Supplementary Material 4: Results of telephone survey

48 telephone interviews were conducted between July 2016 and February 2017. The results of the interviews – which cover 50 hospital sites across 48 trusts – including some sample comments are detailed below.

Note: Questions 1 to 5 contained details about the trust name, site name, trust code and date of interview etc. so have not been included in this summary.

Question 6. What is the average number of emergency department presentations per day?

100 - 124	4.00%	2
125 - 149	16.00%	8
150 - 174	8.00%	4
175 - 199	8.00%	4
200 - 224	14.00%	7
225 - 249	10.00%	5
250 - 274	16.00%	8
275 - 299	4.00%	2
300 - 324	18.00%	9
325 - 349	2.00%	1
	Answered	**50**
	Skipped	**0**

Question 7. What is the average size of the medical take?

10 - 19	2.00%	1
20 - 29	10.00%	5
30 - 39	28.00%	14
40 - 49	16.00%	8
50 - 59	22.00%	11
60 - 69	20.00%	10
70 - 79	2.00%	1
80 - 89	0.00%	0
	Answered	**50**
	Skipped	**0**

Question 8. Who provides medical leadership for the emergency department?

ED has its own clinical directorate	16.00%	8
ED is part of a directorate that includes acute medicine	28.00%	14
ED is part of a directorate that includes acute and general medicine	50.00%	25
Other	6.00%	3
	Answered	**50**
	Skipped	**0**

Question 9. What days/hours do emergency medicine consultants cover ED?

(e.g. Monday-Sunday 8am-8pm)

(Answers not provided)

Question 10. How many emergency physicians are in post substantively?

1	0.00%	0
2	6.00%	3
3	6.00%	3
4	4.00%	2
5	6.00%	3
6	10.00%	5
7	30.00%	15
8	14.00%	7
9	4.00%	2
10	16.00%	8
11	2.00%	1
12	2.00%	1
13	0.00%	0
14	0.00%	0
15	0.00%	0
Other (please specify)		13
	Answered	**50**
	Skipped	**0**

Question 11. How many emergency physicians are funded?

Option		Answer
1	0.00%	0
2	2.00%	1
3	0.00%	0
4	2.00%	1
5	6.00%	3
6	12.00%	6
7	6.00%	3
8	8.00%	4
9	10.00%	5
10	34.00%	17
11	6.00%	3
12	12.00%	6
13	2.00%	1
14	0.00%	0
15	0.00%	0
Other (please specify)		5
	Answered	**50**
	Skipped	**0**

Question 12. Are you using locum consultant staff in the emergency department on a regular basis?

Yes	68.00%	34
No	32.00%	16
Not specified	0.00%	0
Comments on your answer		16
	Answered	**50**
	Skipped	**0**

Question 13. Are the locum consultants for the emergency department provided internally or externally?

Internally	11.43%	4
Externally	51.43%	18
Both	25.71%	9
Not specified	5.71%	2
Other	5.71%	2
Comments on your answer		28
	Answered	**35**
	Skipped	**15**

Questions 14. Do you have problems with junior medical staffing in A&E?

Yes	89.80%	44
No	10.20%	5
Not answered	0.00%	0
Comment		15
	Answered	**49**
	Skipped	**1**

Comments highlighted that problems were mostly in the middle grade. Seen alongside questions 11 and 12, many sites are heavily reliant on locums.

- “Particularly around middle grade appointments. Only one training post out of a rota of 6. Very reliant on middle grades for out of hours cover. It’s a real gap, it’s a real concern.”
- “Considerable failure by the deanery to fill all the deanery posts. Very itinerant group who go where the pay is best.”
- “It’s a complete and utter nightmare, middle grade rota very depleted and vacant shifts SHO level.”
- “Our middle grade rota is not filled and heavily reliant on locums.”
- “Middle grade cover a particular issue.”

Question 15. How are you addressing the challenges with junior medical staff in the emergency department?

Using ANPs (Advanced Nurse Practitioners)	42.00%	21
Using ACPs (Advanced Clinical Practitioners)	20.00%	10
Using trust doctors and clinical fellows	36.00%	18
Physicians associates	4.00%	2
Using GPs	14.00%	7
Using locums	60.00%	30
Other	0.00%	0
Other & comment	80.00%	40
	Answered	**50**
	Skipped	**0**

As well as the options above, comments highlighted that international recruitment and making posts more attractive were also tactics being employed to address the challenges with junior doctor cover:

- “Using up to 14 different locum agencies for middle grade cover. Trying to attract candidates with ‘novel’ posts.”
- “Overseas recruitment, using extra consultants.”
- “Offering fixed-term posts with competitive salary.”/ “Personalise recruitment – offering secondment opportunities or trying other roles.”
- “Working with neighbouring trusts to get similar pay and conditions, using an agency guaranteed prices and fill levels, allied health professionals a more reliable and plentiful workforce.”
- “Mainly use internal locums or doctors on zero-hour contracts.”
- “Recruiting abroad, recruit from locum pool, making posts more attractive through secondment opportunities, offering good support and supervision from consultants.”
- “Recruiting to provide joint service with local urgent care centre.”

Question 16. Does the emergency department have dedicated support from other disciplines?

