The Royal College of Emergency Medicine

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The "on call" role of the Emergency Medicine Consultant

The Royal College of Emergency Medicine is the professional body responsible for setting standards of clinical and professional practice in Emergency Medicine in the UK. This statement outlines the view of the RCEM on this matter.

Emergency Departments (ED) must have an Emergency Medicine (EM) Consultant on-call at all times. An on-call EM consultant has similar responsibilities to other on-call consultants. In consequence they may be required to:

- provide direct senior clinical input into serious/complex cases out-with the expertise of other hospital teams
- provide telephone advice on clinical, medico-legal and ethical issues.

Each ED and hospital should be staffed and resourced to a level sufficient to manage predictable peaks in workload, 24 hours a day, seven days a week.

All hospitals should have clinical and managerial teams on site able to deal with predictable events that may pose a clinical risk to individual or multiple patients, including increased attendance numbers, crowding due to acute bed shortages (exit block) or staffing issues.

Consultants are 'on call' to deliver expertise in clinical cases beyond the experience / skill level of resident clinicians. This enables cost effective delivery of senior clinical expertise. By definition therefore, tasks that do not require senior clinical expertise e.g. acting-down to cover staff absence, are not 'on call' responsibilities and must be addressed via other mechanisms. Where capacity deficits have created queues, these too should be addressed through standard operating procedures that mobilise other clinicians within the hospital or redirect appropriate patients to medical, surgical or paediatric assessment units. Good risk management should seek to maximise resources available to deal with such problems., and avoid concentrating multiple risks in a single area.

If exit block is considered to be such a problem that the ED is rendered unsafe, then the duty management team including the executive on call and the relevant medical and surgical consultants must attend the hospital. Exit block is a problem of 'downstream' capacity - an ED consultant can only mitigate the effects in the ED whilst colleagues seek solutions within the hospital and community.

All escalation policies should follow the guidance published by the Royal College of Emergency Medicine[iii] and endorsed by NHS Improvement (England) and the Scottish Government.

The decision as to whether an ED is unsafe should normally be taken by the nurse and doctor in charge of the ED,

UK employment law requires all employees to have 11 hours of uninterrupted rest in every 24-hour period. In the NHS this is to ensure the health and safety of patients as well as that of employees. Compensatory rest arrangements (taken when the above rest periods are interrupted) are very disruptive to ED rotas and as such the need to trigger them should be minimised.

It is particularly unsafe to require any employee with overnight on call responsibilities to work frequently or substantially in excess of their rostered shift times. This is a significant issue for consultants working late evening shifts and then on-call overnight. No employee should be required to extend their shop-floor shift beyond 12 hrs. Fatigue is not a defence when faced with litigation or regulatory sanction.

<u>Exceptional circumstances</u>

- The on-call EM consultant will provide clinical leadership of the emergency department in the event of a "Major Incident".
- Arrangements for consultant presence 24/7 for other forms of alert or escalation protocol are unfeasible given current UK staffing levels.
- Trusts running separate trauma consultant rotas should have clear guidance in place regarding activation of the trauma team. Ordinarily the trauma team leader role cannot be conflated with other roles or responsibilities

Revised Feb 2016

[i] Emergency Department Capacity Management Guidance
www.**rcem**.ac.uk/CEM/document?id=8691
[ii] Crowding overview and toolkit www.rcem.ac.uk/CEM/document?id=8816