPCH will not publish these reports but will expect Trusts and Health Boards to do so. For units in England, the Care Quality Commission would expect reports to be shared with the relationship manager, particularly as part of the evidence pack ahead of inspection visits.
Chapter 1 – Key Points

- NCYPDQP is a 3-year programme which aims to support improvement in the care, experience and outcomes for Children and Young People with Diabetes in England and Wales.
- It is managed by the RCPCH with support of the 11 Regional CYP Diabetes Networks, and covers England and Wales.
- The programme involves annual Self-Assessment (SA) and External Verification (EV) and a programme of Peer Review (PR) visits across a three-year cycle. It builds on previous work by DQuINs (13/14) and QST (15/16), this time involving more of the MDT as reviewers.
- The remit has been expanded to include formalised QI Collaboratives (QIC), based on evidence from Sweden and a recent UK pilot linking QIC’s to reducing HbA1c levels.
- The framework will be compatible with future migration to a CSAA-approved accreditation scheme in England and align with the NHS Wales framework.
- Findings will produce evidence and compliance information to support BPT Criteria and CQC inspections in England, and contribute to monitoring by the Welsh Government and Healthcare Inspectorate Wales.
- Data will be reported locally and nationally to stimulate enquiry, learning, spread of good practice and celebration.
2. The Peer Review Programme

2.1. Self-Assessment, External Verification and Peer Review

The model is based on a standardised approach followed for many current and recent Peer Review programmes and in the first year (2018-9) will involve around 135 multidisciplinary teams (MDT) in around 120 health organisations in England and Wales.

The programme will supplement the National Paediatric Diabetes Audit (NPDA) and units will be encouraged to use their NPDA data and information gathered about their clinical service during Peer Review to drive improvements in care and outcomes.

The model for Peer Review will consist of three components, illustrated above and outlined in chapters 3-5.

2.2. The NCYPDQP Process

The NCYPDQP process is shown here. Organisations will be expected to complete Self-Assessment and Internal Validation of data every year during the programme’s lifespan. Each MDT will receive one Peer-Review visit per three-year cycle.
2.3. Outcomes from the Process

Following the outcomes from the different stages in the Peer Review process, the National CYP Diabetes Network and its constituent Regional Networks, should agree the actions that need to be taken by PDU’s, within agreed timescales, building on the strengths identified and addressing any aspects in need of improvement. Actions should be included in individual PDU strategic development plans and their annual work programme.

As a principle, it should be recognised that the implementation and follow up of actions resulting from the Peer Review process is primarily a function of clinical and corporate governance systems and not a function of the NCYPD Quality Programme. There is, of course, the scope to involve the RCPCH staff team and other RCPCH services (such as Invited Reviews, &Us team, mentoring) in follow up where this is considered helpful.

2.4. Data Handling and GDPR

The Self-Assessment and Peer Review processes seek information from NHS organisations primarily about systems and services. Sensitive or personal data is not routinely collected but may be submitted by units being assessed. The RCPCH complies with GDPR requirements in the collection, storage, processing and disposal of data using secure portals for uploading information and taking appropriate steps to protect it. The privacy statement for the Quality Programme can be found on the website [www.rcpch.ac.uk/diabetesquality](http://www.rcpch.ac.uk/diabetesquality)
Chapter 2 – Key Points

- The model is based on a standardised approach and will involve around 135 multidisciplinary teams (MDT) in over 120 health organisations in England and Wales. It will consist of three components:
  - Annual Self-Assessment (SA) – online against an agreed set of measures
  - Data Scoring and External Verification (EV) – SA data will be internally validated, moderated, benchmarked and Externally Verified. This ensures the resultant unit scores are clear, consistent and fair.
  - PR visits once in three years providing a qualitative assessment of a broad set of objectives for the delivery of services.

- Following each stage, individual Trusts and Networks will be responsible for agreeing actions and timescales, building on strengths identified and addressing areas for improvement.

- Data handling and processing complies with current data protection legislation.
3. Annual Self-Assessment

3.1. What will be Self-Assessed?

All participating Children and Young People’s Diabetes Services in England and Wales will be invited to complete an annual Self-Assessment against the NCYPDQP measures. The measures were developed by the National CYP Diabetes Network with the support of NICE and were subject to external consultation during 2017 through the Regional Networks amongst all multidisciplinary teams (MDT).

The wording used within these measures correlates with that used in the NPDA, NICE Guidance and BPT (in England). They have been reviewed and supported by NICE and have been shared with the BPT team, HQIP, NHS England and CQC. They complement the NPDA findings by providing service level and process information that is underpinned by good practice and national clinical and professional standards.

The Self-Assessment process has been designed to be simple and swift to complete online with units trusted to have supporting evidence available rather than requiring uploading. The measures used previously have been broken down to provide more granularity and detailed scoring, largely requiring Y/N responses plus inclusion of team member names.

The measures are structured as follows:

<table>
<thead>
<tr>
<th>Network measures</th>
<th>2015/16 DQuINS</th>
<th>2018 Measures</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>12 measures</td>
<td>34 elements</td>
</tr>
<tr>
<td>Hospital/Health Board measures</td>
<td>6 measures</td>
<td>25 elements</td>
</tr>
<tr>
<td>MDT measures</td>
<td>27 measures</td>
<td>95 elements</td>
</tr>
</tbody>
</table>

The measures are detailed separately and available on the website

[www.rcpch.ac.uk/diabetesquality](http://www.rcpch.ac.uk/diabetesquality)
3.2. How to Self-Assess

Submission will be via a web-based portal (www.CYP-SA.rcpch.ac.uk). A Self-Assessment Handbook has been prepared to support teams in using the system. It will enable teams to demonstrate compliance against the measures. Each team should complete the Self-Assessment for their service. Submission of the Hospital and MDT data will be done by the individual MDTs and the Regional Network data by the Network Clinical Leads/Managers, as outlined below. All submissions will require final sign-off by the Clinical Lead in each MDT along with the Trust or Health Board’s Medical Director or their nominated representative.