Physiotherapist	86.00%	43
Occupational therapist	82.00%	41
Social worker	44.00%	22
Pharmacist	8.00%	4
Mental health liaison	22.00%	11
Admission avoidance team	44.00%	22
ANP (Advanced Nurse Practitioners)	38.00%	19
ENP (Emergency Nurse Practitioner)	26.00%	13
Physician Associate	8.00%	4
Other	56.00%	28
Comments on your answer		35
	Answered	**50**
	Skipped	**0**

Other responses included a focus on discharge teams, rapid response and admissions avoidance, as well as other disciplines:

- “Senior nurse acting as ‘clinical navigator’ – liaise with care homes and rapid response team in the community ‘they just work magical things’.”
- “Rapid response service – aims at admission avoidance. Two geriatricians focusing on frailty admission avoidance.”
- “Paediatric nurse”
- “Frailty service”
- “Quite a substantive admission avoidance discharge team including community nurses.”
- “ACP assisted discharge team – Physio, OT, SW.”
- “Cover limited from all staff – not thought to be adequate.”

Question 17. How are patients with acute medical problems that require semi-urgent interventions managed in the emergency department?

A - Managed by the ED staff within the ED	16.00%	8
B - Managed in conjunction with medical staff (specialty or on-call team) in the ED	20.00%	10
C - Referred to the medical team and managed outside of the ED (e.g. in the AMU or specialty wards)	16.00%	8
A+B	12.00%	6
A+C	12.00%	6
B+C	14.00%	7
A+B+C	10.00%	5
Comments on your answer		24
	Answered	**50**
	Skipped	**0**

The comments demonstrated that for some trusts, the answer was dependent on the nature of the problem. Others highlighted that although one option was their ideal situation, the reality was another.

- “Want it to be C but lack of beds means it is B. Learning from doctors’ strike was that admission thresholds changed with consultants – want to get more consultants closer to front door. Often admitting for a specialist opinion – when if it was immediately available could avoid.”
- “Depends on the busyness of the take/ Depends on severity of illness/ Depends on the acuity of the patient”
- “Only very urgent cases dealt with in ED”
- “Exception is patients referred into the ambulatory pathway who are managed by the acute physicians.”
- “Depends on confidence of A&E consultant. Stroke and AF referred to acute medicine.”
- “Cardiology managed directly by the specialty.”

Question 18. Which conditions have fast-track pathways?

	Yes		No		Total
Stroke	98.00%	49	2.00%	1	50
Trauma	94.00%	47	6.00%	3	50
Acute MI	100.00%	50	0.00%	0	50
Neurosurgery	50.00%	6	50.00%	6	12
Renal	22.22%	2	77.78%	7	9
Vascular	53.85%	7	46.15%	6	13
Other	91.67%	22	8.33%	2	24
Comments on your answer					25
			Answered		**50**
			Skipped		**0**

Question 19. If the emergency department needs an opinion from a specialist doctor out of hospital, how do they obtain this?

Via the general medical/surgical team	40.00%	20
Asking the specialty directly	14.00%	7
Both	46.00%	23
Comments on your answer		25
	Answered	**50**
	Skipped	**0**

The answers to this question varied, again depending on the situation.

- “Some specialty support provided externally from other trusts in which case contact directly.”
- “Mainly via medical/surgical team – for some problems may go directly”
- “Number allows team to directly access the consultant of the week – surgery, medicine, cardiology, res, gynae, paediatrics.”
- “Some specialties offer direct advice – haemo, stroke, cardiology.”
- “Can contact cardiology directly and get stroke advice.”
- “Cardio is direct.”

Question 20. What is the pattern of referral for medical patients needing admission?

A - All medical patients are referred to the on-call medical service (e.g. chest pain with minimally elevated troponin goes to the AMU)	92.00%	46
B - Patients are triaged (as much as possible) to specialty teams (e.g. chest pain with minimally elevated troponin goes directly to cardiology)	10.00%	5
C - If neither description is appropriate, please describe the usual pattern of referral of medical patients needing admission	4.00%	2
Comments on your answer		12
	Answered	**50**
	Skipped	**0**

- “Rapid assessment and triage (RAT) direct people to medics for assessment – may send ambulatory care, home or AMU or if assessed in ED them referred on to AMU.”
- “Some pathways – e.g. stroke – will bypass AMU and go to specialist ward.”
- “Mainly A with some exceptions.”
- “Mainly A with a bit of B – e.g. for some cardiology and elderly care.”
- “Specialties don't take direct referrals.”
- “Stroke is triaged.”

Question 21. What are the destinations to where patients might be admitted directly from the emergency department?

A - Clinical decision unit (or equivalent)	63.27%	31
B - Frailty unit	24.49%	12
C - General medical ward	32.65%	16
D - Stroke unit	73.47%	36
E - Other specialty ward	24.49%	12
F - Other hospital	57.14%	28
G - Other	28.57%	14
Comments on your answer		22
	Answered	**49**
	Skipped	**1**

- "Ward if no beds on AMU."
- "C – only if not enough capacity AMU. Medicine running at 125% bed occupancy. Chance of you getting to a bed you might need is negligible."
- "Frailty is part of AMU."
- "Frailty unit is ambulatory – so not a place for admission, could be admitted to elderly care ward behind it. Community Hospitals."
- "Specialty ward occasionally, intermediate care, nursing home, care home, mental health."
- "Older people's short stay unit."

