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Invited Service Reviews

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Introduction

Invited Service Reviews (ISRs) were established in 2000 by the Royal College of Physicians (RCP) to support good medical practice and contribute to better healthcare (Table 1). The process is an important method for improving patient care and provides an independent report with recommendations for the trust to consider.

Modern healthcare is complex and delivered by highly skilled multiprofessional teams. It requires inspired management to motivate employees and deliver change. Recent years have proved challenging. New techniques for early investigation and therapeutic interventions require ongoing training and awareness of clinical risk. In the UK, healthcare has been affected by far reaching changes to the management of the NHS with new ways of commissioning services, including from non-NHS providers, and moving some clinical services from secondary care to the community. The revised contract for general practitioners impacted on out-of-hours services for medical emergencies and has contributed to the rise in attendances at accident and emergency departments and in acute medical admissions. This has affected the management of acute medical care with the focus on early assessment and discharge and altered working practices.

The implementation of the European Working Time Directive (EWTD) reduced the working hours of trainee doctors. The resultant abolition of the traditional 'firm' structure brought major changes to the way in which patients are managed and introduced the need for structured handover between shifts. These have all been reflected in the issues for which reviews have been requested in the last five years. They include clinical competency, team working, staffing levels and clinical facilities. This article describes the process of the ISR and draws together some of the common themes which have emerged.

What are the Invited Service Reviews for?

Any problem relating to the practice of clinical medicine will be considered for an ISR. They are usually requested by the chief executive or medical director of a trust but may also be arranged at the request of fellows or members with the support of their employer. They are designed to help with issues which have proved difficult to resolve locally and for which informed independent advice might prove helpful. They are not appropriate for issues of probity or if there has been referral to the National Clinical Advisory Service (NCAS) or the General Medical Council (GMC). Most frequent concerns involve:

- clinical practice and outcomes
- service delivery
- patient safety
- dysfunctional clinical teams
- clinical governance
- workload issues.

Terms of reference

Terms of reference are developed following discussions with the referring trust and reflect the issues to be considered. However, it is likely that other issues will emerge during the interviews. For this reason the terms usually allow such matters to be included where relevant. Interviews are in confidence and non-attributable and thus different from disciplinary investigations. The terms are shared with all those to be interviewed before the visit which allows them to seek opinion of their legal advisors if they wish.

Table 1. Summary of Invited Service Reviews undertaken between 2005 and 2009.

Trust	Specialty	Date
Trust A	Elderly care	2005
Trust B	Rheumatology	2005
Trust C	Service organisation	2005
Trust D	Acute medicine	2005
Trust E	Genitourinary medicine	2006
Trust F	Genitourinary medicine	2006
Trust G	Cardiology	2006
Trust H	Dermatology	2006
Trust I	Rheumatology	2007
Trust J	HIV/Genitourinary medicine	2007
Trust K	Neurology	2007
Trust L	Dermatology	2007
Trust M	Acute medicine	2007
Trust E	Neurophysiology	2008
Trust N	Palliative care	2008
Trust O	Acute medicine	2008
Trust P	Audio vestibular medicine	2009
Trust Q	Cardiology	2009
Trust R	Respiratory medicine	2009
Trust H	Acute medicine	2009
Trust H	Respiratory medicine and elderly care	2009

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Documentation

A comprehensive list of trust papers relevant to the ISR is compiled before the visit following advice from the RCP team. This will include data about the trust and the service(s) to be reviewed, clinic times and waiting lists, patient satisfaction surveys, patient complaints, records of relevant clinical audits, consultant job plans, clinical guidelines and output data including standardised mortality ratios (SMR).

Composition of the team

The composition of the ISR team will vary depending upon the clinical specialties to be considered and the issues identified. It is led by the ISR medical director and the other members are drawn from a pool of healthcare professionals who have been recruited and undergone training in the process of the review. The team members are chosen for their relevant expertise and usually include two or three consultants from the appropriate specialty with other senior healthcare professionals, for example a consultant nurse or nurse specialist, allied healthcare professional, clinical scientist and senior manager. Where reviews also involve non-RCP clinicians, then a representative is sought from other colleges. During the past five years ISR has worked jointly with the Royal College of General Practitioners, Royal College of Surgeons and the College of Emergency Medicine. A member of the RCP Patient and Carer Network is involved in all ISRs and ensures that patient interests are strongly engaged.

The review visit

Most ISRs last between two and three days and begin with a detailed discussion with senior management, usually the chief executive, medical director, director of nursing and a member of human resources (HR). The terms of reference are reviewed and the trust presents an outline of their concerns to the full review team, which enables them to clarify any issues and to request further data which they believe will help inform the matters to be considered.

Interviews

The list of those to be interviewed is collated by the trust with advice from the college. They are sent details of the planned ISR and terms of reference by the trust with information prepared by the college about the process and confidential nature of the interviews. Other trust employees are able to meet with the team if required. The visits involve discussions with a broad range of staff including trainees, secretaries, senior managers, nurses and consultants. At the end of each visit summary feedback is given which allows the opportunity to raise any urgent issues which may require immediate action by the trust, for example in the interest of patient safety.

