The toolkits can be accessed online at www.rcplondon.ac.uk/resources/acute-care-toolkits.

This is the fourth in a series of acute care toolkits published by the RCP.

Acute care toolkit 1: Handover

Acute care toolkit 2: High-quality acute care

Acute care toolkit 3: Acute medical care for frail older people

Acute care toolkit 4: Additional daytime consultant presence on the AMU.

Integration of GIM/specialist consultants into the rota may help enable an additional daytime consultant presence on the AMU.

Appendices

Appendix 1: Example calculation of programmed activities for direct clinical care on the AMU.

Appendix 2: Calculation of programmed activities for direct clinical care on the AMU.

Appendix 3: Example rotas.

This is the fourth in a series of acute care toolkits published by the RCP.

Acute care toolkit 1: Handover was published in May 2011.

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Acute care toolkit 3: Acute medical care for frail older people was published in March 2012.

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References


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The responsibility of the Society for Acute Medicine (SAM) in delivering this toolkit is gratefully acknowledged.


The rapid expansion of the specialty of acute internal medicine (AIM), along with the development of over 225 acute medical units (AMUs) across the UK, has increased the provision of consultant-delivered care for acutely unwell medical patients. The consultant medicine consultant on the AMU has been shown to be associated with improved outcomes.14 However, there are concerns regarding the consultant presence outside of normal working hours.1

The Royal College of Physicians (RCP) and Society for Acute Medicine (SAM) recommended that consultant presence should be maintained on the AMU for a minimum of 12 hours per day, seven days per week.1

This toolkit has been produced by the RCP and SAM to provide guidance and describe working practices to help achieve this.

What is an acute physician?

Most consultant working on AMUs fall into one of three categories:

1. physicians who have trained specifically in AIM, with or without additional training in gastroenterology (GIM);

2. physicians who have additional training in GIM, with or without a specialty other than AIM, with predominant direct clinical care (DCC) commitment in AIM;

3. physicians who have trained in GIM and a medical specialty other than AIM, with predominant DCC in the specialty but who provide some non-specialty DCC on the AMU.

For the purposes of this toolkit, consultants in the first two categories will be referred to as “acute physicians”, while the third group will be referred to as “acute physicians”.

A recent study... identified an association between consultant working patterns involving greater continuity of care, and improved patient outcomes.11

Setting higher standards

Delivering a 12-hour, 7-day consultant presence on the acute medical unit

October 2012

Recent reports have highlighted the value of consultant-delivered care in improving outcomes for patients. The Academy of Medical Royal Colleges document The benefits of consultant-delivered care emphasises the importance of consultant involvement in the acute setting, where rapid diagnosis, with appropriate investigations and clinical response to the patient’s condition, is paramount.2

Conclusion

Delivery of a 12/7 consultant presence on the AMU should be a priority for all staff involved in the planning and delivery of acute medical services. The numbers of consultants required will depend on: the size and structure of the unit, the patient illness acuity, and the number of patient contacts on a daily basis. Most units will require continuing expansion of AMU consultant numbers to ensure adequate consultant capacity. Further optimisation of working arrangements combining acute physicians with specialists will help to achieve sustainable consultant rotes, optimise continuity, and ensure high-quality patient care.

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Hospitals in which the consultant undertook twice-daily ward rounds were more likely to have a consultant present on the AMU at weekends and patient outcomes is not clearly established, it is likely that patients admitted to hospital at weekends are more likely to die than those admitted on weekdays, and that mortality in the UK will usually require integrated working arrangements, shared responsibilities, and cooperation. Optimal benefit from 12/7 consultant presence on the AMU will only be fully realised if appropriate support and diagnostic services are provided. A recent study by the RCP identified an association between consultant presence on the AMU and mortality. Benefits of early-morning assessment for those who were admitted the previous evening. All patients in the AMU should be reviewed twice each day by the AMU consultant or appropriate specialty team. Consultant working on the AMU should therefore start no later than 8am. How many consultants are required on the AMU each day? The number of consultants required depends on the service on the AMU including, the number of new admissions/patient contacts per day, the number of beds, the level of the AMU, the patient’s initial review of the patient after arrival on the AMU, the number of new admissions/patient contacts by the AMU consultant or, the number of new admissions/patient contacts by other AMU consultants. Consultant working patterns should be designed to enhance the long-term sustainability of the rota pattern. Consultant working patterns should be designed to enhance the long-term sustainability of the rota pattern. Calculation of numbers of consultants required on the AMU should be based on the number of patient contacts during the 12-hour consultant presence. How should overnight consultant cover be provided for the AMU? Most hospitals currently provide a non-resident consultant physician on call as they do not have any consultant available between the shift changes. The RCP’s Acute Care Toolkit recommends an overnight consultant physician be involved directly, as highlighted in the RCP’s Acute Care Toolkit. Consultant working patterns should be designed to enhance the long-term sustainability of the rota pattern. Consultant working patterns should be designed to enhance the long-term sustainability of the rota pattern. Consultant working patterns should be designed to enhance the long-term sustainability of the rota pattern. Consultant working patterns should be designed to enhance the long-term sustainability of the rota pattern. Consultant working patterns should be designed to enhance the long-term sustainability of the rota pattern. Consultant working patterns should be designed to enhance the long-term sustainability of the rota pattern. Consultant working patterns should be designed to enhance the long-term sustainability of the rota pattern. Consultant working patterns should be designed to enhance the long-term sustainability of the rota pattern.
**Acute care toolkit 4: 12-hour, 7-day consultant presence October 2012**

