

National Children and Young People Diabetes
Peer Review Programme
Handbook 2013

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1. INTRODUCTION

This is the handbook for *Children and Young People Diabetes Quality Assurance Programme 2013 (the Handbook)*, which will be used for the NHS Diabetes National Diabetes Peer Review Programme starting from October 2013.

It describes the method and procedures for carrying out the peer review programme for Children and Young People Diabetes services in England. The development of the programme has taken into account the experiences of the Yorkshire and Humber Children and Young People Diabetes pilot, the National Cancer Peer Review Programme and recommendations of an independent evaluation of the National Cancer Peer Review Programme.

The programme is in line with current health policy and supports the development of self-regulated governance with external verification.

The programme has therefore adopted an annual self-assessment process supported by external Peer Review visits. This annual process, supported by the Care Quality Commission, will allow up to date information to be available to support the commissioning of children and young people diabetes services and enable informed patient/carer choice.

It is intended that the programme will adhere to the founding principles of peer review:

- An emphasis on being clinically led;
- Consistency in the delivery of the programme;
- A developmental approach;
- A focus on systems and services within and

- across organisations in a Diabetes Network to ensure coordination of patient care;
- Peer on peer review where a visit takes place;
- Integration with other review systems;
- Carer involvement.

In addition the following principles have informed the process:

- Focus on self-assessments and internal quality assurance;
- Risk targeted visit programme;
- Effective use of resources;
- Responsiveness to NHS changes;
- Emphasis on outcomes;
- Option to make use of existing information and documentation.

1.1. Background and Context

The White Paper 2010 has outlined the case for commissioning care that is defined by quality standards and outcome measures, and the document *Achieving Equity and Excellence for Children* asks for consultation about measurable outcomes.

The NHS Outcomes Framework 2011/2012 is based on five outcome domains:

- Preventing people from dying prematurely;
- Enhancing quality of life for people with long-term conditions;
- Helping people to recover from episodes of ill health or following injury;
- Ensuring people have a positive experience of care;
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

For Children with (Type 1) Diabetes, it is suggested that the following would be important outcome measures

(which could be included in the National Diabetes Audit) linked with these 5 domains. These outcome measures along with structure and process measures have been included in the Peer Review measures where possible.

1. Preventing people from dying prematurely

A 16-20 year **reduced life expectancy** is reported in Type 1 diabetes in childhood. An improvement in life expectancy would therefore be **the most** important outcome for patients and carers. This will be impossible to measure, but will only be achieved by other measurable outcomes.

- reduction in HbA1c levels over long periods of time;
- smoking prevention and cessation;
- screening for complications according to NICE guidance;
- managing complications promptly and appropriately;
- patient and family education.

The other cause of death in children with diabetes is **diabetic ketoacidosis (DKA)**, which causes around 7 deaths per year under the age of 20 in this country. Measurable outcomes include:

- incidence of DKA at diagnosis;
- admissions with DKA in children and young people with known diabetes.

2. Enhancing quality of life for people with long-term conditions

- there is good evidence that improved glycaemic control (ie lower HbA1c levels) are linked with improved quality of life;
- prompt recognition and management of psychological problems;

- education ensuring that patients and their parents/ carers are competent to look after their own condition;
- comprehensive protocols and care pathways managed collaboratively with schools ensuring that all children obtain the care they require in school, including administration of insulin and responsible adult volunteers to carry out blood glucose testing at appropriate times.

3. **Helping people to recover from episodes of ill health or following injury**

- this is not relevant to most children with diabetes, but there could be an outcome measure about diabetes control when a child is admitted to hospital for non diabetes-related problems;
- in order to ensure their diabetes does not inhibit recovery when a child is admitted to hospital for non diabetes-related problems, it is important to ensure their diabetes is well controlled.

4. **Ensuring people have a positive experience of care**

- patient reported experience measures (being developed at present);
- children and young people with diabetes should be cared for by a team of appropriately trained healthcare workers;
- children and young people with diabetes should be reviewed in a dedicated diabetes clinic or in the community by the team at least every 3-4 months;
- HbA1c levels should be measured every 3 months and the results should be available when the patient is reviewed;
- clear pathways for transition of care should exist between

children and young people and adult care;

- there should be easy access to psychological help, or the team should include a paediatric clinical psychologist;
- there should be a written schedule of education for the children and families, according to age and duration of diabetes;
- patient/parent information should be provided including information leaflets, website information and awareness of patient support groups.