Question 22. Who makes the decision about where a patient will be referred? e.g. junior/middle grade doctor, ED consultant

(Answers not given)

Question 23. Who makes the decision about where a patient will be placed? e.g. bed manager, site manager, bed coordinator. Is this different in and out of hours?

(Answers not given)

Question 24. Where is the general medical take run from?

ED	12.00%	6
AMU	64.00%	32
ED and AMU	18.00%	9
Other	6.00%	3
Comments on your answer		8
	Answered	**50**
	Skipped	**0**

- "No capacity on AMU – but would prefer it to be there."
- "It should be AMU but in practice moved to the front door."
- "Run from all four assessment areas – ED, AMU, ACU all linked by computer system."
- "May split into ED if very full."
- "Co-located with A&E."

Question 25. What is the consultant cover for the medical take?

	Yes		No		Total
Cardiology	39.13%	18	60.87%	28	46
Respiratory	90.00%	45	10.00%	5	50
Geriatric medicine	84.00%	42	16.00%	8	50
Endocrinology	86.00%	43	14.00%	7	50
Acute physician	65.31%	32	34.69%	17	49
Gastro	65.31%	32	34.69%	17	49
General medical	45.83%	22	54.17%	26	48
Stroke	17.39%	8	82.61%	38	46
Rheumatology	32.61%	15	67.39%	31	46

	Yes		No		Total
Other	14.71%	5	85.29%	29	34
Comments on your answer					25
			Answered		**50**
			Skipped		**0**

Some of the answers to this question were identified through NHS Digital data as they were not clear from the interview transcript.

- “Gastro just pulled out, cardio just about to pull out.”
- “Gastro about to withdraw to establish a GI bleed rota. Cardiology withdrew from rota 2 years ago.”
- “Cardio, gastro and stroke have all withdrawn in last 5 years.”
- “This applies to out of hours only, in hours covered by acute physicians Took gastro off then put back on ‘didn't do anything’.”
- “Lack of participation if running separate take and/or not dually accredited.”
- “Consultant physician on call 10pm–8am, consultant on site 8am–10pm, separate 24/7 rotas cardiology, GI bleed, stroke and renal.” [Data on specialties comes from NHS Digital]
- “Cardiologists, elderly care physicians, stroke physicians on other rotas too. No one withdrawn from rota yet – but frailty and stroke having commitments reviewed.”
- “Separate on-call rotas for NIV, gastro, oncology and renal, endocrinology also wanting to pull out of the take 7-day working – specialists don't want to be on two rotas.”

Question 26. What is the total number of consultants that takes part on the medical take?

6-9	5.00%	2
10-12	27.50%	11
13-15	20.00%	8
16-18	22.50%	9
19-21	7.50%	3
22-25	15.00%	6
25+	2.50%	1
Comment		18
	Answered	**40**
	Skipped	**10**

This question was not asked on all calls.

- “Half general internal medics, half geriatricians.”
- “This applies only to the take out of hours.”
- “Out of hours.”
- “6 acute physicians and 12 general physician equivalents.”

Question 27. Do you have additional resources for the take? e.g. do you have an acute physician in the ED, admission avoidance teams etc?

(Question not answered)

Question 28. Is there an acute physician in the emergency department for the take?

Yes	24.44%	11
No	66.67%	30
Other	2.22%	1
Comments on your answer	6.67%	3
	Answered	**45**
	Skipped	**5**

Question 29. What about junior doctor cover for the medical take? Are there any challenges? (If so, what is your strategy for addressing these?)

(Question not answered)

Question 30. Do you have an acute medical unit?

Yes	98.00%	49
No	0.00%	0
Other (please specify)	2.00%	1
	Answered	**50**
	Skipped	**0**

Question 31. What percentage of patients with acute medical problems will go via the acute medical unit or medical assessment unit?

50-59	4.00%	2
60-69	2.00%	1
70-79	12.00%	6
80-89	18.00%	9
90 +	58.00%	29
Not known	6.00%	3
Comment on your answer		8
	Answered	**50**
	Skipped	**0**

- “In an ideal world would be 90%.”
- “Everybody should come through AMU and then you don’t lose people along the way and everybody gets the same sort of wait rather than people being fragmented round the hospital.”
- “Majority of patients.”

- “But currently significantly less because of capacity problems.”
- “Everyone except cardiology/significant proportion to ambulatory care.”

Question 32. Does an acute physician provide medical leadership for the unit?

Yes	89.58%	43
No	10.42%	5
Comments on your answer		6
	Answered	**48**
	Skipped	**2**

Question 33. How many beds are on your acute medical unit?

0 - 5	0.00%	0
6 - 10	0.00%	0
11 - 15	4.08%	2
16 - 20	4.08%	2
21 - 25	14.29%	7
26 - 30	18.37%	9
31 - 35	14.29%	7
36 - 40	6.12%	3
41 - 45	8.16%	4
46 - 50	10.20%	5
51 - 55	8.16%	4
56 - 60	10.20%	5
Not known	2.04%	1
Comment on your answer		20
	Answered	**49**
	Skipped	**1**

Question 34. What is length of stay in the acute medical unit dictated by?

