

NHS Wales Peer Review Framework: July 2017

Introduction

1. The all-Wales Peer Review Steering Group¹ has produced this framework document. It provides:
 - a. an overall governance framework within which a national programme of peer review will be managed within NHS Wales
 - b. guidance to executive and clinical teams within NHS Wales on the nature and conduct of peer reviews
2. The framework builds on schemes already developed in cancer, audiology, palliative care and other service areas.
3. The Organisation for Economic Co-operation and Development (OECD) Review of Health Care Quality in the UK published in February 2016 commented positively on peer review in Wales and recommended making the use of peer review more widespread and finding ways of integrating the lessons learned into standard clinical practice.
4. This guidance should be used by NHS Wales to ensure the peer review process across specialties and patient pathways is undertaken in a consistent way, and to examine how well principles such as prudent healthcare are being applied in practice.
5. The Health and Care Standards Framework for Wales together with prudent healthcare principles should underpin any review, complemented by:
 - a. service/condition specific clinical standards
 - b. relevant outcome measures
 - c. metrics related to efficiency, productivity and value
 - d. other relevant guidance
6. The expectation is that NHS Wales will own, agree and oversee an annual programme of peer reviews, akin to the existing programme of clinical audit to support improvement in priority areas.
7. It is recognised that, whilst the direct costs of peer review may be modest, the opportunity costs, particularly in relation to valuable clinical time, are significant. This places a particular onus on those involved in peer review to ensure that it is done well and makes a major contribution to improving the quality of services.

Scope

8. This framework covers the governance and operation of a managed all Wales programme of peer review. However, individual NHS Wales organisations may

¹ The all-Wales Peer Review Steering Group works under the overall direction of the National Quality and Safety Forum

also wish to use the principles of the framework to guide any local peer review work.

Aims and expected outcomes

9. Peer review is a process to drive continuous quality improvement involving self assessment, enquiry and learning between teams of equivalent specialisation and knowledge. Peer review is not an inspection; it is also not just about trying to fix problems. It is really about using 'critical friends' to 'peer in' on internal assurance systems for identifying and sharing good practice and suggesting areas for improvement.
10. Peer review provides a way to:
 - a. focus, in a holistic way, on the quality of a service and the outcomes and experience it delivers for patients/service users across the agreed breadth of the patient pathway being reviewed
 - b. examine compliance with standards and benchmarking with others, including engagement in service/quality improvement and research
 - c. consider the efficiency, productivity and value of services in meeting expected patient outcomes and experience
 - d. identify good practice and areas for improvement
 - e. bring to bear a layperson's view of the service/pathway
11. The expected outcomes of peer review include:
 - a. an improvement in the safety, quality and effectiveness of services
 - b. a better experience for patients
 - c. the consistent sharing of good practice and demonstrable commitment to prudent healthcare.
12. Peer review should provide a positive developmental experience for all those involved. Reviewers can learn as much as those being reviewed, and are then able to take back relevant learning to their own organisations.
13. Peer review is not to be used by clinical teams to develop a 'shopping list' of requirements for their service areas. In addressing any adverse findings of a peer review, a prudent approach should be taken, with an emphasis on innovation and making better use of existing resources, rather than seeing additional investment as the first recourse. It provides an opportunity for looking at how the service and its managers/commissioners work together to resolve quality and safety issues where needed and work to maintain, improve and transform services as needed.

Governance arrangements

Governance and management of the all Wales programme of peer review

14. An all Wales programme of peer review will be managed by the NHS Wales Health Collaborative Team and overseen by the Collaborative's governance structure, which consists of the Collaborative Executive Group (NHS Wales chief executives meeting monthly) and Collaborative Leadership Forum (NHS Wales chairs and chief executives meeting quarterly).