5. **Treating and caring for people in a safe environment and protecting them from avoidable harm**

- lack of insulin errors.
- ensuring an appropriately-trained multi-disciplinary team trained according to an agreed curriculum to an agreed standard;
- written guidelines should be available for the management of children with diabetic ketoacidosis, hypoglycaemia and during surgery.

1.2 **Aims and Outcomes of Children and Young People Diabetes Quality Assurance Programme**

The Children and Young People Diabetes Quality Assurance Programme aims to improve care for children with diabetes and their families by:

- ensuring services are as safe as possible;
- improving the quality and effectiveness of care;
- improving the patient and carer experience;
- undertaking independent, fair reviews of services;
- providing development and learning for all involved;
- encouraging the dissemination of good

practice.

The outcomes of the Children and Young People Diabetes Quality Assurance Programme are:

- confirmation of the quality of children and young people diabetes services;
- speedy identification of major shortcomings in the quality of children and young people diabetes services where they occur, so that rectification can take place;
- published reports that provide accessible public information about the quality of children and young people diabetes services;
- timely information for commissioning;
- validated information which is available to other stakeholders.

The Children and Young People Diabetes Quality Assurance Programme should be conducted in a spirit of dialogue and cooperation between the network, trusts, their staff and the review teams.

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 Children and Young People Diabetes Quality Assurance Programme**

The National Peer Review Programme is lead by Ruth Bridgeman, the National Programme Director, and has seven local review units (see details of the LRUs). The National Clinical Lead for Paediatric Diabetes is Fiona

Campbell.

1.4 Scope of Peer Review

It is intended that the programme will cover all children and young people diabetes services within England.

The National Children and Young People Diabetes Peer Review Programme will review compliance with measures contained within the Children and Young People Diabetes Measures document. Teams will be asked to self-assess against the measures and complete the self-assessment commentary against the four key themes; Structure and Function, Coordination of Care, Patient Experience and Clinical Outcomes.

Although the peer review programme consists of 4 key stages (see section 2 in [the Handbook](#)) the 2013/14

programme will ask services to complete the self-assessment against which a Peer Review visit will be undertaken. Organisations may wish to internally validate their service if they wish and this would be seen as good practice but is not essential for this round of the programme.

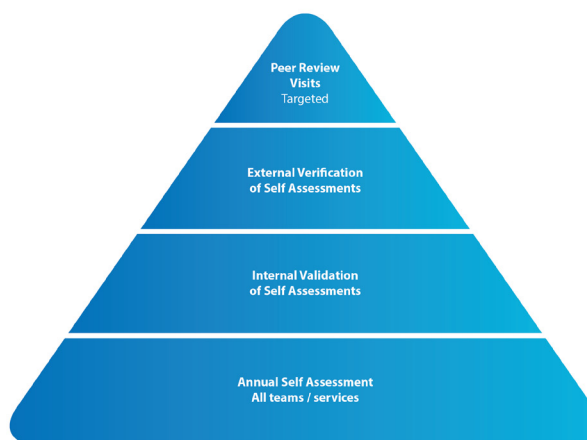
The process of peer review is concerned not only with the review of an organisation's compliance against measures, but also with the qualitative assessment of a broad set of objectives for the delivery of services. This will encompass the whole system of quality and safety in relation to patient care and patient and carer experience. Perhaps most important are the "Clinical Lines of Enquiry" which services are asked to consider when completing the self-assessment commentary in relation to clinical outcomes. While there

are no pass or fail criteria for these clinical indicators services should comment on their position in relation to these indicators.

2. THE PEER REVIEW PROGRAMME

2.1 Self-Assessment, Validation, Verification and Peer Review Process

The peer review programme consists of the 4 key stages illustrated in the diagram:



- Annual self-assessment**
Completion of an annual self-assessment by the team who deliver the particular children and young people diabetes service.
- Internal validation**
Internal validation of the self-assessment should be undertaken by the host organisation or coordinating body for that service.
- External verification**
An external check of validated self-assessments led by the coordinating team. This check will take the form of a desktop exercise. The schedule for which services are to be externally validated is only identified after self-assessment each year.
- Peer Review Visits**
A targeted schedule of peer review visits takes place each year. The schedule of peer review visits will be agreed with the diabetes network. The teams /

services selected for a peer review visit will be informed at the beginning of each peer review cycle.

