

The Academy of Medical Royal Colleges

The development of the Out-of-Hours Medical Team [OoHMT]

The out-of-hours clinical management of acute hospitals

Introduction

This paper on 'The Development of the Out-of-Hours Medical Team' has been approved by the Academy of Medical Royal Colleges and represents a significant step forward in the approach to the out-of-hours clinical management of acute hospitals. The working group responsible for the project was chaired by the Royal College of Physicians of London and had representation from all other specialties involved in out-of-hours provision. Because of this, the methodology proposed has widespread support. The principles set down and the proposals made are both relevant and realistic, and they commit acute specialties to working together collaboratively in new combinations with shared responsibilities.

It should however be noted that this document does not in any way attempt to tackle the problems of obstetric and paediatric out-of-hours provision. These areas, because of their special requirements, need to be considered separately, together with the provision of anaesthesia and critical care which cross all acute services.

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Chairman, AoMRC

Aim

To develop the concept of team working by junior medical staff, to provide mutual support and effective cross-cover, by the development of an Out-of-Hours Medical Team – to care for medical and surgical in-patients. The scheme excludes paediatric and obstetric in-patients.

The context

Much progress has been made in improving the assessment and admission of patients presenting to hospital with acute clinical conditions. Key improvements have been:

- the development of admission (or assessment) units;
- the appointment of physicians in acute medicine;

- initiatives to speed the patient's journey through A&E.

However there remain concerns about the quality of care out of hours for patients who have been admitted to the wards, and remain sick or have an unexpected clinical deterioration. Problems include:

- admission to inappropriate wards;
- very thinly-spread medical and surgical cover;
- complicated referral pathways between specialties;
- poor handover between teams or shifts.

There are three 'out-of-hours' time zones in acute hospitals:

- 5pm - 10pm, Monday-Friday [25h / week]
- 8am – 10pm Saturday & Sunday [28h / week]
- 10pm – 8am every night [70h / week]

The impact of the EWT is going to exacerbate the problems of in-patient care, and the time is right to look at more innovative ways of looking after these patients out of normal working hours.

Key principles

- Every effort should be made to bring forward work from the evening into the day, and from the night into the evening – in practice, this means that doctors should complete their tasks before finishing a shift, and that more resources should be available for emergency work in the hospital during the day and evening – for example, a CEPOD list is a priority, with theatres fully staffed each day for general surgery/gynaecology and trauma, from 9am to 9pm.
- If at all possible, emergency work should be separated from elective care; all consultants and their teams should be freed of elective duties when they are on call.
- Medical staff in the hospital at night are now usually on shifts and are therefore available to work, rather than asleep. They should be proactive rather than reactive – seeking-out problems as well as responding to emergencies. If they are not busy in their own immediate discipline, they should be available to help in other clinical areas that are under pressure.
- There needs to be a move to team-working and flexibility across many specialties. Outside paediatrics and obstetrics, most problems at night are 'medical' [but surgeons and anaesthetists will still be needed in the acute general hospital].
- There should be an identified Out-of-Hours Medical Team [OoHMT] with a physical 'control centre' that would allow a single point of call for all clinical problems.
- The OoHMT would be made up of all the junior doctors on call in medical and surgical specialities [including orthopaedics and gynaecology], geriatrics, anaesthetics and accident & emergency.

- This team of junior doctors should have a clearly identified medical leader, who is vested with the authority to delegate and allocate work to all junior doctors in the OoHMT. In some Trusts the medical leader might be a Consultant until 10pm, in others it will probably be the team member most experienced in the assessment of clinical priorities – usually a junior physician, because he or she can respond immediately to crises. The medical leader should have the authority to call-in junior doctors on-call at home, possibly to provide general assistance, if the need arises. Training will be needed for this important leadership role.
- The OoHMT will require a co-ordinator manning the ‘control centre’, often an experienced nurse practitioner.
- It is not envisaged that the medical leader will allocate every call or duty, but he or she must have the authority to reallocate medical resources if problems arise.
- The person available with the most appropriate skills should assess the patient, whether this is an emergency nurse practitioner or junior doctor – but that person will need to be able to refer the patient to more expert care after the initial assessment.
- The real benefit of the OoHMT should be appreciated when parts of the clinical service are stressed by excessive activity – by encouraging junior doctors to collaborate and help within their range of clinical competence. The practice of some junior doctors working continuously, whilst their colleagues relax in the doctors’ mess, could become something of the past.
- Trusts should consider methods of identifying their patients who are most at risk – for example, each team could hand-over a printed list of its in-patients, graded according to potential risk.
- There should be appropriate facilities for hot meals and breaks – not just a food vending machine. The whole OoHMT could aim to meet for proper cooked meals at, for example, 1am and 5.30am.
- In order to help develop a ‘team spirit’, shift patterns should be similar for the different disciplines within a Trust – for example, all weekly shifts should start on the same day, so that the same team works every night for one week.
- There should be logging of calls and outcomes so that a clearer picture of the work of a hospital out-of-hours can be drawn and any benefits in organisational change assessed. Some Trusts use email to record all but the most urgent messages, which will provide an ideal audit trail.
- Hand-over arrangements must improve – before leaving the hospital in the evening, every junior doctor should have identified each patient’s active clinical problems. Many sub-specialist doctors presently on call at home could work their 56h / week at the bedside, and leave the OoHMT at night with in-patients that are under better control.
- Trusts may wish to consider whether they have sufficient Consultant staff to consider contracting for some Consultants to stay in the hospital for emergency work during the evenings and also the daytime at the weekend [for example, a physician, surgeon, radiologist,