1. **Data submission using web form**
   - Design prevents obviously invalid responses and prompts against incomplete data submission

2. **Monitoring of completion**
   - By RCPCH Staff team and Network Managers
   - Provision of live clarification to all units of any anomalies identified

3. **Internal Validation**
   - Sign-off by Lead Clinician for the MDT in each unit
   - Sign-off by the Trust/Health Board Medical Director or representative

This process will be managed by the RCPCH staff team, who will oversee the submissions, provide administrative support for teams accessing the database and send reminders as required. Monitoring of the submissions and encouragement of the MDTs will also be supported by the Regional Network Managers who will have viewing access to the data submitted by all the units in their regions.

3.3. Internal Validation

Each unit must have their submission Internally Validated (IV) and signed off by a senior clinician, usually the Trust Medical Director, as well as the Paediatric Diabetes Lead Clinician and the Paediatric Services General Manager.
The purpose of Internal Validation is as follows:

- To ensure accountability for the Self-Assessment within organisations and to provide a level of internal assurance
- To develop a process whereby internal governance rather than external Peer Review or inspection is the catalyst for change; that the organisation is using the Self-Assessments for its own assurance purposes
- To confirm that, to the best of the organisation’s knowledge, the assessments are accurate and therefore fit for publication and sharing with stakeholders
- To identify areas of good practice that could be shared

The process adopted for Internal Validation can be determined locally but those responsible must ensure that whatever process is adopted:

- is agreed within the organisation, is integrated with other internal governance procedures and can demonstrate that a robust, fair process has been implemented
- has accountability for the Self-Assessment confirmed by agreement of the Medical Director of the organisation

The process of Internal Validation should include a review of the Self-Assessment and supporting evidence. It is good practice for a meeting to take place between managers and clinicians to agree the submission then another meeting to take place between the Medical Director and representatives of the diabetes team for sign-off. This allows the opportunity for all involved to clarify any questions that may have arisen following a review of the information. It is also an opportunity to review the service’s compliance or otherwise against the BPT criteria and put any necessary resources in place.

Following IV the final ‘tab’ of the Self-Assessment webpage can be completed and the submission ‘locked’. A record of areas of non-compliance and sign-off can be saved as a PDF document locally and the platform remains available to view.

### 3.4. Collating Evidence

During the SA process, the information required to evidence each of the measures should be collated and retained by the Network (for the Network measures) or Hospital
or MDT named lead (for the Hospital and MDT measures). This evidence may be stored electronically and in hard copy as it could be called upon as evidence by the External Verification (EV) team and will be required prior to any Peer Review visit taking place. Routine electronic submission of evidence is not required.

To support the collation of evidence, three template documents have been developed, completion of which should ensure each MDT has collated the necessary documentation:

- Operational Policy
- Annual Report
- Annual work plan

These templates are optional, and MDTs can choose to collate their supporting documentation however they wish, as long as it is available for External Verification (if required) and the Peer Review visit. To reduce bureaucracy, a service should make use of the routine documentation and information already in existence or collected for the effective functioning of that service.

### Chapter 3 – Key Points

- **Self-Assessment (SA)** will take place online
- There will be specific measures for MDTs, Trusts/Health Boards and Networks
- Each PDU must have their submission Internally Validated (IV) and signed off by a senior clinician, usually the Medical Director, as well as the Lead Clinician for Diabetes
- During the SA process, PDU’s should collate and retain the evidence for each measure. It may be called upon for External Verification (EV) and will be required for submission electronically prior to a PR visit. Template documents for evidence collation are available to use but are not mandatory.
4. Data Scoring and External Verification

4.1. What is External Verification?

An external check of selected, validated Self-Assessments. The process will be coordinated by the RCPCH staff team, working through an evaluation sub-group of the Programme Board. Before data notification, the results will be checked and signed off by the Programme Board.

4.2. Purpose of External Verification

The process ensures the quality of data for the Peer Review process, as well as for submission for potential future inclusion in the Clinical Services Quality Measure (CSQM). It also provides a check of consistency of the Self-Assessment process, an opportunity to identify any systemic errors during submission and to check whether appropriate evidence has been collected.

A methodology has been developed for this purpose, which is:

- Consistent – across MDTs
- Logical – in terms of what evidence will be sought to verify scores
- Effective – provide sufficient assurance to be credible
- Simple – minimising burden for MDTs to prove compliance and assure verifiers
- Reproducible – able to be used year on year

4.3. Process for External Verification

Following completion of Self-Assessment (See Chapter 3) there will be three further stages, outlined below:
4.3.1. Data Scoring and Selection of PDU’s for External Verification

Initial scoring will be one point per element. The maximum score will therefore be 95 element points covered by the 27 MDT measures, plus 25 element points covered by the 6 Hospital measures (See section 3.1)

Once initial scoring has taken place, MDTs will be identified as candidates for further EV as follows:
- The five units with the highest and the five with the lowest total scores
- Five units that show the most significant change in percentage score since the 2015/16 EV.
- Ten further MDTs selected at random
- Additional services may be selected for EV if either the Regional CYP Diabetes Network or Programme Board have concerns about their performance

Selecting the top and bottom scoring units, and those showing significant movement provides a check of consistency of Self-Assessment and a chance to identify if systematic errors have occurred during submission. MDTs will not be aware ahead of the sign-off point whether or not they will be selected for EV.

4.3.2. External Verification process

The selected MDTs will be contacted around two weeks after closure of the SA platform with a request to submit their evidence electronically via the RCPCH’s secure SharePoint platform. This will enable the evidence to be swiftly collated ready for systematic, consistent review. Clarification will be sought where necessary to enable the External Verification to be robust.

