Supporting the acute medical take: advice for NHS trusts and local health boards

Purpose of the statement

The acute medical take has proven to be a challenge across acute hospital trusts and health boards within the UK for some years, as documented in a number of publications from the Royal College of Physicians of London, including *Hospitals on the edge? The time for action (2012)* and *The medical registrar: Empowering the unsung heroes of patient care (2013)*. More recently, the workforce crisis in manning the acute medical take has worsened considerably. In 2015, according to the RCP annual census, 40% of consultant physician posts in England and Wales were unfilled either because of lack of candidate suitability or indeed because there was no candidate at all. Moreover, 48% of doctors finishing the Foundation Programme do not directly enter core specialty training and approximately 25% of doctors completing core medical training are no longer in any form of training 3 years later. Transforming this situation will require a systems wide approach. However, we believe there are actions that each individual trust/hospital can take that can ameliorate this situation.

In drafting this document, we are mindful that local configuration and provision of services means each hospital has unique issues requiring locally developed solutions. This document explores potential strategies which may be helpful.

The problems

Medical patients make up the majority of acute unscheduled admissions to most NHS secondary care hospitals. These patients are usually admitted via the acute medical take and their number and complexity are increasing. One third of all hospital admissions are via the acute medical take. Admission numbers rose by 37% in the decade ending 2012, whilst bed numbers fell by 33% in the last 25 years. Those patients presenting on the acute medical take are now older (66% are over 65), more likely to have one or more long term condition, and 25% have dementia. The acute medical take in most hospitals is co-ordinated by a senior trainee (the medical registrar) under consultant supervision. The trainee is likely to be dual training in both a medical specialty and in internal medicine. Medical registrars must possess a number of key clinical and non-clinical competencies. These include the ability to recognise and treat acutely unwell patients, the ability to deal with complexity and diagnostic and therapeutic uncertainty, the ability to supervise trainees and they must, in addition, have well developed organisational and leadership skills. The medical registrar is often the most senior clinical decision-maker, across all hospital specialties, in the trust out of hours, and is often responsible for coordinating the management of the most acutely unwell patients, not only in the physician specialties, but in many other specialties as well.

Currently, there is a shortage of dually accrediting trainees (speciality plus internal medicine) and of trainees in acute internal medicine. This has arisen for a number of reasons. Increasingly trainees successfully completing their foundation programme are not going directly into core specialty or GP training. The proportion doing so has fallen from 71.3% in 2011 to 52% in 2015. The changing

demography of the medical workforce, the desire to be linked to particular regions, the tendency to wish to work less than full time (LTFT) and a desire to step out of training for a period of time have all contributed to this. Moreover, the appeal of the acute hospital specialties, particularly those linked to the acute medical take, has decreased dramatically in recent years. The acute medical take and specialties linked to it are unpopular because of the increasing and unfettered workload (the medical registrar is the only adult services specialty registrar who cannot refuse to accept a patient that other specialties refuse to accept), the acuity of the patients, the challenge of having to deal with complex, increasingly aged, multiply co-morbid patients with increased diagnostic and therapeutic uncertainty, increasing patient and carer expectation and an increasing blame culture with a lower threshold for litigation. This is exacerbated by constantly changing teams and fragmentation of the firm structure which previously provided both clinical and pastoral support for trainees. As a result of these factors, specialty training programmes at ST3 are under filling by approximately 200 each year and these shortages arise particularly in specialties linked to the acute medical take, with some deaneries, trusts and health boards particularly badly affected. Attempts to increase post numbers at core medical training (CMT) have had some success but the number of trainees available to fill these posts has not risen and so the number of CMT trainees remains approximately the same. An expansion to CMT at this point will not help to meet shortages at ST3 level.

What can be done to improve this situation?

A systems wide approach is required. There is a need to increase the workforce for the acute medical take, improve prevention, particularly for patients with long term conditions, upscale admission avoidance schemes, consider how to better organise the acute medical take and encourage other specialties to take more responsibility for their own patients.

