February 2014

The Academy of Medical Royal Colleges Wales’ response to the principle of 7 day consultant-led service for acute and emergency care in Wales.

The Academy of Medical Royal Colleges Wales (Wales Academy) supports the principle of 7 day consultant-led service for acute and emergency care.

The Academy has agreed
1. Senior supervision reduces morbidity and mortality.
2. Senior supervision enables earlier patient discharge following acute admission.

The current position in Wales
1. All acute admissions to hospitals in Wales have a consultant responsible for their immediate care.
2. Investigation and management of acute out of hours (OOH’s) emergencies varies across Wales.
3. Expectations of the duties of on call consultants vary within and between specialities across Wales.
4. Availability of investigation and treatment modalities OOH’s varies between admitting hospitals across Wales.

The way forward in Wales
1. Define for each specialty a clear definition of 7 day working for acute and emergency care
2. Clarify the role of on call consultants in each speciality and admitting unit via
   a. Advisory or practical hands on work or both
   b. Timing of formal assessment of acute admissions
      i. Within xxx hrs
      ii. Next morning
      iii. Next normal working day
   c. Ensure that all OOH’s scheduled and unscheduled work is properly job planned
3. Describe for each speciality “frequent patient” investigation and management pathways and identify the hospitals where these patients might be admitted.
4. Describe how pathways can vary safely between working and OOH’s
5. Engage with Radiology and Laboratory services to determine the cost and feasibility of how enhanced OOH’s diagnostic services could be introduced across Wales.
Immediate actions
1. Agree that all new admissions be personally reviewed by a consultant within 24 hrs if still inpatients
2. Agree that case note review is undertaken of any admissions and discharges that occurred before consultant review
3. Agree that all post op patients have consultant review unless managed on an agreed pathway (medical or nursing) in which case any variations are reviewed.

Long term actions
1. The Wales Academy envisages significant changes for acute admissions.
2. Fewer hospitals will provide enhanced 7 day/night acute care.
3. Service review for unscheduled care is active across Wales and the Academy may be able to assist this process.

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Appendices

Supporting information
1. Academy UK statement on 7 day
2. Comments from members of Academy of Medical Royal Colleges Wales
3. Future Hospital Commission
4. RCP acute care toolkit 4: delivering a 12 hour, 7 day consultant presence on the acute medical unit
5. The AMRC seven day consultant present care project in England
6. NHS England seven day services forum project
7. NHS Improving Quality - Seven Day Services Improvement Programme (SDSIP)
8. NICE Clinical Guidelines to support seven day services
9. Survey form sent to members of the Academy of Medical Royal Colleges Wales.

1. Academy UK statement on 7 day

- Uk Academy welcomes plans for seven day service

The Academy of Medical Royal Colleges has led the argument for moving to a seven-day service for urgent cases and supports, NHS Medical Director, Sir Bruce Keogh's report recommendations to the NHS England Board. These were developed in alignment with the Academy’s own standards and with input from Academy Chair, Professor Terence Stephenson and Dr Chris Roseveare, Clinical Project Lead from the Academy's seven day services project. The Academy looks forward to continuing to be an active member of the NHS England's Forum on Seven Day Services as the
scope of the work broadens to take a whole system view and drive change in the way healthcare is delivered at weekends.

Professor Terence Stephenson, Chairman of the Academy of Medical Royal Colleges said:

"It is unacceptable that for a patient admitted as an emergency, the chances of dying may be 11% higher on a Saturday and 16% higher on a Sunday. The Academy recognises that moving to successful seven-day care will not be easy to achieve, but has led the argument for this principle. We know that junior doctors feel clinically exposed at weekends and that hospital chief executives are rightly worried about weekend clinical cover. The Academy has contributed to the Forum on Seven Day Services and will continue to work with NHS England. The findings from the evaluation of the impact of high intensity specialist led acute care (HiSLAC) that the Academy and University of Birmingham are leading on will be an important next step."

Professor Norman Williams, Seven day services steering Group Chair and President of the Royal College of Surgeons, said:

"It is not acceptable that over weekends and bank holidays, patients receive a lower standard of care than they would during the week. We must use these findings from this NHS England report and the recent Academy report and work together to strengthen the standards and quality of care given to patients regardless of when they are admitted. Royal Colleges will work with NHS England to help implement the delivery of the ten clinical standards that underpin this work.

