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BRIEFING NOTE

**Acute medicine**

Acute medicine relates to the immediate specialist treatment for adults who present as emergencies. Doctors in general internal medicine diagnose, treat and manage the care of inpatients and outpatients with acute and long term medical conditions.

In 2014 Health Education North East (previously known as the Northern Deanery) ended postgraduate doctor training at West Cumberland Hospital (WCH) in acute and general medicine. This was largely in response to concerns relating to the ability to provide adequate levels of supervision to medical trainees from substantive (i.e. non-temporary) consultants.

Since then, the key issue facing North Cumbria University Hospitals NHS Trust (NCUHT) in continuing to provide a safe and sustainable acute and general medicine service at WCH has been the availability of junior and middle grade doctors.

On the withdrawal of medical training at WCH, acute medicine adopted the following clinical workforce structure:

* A team of around 28 advanced practitioners (currently all highly trained nurses) covering all WCH house officer (HO) and some senior house officer (SHO) roles.
* A junior and middle grade workforce of 16 SHO and 2 Registrar ‘non-trainee’ doctors.
* The team was also to be supported by West Cumbria GP trainees working as SHOs.

However the recent significant decline in number of applicants for GP training in west Cumbria, and an inability to recruit substantive junior and middle grade doctors, has meant that the SHO and registrar roles in acute medicine are almost entirely provided through, high cost, temporary, locum medical staff.

This widespread reliance upon medical locums has resulted in:

* A Care Quality Commission grading of ‘inadequate’ for medical care at West Cumberland Hospital.
* Concerns over patient safety, service quality & reliability.
* An annual overspend of nearly £1.5m on premium cost middle grade locums.
* Worsening consultant physician recruitment & retention – there are currently eight consultant vacancies in medicine at WCH.
* An annual overspend of £1.6m on locum consultants - recruitment became even more challenging when medical locum use became widespread at WCH.
* A sense of uncertainty over the future of WCH and the continued provision of acute services.

Proposed solution

Working with advisors from the Northern Clinical Senate, clinicians in acute medicine at NCUHT developed a new workforce model called the Composite Workforce Strategy*.*

The composite model is based upon a team of clinical staff drawn from a variety of professional backgrounds, selected and trained to carry out the traditional HO, SHO and registrar roles. This composite clinical workforce would consist of:

* Trust doctors/clinical fellows (substantive doctors with only a minor level of professional education provided as part of their role)
* Academic Fellows (hospital doctors with a dual teaching role linked to University of Central Lancashire (UCLan) Medical School)
* GP trainees
* GPs with additional training to work in hospital based roles
* Advanced clinical practitioners (highly trained and experienced clinicians; e.g. nurses, paramedics and staff from other health profession backgrounds)
* Physician associates (a new supporting medical role working essentially at HO or SHO level)

All of the above posts are continually supported and supervised by consultant physicians.

This model was selected because it is built upon:

* Experience already gained with advanced practitioners working at WCH in paediatrics, A&E and acute medicine.
* A more realistic view of medical recruitment.
* A modified, more attractive, GP training scheme offering an additional fourth year which equips GPs with the skills to allow them to work part-time in a specialised hospital roles.
* A developing partnership with the UCLan Medical School, providing joint posts with clinical service and teaching components.
* The newly emerging physician Associate Role.

Supporting measures

The composite workforce model in acute medicine will also be supported by a number of additional measures designed to improve patient care and reduce the number of patients admitted to hospital. These are:

* **Enhanced Ambulatory Care:** This is a service which works alongside A&E, providing specific care for comparatively well emergency attenders at hospital. This aims to reduce unnecessary admissions to hospital amongst A&E attenders, and also can be accessed by general practitioners for patients with certain conditions.
* **GP rapid access out-patient clinics:** This is a system where GPs are able to refer patients to a hospital outpatient clinic for review by a hospital consultant specialist at very short notice – potentially the same day. This will support GPs in maintaining patient care at home/in the community, seeking to manage care as early as possible to avoid the need for emergency admissions.
* **Rapid availability of specialist medical advice to GPs:** This is a system where GPs can and quickly contact hospital consultants for specialist treatment advice. Again, this will support GPs in maintaining patient care at home/in the community, seeking to manage care prospectively to avoid emergency admissions.
* **Frailty Services:** This is a specialist assessment service where Care of the Elderly specialists and their teams can review older patients, without needing to admit them to hospital. The aim is that this service will minimise unnecessary hospital admissions amongst older A&E attenders and will support GPs in maintaining patient care at home or in out-of-hospital settings.
* **Catchment area adjustment:** As happens on a day-to-day basis now when the hospitals are very busy, it may be necessary to temporarily adjust ambulance boundaries to switch more work to Cumberland Infirmary Carlisle (CIC) in line with workload/capacity pressures and WCH staff recruitment. In other words, those patients living roughly half way between the two hospitals but slightly nearer to Whitehaven might be taken to Carlisle instead. If this proved necessary it would only be expected to be an interim measure to ensure safety.

Although important in setting the conditions for the success of the composite workforce model at WCH, these developments are recognised good practice in their own right and will therefore be implemented at CIC.

In summary, the Trust believes this model to be a credible solution to a difficult problem, not least because it can be found to work well in other of the country. The Trust is entirely confident that a safe, effective, fulfilling and recruit-able clinical workforce model will result.