15. The Collaborative Team will develop an all Wales annual programme of peer review, for ultimate approval and ownership by the Collaborative Leadership Forum. This programme will be informed by:
 - a. Views from service representatives on those areas deemed to be of the highest priority
 - b. Views and experience within clinical networks
 - c. The principles of prudent healthcare
 - d. Consideration of other relevant programmes such as clinical audit and wider quality improvement initiatives
 - e. Discussion with Healthcare Inspectorate Wales to avoid duplication and overlap with their planned inspection programmes and priorities
16. Existing all- Wales programmes of peer review will be brought within the scope of the new programme.
17. The expansion of the peer review programme will be managed carefully, to ensure that the quality of peer review is maintained, lessons are learned and applied to subsequent cycles and adequate support can be provided from within available resources.
18. Once agreed by the Collaborative Leadership Forum, the Collaborative Team will publish the programme. Health boards and trusts will then be expected to support and engage with this programme as appropriate.
19. Clinical networks within the Collaborative Team will manage the peer review process for those reviews in the all Wales programme that fall within their scope. The review of the clinical networks that reported in May 2015 recommended that one of the roles of the all Wales networks should be to review compliance with standards, including the use of peer review where appropriate.
20. Responsibility for managing the peer review process for reviews outside the scope of all Wales clinical networks will be agreed on a case by case basis and recorded in the all Wales annual programme.
21. To be effective and reliable any peer review has to be undertaken to a required and consistent standard. To ensure this, the process needs to be underpinned by a quality assurance process at different checkpoints in the process. For reviews undertaken as part of the all Wales programme, a Peer Review Oversight Group will be set up by the Collaborative Team to advise and confirm that each review follows the agreed process and is in line with the appropriate standards for the work. The Oversight Group will also give advice as needed to each peer review team.

Health boards and NHS trusts

22. NHS Boards should consider peer review as one of the tools available for improving quality, should support its use and encourage relevant staff to participate. However, the impetus for peer review should come from within clinical teams and should not be imposed from the top down but recognised and supported by the Board as a tool to enable teams to reflect and improve.

Quality and Safety Committees should take the lead in championing peer review and encouraging clinical teams to engage in the process. Following the peer review process there should be a clear commitment at Board level to act on the findings.

23. Prior to a peer review taking place, the scope of the review must be signed off by the medical and nurse director and/or chief executive of the relevant health board(s) and/or trust (see also paragraphs 27 and 28).

Clinical teams within health boards and NHS trusts

24. The clinical team is the driver for peer review within its organisation. The clinical team should see peer review as a two way process of enquiring and learning between two teams of equivalent specialisation and knowledge and should ensure participation from relevant staff.
25. Following a peer review and receipt of the peer review action plan it will be the responsibility of the clinical team to ensure that any actions are taken forward via the organisation's Quality and Safety Committees and acted upon.

The peer review process for each review in the all Wales programme

Peer review chair

26. Each peer review in the programme will be led by a designated peer review chair, who must be identified before the commencement of the process

Scope of each peer review

27. Each peer review in the programme requires a clearly specified and agreed scope before being embarked upon. The scope of the review must be defined, in terms of the:
 - a. services, processes and/or pathways to be reviewed
 - b. broad description of the standards, outcomes and other measures and criteria against which the performance of the service will be reviewed
 - c. time period over which performance will be considered
 - d. individuals and/or teams that will be engaged as participants
 - e. broad description of the likely sources of information and data that will be required to inform the peer review
 - f. planned timing and duration of the review
 - g. expected outcomes of the peer review and how any actions will be implemented
28. The scope of each peer review must be signed off in advance of the review commencing by:
 - a. the Peer Review Oversight Group (see paragraph 21)
 - b. the peer review chair
 - c. the medical/nurse director and/or chief executive of the relevant health board(s) and/or trust

29. Any failure to reach agreement on the scope of a peer review should be referred up through the Collaborative governance structure, if necessary to the Collaborative Leadership Forum.