"As the report acknowledges moving the whole service to seven-day care will not be cost-neutral. Whereas some economies can be achieved by centralisation of services and improving outcomes, extra costs seem inevitable. The further detailed economic modelling needs to be done urgently so that NHS and the public can understand how much better care will cost."

2. Comments from members of Academy of Medical Royal Colleges Wales

A) Royal College of Physicians

1. GIM already provides a consultant led 7 day acute service throughout the hospitals in Wales. My understanding is that all health boards provide consultant led supervision of all acute admissions over a 7 day period.

2. Certainly at the Cardiff & Vale UHB, all medical emergency admissions are physically reviewed by the consultant on call. The on call consultant does a scheduled ward round of all emergency admissions on a 7 day basis. They all
attend when requested by junior staff. A considerable amount of the on call time
on Saturdays, Sundays and certainly in the evenings, consultant staff are physically
present.

3. The transition of the criteria for acute admissions into hospital with or without the
A&E will not take place within 2 to 6 months. The reconfiguration of acute services
will out of necessity take 2 to 3 years.

4. There are limiting imaging and a restricted laboratory service available on
Saturdays and Sundays. There is even more limitations in support services such as
physiotherapy, cardiorespiratory testing, occupational therapy, discharge facilities
and social workers. The access and egress of patients into Units must be in balance
and in sync. Unless there is an investment into a 7 day working with respect to the
back door of the hospital things will not flow in an efficient way.

5. We should be required to do a 5 day working as part of a 7 day service. This should
be emphasised and not by default discussed as a 7 day working programme.

6. The Royal College of Physicians in Wales believes that patients deserve the same
high quality care in the evening and weekends as they receive during the week.
The priority should be to introduce a 7-day service for acute and emergency care,
in line with the 2010 RCP position statement and the recent report of our Future
Hospital Commission, ‘Caring for medical patients’.

7. Doctors, particularly medical registrars, are already under increasing pressure in
the NHS, and many junior doctors are reluctant to take up these hard-pressed
posts. Support services will also need to cover nights and weekends to make
extended working successful. Any changes needed to implement seven day
working must also improve working conditions for acute medical staff so that we
can encourage doctors to take up these posts and continue to provide high quality
services.

8. In December 2010, the RCP president, Sir Richard Thompson released a position
statement which said that ‘patients are still not getting the care they deserve at
night and at weekends. Too many junior doctors are covering too many very ill
patients, and this has to change.’

9. The RCP also recommended for the first time that any hospital admitting acutely ill
patients should have a consultant physician on-site for at least 12 hours per day,
seven days a week, who should have no other duties scheduled during this time.
All medical wards should have a daily visit from a consultant; in most hospitals this
will involve more than one physician.

10. However, not enough questions have been asked about social care support for the
transfer of care out of the hospital setting, or indeed, how we provide truly
integrated health and social care services for these patients out in the community.
This remains one of the key stumbling blocks to running a seven day acute service.
Additional Comments from RC Physicians

- I think that there needs to be a recognition that physicians are already giving out of hours cover during their on call shifts. On call in this hospital a day starts at 7-7.30 am and go on until 10-10.30pm in my experience.
- Currently at UHW there are no routine rounds at the weekend but discharge ward rounds are organised. This ignores the review of sick patients on the hospital wards. There are also retrieval rounds – but these focus on acute admissions and not on deterioration of hospital inpatients.
- At UHW, consultants can be contacted when on call out of hours and will return to review patients if necessary overnight. I do not feel that the 24 hour presence of a consultant is warranted or workable at present – this will result in loss of productivity the next day, and is likely to deskill physicians in training.

- What happens on weekends and overnight in most hospitals is unsustainable – junior physicians in training are the “go-to” doctors for any deteriorating patient or clinical problem. It would seem that management wish physicians to work longer and more intensely with little or nothing in the way of extra resource.
- The presence of a consultant physician on a ward at weekends will generate work, and therefore any plan to increase consultant presence needs to include junior doctors.
- Without extra resource, evening and weekend working will result in time being paid back during the “working week”.
- This will have a predictable impact on scheduled care (clinics, procedures, etc.) and continuity for patients, in a system already disabled by its lack of continuity. Remember that we are having a conversation at a time when it is being proposed that physicians take on greater roles for all hospital inpatients – under the care of surgeons etc. Where is the time to carry out this work coming from? Do we have the medical workforce to provide it? And will agreeing to take this kind of work on attract physicians into training? I suspect not.
- We need to review the ways in which we work – perhaps as consultant teams, to provide as much continuity as possible to patients and juniors.
- Thus job plans will need reviewing – not just those who are part of 7 day working – but to make matters equitable, in my view, the job plans of those clinicians not contributing to intensified rotas and working. This may enable recognition in terms of sessional commitment and therefore remuneration, for those working at higher intensities within the hospital environment. A whole system approach is required. Solutions may call for physicians, and potentially trainees, to rotate through 2 or more units within a health board or further afield.
- Admissions to UHW are likely to increase in the short and probably long term given the changes envisaged at UHL and in light of the outcome of the South Wales Plan.
Whether these increased levels of admissions can be triaged to other units, or flow streamlined through UHW, or both, it will be interesting to see. Similar issues will need to be addressed in Swansea and Newport, and North Wales/Liverpool.