Workforce

The NHS is under doctored. The UK has 2.71 doctors per 1,000 people and, in 2014, was ranked 24th out of 27 EU countries in this respect. So, the UK needs to train more doctors. The three physician Royal Colleges also believe there should be an expansion in medical school numbers. The recent announcement of 1500 more medical students per year in England is welcome, but this doesn't address the other three countries of the UK and the first of these won't achieve consultant status till 2033, so there will still be a significant medical workforce shortfall in the meantime. The service also needs to consider other sources of medical workforce. Approximately 40% of hospital doctors trained outside the UK and 20% of all doctors in the UK qualified elsewhere in the European Economic Area. Following Brexit there are concerns that a significant number may leave and, in the future, that less may come. Therefore, visa requirements for non EU doctors need to be made easier, and the medical training initiative, a scheme run by the Medical Royal Colleges to allow non EU doctors to train in the UK for up to 2 years on a tier 5 visa, needs to be expanded. The Medical Royal Colleges have been very active in this latter respect. In the future, greater numbers of doctors are more likely to work less than full time and to adopt portfolio careers, involving them coming in and out of training at various points in their careers. The training "offer" to young doctors therefore

needs to address this. Moreover, the SAS grades are likely to increase significantly in number and to be increasingly "home grown" doctors. They need to be properly supported. The new Royal Colleges of Physicians Flexible Internal Medicine (IM) Curriculum will increase the number of trainees committed to both acute unscheduled care and the acute medical take and, hopefully, inspire more to commit to IM. However, to encourage trainees into IM, and to keep established consultants in the specialty, will require improving the standing of the specialty and this will entail the system using financial and other levers.

Organisation of the acute medical take

The RCP London's Future Hospital Commission Report (2013) sets out a road map for the organisation of the acute medical take. However, each hospital will have different solutions depending on its size, catchment population and staffing. Use of systems to minimise the number of steps in a patient's journey will improve efficiency and the patient's experience and outcome. Other useful resources include the Royal College of Physicians of London new online resource, Medical Care, which was launched in July 2016 and which replaces the previous document, *Consultant Physicians, Caring for medical patients,* and the Royal College of Physicians of Edinburgh document *Improving quality of care through effective patient flow – it's everyone's business!*

Some trusts/hospitals have co-located the ED and the AMU and some employ GPs in the ED/AMU to whom appropriate patients can be triaged. The RCP London is currently exploring, with the RCGP, the possibility of a post CCT fellowship in acute medicine for GPs.

Junior doctors are a valuable resource. They are often brimming with ideas to improve systems. They benefit from moving between trusts/hospitals and therefore have experience of different solutions to problems. They should be actively engaged in advising on appropriate aspects of the organisation of the acute take. The RCP London hopes that its Chief Registrar project will encourage and facilitate this.

An efficient team is one in which tasks are delegated appropriately. Support should be provided so that, where possible, tasks can be done by non-medical staff – for example, provision of phlebotomists, nurses trained in cannulation, and clerical support staff. Recent developments in this respect include the introduction of Physician Associates, who are now supported through a faculty of the RCP London, and the increasing use of Nurse Practitioners. Support such as this is particularly crucial at night and weekends, however, it needs to be properly organised. At night, one of the most successful models is the Hospital @ Night Team, provided it is properly resourced and supported.

One of the most enervating factors in any profession is lack of control in the workplace. The acute medical take team is the only team that cannot say "no" to referrals. It is important that non physician specialties play their part in supporting the acute medical take team, by not declining to take patients whom they could look after and by managing their patients such that medical complications are avoided and opinions requested when really necessary. This is not just about

support, but also has significant patient safety implications. Speciality referral guidelines should ideally be in place and be enforced within each hospital.

Direct referral to specialty teams

Exploring mechanisms to facilitate early involvement of specialty teams will contribute to more efficient running of the acute medical take. When a patient is known to the trust or health board or the clinical picture is clear, they should be referred directly to the relevant specialty. With the changes to physician training emanating from the introduction of the new Flexible IM Curriculum in the next 2 years, it is hoped that even those specialties not directly undertaking the acute medical take will contribute more to the front door by accepting acute unscheduled patients within their own specialty directly.

