NHS BLOOD AND TRANSPLANT

CARDIOTHORACIC ADVISORY GROUP

Peer Review For Cardiothoracic Transplant Centres

Draft Proposal V1

Background

Both NHSBT and NHS England (and by extension, the relevant commissioning services of the devolved administrations) have stated the need for Peer Review as a component of quality assurance and to ensure adherence to guidelines and standards. A number of the recommendations in the NHSBT – ODT 2020 Strategy document, www.nhsbt.nhs.uk/to2020, lend themselves to a framework of outcomes against which units can be assessed.

The aim of this process should be to use not only quality assurance and adherence to guidelines, but a positive sharing of good clinical practice, to ensure more offered organs are transplanted. It has been stated that "seeking to improve one's practice by comparing with others can be strongly motivating". Involvement in good peer review is an integral part of professionalism. Good data should then bring objectivity and rigour to the process. This should prevent a descent into subjective opinion.

There are a number of evolving strands being developed in parallel. In addition to the intentions of NHSBT, NHS England have some steps in place already:-

1. CQuIn process for adult and paediatric heart and lung
2. NHS England are developing a Quality Dashboard across all the specialized services. This will utilise many of the common sources of data, for the transplantation.
3. Cancer peer review has been devolved to the grand sounding National Peer Review Programme, along with diabetes and some stroke programmes. It is not clear whether this will become an over-arching organisation with NHS England.

It is very important to avoid duplication. Transplant programmes already have review by the HTA for their EUODD compliance, and commissioning visits from NHS England as well as Trust CQC visits.

It is proposed to work closely with NHS England and add NHSBT Peer Review to their visits. This provides an external clinical input for NHS England and means for the Trusts the need to set aside only a single day each year.

An annual visit will therefore fit into the needs of all components. Less frequent Review will not allow timely dissemination of new practice. All transplant programmes will have their own internal processes of audit. Some have additional structures – annual "Away-Days" for self reflection, for instance.

The principle aim is to identify and share good practice and areas of innovation. Quality assurance is important, but secondary.

Mechanics

Transplant teams are by definition multi-disciplinary, and a possible way to knit together the various specialities might be to build the review around the ***patient pathway.***

The Advisory Group will be asked to identify a number of key steps which can be described both qualitatively, and measured. These will differ from organ to organ, but might include:

1 Referral and interaction with secondary care
2 Assessment for transplant
3 Surveillance of listed patients
4 Allocation process on receipt of an offer (if not part of a national process)
5 Decision making with regard to marginal offers
6 Teaching and training in implantation
7 Multi-disciplinary post-operative care
8 Follow up
9 Liaison with primary care
10 Palliative care arrangements

Each heading would need a column of "measurement"

Logistics

Peer review should be annual, with a senior clinician visiting each centre, at the same time as an NHSE or equivalent, commissioning visit. Separate organs will need separate review.

It is suggested that timing is proposed by the Commissioners, the Advisory Groups then provide the reviewer, probably with three months notice.

The agreed data fields will be completed by the programme, aided by NHSBT Statistics and Clinical Studies, one month before the visit, and circulated to the Reviewer and the relevant Commissioning team.

Heart	6
Lung	5

This includes the Scottish units

The paediatric centres will need a separate set of visits by appropriate peers.

In practice, the reviewers needed will be:

Papworth	Adult Heart, Adult Lung	Total 2
Harefield	Adult Heart, Adult Lung	Total 2
Manchester	Adult Heart, Adult Lung	Total 2
Birmingham	Adult Heart, Adult Lung	Total 2
Glasgow	Adult Heart	Total 1
Newcastle	Adult Heart, Adult Lung, Paediatric	Total 3
GOS	Paed Heart, Paed Lung	Total 2

There should be a full day, divided into two halves – a "professional" half day, led by the Reviewer, and a "commissioning" half day, with the Reviewer providing expert clinical advice to the commissioning team.

A brief report will be returned to the Unit, and to the AG, within 1 month of the visit. The chair of the AG will be responsible for producing a brief annual summary of the visits, picking out in particular areas of good practice, and identifying problem areas.

Outcome measures

The aim is a general good for the community, but specifics might include:

1. Reduction in current levels of *variation* in practice, ensuring that all teams perform at the level of the best.

2. Effective mechanism for ensuring that innovative best practice is identified, shared amongst surgical teams and used to inform national policies (I'm not aware of any other processes for enabling this, but I could be wrong).

3. Reduce the discard rate of unused organs.

All of these will need discussion with the Statistics and Clinical Studies team to ensure we are looking at outcomes on which data is collected, to avoid generating additional work.

Unsolved Problems

Funding/reimbursement – suggest this is made a part of the service spec. Small costs for Trusts, and they *should* get a mutual advantage

Training of reviewers – If there is a standardised template, we should leave it to the Reviewers to do the work. There will be variation, and some poor performance, but not much. Visiting another centre should be an incentive for being on good form.

Selection of Reviewers – leave this to the AGs.

Multiple services on one site – NHS England only want to do one visit for above the diaphragm. Difficult to see how everything could be done for some of the larger centres, even if we separate paediatrics.

Are there additional outcome measures?