**B) Royal College of Surgeons**

1. RCS supports 7 day working but wants to stress there is no point just putting consultants on a 7 day timetable if the remainder of the hospital is not also working at full capacity.

**C) Royal College of Obstetricians and Gynaecology**

1. Acute Obstetrics and Gynaecology is currently a 24/7 service.
   i. Variable formal ward rounds at weekend—depends upon activity
   ii. All consultants will attend when requested
2. Separation of acute O+G units from acute medical and surgical services compromises care of acutely ill pregnant women.
   a. The management of Ectopic pregnancy is compromised if O+G is not co-located with Emergency Departments admitting/assessing acute abdominal pain in fertile women
3. OOH’s support for Ultrasound scanning is variable across Wales
   a. Early pregnancy assessment units are not provided daily due to shortage of radiographers and financial constraints
   b. Premature labour diagnostic tests—fibronectin or Actinpartus have been very difficult to introduce across Wales due to funding structures
4. Elective clinics can be provided in evenings and weekends. These may be popular with patients and in some circumstances achieve enhanced productivity of on site supervising consultants.

**D) Royal College of Paediatrics**

1. In paediatrics, most units work to the following
   • Consultant ward round most/every day of the week
   • Consultant attends morning handover Saturday and Sunday
   • Consultant ward round Saturday and Sunday. In most units, the consultant would see ALL patients, new admissions and those admitted earlier in the week.
   • Thereafter on call from home, attend when contacted by either middle grade or nursing staff
2. Reduced availability of blood tests, radiology, pharmacy and CAMHS do affect the care the consultant can deliver. Thereafter on call from home, attend when contacted by either middle grade or nursing staff.
3. Quite often, we have a consultant led management plan that cannot be implemented over a weekend, due to unavailability of supporting services.

4. Paeds has a fast turnaround time, with most admissions going home within 24hrs of admission, and this is extended over a weekend, as results not available, unable to perform USS etc.

5. I think Paediatricians have been working 7 days a week for many years, and we plan to continue to do so. Yes, it’s a pain, but we manage it with rota of 1:6 or so in most units, so it is extremely do-able. The children do get a better service for it, and the evidence points to reduced hospital stays and better satisfaction for families. We are slightly puzzled why every department doesn’t do the same.

6. One issue for us I suppose is that there is only 1 paediatrician in the hospital on a weekend, but without the non urgent work, clinics, meeting etc, there is no need for more. If we extend the service to providing OPD activity on a weekend, that may meet some resistance. It would also likely need workforce expansion to enable the weekdays to be staffed appropriately to enable management meetings etc to occur. They may, however happen on a weekend as well.

7. Most units use a “service week” model whereby a consultant has no admin and OPD based activities for a week, simply runs the acute service, and the weekend is no different to all the other days on the service week, other than going home after the ward round.

8. Some units have consultants on twilight shifts, resident until about 9pm, weekdays and weekends. These tend to be relatively new recruits, and are remunerated with time off during the week. It is something that is likely to become more standard over the next few years, but it can be difficult to integrate management roles into that working schedule. I believe it is work in progress.

E) Royal College of Ophthalmologists

1. Consultants are second on-call and have a very light on-call workload compared to other specialties.

2. Most eye departments in Wales do not offer an open access service, all cases must be referred and are given a scheduled appointment.

3. A recent survey in Aneurin Bevan Health Board found that on an average weekday the Emergency Eye Clinic receives 27 referrals (85.2% within normal working hours). More than half of these referrals are managed with telephone advice or directed to more appropriate care pathways (for example rapid access 'wet' age-related macular degeneration clinics). During normal working hours 1.8% of referrals were graded as immediate or urgent (requiring review on the same day unless a medical decision to the contrary), this proportion rose to 12.5% for referrals received out of hours. Put another way 98.2% of referrals received in hours and 87.5% of those received out of hours can be safely scheduled for review during the normal working day.
4. The vast majority of our operating is performed on a day case basis and increasingly patients are managed postoperatively in the community by optometrists.