Each of the above stages of the peer review process should determine whether each measure has been achieved or not and whether progress is being made towards achievement of the measures. Compliance with the measures will be appraised as yes, no or not applicable according to the evidence available. If evidence is not available then the measure will be considered as not met.

Following the outcomes from the different stages in the peer review process the diabetes network and its constituent organisations should agree the actions that need to be taken within agreed timescales, building on the strengths identified and addressing any aspects in need of improvement. Actions should be included in strategic development plans and the relevant team's work

programme. It is important to recognise that approval and follow up of agreed actions is primarily a function of management systems and not a function of the peer review process. There is, of course, the scope to involve the coordinating team in follow up where this is considered helpful.

2.2 The Children and Young People Diabetes Quality Assurance Process

The cycle for the peer review process is shown in figure 2 (see page 10). In any one year a service will either be completing a self-assessment or preparing for a peer review visit. This years programme is based upon Peer Review visits.

3. THE ANNUAL SELF-ASSESSMENT

3.1 What will be Self-Assessed?

All Children and Young People Diabetes services in England are required to complete an annual self-assessment against the national Children and Young People Diabetes measures.

Peer review is based on self-assessment. The term 'reviewer' is used in this handbook to denote any person validating or verifying assessments and their related measures. The task for reviewers is to test, by means of their own observations and analysis of the evidence provided by each children and young people diabetes service, the statements made in a self-assessment.

3.2 How to Self-Assess

Each team should complete the self-assessment for their service, which demonstrates compliance against the measures, comments on the clinical lines of enquiry and a commentary against the key themes. The key themes have been developed to assist teams to make a holistic assessment as to whether their service is meeting the measures. The themes provide a broad set of objectives for the delivery of a quality and safe service in relation to patient care /experience and clinical outcomes.

Services will need to provide evidence in support of their self-assessment. Evidence guides have been produced which will help teams to structure the evidence in a way that demonstrates compliance against the measures and enable an assessment to be made against the key themes and clinical outcomes.

It is expected that supporting evidence and assessment against the measures will be uploaded on the DQuINS national database. (See section 9).

In order to reduce bureaucracy a service should make use of documentation and information that should already be in existence or collected for the effective functioning of that service.

The evidence guides cover the information requirements for the main documents that services are required to submit as part of their self-assessment and set out the relevant key themes.

Examples are shown below of the key themes for an MDT together with the evidence that they would be required to submit in support of their self-assessment.

MDT key themes

Can you:

- demonstrate that you have a properly constituted and functioning MDT (Structure and function of the service);
- demonstrate that you have effective systems for providing coordinated care to individual patients (Coordination of care/patient pathways);
- demonstrate that your team considers patient centred care and experience (Patient experience);
- demonstrate how you are continually improving your services outcomes (Clinical outcomes/ indicators).

MDT Evidence Documents

The Operational Policy Document

The operational policy should include the following:

- a description of how the team functions and how care is delivered across the patient's pathway;
- an outline of policies / procedures that govern safe / high quality care;
- agreement to and demonstration of the clinical guidelines and treatment protocols for the team.

Annual Report

The annual report should include the following:

- a summary assessment of achievements and challenges;
- the information (including data) that the team is using to assess its own service;
- MDT workload and activity data; local audits; patient feedback; trial recruitment; work programme update.

Work Programme

The work programme should include the following:

- how the team is planning to address concerns and further develop its service, including how any risks will be minimised;
- outline of the team's plans for service improvement and development over the coming year;
- audit programme, patient feedback, trial recruitment, actions from previous reviews.

Demonstration of Agreement

Where agreement for guidelines, policies etc. is required, this should be stated clearly on the cover sheet of the relevant evidence documents, including agreement dates and versions.

Similarly evidence of guidelines, policies etc. require written evidence unless otherwise specified.

The agreement by a person representing the group or team (chair or lead etc.) implies that their agreement is not personal; they are representing the consensus opinion of that group.