Organisation of the medical teams

With the European Working Time Directive, rotas have become more complicated and have disrupted the longstanding team structures. There may also be further impact from the new Junior Doctors contract in England. Consequently, medical teams often have little or no experience of working together. In addition, the wider pastoral support of trainees through the firm structure has been lost. Much could be done by intelligent rota design to improve continuity and quality of care and morale among trainees. It is hope that the RCP Future Hospital Chief Registrar initiative will contribute significantly in this area.

Review hospital at night (H@N) team compositions and functions

An appropriately constituted and clinically led H@N team can ensure safe and effective care during evenings and weekends. Trusts and health boards should be able to demonstrate that they are operating within best practice guidelines and that the service is regularly audited.

Handover should be strengthened, and used as an educational opportunity. Electronic methods are being introduced into some trusts.

Broaden access to acute medical take

All doctors who have completed core medical training and recently passed the MRCP should have the competence to undertake medical registrars' duties, including co-ordinating the acute take under consultant supervision or supporting current inpatients across the specialties. Results from the national CMT survey[1] suggest that many trainees completing core medical training do not feel confident in taking on the role of the medical registrar. Therefore simultaneous efforts must be made to address the lack of preparation for specialty training at CMT level, such as a supervised period of acting up on the specialist registrar rota during CMT2, which will in turn help to improve recruitment into the medical specialties. The introduction of an Internal Medicine 3rd year in the new flexible IM curriculum should help to mitigate this problem.

Currently only those who undertake dual training with internal medicine contribute to the acute medical take, as part of their training in GIM. The Royal Colleges of Physicians have been advised that certain NHS employers are already asking doctors who are currently training in a single specialty to support medical registrars who are formally undertaking dual training. At present, this requires careful consideration to protect both patients and trainees. In the future, with the introduction of the new IM curriculum, most physician trainees will have done 3 years of IM prior to specialty entry, and so there will be a larger pool of trainees with greater IM training to call upon, as suggested by the *Shape of Training Report* (2013). Both now and in the future, single specialty trainees who wish to increase their internal medicine experience should be supported to do so. To be consistent with best practice, any trainee undertaking such a role will require proper notice, appropriate induction, training, consultant supervision, and feedback, with a clear plan in place to protect specialty training.

Involvement of single specialty registrars in the acute take needs to be done in collaboration with Deaneries or equivalent and their respective specialty training committees. The final decision should involve the postgraduate dean, and trainees experiencing difficulties should seek advice from the royal colleges.

Participation of single specialty trainees in the acute take should enhance their overall training and not be detrimental to their specialty training. Many of the key competencies and skills acquired during participation in the acute take are equally relevant to specialty training and should be counted towards such training. Any such attachment will need careful planning with the specialty service so that it does not compromise the specialties' commitment to acute specialty cover or other specialty services.

The more recently a doctor has left core medical training, the safer requesting them to contribute will be for the patient, the employer and for the doctor. Participation of non-IM registrars in the acute take should usually be restricted to the first 12–24 months for most trainees. The Royal College of Physicians of Edinburgh and the Royal College of Physicians and Surgeons of Glasgow would prefer that this is restricted to 12 months for non-IM trainees with no inpatient commitments in their specialty training.

Summary

We recognise that the current situation needs to be addressed as a matter of urgency. The three Physician Royal Colleges are currently undertaking a number of significant work streams which should soon bear fruit. This document suggests a number of possible solutions that could be appropriate in the mean-time.

1 Tasker F, Newbery N, Burr B, Goddard A. Survey of core medical trainees in the United Kingdom 2013 – inconsistencies in training experience and competing with service demands. *Clin Med* 2014; 14: 149–56.

The royal colleges of physicians have a leading role in the delivery of high-quality patient care by setting standards for medical practice and promoting clinical excellence across the UK. They are

committed to patient safety and high-quality training. The colleges provide physicians with education, training and support throughout their careers and, as independent charities, advise and work with government, the public, patients and other professions to improve health and healthcare.

This statement will be reviewed in December 2019. Comments on the statement or its application in practice should be sent to policy@rcplondon.ac.uk and will be considered at the point of review.