5. Consultant ophthalmologists are available for telephone advice 24/7 and in my experience invariably come in to perform/directly supervise trainees for all but the most minor surgical procedures. It is unusual for us to operate out of hours for many reasons including: increased sub-specialisation (retinal detachments are now all performed by sub-specialists), the availability of theatres with specialist microsurgical equipment and nursing staff able to operate the equipment. We rarely commence complex microsurgical procedures after 22.00. Most cases wait overnight to be performed on the next scheduled list taking priority over routine elective work.

6. Individual consultant practice varies but all would come in to review complex emergency admissions over the weekend when necessary. This is rare because management protocols are used effectively for most common eye emergencies.

7. Ophthalmologists do not perceive that any change in current consultant emergency cover is necessary, practical or desirable.

8. We are unable to recruit specialist (SAS) doctors in ophthalmology. As these doctors leave first on-call rotas, many units struggle to remain EWTD compliant. So some change may be forced on us. Consultants in some areas have already indicated their unwillingness to be first on-call so there may be a need for neighbouring units to amalgamate on-call cover. This is already happening to some extent in west Wales.

F) Faculty of Occupational Medicine

1. In relation to Occupational Medicine 7 day working isn’t generally necessary although there is some unscheduled work eg managing high risk needlestick injuries and I know some larger services do provide this outside Mon-Friday and I would support this if adequately resourced.

2. I’m not aware the Faculty of Occupational Medicine has issued a position statement on 7 day working but from a patient perspective I would support acute services being available in line with the RCP recommendations and as others have said this means having all the relevant services available (including Social Care Services) not just the senior doctor present if it is to be effective.

G) Royal College of Anaesthetics

1. The vast majority of consultant anaesthetists take part in on call rotas at weekends and often these are among the busiest on call rotas in the hospital. In some cases
consultants work a resident on call pattern particularly in the biggest critical care units. Anaesthetists cover emergency theatre work, obstetric anaesthesia services (including 24 hour on demand epidural services), critical care units, aspects of resuscitation services, pain medicine as well as being routinely involved in the management of the sickest patients in the emergency dept.

- All patients in critical care under the care of intensivists / anaesthetists will be physically seen at least once a day by a consultant and usually more often than this. In some units the consultant covering the ITU will also have responsibilities to other areas of anaesthetic service at weekends. This is something that should probably be reduced or stopped in the vast majority of units at least during weekend daytimes.
- All admissions will be seen by a consultant either on admission or within 8-12 hours. Many intensive care units insist on consultant to consultant referral to ensure the most senior staff are involved in these patients. It would be hoped all consultant anaesthetists whether covering theatre, obstetric or Intensive care work are well aware of the potential importance of senior involvement and I do not perceive this as being a common problem within the speciality. I believe it is a common finding that patients referred to critical care units particularly those from medical wards (especially when the patient has been admitted a few days prior to a weekend) have not had adequate on going senior review on the medical wards over a weekend.

2. Any hospital with an A&E will require resident anaesthetic staff and one of the problems facing the speciality is exactly this. With many hospitals in Wales several of which have relatively small A&E depts., relatively small obstetric units and small to medium sized critical care units, anaesthetic depts. are either faced with running multiple rotas to separately cover the different areas or have resident staff covering more than 1 area each of which can have time-critical emergencies. Anaesthetic depts. may find it easier to staff fewer rotas on fewer sites. However, the devil is the detail with this as very large units may require multiple staff and so not result in overall reduced staff numbers. In addition if patient transfers to large centres increases this may involve anaesthetists more frequently.

3. Many support services are reduced at weekends although the majority of the lab and common imaging services required by anaesthesia or critical care are available 7 days a week. If there were to be an expansion of work at weekends these services may need to broaden their weekend remit or increase capacity for what they currently provide. Some services such as specialist input may not be available in the smaller hospitals where for example all the medical sub-specialities share an on call rota. Therefore on any given weekend day for example a renal opinion may be available – but a cardiologist opinion may not be available.