The peer review team

30. Having agreed the scope, the peer review team will be formed and resourced by the relevant clinical network or other relevant group (see paragraph 20) responsible for managing the review, with the advice of the peer review chair.

31. The peer review team will typically be comprised of:

- a. peer review chair (see paragraph 25)
- b. clinician(s) – which may need to be multidisciplinary
- c. manager(s)
- d. lay reviewer(s) (e.g. from the Community Health Council)
- e. note taker

Funding

32. The following direct and opportunity costs associated with hosting a peer review will be met by the NHS Wales organisation(s) that is being reviewed:

- a. staff time in the team(s)/service(s) being reviewed
- b. travel and subsistence costs related to the peer review, incurred by the team(s)/service(s) being reviewed
- c. accommodation and refreshments for meetings held on site as part of the review

33. The following direct and opportunity costs associated with carrying out a peer review will be met by each NHS Wales organisation employing each individual member of the peer review team:

- a. staff time devoted to the peer review by the member of the peer review team
- b. any costs associated with providing cover for the member of the peer review team
- c. travel and subsistence costs related to the peer review, incurred by the member of the peer review team

34. The following direct and opportunity costs associated with peer review will be met by the NHS Wales Health Collaborative Team (including relevant clinical networks):

- a. costs associated with the overall management and administration of the all Wales peer review programme
- b. costs associated with the participation of Collaborative Team staff (including clinical network staff) in the peer review process
- c. travel, subsistence and other legitimate expenses of lay reviewers

35. Some of the costs of supporting peer review may be drawn from the £1 million budgets allocated to the Delivery Plan Implementation Groups, since this

would be regarded as a legitimate use of that funding source. This should be considered and agreement sought when designing the programme.

Training for peer review

36. Training for clinicians and others who will undertake or be subject to peer review visits will be required. The training will be shaped by the aims and expected outcomes of peer review, as set out in paragraphs 9 to 13 of this framework, and will need to provide an overview of the process to all those involved. The Collaborative Team will provide training for participants, through clinical networks in the clinical areas within the scope of those networks.
37. In addition, the Collaborative Team has produced briefing documents that describe the peer review process from both the perspective of the reviewers and those being reviewed. These can be found at **Appendix 1a** and **Appendix 1b**.

Development of the self-assessment tool

38. The chair will convene an expert group made up of specialists within the area for review which will agree the standards to be assessed and the data requirements for the review. To ensure the process is not too onerous or that the data is available, the review team should, wherever possible, base their information on data that is routinely collected. The team will also develop, agree and seek internal validation of a self assessment tool setting out the requirements against agreed standards including, but not limited to:
 - a. the Health and Care Standards
 - b. service/condition specific clinical standards
 - c. relevant outcome measures
 - d. metrics related to efficiency, productivity and value
 - e. delivery plans requirements (where appropriate)
 - f. benchmarks
 - g. accreditation standards e.g. such as the Royal Collage of Anaesthetist's Anaesthesia Clinical Services Accreditation (ACSA)
 - h. National Clinical Audits
 - i. Clinical Lines of Enquiry
 - j. NICE Quality Standards, where relevant
39. Achievements against the self assessment tool (and the subsequent visit) should be judged using the agreed maturity matrix at **Appendix 2**.
40. Where, possible the structure of the self assessment tool should mirror the structure of the planned questioning at the peer review visit (see paragraph 47).
41. In terms of internal validation, the self-assessment document must be owned by the organisation, including the members of the MDT that provides the service and management structures that support them. This is because internal mechanisms must be seen as the catalyst for change rather than those which are externally-imposed. It is therefore necessary to have

executive level oversight of the proposed self assessment tool to ensure proper accountability, and links to internal governance.

Three stage peer review process

Stage 1: Internal completion of self-assessments

42. The peer review team will ask the teams under review to complete the self-assessment in relation to the services they provide. These should then be submitted back to the peer review team via the agreed information sharing arrangements.