*QUESTION: Why have the trainee doctors been withdrawn from WCH?*

West Cumberland Hospital is a comparatively small hospital so it can be difficult for the small team of doctors and senior nurses to support the training of medical staff. In addition, the breadth and volume of cases that are ideally available to support medical training is not always available at a small hospital.

Many training centres are reducing the number of sites that trainees are placed, in order to concentrate training resources. In WCH’s case, this was triggered by the rising number of consultant vacancies which, in turn, reduced the levels of training and supervision available to medical trainees.

*QUESTION: Why can’t the Trust recruit junior and middle grade doctors for WCH?*

Most junior and middle grade doctor posts form part of regional training schemes, with doctors receiving specialist medical training as part of their role. This allows them to progress towards the career goals of becoming a GP, hospital consultant, or some other specialist. Junior and middle grade medical roles where specialist training is not part of the role are less attractive and there are fewer doctors looking for these types of roles. Without the ability to fill training posts, the Trust is reliant on non-trainees and locum doctors, or to look at non-medical alternatives.

*QUESTION: Why can’t the Trust recruit consultants for WCH?*

In some specialities, UK-wide, there are shortages of doctors at consultant level, particularly so in acute medicine specialities. Furthermore, it’s more difficult to recruit to consultant posts when the junior doctor team is almost entirely composed of locums, which puts the Trust at a competitive disadvantage to others of the UK when it comes to consultant recruitment in acute medicine. This is why the Trust wants to develop a more stable junior and middle grade workforce in acute medicine.

*QUESTION: What are advanced clinical practitioners (ACPs)?*

They are clinicians performing a role to high level of clinical skill and expertise. They must be professionally registered, have acquired an expert knowledge base, complex decision-making skills and clinical competences for specific areas of expanded scope of practice. Education must be at a Masters level to meets the education, training and continuing professional development requirements for advanced clinical practice as identified within the national framework. ACPs can be drawn from many professional backgrounds, such as nurses, physiotherapists, paramedics and pharmacists. On completion of training they will be able to work at an equivalent to SHO level and, after more experience and further training, can work at the medical equivalent of registrar level.

*QUESTION: Will ACPs be able to provide the same level of care as junior and middle grade doctors?*

All of our clinical staff (doctors and all other staff) are only employed in roles for which they are qualified and assessed as competent. ACPs working at SHO level will have completed a Master’s degree in advanced practice and will have also been assessed as competent to work at that level. ACPs working at registrar level will, in addition, have completed a higher advanced practice course and will again have been assessed as clinically competent by consultants based at WCH.

*QUESTION: What are physician associates?*

The physician associateis a new role to the UK. They are health care professionals who have been trained in a similar way to doctors (‘the medical model’) but start training as post-graduate students. They will typically already hold a 2.1 in a medically-related science degree. Their training equips them with the attitudes, competencies and knowledge base to deliver holistic care under defined levels of supervision.

Physician associates are already widely recognised as part of the clinical workforce in the USA, Canada, Australia, New Zealand and the Netherlands, where research has shown that as part of the wider team they “provide comprehensive, co-ordinated care which enhances the patient’s journey”.

In response to the shortage of doctors in a number of specialities such as emergency and acute medicine, elderly care/rehabilitation and general practice, the appetite for introducing physician associateroles is growing steadily across all health care sectors in the UK. On qualification, physician associates will perform a role similar to that of a first year house officer doctor.

*QUESTION: How will the Trust check the new staffing arrangements are safe?*

All staff must be suitably qualified, experienced and assessed as competent and, in common with other clinical staff, will receive professional supervision and mentorship, and regular appraisal. Staff are encouraged to raise any concerns that may have through these mechanisms.

NCUHT also has the following systems in place, which are able to monitor patient safety, service quality, untoward incidents, and patient opinion of standards of care:

* Like all NHS trusts, NCUHT has extensive incident reporting systems and processes to allow staff to report any incidents, or near misses of concern, so that swift action can be taken. Action taken and learning is fed back to teams, and trends are also monitored.
* Patients and relatives’ complaints are closely monitored for safety issues and specific trends.
* The Trust conducts staff surveys.
* The Trust conducts ‘Friends and Family’ surveys to ensure that the quality of patient experience is understood and kept at a high standard.
* Mortality and morbidity information is subject to regular review.

Further reading

* [*NHS East Midland Advanced Clinical Practice Framework (Dec 2014)*](http://www.wnecumbria.nhs.uk/wp-content/uploads/2016/09/NHS-East-Midlands-Advanced-Clinical-Practice-Framework-Dec-2014.pdf)
* [*NHS Physician Associate Infographic*](http://www.wnecumbria.nhs.uk/wp-content/uploads/2016/09/NHS-physician-associate-infographic.pdf)
* [*NHS West Midlands Advanced Clinical Practice Framework (Dec 2015)*](http://www.wnecumbria.nhs.uk/wp-content/uploads/2016/09/NHS-West-Midlands-Advanced-Clinical-Practice-Framework-Dec-2015.pdf)
* *[Physician Associate Case Study](http://www.wnecumbria.nhs.uk/wp-content/uploads/2016/09/Physician-associate-case-study.pdf)*

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