4. There is likely to be a case for change to ensure critical care services look the same on weekends as weekdays, but the need for other elective aspects looking the same is probably not made. If staff work electively at weekends they will not be available all week and without increasing numbers this may not have benefits overall. There is a good case for fewer but larger sized units rather than multiple small ones – although the exact size of an optimal unit can be complex.
Anaesthetists already provide significant weekend input and increasing weekend (consultant) working significantly with existing staff numbers may not be feasible.

H) Royal College of General Practitioners

1. Looking on from a primary care perspective, I think GPs would hope that:
   - All admissions were seen by a senior medical clinician within a certain time frame.
   - Be available to deal with problems or complications. 7 days a week. That seems to happen in most specialties and it is perhaps concerning that it might not be universal practice across all units.
   - Patients requiring urgent emergency interventions should be able to receive those 7 days a week.
   - Rotas to ensure this may mean that there is reduced routine availability at other times in the week.
   - Clearly laboratory, diagnostic and all other services need to be available with adequate personnel to meet this need. The issue that has been suggested is whether the NHS becomes a 24/7 routine service.

2. Soundings from my colleagues in RCGP Wales are not supportive of this concept although many would like extended access to diagnostics and therapies but few are keen to see 7 day routine primary care.
   - The costs would be considerable in terms of support staff and infrastructure (such as more buildings being heated. Lit, cleaned etc for longer~).
   - It would lead to shift working which is not mainstream in General Practice and less professional interaction. I doubt it would impact significantly on continuity but it would make it more difficult to get full complements for meetings.
   - I note most hospital acute care nurses are now working 12 and a half hour shifts, although I am unsure of the patient safety issues of prolonged shifts if worked at full intensity (I know we did it in our youth! and I suspect many of you still do when on call).
   - I also worry about impact on family life if everyone works 7 day shifts although moving to working 3 or 4 days out of 7 has some attraction.

3. As long as all get adequate rest and workloads are manageable I am not sure that 7 day working would adversely affect quality of care and might enhance it.

I) Faculty of Dental Surgery

1. I don’t think the NHS in Wales can afford 7 day all singing all dancing service.
• More likely with 'robust' job planning mon-fri will continue as present but there will be a consultant on site (not just on call, and not every consultant) at weekends and every patient will have direct consultant contact 7 days a week. There will be limited cost implications I suspect with this option since the JPlanning will look to timetable Consultant A Monday to Friday and Consultant B Wednesday to Sunday. Furthermore this would free up 'on call' payments.

• The next question is whether this is a good use of consultant time on weekends. If a consultant is in then should they be doing lists to take up any free capacity and take pressure off weekday lists? there will be a step up increase in costs with this option since all the support needs to be in place.

• I cant see full OP activity going on on weekends since this really would incur substantial increase in costs to the NHS and conflicts currently with the consultant contract.

• However the first two options would probably deliver what is deemed necessary - reduced morbidities associated with weekend admissions and use of underused theatre space so reducing pressure on weekdays as well as quicker discharge on weekends so freeing up beds ??

• Saying that whether BK will get what he says he wants at this stage (Tesco service) is another thing when the politicians see the actual costs. He is selling a lot of it on robust J planning but this is at a time when there is pressure on expanded GP hours.

**J) Royal College of Pathologists**

• With reference to Pathology, there are differences between the working practices of each discipline, as I expressed in an earlier email. Blood Sciences (haematology and biochemistry run an ‘emergency’ service at the weekend, where most samples/tests that arrive are processed (some more esoteric tests get held over for the next working day) but it is understood that these requests are coming from inpatients. If clinics, GP surgeries etc were held at the weekend then a full complement of staff would be required to be in work. Other disciplines such as Cell Path do not have routine emergency cover at weekends and a change to 7 day working would be huge.

• Blood Sciences labs have emergency cover at weekends already, and have done so for many years, but this service is manned by usually 2-3 staff as opposed to 20 or so during the working week. Microbiology have a similar system. Cellular Pathology have not traditionally run an emergency service and only offer a 5 day Monday-Friday service.

• If full 7 day working is required, then the lab service would need significant investment to be upgraded to provide this level of service.
K) Royal College of Radiologists

- This is where it all starts to get difficult on the imaging side; in theory we could work over 7 days but we would certainly want the surgeons and physicians working similarly to provide the global service as on a normal working day.

But in practice:

- You can’t have the same level of imaging support on the weekend as on current M-F 9-5 without additional resources. If additional resources are not made available, you will lose radiologists from existing weekday work (current elective and inpatient reporting and procedures, and MDT attendance etc) to staff the weekends and evenings and that certainly isn’t what most clinicians want. You also won’t get the full range of sub speciality knowledge available every day; the particular MDT radiologist you work closely with won’t be available every day of every week (24/7) to answer all your specialist queries.