**Recommendations**
- **Consultant working patterns involving greater continuity of care, 12-hour, 7-day consultant presence on the AMU will involve significant challenges:**
  - Extended working on the AMU will require more staff.
  - A newly admitted patient must be seen by a consultant within 14 hours after arrival on AMU.
  - Involvement of a minimum of 10 consultants in the weekend rota should ensure a sustainable frequency of weekend working, with a spread of consultant experience.
  - The number of consultants required at the AMU each day should be based on anticipated number of patient contacts during the core hours of service.

**Why is 12-hour, 7-day consultant working on the AMU so important?**
- 12-hour, 7-day consultant working on the AMU is likely to develop a condition that requires emergency medical admission or resuscitation on Sunday or Saturday.
- There is considerable UK and international evidence to suggest that presence of a consultant on duty at the AMU is essential to achieve both to do this safely as well as to ensure the necessary in-hospital care.
- Although a clear link between reduced consultant availability and weekends and patient mortality has not been established, it is intuitive that patients should expect to receive a high-quality, safe level of care at any time of day.
- A recent study by the RCP identified an association between consultant commitments while on the AMU, had lower adjusted case fatality rates.

**What is the core duty of a consultant on the AMU?**
- The core duty of a consultant on the AMU is to ensure senior review and implementation of a management plan for all patients on the AMU.
- The consultant working pattern should be designed to enhance consultant delivered-care to patients are realised.

**How should a consultant on the AMU prioritize patient care?**
- Consultant working patterns should be designed to ensure that one consultant staff day, if seeking to enable handovers.
- A consultant’s working day will typically involve less one consultant shift day, with seeking to enable handovers.

**When should a consultant on the AMU prioritize patient care?**
- Consultant working patterns should be designed to ensure that one consultant staff day, if seeking to enable handovers.
- A consultant’s working day will typically involve less one consultant shift day, with seeking to enable handovers.
Why is 12-hour, 7-day consultant working on the AMU important?

In order to develop a review of the current state of 12/7 consultant working on the AMU, the RCP Acute Medicine Taskforce (2013) identified key research questions:

1. What is the current provision of 7-day consultant support on the AMU?
2. How many consultants are required on the AMU each day?
3. What is the most efficient way of utilizing consultant working patterns to ensure 24-hour, 7-day coverage on the AMU?

Recommendations

1. Consultant working patterns should be designed to optimise continuity of care on the AMU.
2. Appropriate diagnostic and support services should be provided seven days per week, to ensure that the full benefits of 12-hour, 7-day consultant presence on the AMU are realised.
3. The number of consultant sessions required should be reviewed on an individual department basis, with the overall aim of delivering 24-hour, 7-day consultant presence on the AMU.

What is the current provision of 7-day consultant support on the AMU?

A survey conducted in 2010 by the RCP and the SMG provided an update on the current state of consultant-led care on the AMU. The survey highlighted that 110 acute medical units (AMUs) provided 24/7 consultant support, 138 provided weekday consultant support, and 114 provided weekend consultant support. The survey showed that the most commonly used system was a consultant on call, with provision for immediate consultant review and two consultant shifts per day, with a weekend consultant on call (23% of units). The most commonly used system was a consultant on call, with provision for immediate consultant review and two consultant shifts per day, with a weekend consultant on call (23% of units).

In line with the recommendations of the RCP Acute Medicine Taskforce (2013) and RCP Acute Care Toolkit (2011), consultant presence on the AMU should be reviewed twice each day, the duration of each shift should be between eight and 12 hours, and consultant presence during the early hours of the morning should be offset by less complex cases.

Recommendations

1. The number of consultant sessions required should be reviewed on an individual department basis, with the overall aim of delivering 24-hour, 7-day consultant presence on the AMU.
2. Consultant working patterns should be designed to optimise continuity of care on the AMU.
3. Consultant presence on the AMU should be reviewed twice each day, the duration of each shift should be between eight and 12 hours.

At what times should AMU consultant staff start and finish work on the AMU?

Start time

Finish time

Recommendations

1. Consultant presence on the AMU should be reviewed twice each day, the duration of each shift should be between eight and 12 hours.
2. Consultant presence during the early hours of the morning should be offset by less complex cases.

How many consultants are required on the AMU each day?

The number of consultant sessions required to deliver the service on a day-to-day basis will vary, depending on a number of factors on the AMU, including:

1. The number of admissions / patient contacts per day.
2. The number of beds.
3. The severity of the illness and other characteristics of those admitted to the AMU.
4. The number of reviews of consultant activities listed above.