If, during the External Verification process, there are anomalies identified, for example wrong interpretation of the measures or insufficiency of evidence, the Programme Board may propose that further EV is conducted across some or all MDTs against specific measures. This would only be done in exceptional circumstances.
4.3.3. Data Notification

MDTs will be contacted to clarify details where the evidence submitted is incomplete or fails to justify the SA. Units will be notified of their revised scores with explanations of any amendments made through the EV process. These scores may be used from 2019 in the CSQM and for BPT compliance in England and will be based on the 95 elements in the 27 MDT measures and the 25 elements of the 6 Hospital measures.

There will be an opportunity to appeal or request further explanation by the Trusts who contest any changes made to their score (see Chapter 7 for more details). After checking and resolution of any complaints, the final scores will be sent to Trusts and Health Boards within a benchmarking report and will be published in anonymised form alongside a national benchmarking report.

Chapter 4 – Key Points

- All SAs will be scored against a maximum of 95 for MDTs and 25 for Hospitals
- 25 PDU submissions will be selected to undergo External Verification (EV) and asked to submit their evidence online.
- Additional PDUs may be selected for EV if the Networks or Programme Board have concerns about their performance.
- MDTs will be notified of their revised scores with explanations of any amendments made through the EV process.
- There will be an opportunity to appeal or request further explanation by Trusts who contest any changes made to their score (see Chapter 7).
5. Peer Review Visit

5.1. What is a Peer Review Visit?

The purpose of the Peer Review visit is to provide an opportunity for a team of peers to meet with members of the diabetes service being reviewed. It 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 care and the patient experience. In addition, the visit will provide a further external check on the robustness of Self-Assessment data.

The findings of the Peer Review visit will not influence the in-year SA scores and should not be viewed as punitive or ‘competitive’. They are aimed at supporting units to make best use of their information and team skills to support improvements in outcomes.

5.2. Who is Responsible for Peer Review?

The Peer Review team will include at least three clinical colleagues (doctor, nurse, dietitian, psychologist) plus a patient/parent representative. The team will be supported by a review manager. Team members will be selected by application against criteria and undergo specific training prior to attending a review visit.

Peer Reviewers will usually be drawn from outside the region of the service being visited. There may be some visits within a region depending upon the availability of Peer Reviewers. More detailed information on recruitment, training and Peer Reviewer performance is covered in Chapter 8.

3 Self Assessment is a separate annual process – peer review findings will enable a more accurate SA the following year
The RCPCH Staff team will be responsible for ensuring the service under review has submitted the advance information pack. However, during and after the site visit the Peer Reviewers have a collective responsibility for gathering, verifying and sharing information that enables them to reach robust conclusions about compliance with the national measures and about the quality of the CYP diabetes services.

While undertaking a review, Peer Reviewers are acting on behalf of the NCYPD Quality Programme and are not expected to pursue any individual or organisational interests.

5.3. The Peer Review Visit Process

5.3.1. Notification of visits

Around one third of units in each region will be covered each year. Units will receive notification of the date by the RCPCH staff team. The following diagram illustrates the different stages of the visit process.

<table>
<thead>
<tr>
<th>Before visit</th>
<th>12 weeks</th>
<th>Host site receives confirmed date of Peer Review visit, including link to user survey and pack of information to prepare for the visit.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10 weeks</td>
<td>Review team confirmed</td>
</tr>
<tr>
<td></td>
<td>8 weeks</td>
<td>Deadline for host site to electronically submit evidence via SharePoint</td>
</tr>
<tr>
<td></td>
<td>4 weeks</td>
<td>Reviewers receive evidence pack</td>
</tr>
<tr>
<td></td>
<td>3 weeks</td>
<td>Teleconference between RCPCH Review Manager and host service to discuss schedule, logistics and key themes.</td>
</tr>
<tr>
<td></td>
<td>2 weeks</td>
<td>Peer Review team teleconference to discuss evidence and plan visit. Program Itinerary and reviewer travel arrangements confirmed</td>
</tr>
<tr>
<td>After visit</td>
<td>1 week</td>
<td>Visit takes place. Includes brief feedback of any immediate risks and serious concerns at the end of the day</td>
</tr>
<tr>
<td></td>
<td>1-4 weeks</td>
<td>Initial thank you / feedback letter to host service, identifying any immediate risks or serious concerns identified and confirming any additional information needed</td>
</tr>
<tr>
<td></td>
<td>6 weeks</td>
<td>Review team contributes to report</td>
</tr>
<tr>
<td></td>
<td>8 weeks</td>
<td>Report sent for internal QA process</td>
</tr>
<tr>
<td></td>
<td>10 weeks</td>
<td>Report sent to host service for factual accuracy check</td>
</tr>
<tr>
<td></td>
<td>12 weeks</td>
<td>Report returned to College</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Report finalised and signed-off</td>
</tr>
</tbody>
</table>
5.3.2. Preparation for the Peer Review Visit

Prior to the visit, MDTs will be required to submit the evidence pack from their most recent Self-Assessment, along with any supporting information, and additional documents as requested by the review team. They will also be responsible for ensuring staff are available to meet the Peer Review team during their visit (see 5.3.4 for suggested individuals), and for securing the necessary facilities to host the visit. The following documents will be requested, if available, ahead of the visit.

- Operational Policy*
- Annual Workplan*
- Annual Report *
  
  there are standard templates available on [www.rcpch.ac.uk/diabetesquality](http://www.rcpch.ac.uk/diabetesquality) - units using alternative formats should ensure the evidence covers all the self-assessment measures for MDT and hospital.

