Shared Experiences of Consultant Delivered Care - A toolkit for those responsible for configuring consultant delivered care in Acute Medicine

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Abstract

Background: *NHS London released commissioning standards for Adult emergency services in September 2011. The Pan-London Acute Medicine Network (PLAN) agreed to survey its members regarding these standards.*

Method: *A web-based survey asked PLAN members to comment on the standards which were most relevant to Consultant-delivered care in Acute Medicine. The self-reported rate of compliance with each standard was calculated. The free text comments were grouped by thematic analysis.*

Results: *23 responses were received. The compliance with each standard was variable between 9% and 91%.*

Discussion: *A series of themes are discussed and presented as tips to be considered by those responsible for providing Consultant-delivered care to patients on an AMU.*

Conclusion: *There is still enormous variation between trusts in how acute medical services are supported by Consultant physicians. The demands on each service and the resources available to trusts differ hugely, therefore the solutions to providing a Consultant-led service need to be tailor made for each AMU.*

Keywords

AMU, Acute Medicine, commissioning standards, NHS London, PLAN (Pan London Acute medicine Network), consultant-delivered care

Background

NHS London released commissioning standards for ***Adult emergency services: Acute medicine and emergency general surgery*** in September 2011 (http://www.londonhp.nhs.uk/publications/adult-emergency-services). These standards promote early and continued consultant involvement in the care of all adult patients admitted as an emergency, with the aim of providing the same emergency services at the weekend as during the week, and addressing the higher mortality rates seen for weekend admissions.

The Pan-London Acute Medicine Network (PLAN) is a group of individuals responsible for the provision of acute medical services across London and provides a forum for sharing best practice. PLAN agreed to survey its members regarding these standards.

Methods

A web-based survey was sent to each PLAN member. Each was asked to comment on 22 of the 27 core standards which were most relevant to Acute Medicine. Of these 22 core standards, 5 relate to

Table 1. Compliance with Consultant-delivered care related commissioning standards

	Standard	Compliance with standard (%)
1	All emergency admissions to be seen and assessed by a relevant Consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital.	57
4	When on-take, a Consultant and their team are to be completely freed from any other clinical duties or elective commitments.	48
5	In order to meet the demands for Consultant delivered care, senior decision making and leadership on the acute medical/ surgical unit to cover extended day working, seven days a week.	61
6	All patients on acute medical and surgical units to be seen and reviewed by a Consultant during twice daily ward rounds, including all acutely ill patients directly transferred, or others who deteriorate.	48
9	Rotas to be constructed to maximise continuity of care for all patients in an acute medical and surgical environment. A single Consultant should retain responsibility for a single patient on the acute medical/ surgical unit. Subsequent transfer or discharge must be based on clinical need.	44

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challenges in providing Consultant-delivered care. For these 5 standards, the survey asked the following two questions:

- Does your hospital comply with this standard?
- How did you achieve this standard? Or, what are the barriers to achieving it?

The self-reported rate of compliance with each standard was calculated. The free text comments were grouped by thematic analysis and have been incorporated into the body of this paper.

Results

23 responses were received (from 22 London hospital sites). The compliance with each standard was variable between 9% and 91% (Table 1).

Discussion

Matching Resources To Demand

To provide consultant-delivered care, it is essential that a consultant has no other clinical commitments whilst on take. This requires negotiation with management and effective job planning.

Many hospitals find that currently they are only seeing half of their admitted patients within 14 hours, highlighting the fact that there are currently a limited number of Programmed Activities (PAs) available to cover the acute medical service. This lack of available PAs inevitably leads to certain sacrifices. You need to decide what time of day your acute physicians make the biggest difference for your hospital and patients. The following case examples illustrate two different approaches to this where there is a finite availability of acute medicine specialist time:

Example Hospital 1

This hospital, like most, experiences a peak in referrals for medical admission in the late afternoon. This hospital feels that the acute take benefits most from an acute physician's presence. Accordingly, the acute physician starts their on-call cover in the afternoon, stays late into the evening (8pm to 10pm), and therefore more of the take patients are assessed by an acute medicine specialist. However, by being present at the busiest time of day for the take, the acute physician will not be present in the morning to see patients already on the unit or those admitted overnight. This morning activity then falls to the general physicians, whose competing specialty activities in the morning will need alternative cover.