3.3 When will a Team need to Self Assess?

Self-assessments will need to be completed and uploaded on DQuINS the web based database 4 weeks prior to the scheduled Peer Review Visit. The visit programme will take place between October 2013 and September 2014.

4. INTERNAL VALIDATION

(The internal validation process is optional for children and young people diabetes peer review programme in 2013/2014)

4.1 What will be subject to Internal Validation

All self-assessments will need to be internally validated at least once every three years.

4.2 Responsibility for Internal Validation

The responsibility for ensuring that the internal validation process is undertaken lies with the host trust for the children and young people diabetes service.

The Children and Young People Diabetes Peer Review Programme requires organisations to develop and coordinate their own system for internal validation, culminating in a report that is an accurate assessment of the team and is agreed at CEO level.

4.3 Purpose of Internal Validation

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 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.

4.4 Process for Internal Validation

The process adopted for internally validating self-assessments can be determined locally. Those responsible for internal validation should ensure that whatever process is adopted meets the following requirements:

- the process is agreed within the organisation and is integrated with other internal governance procedures and can demonstrate that a robust and fair process has been implemented;
- the process adopted has agreement with the commissioners within the locality and the children and young people diabetes network;
- accountability for the self-assessments is confirmed by agreement of the chief executive of the organisation;
- there is commissioner and patient / carer involvement in the process;
- the process and outcome of the validation is reported on the nationally agreed proforma. The proforma is should be completed electronically on DQuINS.

The internal validation process should include a review of the self-assessment and supporting evidence. It would be considered good practice for a meeting to take place with representatives of the specific team in question. This allows those undertaking the internal validation and submitting teams to clarify any questions that may have arisen following a review of the information. It also gives the opportunity to ensure that

all the information is available to demonstrate that the team is constituted and functioning properly.

At the conclusion of the internal validation the following action should be taken:

- check and record changes to compliance with any of the measures (this needs to be recorded on DQuINS);
- record in the comments section on DQuINS where those involved in the process of internal validation have physically seen documentation
- ensure that each section of the national proforma is completed and suitable for publication;
- provide feedback to the teams / service;
- ensure that the final self-assessment has the agreement of the chief executive;
- information uploaded onto DQuINS by end of February 2013.

4.5 Categorisation of Issues

The validation proforma asks for identification of concerns and good practice. Guidance on these issues is included in section 10 of this handbook.

4.6 When will internal validation be undertaken

Internally validated self-assessments will need to be uploaded on to DQuINS at least 4 weeks prior to the scheduled Peer Review visit.

5. EXTERNAL VERIFICATION

(This will not take place in 2013/2014 as all services will be subject to a Peer Review visit)

5.1 What is External Verification?

An external check of selected validated self-assessments led by the coordinating team. This check will take the form of a desktop exercise.

5.2 Responsibility for External Verification

External verification will be led by the coordinating team with clinical and carer engagement. The coordinating team will also have access to expert clinical advisors and user reviewers during this stage, whose role is to clarify or advise on any clinical or patient/carer issues arising from the verified assessments.

5.3 Purpose of External Verification

The purpose of external verification is to:

- verify that self-assessments are accurate and have been completed in a similar manner across organisations;

- ensure that a robust process of self-assessment and internal validation has taken place;
- confirm self assessed performance against the measures and any associated issues relating to implementation of best practice tariff;
- support identification of teams or services who will receive an external peer review visit in accordance with the selection criteria.

5.4 Process for External Verification

Following the submission of the self-assessments a process of external verification will take place for all services.

The process of external verification will include the following steps:

- Desk top review of self assessments;
The coordinating team may request further information or seek advice from specialist clinicians or carer

reviewers;

- External verification reports will then be completed using the national proforma and agreed by the quality manager and or clinical lead.
- Externally verified compliance against the measures will also be recorded on DQuINS and any changes to compliance will be explained;
- Organisations will have the opportunity to comment on the outcome of external verification at this stage. Any issues should be submitted in writing for consideration by the coordinating team and clinical expert advisors. In the event of a resolution not being reached, a peer review visit to the team / service should be considered in order to clarify the position.