Stage 2: External verification of self-assessments by the peer review team

43. External verification is carried out as a desk top exercise to assess the completion of the self assessment documentation and provide evidence to highlight areas where the service was lacking. In addition, external verification observes variation between the assessments received and may indicate that further work is required by health boards/trusts to ensure the correct information/data is submitted.
44. External verification is undertaken by the peer review team in collaboration with regional leads and expert clinical advisors for the nominated service. These meetings can also give the advantage of local context to paint a fuller picture of the service under review.

Stage 3: Peer Review Visits

45. The purpose of a 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 achievements and compliance against quality measures, and identifying a broader set of issues concerned with the delivery of a quality and safe service in relation to patient experience and clinical outcomes. In addition the visit will provide a further external check on the robustness of internal quality assurance processes.
46. Peer review visits are clinically led and scheduled around targeted aspects of the performance of the team based on information provided as part of the self assessment exercise. Participation in a peer review visit is a key component to self learning and reflection and as much is learned and subsequently disseminated by the local peer review team as much as those who are being reviewed.
47. It is proposed that questioning should centre around three key areas as set out below:
 - a. Setting the direction. Is the service clear about its purpose and role, its direction and how it meets the needs of its user community? Is it good at listening to its users and partners, and responding to what they say? Does the service have a strong value base?

- b. Enabling delivery. Does the service have the right people, with the right skills, using the right equipment, in the right environment, and using the right information to do the right things in the right way to deliver high quality, safe services?
- c. Delivering results, achieving excellence. Is the service performing well? Does it know where its strengths and weaknesses lie? Does it ensure areas of weakness are proactively identified for development, is action taken and do improvements follow? Does it learn from its own and others experiences and does it share that learning with others? Could improved performance and outcomes be achieved through better use of existing resources?

Identification and escalation of concerns

- 48. During the review visits there may be times when immediate risks or serious concerns about patient safety and service quality are identified that need immediate action. In such a case the review team will raise the concerns with the health board or trust lead executive and clinician during the visit and seek assurance that immediate action will be taken. This will be followed up in writing to the organisation's chief executive.
- 49. Specific processes have also been agreed whereby networks/peer review teams must escalate immediate risks and/or serious concerns relating to patient safety to Healthcare Inspectorate Wales (HIW) so that they can seek assurance from health boards regarding these matters.
- 50. In circumstances where HIW is notified of immediate risk(s)/serious concern by the local peer review team, HIW will write to the health board's chief executive to seek assurance that actions are being taken to address the immediate risk/s found during the review.

Peer Review Visit Feedback, Reports and Action/Improvement Plans

- 51. Immediate but limited feedback is given to teams at the conclusion of the visit. A draft report will then be written summarising the key detail and findings of the local peer review team and sent to the health board/trust for accuracy checking before the final report is issued to the responsible chief executive.
- 52. Alongside these reports the Collaborative Team will ensure the production of an overarching, thematic report at an all Wales level in order to identify and drive improvements at the system level.
- 53. Following the release of the final report, health boards/trusts are required to develop an action plan detailing how they will address the finding of the peer review process which must be signed off by both the clinical lead for that service and the chief executive for the host organisation. The health board/trust is expected to publish action plans on its website and annually assess them for progress.
- 54. The action plans should be submitted to the peer review team that undertook the review to determine whether the proposed actions and timelines for completion of actions are appropriate. The peer review team should confirm its

approval or changes with the health board/trust as soon as possible and simultaneously copy the action plan to the Peer Review Oversight Group. Both the peer review visit reports and the resultant action plans will be made available to the public through the Collaborative and health board's/trust's websites. The action plans will also inform part of the organisation's integrated medium term delivery plan as appropriate.