This document reinforces previous recommendations that each AMU is reviewed twice each day, the duration of the second consultant shift is usually finished by 8pm, but patterns of patient arrival may justify a second consultant shift or, if required, a weekend consultant on call (23% of units).

Consultant working on the AMU should therefore start no later than 7am.

Recommendations

1. Consultant presence on the AMU should be reviewed twice each day, the duration of each shift should be between eight and 12 hours.
2. Consultant presence during the early hours of the morning should be offset by less complex cases.

Larger units may require more than one consultant working simultaneously on the AMU. It is important that patients should expect to receive a high-quality, safe service appropriate to illness severity. Patients are just as likely to die on the weekend as on weekdays, and that mortality in the long-term is significantly higher in patients admitted in an emergency. Quality standards from the Society for Acute Medicine include:

1. Patients should receive a high-quality, safe service appropriate to illness severity.
2. Patients are just as likely to die on the weekend as on weekdays.
3. Mortality in the long-term is significantly higher in patients admitted in an emergency.

In order to develop a review of the current state of 12/7 consultant working on the AMU, the RCP Acute Medicine Taskforce (2013) identified key research questions:

1. What is the current provision of 7-day consultant support on the AMU?
2. How many consultants are required on the AMU each day?
3. What is the most efficient way of utilizing consultant working patterns to ensure 24-hour, 7-day coverage on the AMU?
Acute care toolkit 4: Delivering a 12-hour, 7-day consultant presence on the acute medical unit October 2012

Recent reports have highlighted the value of consultant-delivered care in improving outcomes for patients. The Academy of Medical Royal Colleges document The benefits of consultant-delivered care emphasises the importance of consultant intervention in the acute setting, where rapid diagnosis, with appropriate investigations and clinical response to the patient’s condition, is paramount.1

What is an acute physician? Most consultant working on AMUs fall into one of three categories:  
- Physicians who have trained specifically in AMU, with or without dual accreditation in general internal medicine (GIM).2,3  
- Physicians who have adequate training in GIM, with or without a specialty other than AMU, whose predominant direct clinical care (DCC) commitment is on the AMU.4  
- Physicians who have trained in GIM and a medical specialty other than AMU, who provide direct DCC in the specialty but who provide some non-specialty DCC on the AMU for the purposes of this toolkit, consultants in the first two categories will be referred to as “acute physicians”, while the third group will be referred to as “specialty/general physicians”. The term “consultant” will be used to refer to a consultant in any of the above categories, working on the AMU.

A recent study... identified an association between consultant working patterns involving greater continuity of care, and improved patient outcomes.8

References
Appendices

The three appendices to this toolkit can be found alongside the online version of the document on www.rcplondon.ac.uk.

Appendix 1: Example calculation of numbers of patient contacts per consultant

Appendix 2: Calculation of programmed activities for direct clinical care on the AMU

Appendix 3: Example rotas

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Conclusion

Delivery of a 12/7 consultant presence on the AMU should be a priority for all staff involved in the planning and delivery of acute medical services. The numbers of consultants required will depend on: the size and structure of the unit, the patient illness acuity, and the numbers of patient contacts on a daily basis. Most units will require continuing expansion in AMU consultant numbers to maintain or achieve sustainable consultant rotas, optimise continuity, and ensure high-quality patient care.

References


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Most consultants working on AMUs fall into one of three categories:

• physicians who have trained specifically in AMU, with or without additional training in general internal medicine (GIM)
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• physicians who have trained in GIM and a medical specialty other than AMU, whose predominant DCC is in the specialty but who provide some non-specialty DCC on the AMU

For the purposes of this toolkit, consultants in the first two categories will be referred to as “acute physicians”, while the third group will be termed “general physicians”. The term “Acute Physician” will be used to describe a consultant in any of the above categories, working on the AMU.

A recent study... identified an association between consultant working patterns involving greater continuity of care, and improved patient outcomes.11

Failure to achieve access to a consultant on the AMU can lead to patient harm.12

Acute care toolkit 4

Delivering a 12-hour, 7-day consultant presence on the acute medical unit

October 2012

Recent reports have highlighted the value of consultant-delivered care in improving outcomes for patients. The Academy of Medical Royal Colleges document The benefits of consultant-delivered care1 emphasises the importance of consultant intervention in the acute setting, where rapid diagnosis, with appropriate investigations and clinical response to the patient’s condition, is paramount.2

The rapid expansion of the specialty of acute internal medicine (AIM) along with the development of over 225 acute medical units (AMUs) across the UK has increased the pressures on consultant-delivered care for acutely unwell medical patients. A recent report1 states that consultant-delivered care in the AMU has been shown to be associated with improved outcomes.3 However, there remain concerns regarding the consultant presence outside of normal working hours.4

The Royal College of Physicians (RCP) and Society for Acute Medicine (SAM) recommend that consultant presence should be maintained on the AMU for a minimum of 12 hours per day, seven days per week.5 This toolkits has been produced by the RCP and SAM to provide guidance and describe working practices to help achieve this.

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