6. NATIONAL SCHEDULE FOR PEER REVIEW VISITS

It has been agreed all PDTs should be visited in 2013/14. Each network will be allocated a fixed time when peer review visits will occur.

This will enable networks to pre-plan for review visits and help the coordinating team plan their annual work programme. Dialogue will occur between networks and the coordinating team to agree the exact visit dates within this allocated review period.

7. ANNUAL MEETING WITH THE CHILDREN AND YOUNG PEOPLE DIABETES NETWORK

The Quality Manager from the Local Review Unit (LRU) will meet with the Children and Young People Diabetes Network to discuss the visit programme for the year.

It is expected that the clinical lead, network coordinator and a commissioning representative will attend.

The purpose of the meeting will be to:

- inform the coordinating team of any key issues within the network

- to confirm the configuration of services within the network with the coordinating team

Following the meeting the LRU will formally notify the network of the agreed programme of visits.

7.1 Selection Criteria for Selection of Visits

Prior to the network meeting and following the external verification exercise the coordinating team will notify the network which services are identified, using the following criteria, as priorities for inclusion in the visit programme:

1. New services. (All services to be reviewed 2013/2014)
2. Immediate risks identified at previous peer review that have not yet been resolved.
3. Requests from organisations i.e. commissioners and acute trusts.
4. Percentage of compliance with children and young people diabetes measures. This information will be identified from the DQuINS database.
5. Where there are concerns regarding the robustness of the internal governance process or failure to

complete a self-assessment.

6. Concern regarding the implementation of best practice tariff.

7.2 Proposed Agenda for the Annual Meeting

- Developments from the previous year
- Self Assessment / Internal Validation – to include any issues with regard to the process or programme.
- Network/ other organisations requests for visit
- Proposed Visit Schedule – to be agreed

8. PEER REVIEW VISIT

8.1 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 service being reviewed. The peer review visit 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 internal quality assurance processes.

8.2 Who is responsible for peer review

The coordinating team invites nominations for reviewers from the network. The network has a responsibility to nominate an appropriate number of reviewers against the person specification (see appendix 1).

These nominees are trained and reviewers' names are listed on the reviewer database. The coordinating team selects an appropriate review team from this list. Visiting teams will be made up of a multi-disciplinary group of clinicians, managers and service representatives, and patients/carers, with appropriate skills and training. As far as possible 'peers' will be people who are trained and working in the same discipline as the people they are reviewing. The views of all team members from all backgrounds will be respected.

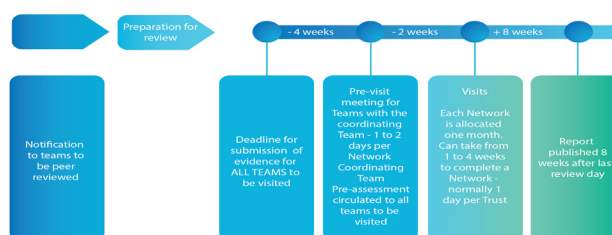
Reviewers have a collective responsibility for gathering, verifying and sharing information that enables them to reach robust conclusions about compliance with the

national measures and about the quality of children and young people diabetes services. While undertaking a review, reviewers are acting on behalf of the Peer Review Programme and are not expected to pursue any individual or organisational interests.

8.3 The Peer Review Visit Process

8.3.1 Notification of visits

Services, if selected for a visit, will be notified of the dates for that visit. The list of services to be visited will be available on the DQuINS web-site. The following diagram illustrates the different stages of the visit process.



8.3.2 Deadline for submission of self-assessments

The deadline for submission of self-assessment and supporting evidence is **four weeks** prior to the commencement of the peer review visit. The success of the visit will be dependent on the ability of services to meet this deadline.

8.3.3 Pre visits

The pre visit meeting will take place after the uploading of self-assessment documentation on the DQuINS web-site and following a period of time to allow for some analysis of the submission information. It is likely that this will be approximately two weeks

after the self-assessment documentation is uploaded on to the DQuINS website.

The purpose of the pre visit meeting can be summarised as follows to:

- enable the coordinating teams to review the self-assessment with a representative from the trust lead team;
- engage in dialogue with network / localities on key findings from the self-assessment and review of all other supporting evidence;
- provide a forum for points of clarification to be discussed with the localities / network

with regard to the agreed level of compliance which will be included in the briefing packs for reviewers;

- provide initial feedback on the extent to which the service is currently meeting the quality measures;
- agree the logistical arrangements for the visit to the network .