55. Organisations must keep their action plans under review and updated as appropriate. Subsequent peer reviews will review progress and escalate any areas where any significant issues remain unresolved.
56. HIW is committed to sharing and receiving intelligence in order to discharge its functions. The peer review programme provides a rich insight into the quality of services being delivered by multi-disciplinary teams and health boards in Wales. HIW has therefore agreed that all final peer review reports will be copied to it for information and to inform its future work plans.
57. Annually, the Collaborative Team will compile and publish an overall report on the previous year's peer review programme, identifying common themes and issues. This will be considered by the National Quality and Safety Forum to consider if any themes and issues have emerged that require national action or provide opportunities for wider shared learning.

Brief for Teams Being Reviewed

Prior to review visit

- Health board/trust and Peer Review Team will agree date for the visit
- Health board/trust and Peer Review Team will agree a liaison/coordinating person in the health board/trust and in the Peer Review Team
- Self assessment documentation released to health board/trust/team (e.g. MDT team or similar) lead clinicians (approximately 12-16 weeks before visit day)
- Health board/trust liaison lead will collaborate with local clinicians and managers to collect the required data and complete the self assessment
- Once completed, the self assessment needs to be signed off by the health board/trust and submitted via the Peer Review Portal (7-10 weeks after release of documentation and 7-10 weeks before visit day)
- Health board/trust will liaise with Peer Review Team regarding arrangements for review visit (e.g. venue, timetable and refreshments)
- Health board/trust/lead clinician to agree which members to attend review visit and inform local team members of date, time and venue and circulate final copy of self assessment documentation submitted

Peer review visit

- Health board/trust should ensure all local staff participating in the review visit have a copy of the self assessment documentation submitted and are familiar with the information

Thanks, introductions and setting the scene (Chair)

- Introductions – review team and team members being reviewed
- Peer Review Panel Chair will :
 - Explain purpose of the review visit and the way it will proceed
 - Advise that acknowledgement of discussion does not necessarily reflect agreement by the review team, as consideration of the issues will be made during report writing session
 - Explain what will happen if any issues concerning patient safety need to be escalated
 - Explain that note taker will be taking notes and recording any discussion for factual accuracy

Structure of Meeting

- Local team members will be invited to talk about their service/activity – what progress is being made including examples of good practice, challenges, improvements, areas for development, what they are proud of
- Questions by Review Panel will be structured including general questions regarding the service/activity and specific to evidence in the submitted self-assessment

- Members of the local team will be invited to add further information, including anything they particularly want to highlight
- The Review Panel Chair will advise you of the high level feedback session at end of the review day followed by a draft report available for comment on factual accuracy
- The Review Panel Chair will check that the local team has no further questions or last minute comments and ensure the team has had ample opportunity to present good practice
- Closure and thanks

Feedback and update session (up to 1 hour)

- After the review visit the Review Panel will adjourn to participate in discussion, review answers and risks/concerns identified to reach conclusions and write up a consensus team report and feedback for the high level feedback session at end of the day (timescales dependent on how many teams are being reviewed on that day)
- Health board/trust/team leads to decide who needs to attend feedback session (minimum recommended: executive lead for the service, team leads, service manager, but all local team members are welcome/encouraged to attend)
- Review Panel Chair will provide verbal feedback of review visit
- Draft report will be sent to Health Board within three weeks of review visit for them to identify any matters of factual accuracy
- Health board/trust/local team asked to provide an action plan within 10 weeks
- Final report and action plan published on the health board/trust website

Brief for Reviewers

Reviewer preparation (approximately 15-20 weeks prior to visit day)

- The Peer Review Programme Lead liaises with the reviewers regarding availability for participating as Peer Review panel member, including undertaking any training required
- Information pack sent including:
 - practical details of visit e.g. accommodation details, timetable, directions, membership of review panel
 - review documentation and access to electronic portal to access self assessment and evidence documents
- Potential reviewers must inform the Peer Review Programme Lead if there is any potential conflict of interest with the service area they will be reviewing

Evidence Review (prior to the visit day)