Maximum length of stay	27.27%	12
Patient need	52.27%	23
Both	20.45%	9
Other	0.00%	0
Other + comment		18
	Answered	**44**
	Skipped	**6**

- "But frequently longer than want – due to capacity issues."
- "Bed availability downstream affects this."
- "Flow through hospital has a big impact."
- "Depends on number of admissions coming in."
- "Patient need can override LOS."
- "But lack of beds mean that often greater than 24 hour target."
- "Often dictated by availability of beds."
- "Not directly asked – set target 12 hours stay but frequently exceeded."
- "Dictated by capacity on downstream wards."

Question 35. What is the maximum length of stay in the acute medical unit?

12 hours	2.04%	1
24 hours	20.41%	10
48 hours	26.53%	13
72 hours	36.73%	18
Other	0.00%	0
Other + comment	14.29%	7
	Answered	**49**
	Skipped	**1**

- “Want it to be 72 hours – in reality 4–5 days.”
- “If there's somebody we need to keep a close eye on, we can do that more easily in a confined space, than scatter to the wards... We've had people there for a long time, several weeks.”
- “Currently about 5 days.”
- “48 hours main AMU, 72 hours frailty but often significantly longer.”
- “Aim to move people on within 8 hours.”
- “Don't have a maximum.”

Question 36. How many acute medicine consultant posts are currently filled?

1	8.00%	4
2	6.00%	3
3	16.00%	8
4	20.00%	10
5	14.00%	7
6	20.00%	10
7	6.00%	3
8	2.00%	1
9	0.00%	0
10	2.00%	1
0	6.00%	3
Comment on your answer		16
	Answered	**50**
	Skipped	**0**

Question 37. How many acute medicine posts are currently funded?

0	0.00%	0
1	0.00%	0
2	2.08%	1
3	22.92%	11
4	14.58%	7
5	12.50%	6
6	25.00%	12
7	6.25%	3
8	8.33%	4
9	2.08%	1
10	4.17%	2
0	2.08%	1
Other (please specify)		10
	Answered	**48**
	Skipped	**2**

- “The posts have been approved, but the money hasn't followed for some reason.”
- “4.5. We know we need more, but there's just, as you know, a complete lack of people to fill the posts.”
- “25 PAs funded.”
- “Don’t use acute physicians.”

Question 38. Are you using locum consultants for acute medicine on a regular basis?

Yes	71.43%	35
No	28.57%	14
Not specified	0.00%	0
Comment on your answer		23
	Answered	**49**
	Skipped	**1**

- “Every single day.”
- “To trial consultant working in A&E.”
- “All posts currently filled by locums.”
- “Trying to recruit to the 2 locum posts.”
- “Using sessional commitment from other physicians.”
- “Only to cover sickness and leave.”
- “One long-term locum.”

Question 39. Are these acute medical locums provided internally or externally?

Internally	14.29%	5
Externally	74.29%	26
Both	11.43%	4
Not specified	0.00%	0
Comments on your answer		18
	Answered	**35**
	Skipped	**15**

Question 40. Do you have problems with junior medical staffing for acute medical unit and medical take?

Yes	80.00%	40
No	20.00%	10
Not answered	0.00%	0
Other (please specify)		16
	Answered	**50**
	Skipped	**0**

- “Have lots of rota gaps – don’t have a full complement of trainees.”
- “Primarily covering illness.”
- “Gaps due to vacancies and issues with sickness – particularly changeover days.”

- “It’s a nightmare – there's been an imbalance of junior doctors from teaching hospitals and district general hospitals for a long time.”
- “3–4 gaps in middle grade rota – had nights where no middle grade in the hospital.”
- “50% vacancy rate with registrars.”
- “Over-recruit to ensure all posts covered.”
- “Middle grade cover a particular problem, especially middle grades.”
- “Primarily high levels of sickness.”

Question 41. How are you addressing this?

Using ANPs	30.61%	15
Using ACPs	14.29%	7
Using physicians sssociates	16.33%	8
Using trust doctors and clinical fellows	28.57%	14
Using GPs	0.00%	0
Using locums	42.86%	21
Other	0.00%	0
Other & comment	77.55%	38
	Answered	**49**
	Skipped	**1**

- “Recruiting from abroad.”
- “Training non-medical workforce to F2 and ST3 competency.”
- “Trying to make the rotations more attractive/improved sickness management.”
- “Created a shadow rota to provide locum cover – made up of clinical fellows doing a further degree – reduced agency spend.”
- “Consultants acting down and more junior doctors acting up.”
- “Offer career progression and training. International recruitment supported by digital marketing campaigns.”
- “Planning to offer financial incentives for locums to become permanent.”
- “Persuaded deanery for junior doctors in specialties like gastro to contribute to the take.”