- It does need to be clarified specifically what clinicians (both hospital clinicians and GPs) are asking for. This will vary very widely across Wales and certainly the Welsh Government needs to clarify this aspect. The situation will be different between UHW, where emergency services are currently largely provided by trainees, and other hospitals in Wales where the imaging service is largely provided by consultants. I don’t think it is the role of the Academy to provide this detailed information.

- I cannot speak for other health boards but as an example the Aneurin Bevan Health Board radiology directorate where I am based, provided the following in the recent 2013 Christmas/New Year period:

  December 25th 2013 Christmas Day) 239 plain radiographs: 23 emergency CT scans.
  December 26th 2013 (Boxing day) 335 plain radiographs: 22 emergency CT scans.
  December 28th 2013 (Saturday) 398 plain radiographs: 32 emergency CT scans.
  December 29th 2013 (Sunday) 330 plain radiographs: 25 emergency CT scans.
  January 1st (New Years Day) 2014 345 plan radiographs: 31 emergency CT scans.

- Furthermore the directorate also undertook routine elective (outpatient) MRI on Saturday 28th December (35 MRI examinations) and 21 similar MRI examinations on Sunday 29th December. MRI is available in ABHB if requested for emergency inpatients: one inpatient MRI request was received and undertaken on 1st January. These emergency CTs and MRI were reported by consultant radiologists. A separate interventional radiology rota covered emergency interventional procedures across the local Health boards of South East Wales.

- So what is required – more reporting of plain films, a different range of scans, more GP access, more interventional work?

- It isn’t just about money. Ultrasound is a hands on service; you can’t outsource ultrasound to the far East or India. There is an international shortage of sonographers (Australia now imports locum sonographers from the UK – in the past we have kept many Welsh departments going with Australian locum sonographers who wanted to work for a short time in the UK). We currently can’t get enough
sonographers to staff current services in Wales much less look for additional sonographic staff for weekends. That’s largely why we have approx 6000 patients waiting for US in ABHB. Radiographers now find other paths of career development more attractive than doing sonography.

- Likewise even if money is provided, where will any additional radiologists come from? The RCR has highlighted to the CMO for some years the various problems with recruiting radiologists to Wales. Only 70% of our welsh trainees apply for jobs in Wales and few advertised posts attract applicants from outside Wales. Many welsh radiologists are over 50 and Wales has the highest level of anticipated UK radiologist retirements over the next few years; there aren’t enough radiologists in training to fill existing vacancies, much less cope with these retirements and certainly not an expansion of the service. I am told Hywel Dda has fewer radiologists in post now than it did 20 years ago.

- Some sites might also need additional cross sectional imaging equipment, depending on levels of existing elective work already done on weekends.
- There would also be costs for secretarial and portering services. Comprehensive IT backup provided both by health boards locally and nationally via Welsh health IT services would be essential.

L) Trainee Comment

- There are training implications associated with the introduction of a 7 day week. Trainees are on the whole supportive of the concept as it allows for greater supervision at weekends and out of hours work. The trainees of the UK Academy have expressed their support but retain a wish for some degree of unsupervised work in order to develop their independent practice skills.

Wales Deanery

Secondary Care

A) Current arrangement of 7 day working in Wales:

- The Deanery currently closely monitors clinical supervision of trainees at all hospital sites across Wales. It is clear that there are many, and increasing, examples of scheduled direct consultant presence in evenings and at weekends e.g. O&G, Anaesthesia, ICM.

- Deanery quality management (QM) processes place great importance on the ability of trainees to receive consultant support when necessary. It is now rare to find instances of consultants not responding appropriately to trainee requests for support. In general, most consultant supervision Out-of-Hours (OOH) and at weekends is “remote” i.e. from home. Feedback from consultants reveals a perception that current Health Board priorities mainly relate to elective activity with
less support for increased scheduled direct consultant presence OOH and at weekends.

- When there have been concerns with clinical supervision these often, though not exclusively, relate to both OOH and weekend activity. A recurring theme has been the difficulty in ensuring appropriate “middle-grade” cover for junior doctors at all current acute sites across Wales. This is due to unrealistic rotas which do not allow for maternity leave, Out of Programme training and failure to recruit trainees. In particular, there are major recruitment difficulties for the non-training grade doctors that are essential to maintain rotas at the current large number of acute hospitals across Wales.