Where not included in the documents above the reviewers would need to see:

- Minutes, correspondence, business cases etc relating to diabetes service monitoring, development or redesign
- Links to or copies of reports from regulators or any external review / inspections / serious incidents relating to the diabetes service in the last 12 months together with action plans and progress
- Audit and Quality Improvement activity – local and national findings and action plans for the last 18 months if not included in documents above
- Details of patient engagement activity, feedback and how it has changed service delivery
- Complaints and Incident summaries over the last 12-18 months
- Any other information which you feel is pertinent (with a rationale please!)

It is important for the review team to hear the voice of Children, Young People and Families within the review process and units will be encouraged to circulate a survey link through their Families with Diabetes Regional Network or other user groups to inform the review team ahead of the visit.
5.3.3. Pre-visit teleconference

Services will have a teleconference with a RCPCH review manager prior to the review. This will take place after submission of the data packs and may also involve the Network Manager. It aims to:

- enable the RCPCH staff team to review the Self-Assessment evidence with a representative from the Trust / Health Board team
- Provide a forum for points of clarification to be discussed with the Localities / Networks with regard to the agreed level of compliance
- Provide initial feedback on the extent to which the service is currently meeting the quality measures
- Discuss the draft programme for the visit day
- Agree the practical arrangements for the visit to the service (parking, lunch, access).

5.3.4. Visit

Visits will be designed around a sessional structure, with the norm being a one-day visit to each service. Regional Network compliance will be reviewed on a separate day at the Network host site.

Each visit will take place between 09:30–17:30. The Peer Review team will meet between 09:30–10:30 and 16:00-16:30 on the day of the review. Time will be allowed for discussion, unit tour and review of clinical practice. Initial feedback will be provided at the end of the visit, including any areas of immediate risk or serious concern.

The following individuals would usually be interviewed by the review team, although others may be suggested by the unit where relevant:

- Medical / Clinical Director
- Service Director /general manager for paediatrics / diabetes
- Lead Consultant and Lead PDSN
- Multi-disciplinary team members (grouped however they prefer)
- Administration / Clerical staff / Data entry clerks
• Clinicians who work with the team – Emergency Department staff, ward manager, school nursing representative, trainees
• Representatives from CCG and / or Primary care
• Patient group representative(s) – if a patient group exists.
• Patient engagement lead (if relevant)
• Chief Executive (optional – may be handy at the end for feedback)

5.3.5. Preparation of Visit Reports

There will be one report per Trust or Health Board, with sub-reports where there is more than one MDT. Where one MDT covers two or more NPDA reporting units there will be a single report highlighting areas of difference.

The structure of the reports is based on feedback from other Peer Review Programmes, and will comprise:

• Quantitative data – reflecting the SA and NPDA compliance ‘score’ broken down to sites, where relevant
• Qualitative narrative, including:
  o Structure and function
  o Co-ordination of care / patient pathways
  o Patient experience
  o Clinical outcomes / indicators
  o Governance arrangements
  o Areas of good practice
  o Areas for improvement

• Recommendations – with timescales – for Regional Network, Trust / Health Board and MDT action plans
• Immediate Risks / Serious Concerns will be highlighted immediately to the Chief Executive, Medical Director and Clinical Lead of the Trust or Health Board and followed up in a formal letter within a week of the visit (for further details see chapter 6).
All reports will be quality-assured by clinical reviewers to ensure a consistent approach and objective decision making. There will be an opportunity and process for review / challenge by the Trust / Health Board and MDT of the factual accuracy of the draft report.

It is expected that organisations will share the full report, once finalised, amongst as many of those who contributed as possible. It is also recommended that the Commissioners of the CYP Diabetes service receive a copy of the final report. The RCPCH will endeavour to structure and phrase the report to reflect a wide readership.

Periodically, anonymised summaries of learning from reviews and notable practice will be published on the RCPCH website.

**Chapter 5 – Key points**

- Peer Review (PR) aims to support units to make best use of information and their team skills towards improving outcomes.
- It aims to identify issues influencing delivery of a quality and safe service in relation to patient care and the patient experience.
- The findings will not be ‘scored’ nor be viewed as punitive or ‘competitive’ but will enable improvement in compliance in the next Self-Assessment round.
- Each PDU and Network will receive one visit in the three years from a multidisciplinary team of trained reviewers.
- PDU’s will receive 12 weeks’ notice of a visit and be asked to submit their evidence electronically within four weeks.
- Visits will last one day and be semi-structured. Initial feedback will be provided at the end of the day. The RCPCH will usually send draft reports within eight weeks following an internal quality assurance process.
6. Identification of Concerns

It is expected that areas of practice that do not fully meet National standards will be identified during the Peer Review process: the underlying principle of supporting MDTs to improve outcomes and care for patients is central to the work undertaken. However, on occasion concerns may be of greater significance and therefore require escalation and action.

Below are examples of the type of issues that might cause such concern and the recommended approach for dealing with them. This list is not exhaustive and if Peer Reviewers are in doubt about whether to escalate a concern, it should be discussed within the Peer Review team or with the NCYPD Quality Programme Manager. In 2013/14, the Peer Review of 155 MDTs in England and Wales revealed 12 Immediate Risks (IR) and 90 Serious Concerns (SC).

**Categories of concern**

Within the Peer Review Process there are three categories of concern:

- Concern
- Serious Concern
- Immediate Risk

All require remedial action to be taken, however timescales and management will vary.

6.1. Concern

A Concern is an issue that affects the delivery or quality of the service which does not require immediate action and which can be addressed through the MDT/Board/Trust’s work programmes. It would usually be listed as a recommendation in the report.
6.2. Serious Concern

A “Serious Concern” is an issue that, whilst not presenting an immediate risk to patient or staff safety, could seriously compromise the quality or outcome of patient care and requires urgent action to resolve. If identified through the Self-Assessment or Internal Validation, it is expected that this would be addressed through the organisation’s risk management process and details of actions shared with the NCYPD Quality Programme staff team.