- “We have two medical registrars overnight... We have had to increase money to fill those roles. Improved handover, increased support from registrars in ED.”
- “Mainly covering sickness. Trying to get juniors to work more flexibly across different areas in hospital.”
- “Overseas recruits.”
- “Using clinical nurse navigators.”
- “Used to cover high rates of sickness – trying to develop internal bank to cover.”
- “7-day pharmacy support, quite a lot of non-medical help, using fixed term rather agency cover.”
- “Improved sickness management including return to work interviews.”

Question 42. When do acute physicians provide cover for the acute medical unit?

	Yes		No		Total
Mon - Fri In Hours	90.00%	45	10.00%	5	50
Mon - Fri Extended Day	56.52%	26	43.48%	20	46
Mon - Fri Out of Hours	0.00%	0	100.00%	46	46
Sat/Sun In Hours	43.48%	20	56.52%	26	46
Sat/Sun Out of Hours	0.00%	0	100.00%	46	46
Comments on your answer					32
			Answered		**50**
			Skipped		**0**

- “AMU has on-site cover 8am–10pm, 7 days a week.”
- “Includes cover from geriatricians and respiratory physicians.”
- “Morning shift three acute physicians + geriatrician afternoon – drops to one or two physicians.”
- “No period when only acute physicians – always a mix of consultants – most people with AP sessions in job plan have other specialist commitments. Resident cover provided 8am–8.30pm 7 days a week.”

- “Cover provided by the 15 consultants on call.”
- “No dedicated cover from acute physicians – covered by medical take.”
- “On site cover 8–8 7 days a week – mix of acute and general physicians – 75% acute physicians, 25% rest.”

Question 43. How are patients with acute medical problems managed in the acute medical unit?

A - The acute medical team in charge of the AMU has clinical responsibility for all patients in the AMU, inviting specialist opinion where necessary. Some call this a "closed model" for AMU	68.00%	34
B - Specialist and acute teams have clinical responsibility for patients on AMU triaged to their teams. Some call this an "open model" for AMU	14.00%	7
A+B	14.00%	7
C - Other	6.00%	3
Comments on your answer		25
	Answered	**50**
	Skipped	**0**

- “No specialty input – if need specialist care try to move to bed ASAP.”
- “Cardiologists are supposed to come down most days. Acute physicians do day to day inviting specialist opinion when necessary.”
- “Model distorted by lack of acute physicians and reliance on specialists to provide AMU cover.”
- “Cardiology and respiratory review daily but they don't take over the patient. Gastro needs official referral.”
- “Cardiology may be invited to review patients, but do not take over the care of the patient.”
- “Haven't got enough acute physicians to manage patients or enough specialists to do consistent in-reach.”
- “Acute medical team in hours, specialists acting as generalists out of hours.”

- “Closed model but using a mix of specialist staff who divide work between them – increasing likelihood of specialist input.”
- “The one exception is cardiology – that in reaches to unit and picks up cardiology patients.”
- “But trying to change it from A to B – want specialty team to repatriate patients.”
- “Depends on acute physicians – some try to manage, some try to get others to manage.”

Question 44. Do you have dedicated support from other disciplines?

Physiotherapist	97.96%	48
Occupational therapist	93.88%	46
Pharmacy	38.78%	19
Social worker	57.14%	28
Speech and language	6.12%	3
ANP	8.16%	4
Physician associate	2.04%	1
Specialist nurse	10.20%	5
Admission avoidance team	10.20%	5
Other	42.86%	21
Comments on your answer		25
	Answered	**49**
	Skipped	**1**

- “Someone from complex discharge”, “Discharge facilitator”, “Integrated discharge team”, “Person from delayed discharges team”
- “Home safe team for frail elderly – physio, OT, social worker. Discharge team – nurses, social workers, discharge coordinators.”
- “Heart failure team, alcohol liaison service”
- “Frailty nurse”, “Elderly care team – frailty”
- “Psychiatric liaison”
- “Alcohol liaison service”

- “Social work input limited”

Question 45. What are the destinations for patients leaving the acute medical unit?

A - Frailty unit	38.00%	19
B - Short stay unit	34.00%	17
C - General medical ward	76.00%	38
D - Geriatric ward	86.00%	43
E - Specialist ward	94.00%	47
F - Other hospital	74.00%	37
G - Other	32.00%	16
Comments on your answer		21
	Answered	**50**
	Skipped	**0**

- “Home”, “Hopefully home”
- “AMU works as a short stay unit.”
- “Would not go to frailty unit as that is at the front door.”
- “Mental health services”
- “No separate frailty unit or short stay unit.”
- “Other hospital – renal/ other hospital – renal/ vascular”
- “Community hospitals”
- “Older persons short stay unit”

Question 46. Who makes the decision about where the patient will go?

(Question not answered)

Question 47. What is the decision-making process for transferring general medical patients to downstream wards?

A - Patients with 'general medical' problems are allocated to general medical beds	6.00%	3
B - Patients with 'general medical' problems are allocated to the specialist ward/service that fits with their primary problem (e.g. patients who are breathless go to a cardiology or respiratory ward/service)	48.00%	24
C - Patients with 'general medical' problems go to any available bed	12.00%	6
A+B	10.00%	5
A+C	2.00%	1
B+C	22.00%	11
Comments on your answer		13
	Answered	**50**
	Skipped	**0**

- “Ideally B but lack of beds means C all specialist wards take general medical patients”, “Would like to do B but in reality it’s C”
- “Ideally B”, “Ideally should be B but lack of beds can inhibit”
- “All wards take general medical patients to some degree, all specialist wards take general medical patients. No dedicated general medical ward.”
- “Depends on expected length of stay and complexity of problem.”
- “Only 50% going to the right ward.”
- “Driven by bed shortages.”
- “General medicine doesn’t really exist here as a nomenclature.”