- A key outcome from the proposed reconfiguration to fewer training sites would be the provision of more robust middle-grade cover. Such a concentration of training activity is also likely to enhance the ability of consultants to have a greater direct input to OOH and weekend clinical supervision. In addition, a concentration of acute activity would facilitate the much-enhanced laboratory and radiology service that would be required for increased activity OOH and at weekends.

B. Acute admissions into hospitals with and without A + E?

- Recent Deanery QM issues have identified training and supervision difficulties in hospitals without a broad range of on-site specialities. This includes Emergency Medicine but in particular relates to the absence of critical care support, whether from Acute Medicine, Anaesthesia or a dedicated ICM provision.

- GMC approved specialty training curricula are now increasingly explicit on the caseload required for training and the associated supervision. Hospitals, which reduce the spectrum of admissions because of the absence of certain specialties, are unlikely to provide an appropriate acute training environment for full-length, or possibly any, trainee attachments.

- If acute services reconfigure, the Deanery will work with Health Boards to identify appropriate future training allocations. Any patient safety issue (e.g. insufficient supervision) will require immediate action, but within a maximum of 12 months there must also be action to address significant training deficiencies.

General Practice

- With the current working week the much feminised GP workforce is under considerable strain and most choose not to work more than two to four days of around 10 hours working day duration.

- General Practice is currently working (and for the most part run) very well across the majority of Wales during Out-of-Hours (OOH) and at weekends for acute medical issues. This is organised at LHB OOH provider supra-practice level.
• Offering working week type availability of GPs (at single practice or small practice collective level) to additionally provide for care of self limiting and chronic disease before 8am and after 6.30pm during the week and at weekends would require very many more GPs than are currently available. Medium term prospects for additional recruitment are extremely poor for Wales and the rest of the UK. GP recruitment is currently imploding in much of Wales and England.

• Considerable amounts of extra sessional pay would be needed for GPs (if more could be trained and persuaded not to retire early), practice nurse, health care assistants and ancillary staff). There would also need to be additional reimbursement of heating and lighting costs.

• The oft-mooted issue of the ‘excess’ attendance at A+E being due to lack of GP availability is a fallacy. The numbers don’t support this as the perceived excess is a tiny fraction of numbers seen in GP daily and would amount to about 2-3 extra patients per GP per day.

3. Future Hospital Commission Report

Future Hospital Commission report, ‘Caring for medical patients’, in September 2013. This report recommends that:
‘Acutely ill medical patients in hospital should have the same access to medical care on the weekend as on a week day. Services should be organised so that clinical staff and diagnostic and support services are readily available on a 7-day basis ... There will be a consultant presence on wards over 7 days, with ward care prioritised in doctors’ job plans. Where possible, patients will spend their time in hospital under the care of a single consultant-led team. Rotas for staff will be designed on a 7-day basis, and coordinated so that medical teams work together as a team from one day to the next.’

The key recommendations on seven day working include:

- A named consultant lead, seven days week, for any given ward area
- An acute care hub to stabilize acutely ill patients, with same access to diagnostics and interventional services on weekend as on a week day
- Specialist medical care delivered across the hospital and in the community seven days a week
- Staff rotas planned on 7-day basis and seamless transition between teams from one day to next
- Planning for recovery to begin as soon as patient admitted and arrangements for discharge operating on 7-day basis, including early supported discharge through community teams
- Dedicated on-site psychiatry liaison services covering all wards, emergency department and acute medical unit across seven days for a minimum of 12 hours a day
- Assessment of how the current workforce needs to adapt to deliver seven day working.
4. RCP acute care toolkit 4: delivering a 12 hour, 7 day consultant presence on the acute medical unit

Acute medical illness is a 7-day problem – patients are just as likely to develop an acute illness requiring an emergency admission on a Saturday or Sunday as on a weekday. Evidence that patients admitted at weekends have poorer outcomes than those admitted on weekdays, and that patient mortality is higher at weekends, led to the RCP and the Society of Acute Medicine (SAM) recommending that a consultant physician – dedicated to the care of acutely ill patients – should be available on site to review patients for at least 12 hours a day, every day.

This toolkit provides practical guidance to senior hospital managers and clinical staff on how to organise acute medical services to ensure that the 12-hour consultant presence delivers consistent high-quality care to acutely ill patients.

5. The AMRC seven day consultant present care project in England

The recent Academy seven day consultant present care project in England delivered a report in December 2012 detailing three service standards. We welcomed the Academy report, and accepted its recommendations as an aspirational standard for all physicians, but we warned that this will require service redesign and may have resource implications to make this standard a comprehensive reality.

