Peer review guidance

September 2016
1. INTRODUCTION TO PEER REVIEW

It is vitally important for doctors to regulate themselves and this represents a major component of clinical governance. Peer review is a clinical governance tool whose primary aim is ensure that departments meet minimum standards and to facilitate improvement in quality of clinical services. Several medical specialties have developed Peer Review programmes, notably the British Thoracic Society with the support of the Royal College of Physicians (RCP). More recently NHS England through the National Peer Review Programme has supported specialist areas such as cancer, paediatric diabetes and trauma service. A typical peer review programme comprises of an ordered series of individual specialist unit visits by teams of health professionals randomly selected from other units in the programme.

A detailed proforma highlighting the nature, extent and standards of clinical practice is prepared by the unit to be visited and sent to the visiting team prior to a Peer Review visit. This gives the visiting team a good depth of knowledge of the unit they are to review and facilitates planning of a visit, for example, to focus on any particular areas of interest or concern to either the visitors or host unit. The visiting team then complete a detailed report of the visit which is circulated to the clinicians and managers of the visited unit.

The BSR initially introduced a peer review scheme in 1996 with a model and proforma produced nationally. The voluntary programmes were organised on a regional basis with cycles of one day unit visits every 5 years. Uptake of the scheme was variable, but by 2006 six regions had completed at least one full cycle of peer review of their units. The West Midlands published an analysis of their experience (Piper et al, Rheumatology, 2006; 45:1110-1115), highlighting the educational value of their programme as well as indicating that the individual reports were perceived to be valuable in facilitating changes in practice. For those in active peer review schemes the process is seen as mutually beneficial and an educational experience for both reviewers and those reviewed. It is seen very much as a formative opportunity and not as a threat.
Following renewed interest from the RCP and other health agencies in assessing clinical competence, the BSR Clinical Affairs Committee revised the peer review documentation and provided support for regional chairs to implement programmes in regions in which peer review activity had dwindled or never been set up.

The scheme was developed to incorporate advances in the specialty, namely the multidisciplinary approach to rheumatology care, use of biologic agents, evolving patterns of working (day case versus in-patient work), evolving diagnostic tools and nationally-produced guidelines against which quality of care could be assessed. To reflect the importance of nursing and allied health professionals in rheumatology, peer review was developed and has progressed as a joint venture with the BHPR.

The BSR/BHPR would like to promote peer review to all regions. BSR/BHPR provides the documentation and tools on the BSR website to facilitate the process, and believes that the process should continue to operate on a voluntary and regional basis. Regions may also wish to vary the process depending on individual needs or involve neighbouring region(s) if appropriate. In London, for example, where a trust is composed of several rheumatology “units” the process may need to involve a larger team, visiting sites over a number of days.

For advice regarding the peer review scheme please contact the chair or member of the Peer Review Working Group. Feedback regarding the proforma, the process of peer review, or suggestions to the BSR Peer Review Working Group would be welcomed.

2. REGIONAL PROGRAMMES

The BSR council has now an elected representative for each region. Ideally this should facilitate the development of regional activities such as audit and peer review by building on shared experience but with regional knowledge. Historically most regional peer review programmes have operated on an approximately 5 year basis, coinciding with the frequency planned for revalidation. Regional programmes may vary according to local requirements and interests, some regions have expressed interest in some liaison with neighbouring regions to facilitate development and provide some “external” input.

Regional organisation of peer review requires a lead or small committee to oversee the planning of visits. Typically the lead will randomise both the order in which units are visited and the leads of the visiting teams to ensure that reviewers experience and home unit complement that of the one they are reviewing (a list of regional leads is available on the BSR website). Occasionally peer review visits may be brought forward if a unit feels it would be helpful for local reasons in negotiation with the regional committee.

The regionally organised model of peer review operated in rheumatology with one day visits has required no external funding.

3. PLANNING THE VISIT

The regional lead will inform units and visiting leads well in advance to start work on preparing the visit and the composition of the visiting team respectively. Peer review visits in rheumatology have historically only taken one day and therefore careful planning is essential prior to the visit by the lead of the visited unit and the lead reviewer. This may cover issues of concern to either party including any potential conflicts of interest particularly of closely neighbouring trusts, precise composition of teams and any areas identified in the proforma when completed by the host team
4. ESTABLISHING THE VISITING AND HOST TEAMS

The structure of the visiting team may depend on regional policy or result of discussion between the lead visitor and lead for the visited unit. Typically however the visiting team should include 2 consultants (from different units) and at least 2 nursing/allied health professionals such as specialist nurses, physiotherapists and occupational therapists. Similarly there may be variation in the membership of the visited unit’s representatives, but generally all consultants and leads for nursing, physiotherapy and occupational therapy will be involved.

Involvement of managers in both teams has proven to be very educational and helpful for both reviewing team and the unit being reviewed. Managers, having a different perspective, will contribute to the discussions and the ability of the visited team to take forward any agreed suggested developments resulting from the peer review. Similarly planning a meeting with the Chief Executive and Medical Director during the visit, usually later in the day when initial outcomes have become apparent, may be very constructive in facilitating change.

If possible the BSR would also encourage involvement of lay or patient members (such as members of a local “ARMA Network”) in the peer review process allowing further patient-orientated focus into the service provided.

Involvement of trainees such as Specialist trainees/registrar (STs/SpRs) may also provide useful insights into training issues. Furthermore as they rotate through regional units they bring with them experience from other regional centres.