It is essential that reviewers examine the self assessment and evidence prior to the visit day in order to be adequately prepared and informed

- Access documentation via the secure portal (log on details will have been provided)
- Examine information and evidence submitted to make an initial assessment of performance and quality of the service provided
- Refer to supporting narrative and supplementary evidence
- Make notes of potential queries or questions you would like raised during the visit
- Refer and queries back to the visit facilitator/Peer Review Programme Lead

Reviewers may wish to take their own notes during the course of the visit although a note taker will be present for the formal notes (usually the visit facilitator)

Evidence review on day of visit

Agreement of roles

- Agreement of roles during evidence review, including chair and note-taker and who will be asking which questions

Evidence Review

- Chair leads the review team through the documentation, discussing comments/concerns identified and agreeing areas requiring further clarification/questioning
- Review the list of questions drawn up and decide as a team who will ask what questions and in which order

Peer review visit

Thanks, Introductions and Setting the Scene (Chair)

- Introductions
- Establish rapport e.g. 'been in your position' or 'our turn will come'
- Ethos of peer review: 'appreciative enquiry'; acting as a 'critical friend'; holistic and developmental approaches
- Explain purpose of the meeting and how it will progress and how any immediate matters of patient safety would be escalated
- Advise that acknowledgement of discussion does not necessarily reflect agreement by the review team, as consideration of the issues will be made during report writing session
- Explain that note taker will be taking notes and that the discussion will be recorded for factual accuracy

Structure of visit

- Invite team to talk about their service/activity – what progress is being made including examples of good practice, challenges, improvements, areas for development, what they are proud of
- Questions should be both general regarding the service/activity and specific to evidence relating to the measures and broader qualitative aspects of care
- Team invited to add further information, anything they particularly want to see in report
- During the visit reviewers should not be pressured into giving opinions on how well or otherwise the team is doing
- Advise the team that there is a high level feedback session at end of the review; a draft report will be available for comment on factual accuracy within three weeks
- Chair checks that reviewers have no further questions or last minute comments from the team, ensure the team has had opportunity to present good practice
- Reviewers retire to a quiet room to reflect on all the written and other information they have been given and to draft the outline report prior to high level feedback session

Key issues to be confirmed during the review

Below are some of the areas to be covered in questioning, focussed around the key three areas of leadership/planning, service delivery and patient outcomes and experience. These questions are not exhaustive and should be adapted to the needs of the particular service as appropriate.

Leadership and planning

- Is there a clinical and managerial lead for the service?
- Does the evidence indicate that the health board/trust has a clear plan for the development of the service?

- Will implementing that plan ensure that they meet the requirements set out in any Welsh Government Delivery Plan, national guidance or standards and in line with prudent healthcare principles?
- Is there evidence that the plan has been informed and agreed by clinicians, service users/carers?
- Does the Board receive regular updates on the performance of the service?

Service delivery

- How well does the service meet national standards?
- Are there any serious service shortcomings and what are the causes of these?
- Are national guidelines followed, e.g. NICE, NCEPOD, etc.?
- How well does the service capture and act upon patient feedback?
- Is patient /service user experience of the service positive?
- Is the staff experience positive and where they feel engaged?
- Are staff engaged in personal and team development?
- If there are gaps/issues, what has the local team done to try to resolve?
- Are there any examples of good practice, in terms of service delivery, that should be highlighted?
- Is the service engaged in service/quality improvement and supported by the organisation to do so?
- Is the service participating in any clinical audits or research and development?

Use of resources

- Is the service making efficient use of its resources?
- Is the service achieving acceptable levels of productivity?
- Is the service making innovative use of staff, facilities or technology?
- How could efficiency and productivity be improved within existing resources?
- Are there any examples of good practice, in terms of use of resources that should be highlighted?

