Preface for the Liver Advisory Group

The document below was circulated to CTAG in April, and proposes a peer review process. The concepts, if not the detail, were widely accepted and we hope to move forward with a series of visits in the late autumn of 2014.

There are similarities and differences between the two specialities, but I would like to use the document as a starting point for establishing something similar in liver transplantation.

Heart and Lung Transplantation differs importantly by not having any separate professional grouping – CTAG is effectively the only body. This is obviously not the case for many of the other organ types, liver and kidney in particular

The additional activities – CQUIN meetings, the NHS England dashboard for instance, are common to both specialities. Reduction of repetition and duplication is a key component of this process.

Members are asked for their views of practicality, the role and selection of professional bodies, the role of the LAG Chair, and in particular what measurable gains they would like to see from the whole process

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 rigor 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 has 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 utilize 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 organization 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 specialties 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 Stats and Audit, 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 required 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, lead 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 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 Stats 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, ad they *should* get a mutual advantage

Training of reviewers. If there is a standardized 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 AG’s

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 paeds

Are there additional outcome measures?