If identified during External Verification or the Peer Review visit, the NCYPD Quality Programme Peer Review Manager and/or Lead Reviewer will notify the service immediately. This will be followed up within a week of the visit by a formal letter from the NCYPD Quality Programme Manager to the Trust Chief Executive, Medical Director and MDT Clinical Lead, outlining the serious concern and inviting a written response from the Trust / Board within four weeks. It is recognised that in some instances resolution will require longer-term actions: in these circumstances it is requested an action plan with specific timescales is included with the response.

Examples of Serious Concern Issues:

<table>
<thead>
<tr>
<th>Issues</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant shortfall in staffing levels.</td>
<td>There are gaps in provision of core team functions meaning patients do not have access to – for example – psychology support or dietetics input.</td>
</tr>
<tr>
<td>Signs that patient rights are being breached.</td>
<td>Parents have fed back that the service does not include them in their child’s treatment decisions.</td>
</tr>
<tr>
<td>Signs that staff rights are being breached.</td>
<td>Staff have fed back that some team members are experiencing bullying behaviour.</td>
</tr>
<tr>
<td>There is not one stand-out issue, but there are concerns about the overall safety of the service due to an unusually large number of standards not being met.</td>
<td>The service is meeting significantly fewer standards compared to other members.</td>
</tr>
<tr>
<td>Signs that a group of unmet standards are leading to potentially unsafe practice.</td>
<td>Staffing issues within a team may indicate that certain staff members are covering the shortfall within the team by doing jobs above and beyond their banding.</td>
</tr>
</tbody>
</table>
Actions required for serious concerns

The RCPCH Review Manager attending the peer review visit will – following discussion with the Lead Reviewer and Peer Review team – raise the issue promptly with the local clinical team lead, asking for an explanation and (if needed) the action they propose to take. Care will be needed in deciding whom to contact if the local clinical team lead is implicated in the concern. Advice from the NCYP Diabetes Quality Programme Manager can be sought if needed.

The response from the local clinical team lead will then be recorded and considered. If the response received is sufficient, the matter can be logged and closed.

If concerns remain, these will be highlighted in the Peer Review report and reported in line with the NCYP Diabetes Quality Programme’s process for managing concerns.

6.3. Immediate Risk

An immediate risk suggests that patients or staff might face imminent danger or that there might be breaches of human rights such that the potential impact is serious, to the extent that it would likely result in an investigation. In this instance, it is likely that the Peer Review visit should be adjourned. Multiple “Serious Concerns” type issues in a single service might raise the problem to Immediate Risk. Where an Immediate Risk is identified as a result of serious issues with clinical practice or system failure that presents a risk of harm to patients, the RCPCH will adhere to the guidance RCPCH Identification and Management of Cause for Concern in Clinical Audits and Clinical Outcome Review Programmes in England and Wales.

Examples of Immediate Risk Issues:

<table>
<thead>
<tr>
<th>Issues</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant safeguarding concerns</td>
<td>Concerns about the safety of patients and quality of safeguarding awareness / action</td>
</tr>
<tr>
<td>Serious concerns about a member of staff’s fitness to practise</td>
<td>A member of the peer-review team believes that a member of staff is not fit to practice.</td>
</tr>
</tbody>
</table>
Concerns about the safety of an individual | A staff member has alluded to being at risk of suicide due to stress.
---|---
Patient safety is at risk | Staff shortages within the service mean that patients are not being provided with the level of treatment that is an immediate risk to their health.

**Actions Required on Immediate Risks**

All Reviewers must notify the Peer Review Manager if they believe the threshold for immediate risk has been reached. This will be discussed within the Peer Review Team and the NCYP Diabetes Quality Programme Manager will be contacted. They or in their absence the Assistant Director of Research and Policy at RCPCH will decide what action to take and to whom communication should be addressed. This may be any combination of the following: the local clinical team lead; the Clinical, Nursing, Operations or Medical Director; Senior Executive; Social Services or the Police. This will also be escalated to the NCYP Diabetes Quality Programme Board and follow the process outlined in the RCPCH guidance *RCPCH Identification and Management of Cause for Concern in Clinical Audits and Clinical Outcome Review Programmes in England and Wales*.

If a patient is deemed to be at immediate risk (e.g. for example where there are child protection consequences), contact should be made with a senior member of the host service as soon as possible and within one working day. If it is possible to identify the patient, the local service will be asked to follow this up promptly, following their local risk protocols.

**6.4. Use of Risk-Assessment Matrix**

Often, it will be clear which category of concern is appropriate, however individual circumstances may vary and the issues need to be taken into account when assessing the risk. It is important to identify the actual risk, with further questions asked to ascertain the impact, likelihood of occurrence and if any action has been taken to remedy or ameliorate the risk.
Having determined the exact nature of the risk it is recommended that a risk-scoring matrix be used to identify the appropriate category as shown below.

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</tr>
</thead>
<tbody>
<tr>
<td>1. Rare</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Unlikely</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>3. Possible</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>4. Likely</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>5. Almost certain</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
</tbody>
</table>

For the purpose of Peer Review these guidelines have focused on Safety and Quality of patient care.

### Chapter 6 – Key Points

- At any stage of the NCYPDQP process, concerns may be identified about a service. This includes Immediate Risks, Serious Concerns and Concerns.
- The CEO, MD and Clinical Lead should be advised.
- Follow-up on actions must be reported and monitored both by the Trust / Health Board and RCPCH through the NCYPDQP Programme Board.
7. Feedback and Request for review

7.1. Post-visit feedback

After each review visit the Trust / Health Board / Network is offered an opportunity to provide feedback via an online survey link which enables those involved to comment on their experiences of the visit. Aggregated feedback is shared with the Programme Board to support process improvement if required.