Example Hospital 2

This hospital suffers from poor patient flow in terms of delayed acute medicine specialist decision making and morning discharges. This hospital's Acute Medical Unit (AMU) benefits most from having acute physicians starting early in the morning to review all of the patients admitted overnight and those still present on the AMU from the previous day(s). This model does mean, however, that after 5pm the responsibility for acute admissions may have to be passed to a general physician. Anecdotally, non-acute physicians may be less pro-active at reviewing and discharging acute admissions.



Collect data on your acute medicine service to allow you to match resources to the busiest and most acute medicine specialist dependent times

Commissioning for Quality Innovation (CQUIN)

In order to achieve standard 1, all patients must be seen within 14 hours of arrival at the front door of the hospital. One way to galvanise a hospital to configure their system appropriately is to set a target that attracts a CQUIN. One hospital has agreed a CQUIN for a percentage of patients to be seen by a Consultant within 24 hours.



A trust may fund additional PAs for acute physicians if they can attract a CQUIN payment

Morning Ward Rounds

There seem broadly to be two patterns of AMU ward round in the morning:

Pattern 1

One Consultant arrives on the AMU in the morning to see all of the patients admitted overnight, then to see the remainder of the patients on the AMU. This system has the advantage of requiring only one Consultant PA and one team of juniors. The disadvantage is that this single Consultant may be required to review more patients than might be considered safe. This ward round is also likely to take several hours, during which time the plans for each patient may not be enacted. Also, during this time there are likely to be more new admissions.

Pattern 2

Two (or more) Consultants arrive in the morning. One concentrates on the overnight patients, whilst the other(s) sees the remainder of patients. Alternatively the Consultants split the ward into geographical areas and complete their rounds in parallel. There may also be another Consultant to see new admissions or run an ambulatory care/admission avoidance clinic. This is more time efficient by aiding early senior clinical decision making, and will certainly be needed for larger AMUs, but it will usually require at least two teams of junior doctors and at least two Consultant PAs.

As already mentioned, each hospital will need to decide where they wish to concentrate limited resources.



Match Consultant job plans to junior doctor availability and the number of patient reviews required

Avoid lengthy ward rounds which hold up junior medical staff and prevent management plans being implemented in a timely fashion

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Twice Daily Ward Rounds

All patients on an AMU should be seen twice daily by a Consultant. There is an association between this pattern of work and a lower length of stay and case fatality rate[1,2] (Ahmad *et al*, 2011; Royal College of Physicians, 2012). Most hospitals currently operate a system where each patient is discussed at a 'board round'. Although such multi-disciplinary meetings have a very positive role, they do not count as a second Consultant led ward round where patients are seen by their bedside.

Most units do not perform twice daily ward rounds of all patients on the AMU. Any second ward round tends to target new patients, sicker patients and potential discharges only. It is difficult to do two Consultant ward rounds of all patients a day, especially at weekends. One respondent highlighted that if you are doing two ward rounds a day, when will you actually find time to do any work?

Smaller AMUs may find it easier to do two ward rounds per day. Larger AMUs will usually require more than one parallel Consultant to see all of the patients. Again, this is costly in terms of PAs. For units unable to allocate any additional PAs there may be some practical solutions to speed up each ward round.



Speed up a ward round with:

- Mobile computers
- Digital requests and referrals
- Ward rounds outside of visiting hours
- Using calling cards with written information to give to patients for the first ward round (Box 1)
- Have nursing staff present on the ward round
- IT solutions, e.g. interactive electronic white boards

Post-take Consultant Ward Rounds Vs. Continuous Review

Whilst on take, patients are often reviewed by the Consultant on-call as soon as they have been clerked. This has been referred to as continuous review of admissions. This style of review is beneficial for the patient as they get a prompt review by a Consultant, well within the recommended 14 hours. However, the survey highlighted some problems that may arise with this style of review.