Outcomes (experience, quality of life, survival)

- How is the service performing against relevant clinical Indicators, patient feedback on their experience and clinical outcomes?
- There should be special focus on any potential outliers and the relative performance teams in relation to the national range

Review debrief, summary and report writing

After the review meeting all team members participate in discussion, reviewing answers and risks/concerns identified to reach conclusions and write up a consensus team report and high level feedback at the end of the day.

It is important to consider the following when compiling a peer review report:

- Include all aspects of the key themes in the report, including comments on individual measures where appropriate
- It is a consensus report so make sure all members of the review team have had a chance to put forward their views

Identifying good practice

Peer review encourages identification of good practice and provides a definition to help review teams to determine whether or not practice could be classified as 'good'

Good practice should be directly linked to the service being reviewed, it may be innovative, but may be common practice that is undertaken very well. We suggest the following definition is used:

'Good practice is practice that has delivered or has the potential to deliver positive improvements in care elsewhere'

For example it may have:

- contributed to the delivery of high quality patient centred care
- successfully integrated services
- facilitated achievement of the measures
- improved patient/carer experience
- improved outcomes of care
- improved teamwork
- improved the efficiency and/or productivity of service delivery

Identifying risks and serious concerns

There may be occasions during a review where immediate risks or serious concerns emerge which need to be escalated. In such situations appropriate and timely escalation needs to be agreed with the chair. Agreement should be reached on any follow up action by the most appropriate party to ensure all immediate risks or concerns are being managed. .

Feedback and update session

Chair will provide feedback to the team leaders

Report drafting, checking and publication

- Draft report will be circulated to panel members approximately a week following visit to check for factual accuracy
- It is important that panel members submit comments and or amendments to the report within one week. Please make sure that you respond even if you do not have any comments to avoid delay in this process

- Ensure the report is clear, specific and unambiguous, if something needs clarifying/confirming/developing state precisely what it is
- Take a prudent approach, with an emphasis on innovation and making better use of existing resources, rather than simply proposing additional investment
- After each point/paragraph reflect on the 'so what' so that the reader is not confused or unsure about what reviewers are saying
- Where possible, avoid writing in the negative; peer review is developmental so tell teams what the problem is i.e. 'there is a need to ensure all patients have equitable access to specialist nursing support etc.', rather than focusing on a lack of adequate numbers of CNSs for the workload
- Cross check the different sections of the report to check for inconsistencies
- The report template includes sections that reflect the key themes/performance measures. Reviewers are required to determine achievement against the measures and identify concerns and good practice
- Confirm achievement and position on maturity matrix
- Draft report should be sent to the health board/trust within three weeks of review visit
- Health Board should be asked to provide an action plan with 10 weeks
- Final report and action plan published on health board/trust website
- Action plans should be kept updated. Subsequent reviews will ensure that agreed improvement has taken place.

Appendix 2

Judging how well a service is doing - Using the maturity matrix

A maturity matrix enables the service to assess its performance along a pathway of organisational development. This informs how well it is doing and the extent to which its improvement actions are achieving their intended outcomes.

Services should be able to demonstrate alignment with the positive statements within each theme through the supporting narrative. This narrative must focus not only on what they are doing, but how well it is working and the resulting impact on performance.

The matrix definitions are:

We do not yet have a clear, agreed understanding of where we are (or how we are doing) and what / where we need to improve.	We are aware of the improvements that need to be made and have prioritised them, but are not yet able to demonstrate meaningful action.	We are developing plans and processes and can demonstrate progress with some of our key areas for improvement.	We have well developed plans and processes and can demonstrate sustainable improvement throughout the organisation.	We can demonstrate sustained good practice and innovation that is shared throughout the organisation, and which others can learn from.
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These definitions link directly to the alignment scale that services are asked to use in relation to the positive statements made in the self-assessment:

<i>Strongly disagree</i>	<i>Disagree</i>	<i>Agree in part</i>	<i>Agree</i>	<i>Strongly agree</i>
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