Only changes to self-assessments arising from the discussion at the pre visit meeting or from the pre assessment will be permitted at this stage and these will have to be submitted not later than two weeks prior to the commencement of the visit.

The confirmed self-assessment documentation will be available to the peer review visiting team at this stage and no further changes will be accepted after this date.

8.3.4 Information Available for Reviewers

Two weeks before their visit visiting teams will be able to access via the VIMS (Visit Information Management System) web-site the following information:

Self Assessment Documentation

- Compliance against the measures
- Supporting evidence

At the visit reviewers will need access to one hard copy of the self-assessment documentation provided by the service under review. Clinical guidelines that are available via a Trust intranet are acceptable, but access must be made available to visiting review teams at the time of review.

In addition the review teams will receive:

Logistical Information

- directions, emergency contact number;
- membership of the visiting team;
- timetable;
- access to VIMS– to allow review of any evidence and relevant reports;
- travel expenses form.

8.3.5 Visit

The visit itself will be designed around a sessional structure with the norm being a one day visit to each service within the children and young people diabetes network and a one day visit to the network team.

MDT review module - 4.5 hrs

Activity	Approx. Time
Review team to review evidence in preparation for meeting	1.5 hrs
Meeting with the service	1.5 hrs
Review team to write report	1.5 hrs

It is essential that peer review visits are 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.

8.3.6 Preparation of visit reports

The draft reports will be written by the reviewers and signed off by the local review team. The network and its trusts will be given the opportunity to comment on the factual accuracy of the report before it is made publicly available on the DQuINS web-site.

Any comments relating to the draft report should be submitted in writing to the coordinating team within two weeks of receipt of the draft

The circumstances where an appeal against the contents of a report will be considered are where reviewers have concluded that a service gives cause for serious concern or the reviewers have concluded that the service’s performance in complying with the measures is assessed as being unsatisfactory. These are the only circumstances in which an appeal can be submitted against the conclusions of reviewers.

Any such appeal can only be submitted by a Chief Executive of one of the trust’s in the network, or by the lead clinician of the Network. The appeal must be submitted within four weeks of the publication of the peer review report. Any appeal received will be considered by the coordinating team and the appropriate commissioners.

They will review the methodology and process used by the review team and the conclusions formed. In doing so, it will examine whether, in the light of the points made in the statement of appeal the team’s conclusions were reached reasonably and fairly. It will consider whether the team’s conclusions were unreasonable or disproportionate in the light of the available evidence. Reasonableness may be called into question if irrelevant matters are taken into account, or relevant matters not taken into account.

They will consider whether there was evidence within the appeal statement which might lead to different conclusions being reached from those contained within the report. Any such evidence must have been submitted during the period of the review.

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

9. OUTCOMES OF THE PEER REVIEW PROCESS

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 peer review.

9.1 Following Internal Validation

Following internal validation a completed proforma agreed by the host Chief Executive will be available on the **public** section of the DQuINS web-site each year. This will provide feedback to the teams / service and will confirm the level of compliance with the measures.

9.2 Following External Verification

Following external verification a completed proforma agreed by the Coordinating Team Quality Director and or Quality Manager will be available. This will provide external feedback to the service, confirm the level of compliance with the measures and inform development of the following year's visit programme.

Please note it has been agreed

that the 2012/2013 external verification reports will not be in the public domain.

9.3 Following Peer Review Visit

Following a peer review visit an individual report for each service, prepared by the visiting review team, will be available on the **public** section of the DQuINS web-site eight weeks after the completion of the visit to the network. This will provide external feedback to the service, will confirm the level of compliance with the measures, and comment on a broader set of issues concerned with the delivery of a quality and safe service in relation to patient care and the patient experience.

Following the publication of any of the above on the DQuINS web-site the network and its constituent organisations should agree the actions that need to be taken within agreed timescales, building on the strengths identified and addressing any aspects in need of improvement. Actions should be included in strategic development plans and the relevant team's work programme. It is important to recognise that approval and follow up of agreed actions

is primarily a function of management systems and not a function of the peer review process. There is, of course, the scope to involve coordinating team in follow up where this is considered helpful.