The junior doctor should be allowed to complete a full clerking of a patient before a review. Consultants should avoid sitting at the shoulder of a junior as they write up their clerking. Such Consultants were perceived as getting in the way. Also, if a patient is reviewed before initial investigation results are back, there is a risk that these will not be properly reviewed later in the day.

If the Consultant is present to review all admissions, this may be perceived as diminishing the role of the Registrar on-call. Their role of running the take and reviewing patients may be removed by an enthusiastic Consultant. This is especially true where there are also two Consultant ward rounds per day. Thus overall, an on-call Consultant should avoid an over-zealous approach.



A Registrar's training may be enhanced by asking them to lead a patient review or a whole ward round with the Consultant assessing and guiding in the background

Think of ways to enhance the educational value of the clerking experience and Consultant review

Continuity of Care for all Patients on AMU

Even in hospitals with average numbers of admissions, it is challenging to have a single Consultant responsible for all admissions for more than one day at a time. The obvious solution is to have multiple parallel Consultants managing admissions. This often requires additional Consultant PAs which is a resource that many will not have.

A similar, but possibly more realistic solution may be to divide admissions geographically, so that patients admitted to particular beds/bays in an AMU become the responsibility of a particular Consultant. Alternatively, the take could be divided based on gender. Some hospitals operate a system whereby the on-call Consultant will undertake initial review of a patient, and then formally hand over to a Consultant responsible for a geographical area on AMU. That patient will then remain under the care of that second Consultant for the remainder of their stay on the AMU. A further advantage of this system is that any particular area of AMU has continuity for a period of time (i.e. a week) at senior clinical level, helping insert to support both medical and nursing teams.

Prospective Cover

We have already highlighted that acute physician numbers are limited. A rota for acute physicians needs to ensure that the system does not break down whenever one takes leave. Clever job planning may have one or more acute physicians timetabled as 'off the AMU' to allow flexibility.

Care should be taken to avoid acute physicians frequently losing administrative time or specialty interest time in providing prospective cover. Some units may not have enough acute physicians to allow such a working pattern. In this case, general physicians will need to agree to provide prospective cover for the acute physician.

Size Of The AMU

The AMU needs to have enough capacity to be able to accommodate the number of patients you are admitting. Put simply, if you are admitting 50 patients per 24 hours, you will need to find 50 empty beds on your AMU.

The length of stay (LOS) of patients on an AMU should be no more than 72 hours. Many units will operate with shorter stays. Thus, to calculate the

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Box 1

AMU Consultant Calling Card

Date: _____

Patient name: _____

You were seen today by doctor: _____

A working diagnosis at this time is: _____

And / or: _____

My doctor needs to rule out: _____

The investigations I am waiting for are: _____

I will most likely be discharged / transferred on: _____

My consultant recommends the following health advice: _____

(Modified version of the oral poster abstract presented at SAM London 2011: Will the Introduction of a 'Consultant Calling Card' Improve Patient Satisfaction on the Emergency Assessment Unit at Salford Royal Foundation Trust? Minan Abbas, Manchester)

number of beds you require, you will need to add the following to the equation:

- How many patients have a zero LOS? As a rule of thumb, many units will discharge a third of their take within 24 hours of admission.
- How many patients are diverted to Ambulatory Care or other outpatient management strategies?
- How many patients are transferred direct from ED/GP to specialty beds, avoiding the AMU completely? (i.e. Coronary Care Unit)
- Will patients be able to flow promptly from AMU to inpatient beds once it is decided that they need to transfer from AMU? If flow downstream is slow, the AMU will need to be able to accommodate some patients for longer than 24-72 hours.

Consultant-led Bed Management

It is important that patients should only be transferred according to clinical need. "Safari ward rounds" of new patients are inefficient. All new medical admissions should therefore be admitted to an AMU bed or to a clinically relevant specialist bed only i.e. HDU/ITU, Coronary Care, Hyperacute Stroke Unit. If a patient on AMU is deemed to require a specific specialty ward bed, they should wait until a bed becomes available on that ward and not be 'outlied' to a bed elsewhere in the hospital. Inappropriately transferred patients are more likely to have a longer length of stay. Thus, a short-term gain, usually to achieve the emergency access target, will ultimately lead to a long-term problem.