anaesthetist], realising that these sessions will need to be paid at appropriate rates and that this will mean that these Consultants may not be available in the daytime.

- Diagnostic services – especially Radiology – should consider implementing a Consultant-led service until 10pm Monday to Friday, and 9am to 5pm at the weekend and on Bank Holidays. All diagnostic services should have sufficient spaces available for immediate booking of patients on the day after night admission. Picture Archiving and Communication Systems (PACS), including teleradiology, could be an integral component to deliver such a service with experts (eg Neuroradiologists) available for advice from home.

Some details

The solution for different hospitals will vary, but the OoHMT will need to have strong links with:

- The critical care / high dependency unit;
- The medical admissions unit;
- The Accident & Emergency Department;
- Support services such as radiology.

The potential members of the OoHMT will be drawn from all of the junior doctors on call for the following specialties:

- Medicine, plus its sub-specialties;
- Surgery, plus its sub-specialties;
- Anaesthesia and critical care;
- Accident and emergency;
- Gynaecology.

Liability of the OoHMT

- To be called anywhere for clinical emergencies (including gynaecological and psychiatric emergencies) within the hospital. Separate arrangements would need to be made for paediatric and obstetric emergencies.
- The OoHMT will not provide any cover for paediatrics or obstetrics, but could provide cover for gynaecology [and, in turn, the gynaecology junior staff could join the OoHMT, and provide reciprocal assistance for the other specialties].

Duties of OoHMT members:

- To attend and assess patients with acute deterioration of health;
- To resuscitate patients, whilst awaiting arrival of expert assistance or transfer;
- Resuscitation after cardiac arrest.

Specific limitations

Members of the OoHMT cannot be expected to perform specialist work outside their competency – for example:

- A surgeon admitting unselected medical emergencies;
- A physician admitting unselected surgical emergencies;
- Physicians or surgeons giving a general anaesthetic, or establishing a patient on a ventilator.

Problems of flexibility

- The doctors cannot double-task or be in two places at the same time. For example, an anaesthetist giving an anaesthetic drops out of the team; similarly a surgeon when operating on a patient; the physician managing acute medical admissions in A&E may not be free to attend immediately a problem on the wards.
- Every Trust will have to determine the rules for reasonable cross-cover between specialties or sub-specialties within a major discipline. It may prove impossible to provide 168h / week SpR cover for every specialty; however, cover may be possible except from 10pm to 8am, which would save 70h / week – essentially the establishment of 2 SpRs. The expert cover outside those hours could come from the OoHMT using pre-defined protocols, re-calling juniors living outside the hospital [subject to the rules of the junior doctors contract], or Consultant intervention. Most importantly, the patients under these specialty firms should enter out-of-hours periods fully sorted-out, and with a management plan.

Teaching opportunities

The OoHMT, in association with proactive clinical care out-of-hours, provides a real opportunity for the clinical teaching of both undergraduates and postgraduates.

Proposal

The concept of the Out-of-Hours Medical Team [OoHMT] has been approved by each of the relevant Royal Colleges, as members of the Academy of Royal Colleges. It is proposed that it should be discussed by each Acute Trust, and that some or all of the plan is considered for implementation. Whilst this paper has largely dealt with the medical team that is working outside normal hours, the proposals should be considered to complement the multidisciplinary working that is being developed by The Hospital at Night initiative.

Working Party Members and AoMRC approval

8th May 2003

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Approved in principle by the Academy of Medical Royal Colleges