9.4 Annual Peer Review Reports

9.4.1 Network Report

Following completion of each peer review cycle, the coordinating team will write an overarching report for the network, compiled using information from each stage of the peer review process. These reports will include an executive summary prepared by the coordinating team. The reports will appear in the public section of the DQuINS web-site.

The following will be notified that the reports are available on the DQuINS web-site:

Chief executives of NHS trusts and commissioners, network lead clinicians, primary care children and young people diabetes leads within networks.

10 IDENTIFICATION OF CONCERNS

Reviewing children and young people diabetes services either during self-assessment and validation or as part of a planned visit may identify concerns. There will be occasions when these concerns are more serious and pose an immediate risk to patient safety or clinical outcome. The following guidelines provide a framework for organisations involved in validating self-assessments and members of Review Visit Teams to identify and manage the different levels of concern.

Within the Peer Review Process there are 3 categories of concern:

- Immediate Risk
- Serious Concern
- Concern

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

10.1 Immediate Risks

An “Immediate Risk” is an issue that is likely to result in harm to the patient or staff or have a direct impact on patient outcome and requires immediate action. 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 included on the validation proforma.

In the case of the issue having been identified at the time of a peer review visit, the coordinating team will notify the organisation immediately. This will be followed up within a week of the visit by a formal letter from the coordinating team to the Trust Chief Executive or Network Lead Clinician, outlining the immediate risk and inviting

the organisation to respond with a plan as to how that risk will be addressed. The issue will also be brought to the attention of the relevant lead commissioner and network.

The written response identifying actions to resolve the issue is expected within 2 weeks. There may be occasions when the action required to fully address the problem cannot be achieved immediately, e.g. if recruitment to a post is required, however it is expected that interim solutions will be found to minimise the risk.

10.2 Serious Concerns

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 validation it is expected that this would be addressed through the organisation’s risk management process and details of actions included in the validation proforma.

In the case of the issue having been identified at the time of a peer review visit, the Coordinating team will notify the organisation immediately. This will be followed up within a week of the visit by a formal letter from the coordinating team to the Trust Chief Executive outlining the “serious concern” and inviting a written response from the organisation within 4 weeks. It is recognised that in some instances resolution will require longer term solutions in which case it is acceptable for the organisation to submit an action plan with specific timescales for addressing the issue.

10.3 Concern

A Concern is an issue that is affecting the delivery or quality of the service that does not require immediate action but can be addressed through the work programmes of the service.

10.4 Use of Risk Assessment Matrix

In some cases it will be clear which of the categories should be assigned, however there will be issues in which individual circumstances may vary significantly and would need to be taken into account when assessing the risk.

In assessing the risk it is important to identify the actual risk, further questions should then be asked to determine the impact of the risk, the likelihood of this happening and whether any action has been taken to remedy or ameliorate the situation.

Having determined the exact nature of the risk it is recommended that a risk scoring matrix is used to identify the appropriate category as shown overleaf.

Likelihood		Consequence				
		Insignificant	Minor	Moderate	Major	Catastrophic
		1	2	3	4	5
Rare	1	1	2	3	4	5
Unlikely	2	2	4	6	8	10
Possible	3	3	6	9	12	16
Likely	4	4	8	12	16	20
Almost certain	5	5	10	15	20	25



Concern



Serious Concern



Immediate Concern

Consequence descriptor

Insignificant	Minor	Moderate	Major	Catastrophic
Reduced quality of patient care	Unsatisfactory quality of care	Mismanagement of patient care	Minor injury to patient or staff	Fatal/Major injury to patient or staff

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

11. USE OF DIABETES QUALITY IMPROVEMENT NETWORK SYSTEM (DQUINS)

What is DQuINS?

DQuINS is a secure web-based database that supports each stage of the peer review process. It provides the functionality for system users to attach documents to their records to support the evidence that their organisations comply with the measures. It allows Trusts and networks to have an interactive tool to manage quality and improvements; it allows assessments and supporting evidence to be kept together; it provides those validating and verifying evidence access to the evidence on-line; it encourages the transfer of good practice between organisations by providing the potential for other users to access documents for use in their own organisations; it provides information for national analysis and reporting; it provides information to NHS choices and the Care Quality Commission.