Question 48. Faceted classification (Domain C): Is the acute medical unit open, closed or partial?

1 - Closed	38.78%	19
2 - Partial	42.86%	21
3 - Open	18.37%	9
Comments on your answer		7
	Answered	**49**
	Skipped	**1**

Question 49. Faceted classification (Domain D): Define the acute medical unit generalist/ specialist split

1 - Acute physician only	6.38%	3
2 - Acute physician dominant	38.30%	18
3 - Mixed	46.81%	22
4 - Specialist dominant	8.51%	4
Comments on your answer		5
	Answered	**47**
	Skipped	**3**

Question 50. Do you have an ambulatory care service?

Yes	98.00%	49
No	2.00%	1
	Answered	**50**
	Skipped	**0**

Question 51. Does the ambulatory care service include a dedicated ambulatory care unit?

Yes	96.00%	48
No	4.00%	2
	Answered	**50**
	Skipped	**0**

Question 52. What hours does this operate?

Mon- Fri, In hours	100.00%	49
Mon- Fri, Extended day	77.55%	38
Saturday	53.06%	26
Sunday	48.98%	24
Comments on your answer		16
	Answered	**49**
	Skipped	**1**

Question 53. Which of the following services does the ambulatory care service provide?

A - Primary assessment for patients referred by the GP	91.84%	45
B - Primary assessment for patients referred from the ED	87.76%	43
C - Investigation/treatment/follow-up for patients on certain pathways (e.g. cellulitis, VTE)	97.96%	48
D - 'Hot' clinics for rapid assessment of patients	63.27%	31
E - 'Hot' clinics for rapid follow-up of patients	83.67%	41
F - Day-case type procedures (e.g. iron/blood transfusions, lumbar punctures)	61.22%	30
G - Other	12.24%	6
Comments on your answer		10
	Answered	**49**
	Skipped	**1**

- “Ward attenders, acts as low acuity inpatient unit.”
- “Currently the area is bedded – has been continuously bedded since the beginning of December.”
- “Pull patients from ED rather than waiting to be referred. Cellulitis and DVT managed in the community.”
- “Limited in function currently – 10 trolley spaces – planning to expand.”
- “Stream patients with minor ailments from A&E.”
- “Rapid follow-up but not ‘clinics’. Offers blood transfusions.”

Question 54. How many patients per day does it see?

(Question not answered)

Question 55. If patients are referred from the ED to the ACU, how many patients per day are referred?

(Question not answered)

Question 56. What percentage of patients with acute medical problems go to the ambulatory care unit from the A&E?

0-10%	44.90%	22
11-20%	30.61%	15
21-30%	14.29%	7
31-40%	0.00%	0
Not known	10.20%	5
Comments on your answer		6
	Answered	**49**
	Skipped	**1**

Question 57. Is the ambulatory care unit run by the acute physician?

Yes	75.51%	37
No	12.24%	6
Other	12.24%	6
Not specified	0.00%	0
Comments on your answer		47
	Answered	**49**
	Skipped	**1**

In the majority of cases, the ambulatory care unit was run by the acute physician (with support from other disciplines if needed).

- “Run by the on take consultants with support from 8 ANPs.”
- “Acute physicians, physicians associate ‘who is fantastic’ + trust grade + SHO.”
- “Emergency physicians”
- “Nurse practitioner”
- “Dedicated physician plus specialist in-reach.”
- “Mix of consultant led (am) and nurse led cover (pm).”
- “ED Lead for Directorate – use mixed consultant staffing.”
- “Part of general medicine. Run by matron staffed by experienced nurses – don't see doctor unless need to.”
- “Cardiologist and respiratory physician and one acute physician, locums, junior doctors, physicians associate.”
- “Run by through the medical take, 1 junior based there, staff flex to support.”
- “Acute physician provides cover but can call on specialist opinion.”
- “Cover provided by general physicians including diabetology, rheumatology and acute physicians.”
- “Run by consultant on shop floor supported by junior doctor.”
- “Covered by GPs and acute physicians – acute physicians attend in ‘ad hoc’ way.”

Question 58. How many geriatricians do you have?

1	6.00%	3
2	6.00%	3
3	16.00%	8
4	16.00%	8
5	16.00%	8
6	12.00%	6
7	0.00%	0
8	8.00%	4
9	6.00%	3
10	14.00%	7
Comments on your answer		29
	Answered	**50**
	Skipped	**0**

Question 59. What is the criteria for referral to a geriatrician?

A - Determined by age	16.00%	8
B - Determined by condition	36.00%	18
C - Both of the above	32.00%	16
D - None of the above	16.00%	8
Comments on your answer		26
	Answered	**50**
	Skipped	**0**

There were an interesting mix of responses for this question, and varied answers. Where referral was determined by age, the age varied. For others, it was a mix of criteria including the use of various frailty scores. Some responses showed that it depended on the particular geriatrician.