7.2. Factual Accuracy of Draft Reports

The Trust / Health Board / Network is given the opportunity to comment on the factual accuracy of the Draft report from a Peer Review visit before the Final Report is delivered. The Draft report is sent to the clinical lead who will be invited to share it with a small number of colleagues in order to correct inaccuracies and suggest any minor amendments to improve potential for implementation of the recommendations.

Comments relating to the Draft report will need to be submitted via e-mail to the NCYPDQP staff team within two weeks of receipt (diabetesquality@rcpch.ac.uk). These written comments will be considered by the visiting Peer Review team and the report may (or may not) be amended. If required, the staff team may seek advice on clinical aspects from the NCYP Diabetes Quality Programme Clinical Advisory Group. Further discussion will take place and a written response will be provided by email within two weeks of the email submission (unless actions agreed during discussions necessitate an alternative deadline is set). Depending on the nature of the comments, it is expected that the Final report will usually be delivered to the service and Medical Director within two weeks of receiving the comments.
7.3. Process for concerns in relation to the Final Report

If, following receipt of the Final Report, the Trust / Health Board / Network has concerns about the content of the report, they may seek a decision by the NCYPDQP Programme Board. The Medical Director should email diabetes.quality@rcpch.ac.uk for a copy of the procedure and application form.

Chapter 7 – Key points

- Units and Networks will always be given the chance to comment on the factual accuracy of the report from a Peer Review (PR) visit, before publication.
- These comments would be considered by the visiting PR team and the report may (or may not) be amended.
- If the Unit or Network has continued concerns about the content of the report, they are invited to discuss this with the RCPCH staff team towards resolution.
- If a dispute cannot be resolved in this way, the organisation may submit a formal request for review via the process outlined.
8. Guidance and Support for Peer Reviewers

8.1. Supporting and Developing Our Peer Reviewers

8.1.1. Application, Induction and Training

Applicants should complete an application form and seek the agreement of their organisation / line manager to participate. Applications will be assessed against the criteria set out in the role profile. The aim is to involve as many MDT members as possible, aiming at training at least one from each participating MDT.

Successful applicants are required to attend a one-day training course. These will be held at various locations throughout the year and provide an opportunity to introduce applicants to the Peer Review Programme, each other and the faculty as well as enhancing skills and knowledge relevant to the role. Learning takes place through advanced reading and self-study, presentations, discussions, case study, observed role-play and facilitated group activities. Whilst it is anticipated that the large majority of those attending training will become Peer Reviewers this is not guaranteed and is dependent on attendees demonstrating the competencies outlined in the role profile.

Upon appointment, Peer Reviewers will receive on-going support in their responsibilities by the other members of their Peer Review team, the NCYPDQP Clinical Lead and the RCPCH staff team.

8.1.2. Payment and Expenses

Peer reviewers will receive reimbursement of reasonable expenses incurred for travel (including mileage) and subsistence, in line with the College’s expense claims policy. These are paid on receipt of a completed claim form and original receipts and should be claimed within one month of the expenditure.
Attendance at induction and the first Peer Review visit qualifies for CPD points under the RCPCH scheme, and other professionals can use the sessions for their own CPD arrangements. Certificates of participation are available on request. Additional benefits of being a Peer Reviewer include the opportunity to work with and learn from colleagues across England and Wales and to develop Quality Improvement (QI) skills.

8.2. The Review Process

8.2.1. Setting up the Peer Review Visits

All Peer Reviewers will be registered on our database, which shows whether they have completed the RCPCH Peer Reviewer training, together with any specialist knowledge or experience they bring. This will be updated with all review visits and any QA completed. Appropriate arrangements will in place to protect personal data.

The schedule for the Peer Review visits will be arranged by the RCPCH staff team with agreement from the host sites.

Guidance is provided for host sites on preparing for the visit, including setting up the timetable and gathering required evidence. A flyer will be prepared for host staff about the Peer Review process and Peer Reviewers will be asked to prepare a short biography and include a picture.

The RCPCH staff team usually arranges travel, although Peer Reviewers can arrange this themselves within the RCPCH guidelines and claim expenses back in line with the College’s expenses policy.

8.2.2. Contracts and Indemnity

Peer reviewers will be required to sign a Peer Reviewer Agreement which sets out the agreed terms and conditions and which protects them from liability should action be taken against them or RCPCH as a result of, or during, the Peer Review.
While undertaking a review, Peer Reviewers are acting on behalf of the NCYPD Quality Programme and are not expected to pursue any individual or organisational interests.

8.2.3. Preparing for the Review Visit

The main point of contact for the Peer Review visit will be the RCPCH staff team. It is their role to:

- Liaise with the unit under review
- Analyse the data provided ahead of the visit
- Prepare the briefings for the reviewers
- Work with the Lead Reviewer and PDU representative to plan the visit day
- Identify the key issues to explore on site
- Support the Lead Reviewer and members during the visit
- Draft with the Review Team the feedback letter, main report and recommendations

Approximately four weeks before their visit, the Peer Review team will be able to access the following information about the host service via SharePoint:

- Compliance against the measures
- Supporting evidence
- Logistical information, including:
  - Membership of the visiting team
  - Timetable
  - Directions
  - Travel expenses form

A teleconference with all members of the Peer Review team will usually be organised by an RCPCH staff member about two weeks before the visit. This will allow the team to confirm areas to probe, lines of questioning, responsibilities within the team and timelines for report production.

8.2.4. On the Review Visit Day
The visit will take place on a single day, clearly structured with advance notice of the key issues to be explored. During the visit, the host service should provide access to a copy of their Self-Assessment evidence documentation – this may include online access to Clinical Guidelines via a Trust intranet.

Peer Review team members will use a structured template for recording activity and discussion through the day and the RCPCH staff member will provide support to ensure that everyone is comfortable with the process. The interviews will be set up by the PDU staff based on guidance from the RCPCH staff team.