The report

The trust is sent a final draft to correct factual errors. The final report is agreed with the president and other senior RCP officers and is usually completed within two months of the visit. It then becomes the property of the trust who must consider actions to take concerning the recommendations. Copies of the report should be made available to all those who have taken part in the interviews. Recommendations range from issues of service restructuring and changes to working practices to detailed audit of clinical pathways when we are concerned with the quality or safety of patient care. Occasionally it may be suggested that an individual undergoes retraining. Exceptionally a referral to the NCAS, with whom we have a joint working protocol, or the GMC is requested.

Evaluation

Within a few weeks of the completion of the report an evaluation form is sent to the trust to help improve the ISR process and effectiveness. At around six months a detailed assessment of actions taken concerning earlier recommendations is requested.

Main findings

Immediate feedback on the visits was nearly always very positive with over 90% stating that the ISR had been well organised and helpful. Subsequent analysis of the actions taken by trusts concerning the many recommendations has also been positive with most being accepted even where consultant retraining had been suggested. The ISR team has occasionally asked for a clinical service to be halted when safety concerns have been identified and all trusts have complied. While the findings and recommendations are specific to each ISR a number of common themes have emerged.

Management

Frequently the ISR is requested long after the concerns are first raised which should have been dealt with locally and much earlier. Weak management of clinical teams and concerns about clinical competency are common. There appears to be a reluctance to engage with such issues perhaps because of the perceived medical hierarchy. A failure by trusts to follow due process in matters of competency and discipline has been surprising. They may have recognised long-term problems with the working practices of consultants, nurses and others and yet there has been little engagement with HR. If poor practice is identified then employers are responsible for taking action in line with their staff policies.

Another common theme is the variable quality of many clinical directors some of whom appear to have accepted the post with reluctance and have not been supported with adequate training in the necessary skills or given protected time to carry

out the job to a satisfactory standard. Many of the trusts provided extra salary for these clinical management roles but expect clinical responsibilities to remain as before. Clinical directors have a difficult job and not all are suited to the task. It was seen that many remained in post for too long without senior review and with no attention to succession planning. Unsatisfactory working relationships with clinical teams were frequently observed with evidence of bullying and insufficient management expertise. Trusts need to invest more at this level of clinical management; clinical directors are an important resource and need effective development. In many instances there was obvious lack of communication between the clinical directors and their senior colleagues on the board and thus little meaningful involvement with strategic planning even when this impacted on their directorate. A disturbing lack of engagement and planning with commissioners and primary care was evident in many of the reviews. This has to improve if service providers are to work together for the benefit of patient care.

Consultant job plans and appraisals

The job plan is a standard part of the consultant contract. The plans were, however, often unclear and sometimes it was impossible to identify all the paid sessions and even where consultants were working throughout the week. This also applied to on-call responsibilities and many examples of excessive payments, and where paid activities far exceeded the national average (11) or what was appropriate for the hours claimed, were found. This reflects poor management and requires urgent attention by HR managers, something which the ISRs regularly recommend.

Annual appraisals were not always carried out and were often inadequate which suggests a need for more training for medical directors and others. Too often they had been left to inexperienced clinical directors, sometimes with no understanding of the specialty if it was not their own. Occasionally the appraisals were arranged by a non-clinical manager which is not appropriate. There were particular difficulties in achieving a meaningful appraisal where consultants were employed in smaller departments and especially primary care trusts (PCTs). There are increasing numbers of physicians who now work as a single specialist for a PCT. They require more support from colleagues to facilitate good working practices and allow joint clinical audit and professional development. Problems of this nature were observed in specialties such as genitourinary medicine and dermatology when they were managed in the community.

Clinical outcome data

A persistent lack of good outcomes data for most specialties, with the exception of cardiology, was noted. Publication of SMRs for different trusts by Dr Foster has increased public interest in outcome measures. Despite this, and the long history of clinical audit of medical patients that began with reviews of hospital deaths, only a minority of the visited trusts held regular multiprofessional mortality and morbidity (M+M) reviews. These are essential since clinical management in many specialties, particularly acute medicine, involves initial assessment by one team and transfer to others which makes follow up difficult for the admitting team with little opportunity to learn from diagnostic (frequent) and other errors.

It was often suggested that M+M reviews should be established and the results shared with the trust board at several ISRs. This advice was invariably well received and should be included as part of all consultant job plans (non-clinical activities). Trusts recognise the need for robust systems to collect and analyse outcome data, essential for improving patient safety, and yet few do so.

Patient consultation and commissioning

Unfortunately only a minority of the reviewed services provided evidence that the views of consumers were actively sought. While records of patient complaint investigations were seen there were few examples of structured engagement with local patient organisations which might influence clinical services and contribute to commissioning. There was a general lack of joint planning between secondary care trusts, the PCTs and commissioners even where services had been moved from secondary to primary providers. The lack of patient participation detracted from service developments and contributed to the demotivation of clinical teams and their managers.

Conclusions

ISRs have been well received and offer opportunities for trusts to obtain an independent and multiprofessional peer review. It is suggested that trusts should consider an ISR for their clinical services when local management has not been able to provide solutions. The reviews will improve patient safety and raise clinical standards. They should be considered at an early stage in the process of investigation and when planning new services.

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