- “Consultants’ frailty assessment.”
- “Traditionally used 80+ as criteria for referral – but now using Bournemouth Criteria (Frailty Score) for frailty unit.”
- “85+”, “over 80 but Home Safe Service – 65+”, “75+”, “65+ Use frailty screening tool”, “75+ – geriatricians want it to be 80+”
- “Use frailty score pathway.”
- “Mix of biological age, mobility, presentation, mental state.”
- “’Loose’ definition of frailty – are using a scoring tool.”
- “Don't ask geriatricians for opinions – there are not enough of them.”
- “Predominantly by age but its flexible.”
- “Ongoing debate with geriatricians about the criteria they use.”
- “Depends on the geriatrician – some have age threshold 75”, “Dependent on geriatrician”
- “Whoever is in the bed.”

Question 60. Do you have a dedicated frailty unit or equivalent?

Yes	56.00%	28
No	44.00%	22
Comments on your answer		14
	Answered	**50**
	Skipped	**0**

Question 61. Where does the frailty unit sit?

Co-located with A&E	6.25%	2
Co-located with AMU	31.25%	10
Co-located with ward	34.38%	11
Other	0.00%	0
Not applicable - no unit	28.13%	9
Other + comments		26
	Answered	**32**
	Skipped	**18**

Question 62. How many beds does it have?

0-10	13.89%	5
11-20	30.56%	11
21-30	27.78%	10
31-40	0.00%	0
Not known	0.00%	0
Not applicable - no unit	27.78%	10
Comment on your answer		27
	Answered	**36**
	Skipped	**14**

Question 63. What are the sources of referral to the frailty unit?

ED	56.76%	21
AMU	51.35%	19
GP	32.43%	12
Ambulance service	5.41%	2
Not applicable - no unit	37.84%	14
Comments on your answer		24
	Answered	**37**
	Skipped	**13**

- “Medics”
- “Geriatrician based in ED”
- “Experimented with direct access for ambulance. Consultants and ANPs have phone for referral.”
- “AMU triage”
- “Frailty nurses”
- “Short stay unit”
- “Admission avoidance team”

Question 64. What are the destinations for patients discharged from the frailty unit?

A - General medical ward	22.86%	8
B - Geriatric ward	54.29%	19
C - Slow-stream rehabilitation ward	57.14%	20
D - Specialist ward	22.86%	8
E - Other hospital	34.29%	12
F - Other	0.00%	0
Not applicable - no unit	28.57%	10
Comments on your answer		33
	Answered	**35**
	Skipped	**15**

- “Community hospital or care home”, “Community hospital”
- “Also home”, “discharged home”
- “Community Hospital Discharge to Assess scheme”
- “Intermediate care beds”
- “Institutional care, mental health”

Question 65. Describe your medical ward configuration – excluding acute assessment, including frailty

	Yes		No		Total
Cardiology	95.92%	47	4.08%	2	49
Respiratory	90.91%	40	9.09%	4	44
Geriatric/elderly care inc frailty unit	97.92%	47	2.08%	1	48
Endocrinology	23.53%	8	76.47%	26	34
Endocrinology/Combined	67.57%	25	32.43%	12	37
Gastro	78.57%	33	21.43%	9	42

	Yes		No		Total
General medical	51.22%	21	48.78%	20	41
Stroke	89.36%	42	10.64%	5	47
Other	65.63%	21	34.38%	11	32
Comments on your answer					37
			Answered	**50**	
			Skipped	**0**	

- “Geriatrics includes – dementia ward, frailty unit, geriatric neuro rehab.”
- “Gen med – gastro/endo stroke – rehab/gen med.”
- “Cardiology beds part of AMU.”
- “Cardiology won’t take general medical patients.”
- “6 geriatric include – 2 dementia friendly, 2 rehab.”
- “Medically fit step down ward. Endo/combined – Endo/gastro – lot of general medical patients.”
- “Gen Med – 1 x Short stay medical ward, 2 x mixed specialty ward (renal, diabetes, resp), 1 gen med Geriatric – 2 x complex dementia, 1 geriatric 1 geriatric/stroke.”
- “Geriatrics includes – 2 frail elderly, 2 predominantly elderly, 1 includes orthogeriatrics.”

Question 66. How are patients managed on acute medical wards?

A - The medical team responsible for the ward manage the patient - irrespective of their diagnosis	80.00%	40
B - The relevant specialist consultant team manage the patient - irrespective of their location	12.00%	6
A+B	8.00%	4
Comment on your answer		14
	Answered	**50**
	Skipped	**0**

- “All of our specialists look after general medical patients – even our cardiologists – who tend to be quite sniffy about looking after non-cardiology patients – do take part.”
- “Patients with very specific problems will be picked up by relevant consultant.”
- “Patients on cardiology ward treated as medical outliers as cardiology not dual accredited.”
- “Currently B moving to A.”
- “With support from buddy system for specialist care”, “Run a buddying system”
- “Currently A but would like to move more towards B.”