During the visit, all Peer Reviewers will lead or support on key areas of the review as required. It is important that all reviewers are engaged with all aspects of the review, not just their specialist area.

8.2.5. Following the Review Visit

After the visit Peer Reviewers will be expected to contribute to sections of the report pertinent to their area of expertise or lines of questioning. The RCPCH staff team will co-ordinate this with the Lead Reviewer. The draft report should be completed within 6 weeks of the visit. This will then undergo an internal Quality Assurance process before being submitted to the PDU Clinical Lead for factual accuracy comment as outlined in section 7. On receipt of the PDU Clinical Lead comments, the final report will usually be forwarded within two weeks.

8.3. Information Management

8.3.1. Data Protection and Information Management

Information related to a Peer Review is by default confidential between those involved at RCPCH (including the Peer Reviewers) and the host organisation. Whilst the reports may be published by the Trusts / Health Boards in due course, the information available to reviewers ahead of or following a review visit remains confidential until it is published. Reviewers should be mindful to avoid casual communication about things they have
learned about the host site and ensure that they do not enter into dialogue or correspondence about a review (even with the host team) without the express knowledge and involvement of the RCPCH staff member. This is to ensure that all information relating to a review is shared through a formal documented process and any findings can be evidenced.

Reviewers will be required to comply with the workings of Information Governance [1] including UK Data Protection legislation (currently GDPR and the Data Protection Act 2018) and responsibilities over protection of confidential information [2]. NHS Peer Reviewers are required to undertake the mandatory modules of the NHS Information Governance Training Tool.[3] Whilst for Peer Review most of the information handled will be of a general or service nature, it is possible that the client or interviewees will disclose confidential information and personal data to you during the course of a Peer Review. The term “confidential” broadly means that the information is not in the public domain nor readily accessible to the public, and can include information about patients, families, staff, working relationships, safety and data or business-related information. Personal data (as defined in GDPR) is any data relating to a living individual, where they can be identified or are identifiable either directly or indirectly from that information in combination with other information.

Reviewers should inform participants of the privacy notice (https://www.rcpch.ac.uk/resources/national-children-young-peoples-diabetes-quality-programme) which explains how their personal data will be used and their rights in relation to it. Only the minimum amount of information should be collected as necessary for the review and the reviewer should avoid collecting personal data unless necessary to support the review.

There is a fine balance between encouraging staff to talk and share openly in order to determine the full facts required for a thorough review and ensuring that any information included in the final report is legitimate for disclosure. Peer Reviewers must be clear in

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[1] See a guide to information governance Connecting for Health 2010  
their interviews and notes when information recorded is either confidential or anecdotal and triangulate or check details before overt inclusion in the report.

All documentary material relating to a Peer Review must be handled by the RCPCH staff team who will securely store evidence and, where necessary, redact or anonymise material before further transmission. NHS and independent sector client bodies themselves are subject to Data Protection legislation and material should be transmitted in an appropriately secure format. For the NCYPDQP we use a secure cloud arrangement called SharePoint. Information received from the client in advance of the review visit will be uploaded there and Peer Reviewers will be emailed a personal link to access this, and may need to register if they have not used it before. Peer Reviewers must not download files to devices (personal or work PC, laptop, tablet, mobile phones or other devices)

Responsibility for data security lies with the Caldicott Guardian[6] within each organisation who should oversee the content and approach to sharing information. It is expected that they would be aware of any Peer Review being undertaken by their Trust.

At the end of each review cycle, once the final report is sent to the Trust, the RCPCH team will seek confirmation that all material relating to the Peer Review has been either shredded, forwarded to the RCPCH for secure storage or deleted permanently from the local storage media of Peer Reviewers.

Peer Reviewers should endeavour to protect information from unauthorised access or disclosure, e.g. by not leaving files, printers or computer terminals unattended, double checking to avoid transmitting information to the wrong person, and not allowing confidential conversations to be overheard. The use of SharePoint on a phone or tablet risks theft and any passwords must be secure and not ‘remembered’ by the device, with equipment locked when not in use.

In the event of a security breach, Peer Reviewers must inform the RCPCH staff team immediately as the RCPCH has an obligation to report any high-risk breaches to the ICO within 72 hours (email diabetesquality@rcpch.ac.uk).

8.3.2. Storage of documents

All interview notes should be returned to the RCPCH Staff team for storage once the report has been finalised and sent to the client. Printed documents must be either returned or securely disposed of and all reviewers will be asked to confirm that this has been done.

8.4. The RCPCH approach to Peer Review Interviews

8.4.1. Preparing for Each Interview

Question order and topics should usually be agreed between the Peer Reviewers before each interview. This ensures all necessary topics are addressed and should allow each Peer Reviewer to follow their line of questioning uninterrupted.

8.4.2. Interview Structure

The Lead Reviewer makes the introductions, thanks the interviewees for attending, apologises for any delays and checks receipt of the ‘flyer’ beforehand. Understanding of the Peer Review Programme and process is usually checked and reiterated for clarity.

It should be emphasised that confidentiality is important but a report will be produced based on all the information provided to the Peer Reviewers. It is often not possible to totally disguise the source of information, particularly where there may be recognisable features of a scenario and wherever possible all information will be triangulated with other interviewees or data. Notes will be taken but verbatim accounts of interviews will not be made available to any parties.
8.4.3. Record of Interviews

Peer Reviewers must record notes in the booklet provided by RCPCH staff and hand all paperwork back to the Peer Review Manager at the end of the review day.

It is important to put the interviewee at ease that at least one reviewer (usually the one asking questions) is engaging in eye contact at all times rather than the whole team writing!

The RCPCH staff member will always take detailed notes but if they are not present please ensure that someone else is responsible for formal note taking.