Outlying direct from AMU due to lack of specialty beds can be avoided by all specialty wards identifying discharges early and having daily Consultant led ward rounds

If outlying is absolutely necessary, i.e. during winter bed pressures, identifying 2 or 3 suitable stable patients daily from each specialty ward to outlie is preferable to outlying new admissions directly from AMU

Specialty Consultant Triage and Specialty 'Pull'

Patient outcomes can be improved if patients who require specialty input are seen and taken over as soon as possible by that specialty.[4] If patients who need a particular specialty are identified early, their care can be transferred promptly. This process should leave an acute physician with a more manageable number of patients. This process requires coordination between acute physicians and each specialty.

Triage to specialty may occur in person at a daily triage meeting, be documented in medical notes and on white boards or done through electronic patient systems. The specialty will then be aware of who they need to 'pull' out of AMU to their own bed base.

Some patients may not fit within a particular specialty, but will clearly need a longer than 72 hour stay. These patients may benefit from transfer out of the AMU bed base into a general medical ward.

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Specialties may wish to set prioritisation rules where certain patients are moved from AMU to a specialty ward in preference to others, e.g. patients with chest drains are transferred as a priority over patients with simple exacerbations of COPD

Long stay general medical patients moved from AMU should go under the care of a designated physician's team, ideally as part of a ward based care system

Non-acute Specialty Physician Involvement In The Acute Take

Specialty physicians are not only a crucial part of the acute take in the way that they provide a prompt specialty opinion and pull specialty patients under their care. Due to the small number of acute physicians currently in post, almost all hospitals are also dependent on the specialty physicians' involvement in actually managing the acute take. This is especially true for out-of-hours and weekend work.

To some specialists, the acute take may feel like an obstacle to continuing specialty activities, such as clinics or procedure lists. One way to improve this situation may be to confine specialists' on call time to out-of-hours. Another solution would be to timetable a regular weekly slot on call, rather than a rolling slot which may crop up on any day of the week. Some physicians may prefer to act as a Consultant of the week whereby they cancel all specialty activity during that week, but remain undisturbed by the acute take for a period of time. Beware however, that having long breaks between stints on the acute take can lead to Consultants de-skilling in the art of acute medicine.

Regardless of the solution found, the non-acute physician will probably only have a very small proportion of their Direct Clinical Care PAs to allocate to on call activities. This can make designing rotas challenging, especially when attempting to cover 12 hours a day at weekends.

Weekend Cover

Most hospitals have made arrangements for on-site Consultant cover until 8pm on weekdays using either acute physicians or interested non-acute general physicians. Some have recognised the peak in referrals in the early evening and extended cover until 10pm. However, significant numbers are not providing the same service at the weekend.

Again, this problem seems to stem from the lack of acute physicians and the lack of PAs to provide Consultant cover for at least 12 hours a day, 7 days a week. As with the involvement of non-acute physicians in the acute take, this requires innovative rotas and careful job planning with general Consultants who are proactive, enthusiastic, and effective on the AMU.

Handover On AMU

To be effective and educational, there was agreement from those surveyed that handover should be Consultant-led.



Consultant presence at handover meetings should be ensured by careful job planning.

Conclusion

There is still enormous variation between trusts in how acute medical services are supported by Consultant physicians. This paper focuses on the responses and ideas from London hospitals, but is likely to reflect many trusts throughout the country. The demands on each service and the resources available to trusts differ hugely, therefore the solutions to providing a Consultant-led service need to be tailor-made for each AMU.

Until there are sufficient numbers of acute physicians in post there will be dependence on non-acute specialist physicians to take on some of the acute medicine work and there will be compromises made in the level of support that can be negotiated.

However, the prioity now is to match the consultant workforce to meet the demand, and to design new, innovative rota solutions that are sustainable, safe and effective.

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