Royal College of Physicians

Royal College *of* Physicians *of* Edinburgh

Educating doctors, improving care.

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

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

Purpose of the statement

The acute medical take is proving a challenge across hospitals within the UK as documented in recent publications from the Royal College of Physicians of London, including *Hospitals on the edge? The time for action* and *The medical registrar: Empowering the unsung heroes of patient care*.

The local configuration and provision of services mean that each hospital has unique issues that will require locally developed solutions. This document explores potential strategies that might be helpful.

The problems

The number of admissions via the acute medical take is increasing. The medical take in most hospitals is generally managed by a senior trainee (under consultant supervision) in a medical specialty who dual accredits in general internal medicine (GIM). Medical registrars must possess several key clinical competencies, including the ability to recognise and treat acutely unwell patients and supervise trainees, as well as leadership skills. They are often the most senior medical decision-maker in the hospital out of hours, and are responsible for coordinating management of the most unwell patients. These activities constitute the majority of their acute medical training.

Currently, there is a shortage of dually accrediting trainees and trainees in acute medicine, which has arisen because there are too few (by roughly 300) core medical trainees (CMTs) to fill available specialty training posts at ST3. These shortages arise particularly in acute medicine and geriatric medicine, but are spread unequally, with some deaneries, trusts and health boards particularly affected.

What can be done to improve this situation?

There is no single or simple solution, and expansion of the medical workforce will require a series of different solutions to resolve the short-, medium- and long-term problems. Other potential solutions are possible across the acute care pathway, such as adaption of the provision of appropriate services in the community (allowing management without admission to hospital); improvement of the management of patients with chronic diseases in the community, including facilitating the provision of fast outpatient access to specialty clinics; and provision of acute specialist clinics to provide an alternative to admission (with appropriate infrastructure to allow outpatient management).

Workforce

The royal colleges of physicians are pressing for action to redress the imbalance in the number of CMTs entering specialty medical registrar training programmes at ST3 (of note, Scotland has increased CMT numbers by 10 for August 2014). National recruitment makes it difficult at a local level to fill vacancies. Trusts and health boards with foresight will look well in advance of start dates for solutions beyond using expensive (and often inefficient and unsatisfactory) short-term locums. These should include diversion of the funding used for locums to additional training posts (including locum appointment for training posts [LATs]), which could expand opportunities open to international medical trainees via the Medical Training Initiative (MTI) run by the royal colleges.

Organisation of medical take

Every hospital will have different solutions depending on its size, catchment population and staffing. Use of systems that minimise the number of steps in the patient's journey will probably improve efficiency and the patient's experience and outcome. Useful resources include the Royal College of Physicians of London document *Future Hospital: Caring for medical patients* and *Acute medical care. The right person in the right setting – first time*, and the Royal College of Physicians of Edinburgh document *Improving quality of care through effective patient flow – it's everyone's business!*

An efficient team is one in which tasks are delegated appropriately. Support should be provided so that tasks can be done by non-medical staff – for example, provision of phlebotomists, nurses trained in cannulation, and clerical support staff. This support is particularly crucial at night and weekends. Additionally, the role of specialist nurses and physician associates should be fully explored to support the medical on-call team.

Direct referral to specialty teams

Exploring mechanisms to facilitate early involvement of specialty teams will contribute to more efficient running of the 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.

Organisation of the medical teams

With the European Working Time Directive, rotas have become more complicated and have disrupted the longstanding team structures. Consequently, medical teams often have little or no experience of working together. Much could be done by intelligent rota design to improve continuity and quality of care and morale among trainees.

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.

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 running the acute take 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.

Currently only those who undertake dual training contribute to the acute general take as part of their training in GIM. The royal colleges of physicians have been advised that NHS employers are already asking doctors who are currently training in a single specialty to support medical registrars who are formally dually training. This requires careful consideration to protect patients and trainees. Single specialty trainees who wish to increase their general medical 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 Local Education and Training Boards or equivalent and their respective specialty training committees. The final decision must 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 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 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-GIM 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-GIM 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. Interim solutions, including participation of single specialty registrars in the acute take, might be necessary, but the royal colleges of physicians will continue to work with all stakeholders to develop more sustainable long-term solutions. ■

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.

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This statement will be reviewed in December 2016. 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.

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