5. COMPLETING THE PEER REVIEW PROFORMA

The purpose of the proforma is to enable the reviewers to have a detailed profile of a unit before the review. This depth of detail will assist the reviewers by forming a good understanding of how the unit functions, its strengths and areas that warrant development. Having the data available ahead of the visit leaves more time for inspection of facilities and for discussion and sharing of ideas about the delivery of services. It should be completed involving all key members of the rheumatology multidisciplinary team; it is not anticipated that this will be completed just by one individual. The proforma will help direct the focus of the review and it will facilitate the preparation of the report. Some of the questions relate to facilities and staffing levels and perception of their adequacy. Other questions assess working practices and quality of care. Some of the questions aim to identify areas of excellence. The visited team should highlight in the form any innovations in practice that have been developed or introduced locally.

6. PREPARING THE PEER REVIEW REPORT

An initial discussion between the reviewing team and the host unit at the end of the visit may be very useful in agreeing the main issues that have arisen during the process and to formulate the major points to be made in the report. This may also be a useful time to involve the host Chief Executive and Medical Director in the discussions.

The report should include the principal findings of the visit. This could usefully include a brief introduction, brief profile of the unit, detailed comments relating to each of the subsections of the proforma, broad conclusions and a summary. It is important to highlight areas of excellence and examples of good practice and to include key recommendations for change. In addition, it should be indicated that the report is advisory, and that neither the reviewers nor the BSR/BHPR accept any liability for any problems or
deficiencies that were not apparent to them during the review or for any problems that might arise as a result of implementation of any of the recommendations for change made. (See disclaimer at end of Proforma.)

A schematic overview of the Peer Review process and the “Proforma journey” are provided in Section 8. Following the visit, the completed together with the reviewers’ report will be sent to principal members of the multidisciplinary team, the Medical Director (MD) and Trust Chief Executive (CEO) of the reviewed unit. Copies will also be sent to the Chair of the regional rheumatology committee or other locally agreed body. The aim should be to complete the report within three months.

7. ACTIONING THE PEER REVIEW REPORT

Ownership of the peer review report lies with the visited unit and responsibility for taking forward any recommendations or addressing any concerns regarding practice ultimately lies with the CEO and MD of the visited unit. With this in mind it would be recommended that clinical leads make their CEO and MD aware of a potential visit to ensure their approval and support ahead of the visit.

Units that have used the report to successfully facilitate change have however generally sought to include managers in the visit and arrange for a session to include the CEO and MD during the visit. Using the report to then produce an action plan with management has been a strategy usefully adopted by some units. Assessment of implementation will form a part of any subsequent peer review. From the CEO perspective this visit would complement preparation for a CQC visit and hence should be seen in a positive light.
8. BSR/ BHPR PEER REVIEW FLOW CHART
This peer review documentation has been produced by the Peer Review Working Group which reports to the Clinical Affairs Committee of the BSR. The current proforma was updated in summer 2015; it is planned to be reviewed and updated at 2-yearly intervals. Further information can be obtained from members of the Peer Review Working Group:

**Dr Karen Douglas (Chair)**
Consultant Rheumatologist  
Dudley Group NHS FT  
Russells Hall Hospital  
Pensnett Road  
Dudley DY1 2HQ  
karen.douglas@dgh.nhs.uk

**Dr Neil Snowden**
Consultant Rheumatologist and Chair of the BSR Clinical Affairs Committee  
Pennine MSK Partnership Ltd  
Integrated Care Centre  
New Radcliffe Street  
Oldham, OL1 1NL  
neil.snowden@nhs.net

**Mr Ali Rivett**
Director of BSR Clinical Affairs Committee  
British Society for Rheumatology  
Bride House  
18-20 Bride Lane  
London EC4Y 8EE  
arivett@rheumatology.org.uk

**Dr Samantha Hider**
Consultant Rheumatologist  
Haywood Hospital  
High Lane  
Burslem  
Stoke on Trent  
Staffordshire  
ST6 7AG  
samantha.hider@uhns.nhs.uk

**Jill Firth**
Rheumatology Consultant Nurse  
Pennine MSK Partnership and Secretary to the BHPR Council  
Pennine MSK Partnership Ltd  
Integrated Care Centre  
New Radcliffe Street  
Oldham, OL1 1NL  
jill.firth@nhs.net

**Dr Sabrina Raizada**
Consultant Rheumatologist  
New Cross Hospital  
Wolverhampton Road,  
Wolverhampton,  
WV10 0QP  
sabrina.raizada@nhs.net

**Dr Cathy Laversuch**
Consultant Rheumatologist  
Musgrove Park Hospital,  
Taunton,  
TA1 5DA  
cathy.laversuch@tst.nhs.uk

**Ms Pru Biddle**
Rheumatology and Hand Therapy Team Lead/ESP OT Rheumatology  
Maple Therapy Department  
St. Albans City Hospital  
Waverley Road  
St. Albans  
AL3 5PN  
pru.biddle@nhs.net

**Robert Field,**
Lead Podiatrist (Rheumatology Service)  
Bournemouth & Poole Community Health Care  
c/o RFU Office  
Christchurch Hospital  
Fairmile Road  
Christchurch. Dorset. BH23 2JX  
rfield@nhs.net

**Dr Sandeep Dahiya**
Consultant Rheumatologist  
Dudley Group NHS FT  
Russells Hall Hospital  
Pensnett Road  
Dudley DY1 2HQ  
Elizabeth.Hale@dgh.nhs.uk

**Mrs Elizabeth Hale**
Research Psychologist  
Dudley Group NHS FT  
Pensnett Road  
Dudley DY1 2HQ  
Elizabeth.Hale@dgh.nhs.uk

**Dr Sabrina Raizada**
Consultant Rheumatologist
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