8.4.4. Gathering Information

The approach of the Peer Reviewers at interview is crucial to put interviewees at ease, so they talk freely, feel comfortable doing so and leave feeling ‘listened to’.

Peer Reviews are not ‘inspections’ – staff should never feel ‘judged’ or intimidated. Questions, where needed, should be focused on clarification rather than offering a view. Peer Reviewers are there to get the best from the interviewees, find out how things work in their department and organisation and what their honest views are on their situation.

Peer Reviewers should ask open questions for each area of discussion to be explored during the interview, with closed questions to confirm understanding. Peer Reviewers should ensure clarity and separate opinion from fact, e.g. by asking for examples. Secondary questions may be necessary to gain specific information.

The Lead Reviewer will manage the interview unless agreed otherwise, and will invite colleagues to put their questions/lines of enquiry as appropriate. Peer Reviewers should be mindful of the duration of the interview and ensure everyone has an opportunity to speak.
At the end of the interview, Peer Reviewers should summarise the conversation to ensure agreement on the interpretation of the individual's statements, and explain the next steps in the process.

### 8.4.5. Do’s and Don’ts for Peer Reviewers

- **Do** actively listen and make appropriate eye contact when leading the questioning.
- **Do** consider the level/job role of the interviewee.
- **Do** remain focused; listen carefully to colleagues’ questions and the responses.
- **Do** consider balance of depth and breadth in the level of detail.
- **Do** keep an eye on everyone’s body language
- **Do** adhere to the timetable for the day (as much as possible)
- **Only** accept direct observations of fact and disregard hearsay and opinion

- **Don’t** make rapid judgments
- **Don’t** relate your own experiences
- **Don’t** cut in over a colleague’s line of questioning
- **Don’t** appear to disagree with a colleague during an interview

### 8.4.6. Example questions could include…

- In what capacity and for how long have you worked for this service?
- How would you describe the department’s standard of practice, with examples?
- How effectively are Network / national guidelines used in the management of patients?
- How do the doctors communicate with patients, each other and colleagues?
- How does the department work as a team, using formal and informal mechanisms?
- What are the department’s strengths, with examples of good care/practice?
- What, in your view, are the department’s weaknesses, again supported by examples?
- Are there any organisational issues affecting the way in which the Department performs?
- What changes (if any) do you think might resolve the issue(s) under consideration?
• What are your department most proud of?
• Do you wish to make any other relevant comments?

8.4.7. After each interview or group of interviews

The Peer Review team should come together to consider:
• Have the relevant elements of the measures been adequately covered?
• Has any new information come to light that needs to be checked?
• Are there any additional new documents/interviewees to see?
• Did the interviewees appear to be relaxed and comfortable sharing information?
• Were there any behaviours or questions that were perhaps inappropriate?
• Are all Peer Reviewers comfortable with the interview approach?
• Are there any early recommendations emerging?

8.4.8. Verbal Feedback to the Team

The staff undergoing Peer Review will probably be anxious to get the Peer Review team’s opinion and seek their views before they depart. Feedback will usually be provided at the end of the visit and will usually include an overview of preliminary findings and any major concerns but must be kept in general terms and should not be specific. It would usually involve the lead representative from the team visited (e.g. Clinical Lead, Medical Director, etc.) and any colleagues they wish to accompany them.

8.4.9. Objectivity, Equality and Fairness

It is recognised that Peer Reviews may cover issues that are sensitive to one or more of the clinicians and/or managers involved. Whilst Peer Review is not designed to focus on an individual’s practice, behavior or clinical competence, the Peer Review team may be perceived as doing so by those involved. The Lead Reviewer needs to be sensitive to interpersonal issues that may arise during the preparation and conduct of the Peer Review and ensure at all times that openness and objectivity is encouraged.

For example, there may be requests for individuals to speak to the Peer Reviewers privately before the visit, or attempts to influence others in the College (for example, Officers or Regional Reps) to gain more information about the Peer Review process.
Such requests must be referred to the RCPCH staff team in order to focus resources and information gathering on the visit day and ensure the Peer Review is objective and seen to be as such. The host PDU is provided at an early stage with a ‘flyer’ that sets out the purpose of the Peer Review visit and provides details of the Peer Reviewers in order to mitigate anxiety and miscommunication.

There is nothing to stop individuals communicating with the RCPCH staff team (in confidence) by email but where this happens the information should be acknowledged and perhaps trigger lines of enquiry for the reviewers to pursue. They should not be used as formal evidence without authorisation from interviewees on the day.

8.5. The RCPCH Approach to Report Writing

The report is the prime deliverable of a review and needs to be:

- Comprehensive – including all pertinent points
- Agreed – the product of the whole Peer Review team
- Understandable – flow clearly through the issues, findings, and proposals
- Targeted – focused only on the aspects under Peer Review
- Informed – reference standards, evidence, similar models of working
- Objective – provide a “College” view taking perspectives into account
- Upbeat – proposing positive recommendations and solutions
- Sensitive – be written with awareness of who may see it following release

The report is written primarily for the host – usually the Clinical lead and Medical Director, but we recommend dissemination within the diabetes team’s organisation, particularly to those who contributed to the Peer Review. It should, therefore, stand-alone and be complete for a wider audience (for example, the Trust Board). The content needs to be meaningful and pertinent to them and, as far as possible, immune from misinterpretation.

A standard report template is used as a framework with the main findings and evaluation section following a standard format.
Chapter 8 – Key points

• Reviewers will be recruited, inducted and supported throughout their time with the programme.
• There is a clear timeline for activities relating to a review that should be noted by Reviewers.
• Peer Reviewers have a responsibility to maintain confidentiality and comply with data protection legislation and information governance rules.
• Interviews should be carefully conducted to glean the maximum information from the interviewee, putting them at ease and asking open questions.
• Reviews should be conducted in an open and objective manner.