Principles for Uploading Documents as Evidence

A self-assessment can only be completed if each of the evidence documents required for the topic area being self-assessed has been uploaded to the DQuINS database. Failure to supply this information on DQuINS in accordance to the national schedule (on DQuINS) may trigger a peer review visit.

For teams self-assessing on the annual cycle, once a self-assessment has been internally validated (optional this year) then the assessment and evidence documentation cannot be changed. The peer review will be undertaken using this evidence.

For teams that are identified for a peer review visit, final evidence should be uploaded on to DQuINS four weeks before the visit. Minor revisions can only be made following a pre visit or pre-assessment by arrangement with the coordinating team, such revisions **must** be uploaded no

later than two weeks before the start of the network review. This is to enable the review teams to access the information in preparation for the review.

No uploaded documents should contain patient identifiable information. In addition, organisations should not upload any documents that have patient identifiable data that has been anonymised by using a marker pen or any other correction type substances, as this is often visible once scanned.

The preferred format for uploaded documents is pdf (Portable Document Format). This will enable maximum functionality of the DQuINS database.

The address for the DQuINS web-site is www.dquins.nhs.uk and this will provide open access to the public web-site.

The DQuINS database is on the closed section of the web-site and can be accessed via the above web address by registered users only.

Appendix 1 – Reviewer Person Specifications

Team Member Reviewer Person Specification

Experience (not applicable to patient / carer reviewers).

At least two years working in the role they will be undertaking during the visit.

Working at a senior / expert level within the context of children and young people diabetes services (as clinician [including non-medical clinician], manager, commissioner).

Skills

Communication	Presents own viewpoint clearly and concisely Actively listens to others Reflects back own understanding others' contribution Tactful and sensitive to others' verbal / nonverbal reactions Accurately records and reports on findings Diplomatic Confidential
Team orientation	Actively seeks views from other team members Demonstrates respect for others' viewpoints Adapts own behaviour to suit situation Demonstrates ability to work within a multi-disciplinary team
Analysis & problem solving	Bases judgement on an unbiased logical approach Asks probing questions Searches for evidence on which to base judgements Carefully uses observation as a source of evidence
Task oriented	Prepares fully Focuses on achieving an outcome Takes personal responsibility for delivering results Completes required tasks
Resilience	Maintains and projects enthusiasm despite pressure Can adapt to a variety of situations
Organisational awareness	Able to identify the essentials Considers individual events within the context of the wider system

Knowledge, understanding and commitment to:

- Principles of the peer review programme;
- Principles and implementation of NICE Guidance;
- Multi-disciplinary approaches to care;
- Patient / carer and carer involvement in service delivery and service improvement;
- Modernisation of children and young people diabetes services.

Peer Reviewers will undergo mandatory training and should be able to commit to undertaking peer review visits over the period of the national programme.

Patient/Carer Person Specification

The following person specification for patient/carer reviewers.

Experience

It is essential that patient/carer reviewers should have first hand experience of children and young people diabetes services (this includes experience as a carer of a patient with diabetes).

Essential Skills

Listening and Communication	Presents own viewpoint clearly and concisely Actively listens to others Reflects back own understanding of others' contribution Tactful and sensitive to others' verbal / nonverbal reactions
Team orientation	Actively seeks views from other team members Demonstrates respect for others' viewpoints Adapts own behaviour to suit situation Demonstrates ability to work within a team
Analysis & problem solving	Ability to assimilate large volumes of information Asks probing questions without being confrontational Searches for evidence on which to base judgements Carefully uses observation as a source of evidence
Task oriented	Prepares fully Completes required tasks
Resilience	Maintains and projects enthusiasm despite pressure Can adapt to a variety of situations

Knowledge, understanding and reasonable commitment to:

- Principles of the peer review programme;
- The purpose of peer review and the contribution that patient/carer team members can make;
- Modernisation of children and young people diabetes services.

Necessary attributes will include:

- Self confidence
- A facilitative manner
- Punctuality
- Objectivity
- Diplomacy
- Confidentiality

In addition, nominees for peer review should be:

Able to support (buddy) new patient/carer/carer team members as individuals become experienced.