Standard 1: Hospital inpatients should be reviewed by an on-site consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient’s care pathway.

Standard 2: Consultant-supervised interventions and investigations along with reports should be provided seven days a week if the results will change the outcome or status of the patient’s care pathway before the next ‘normal’ working day. This should include interventions which will enable immediate discharge or a shortened length of hospital stay.

Standard 3: Support services both in hospitals and in the primary care setting in the community should be available seven days a week to ensure that the next steps in the patient’s care pathway, as determined by the daily consultant-led review, can be taken.

Download the Seven Day Consultant Present Care report.

In November 2013 the project delivered a second report: Seven Day Consultant Delivered Care: Implementation Considerations designed to help organisational and clinical leaders with both identifying their starting point on the path to delivering seven day consultant-present care for patients in hospital, and setting out a view of the target destination.

6. NHS England seven day services forum project

In December 2013, the RCP welcomed new measures unveiled by the NHS England Medical Director, Sir Bruce Keogh, to implement a seven day service across the NHS. Sir Bruce set out ten new clinical standards that describe the standard of urgent and emergency care all
patients should expect seven days a week. They describe, for example, how quickly people admitted to hospital should be assessed by a consultant, the diagnostic and scientific services that should always be available, and the process for handovers between clinical teams.

The RCP believes that patients deserve the same high quality care in the evening and weekends as they receive during the week. We welcome the plans set out by NHS England. In 2010 the RCP called for there to be a consultant presence on acute medical wards for at least twelve hours a day, seven days a week, and in many parts of the country, this is already happening.

However the RCP insists time off is allowed in lieu, and this is not always happening. We are pleased that NHS England agrees with the RCP that priority must be given to introducing a seven-day service for acute and emergency care. We look forward to working with NHS England to implement these changes and to solve the challenges ahead. We must develop a truly integrated seven day service that goes beyond the hospital and incorporates primary, community and social care.

7. NHS Improving Quality - Seven Day Services Improvement Programme (SDSIP)

This 3-year programme, led by NHS Improving Quality (NHS IQ) in England, is designed to support the spread and implementation of seven day service models at scale and pace across the NHS. Using proven transformational improvement methodologies, NHS IQ will work with a wide range of stakeholders to:

- Build the body of evidence on how to implement and embed seven day service models
- Baseline review the extent to which seven day services has already been adopted
- Test evidence of the impact of seven day service models and transferability
- Evaluate and capture learning to support wider adoption of the models
- Evidence patient and public involvement in helping to shape future services
- Evidence the adoption of seven day services within commissioning intentions
- Support an integrated approach to the development of seven day services, examining finance, workforce, clinical leadership, integrated service provision and commissioning
- Build capacity for shift towards routine services being available seven days a week.

NHS England and NHS IQ have invited expressions of interest from across the health and care system to become 'early adopters' of the programme, who can demonstrate leading the way in developing sustainable, patient centred seven-day service models. Phase One of the programme includes emergency, urgent and elective care and diagnostics such as endoscopy, interventional radiology, and pathology.

8. NICE Clinical Guidelines to support seven day services

NHS England has commissioned NICE to develop an evidence base to support seven day services. It is likely that many of these will be developed through the RCP National Clinical Guidelines Centre from the summer of 2014. Topics include:

- Acute medical admissions in the first 48 hours
Consultant review within 12 hours

Out of hours care
Readmissions, including those which come into ICU within 48 hours
Service delivery of trauma services
Seven day working
Urgent and emergency care

9. Survey form sent to members of the Academy of Medical Royal Colleges Wales.

1. How does your speciality perceive the current arrangement of 7 day working in Wales with regards to the supervision of acute admissions and post-operative cases on Saturdays and Sundays? eg

   a. Do most consultants on call at the weekend ...?
      i. physically review all weekend emergency admissions - or
      ii. do a scheduled ward round on Saturday and Sunday?
      iii. Attend when requested by junior staff

2. How does your speciality envisage a transition/change for acute admissions into hospitals with and without A + E?
   a. short term (next 2-6 months)
   b. long term (next 2-3 years)

3. Are your current weekend needs met for assessing/managing complexity? How should these be improved in the short and long term?
   a. Laboratory
   b. Imaging
   c. Other services eg physio, cardio respiratory testing etc.

4. Any other observations eg need for change etc.