Question 67. Which models of consultant cover are used by specialties in the hospital?

Consultant of the day	19.44%	7
Consultant of the week	88.89%	32
Consultant of the month	33.33%	12
Comment on your answer		36
	Answered	**36**
	Skipped	**14**

The comments to this question highlighted that it varied by specialty.

- “Varies by specialty”, “for some specialties”, “different specialties do differently”
- “None of the above – consultants share cover, call in the doctor you need.”
- “All specialties have different internal rotas, cardiology – runs consultant of the week.”

Question 68. Does one consultant retain responsibility for each patient’s care?

Yes in all specialties	28.57%	14
Yes in some specialties	26.53%	13
No	22.45%	11
It is not clear	22.45%	11
Comment on your answer		8
	Answered	**49**

	Skipped	**1**

- “Depends on specialty”
- “Short stay patients stay under same consultant”

Question 69. Faceted classification (Domain E): Are the wards open/ closed/ partial?

1 - Closed	51.02%	25
2 - Partial	42.86%	21
3 - Open	6.12%	3
Comments on your answer		2
	Answered	**49**
	Skipped	**1**

Question 70. Faceted classification (Domain F): Define the wards’ generalist/specialist split

1 - General medical wards only	4.08%	2
2 - Designated general medical wards and specialist wards	34.69%	17
3 - Mixed wards	44.90%	22
4 - Specialist wards only	16.33%	8
Comments on your answer		3
	Answered	**49**
	Skipped	**1**

Question 71. Have you made any changes to your service model in the last year?

	Yes		No		Not known		Total
A&E	66.67%	24	25.00%	9	8.33%	3	36
Ambulatory care	66.67%	26	25.64%	10	7.69%	3	39
AMU	50.00%	16	43.75%	14	6.25%	2	32
Frailty unit	41.94%	13	54.84%	17	3.23%	1	31
Changes to ward configuration and cover	61.90%	13	33.33%	7	4.76%	1	21
Other (please specify)							45
					Answered	**46**	
					Skipped	**4**	

- “Agreed recruitment additional staff to A&E.”
- “Rapid assessment in A&E plus frailty unit in A&E, using red and green days on the wards to speed up discharge.”
- “Expanded ambulatory service, changed medical cover AMU.”
- “Expanded acute medical unit staffing.”
- “We have had some significant bed changes and lost a number of beds, which has impacted on urgent and emergency care.”
- “Introduced 12-hour resident consultant cover at weekends.”
- “Moving frailty unit to EAU and trying to invigorate it.”
- “Expanding general medical bed stock and reducing specialist bed stock, fast track access to cardiology, more dedicated registrars AMU, moved DVT care to community.”
- “Had a lot of problems with 4-hour target and high numbers of medically fit for discharge patients, had building work and relocated AMU to be next to A&E, expanded number of acute physicians.”
- “Introduced short stay ward.”
- “Gastro came off the on take rota.”

- “More geriatric input to A&E, extending ambulatory care and hours of acute physicians.”
- “GP assessment in A&E, introduced consultant of the week model in many areas.”
- “Changes to medical cover including withdrawal of cardiology from take, short stay separated from AMU.”
- “Ambulatory care is new and new GP assessment unit, building work in A&E, better mental health liaison.”
- “Changes to medical on take – acute physicians taking on greater role, putting geriatrician into ED.”
- “Set up an urgent care centre next to A&E. Frailty, short stay older person's unit ACU set up a year ago.”
- “Opened new A&E co-located AMU with frailty unit.”

Question 72. Do you have any plans to change your service model in the next two years?

	Yes		No		Not known		Total
A&E	75.00%	27	16.67%	6	8.33%	3	36
Ambulatory care	55.17%	16	31.03%	9	13.79%	4	29
AMU	65.52%	19	20.69%	6	13.79%	4	29
Frailty unit	53.57%	15	28.57%	8	17.86%	5	28
Changes to ward configuration and cover	45.00%	9	30.00%	6	25.00%	5	20
Other (please specify)							48
					Answered	**43**	
					Skipped	**7**	

- “Planning a rapid movement event to make the process more efficient.”
- “Looking into having a frailty unit.”
- “Move to open AMU. Change ward configuration – reduce geriatrics, more non-medical wards, consultant of week, team-based job plans.”
- “Aiming to separate the minors caseload from A&E, new expanded frailty unit.”

- “Aiming to develop an assessment unit approach for all specialties behind A&E.”
- “Want to move AMU to open model.”
- “Aiming to co-locate AMU and frailty unit.”
- “More engagement geriatricians in A&E, fewer specialties in acute take – more reliance on acute physicians.”
- “Developing ward based care – moving to consultant of the week model, creating separate cardiology rota.”
- “More acute physician input A&E, create acute medical hub incorporate 2 AMU wards, outreach to nursing homes.”
- “Strengthen acute physician workforce – reduce reliance on locums and non-acute physicians.”
- “Establish a frailty unit and daily consultant ward rounds of all patients.”
- “Want to move away from age-based to needs-based model of care, re-profiling wards, aiming to get patients more quickly to relevant specialist team, single clerking model.”
- “Integrating GPs with A&E, developing ambulatory care, developing frailty unit/bay.”
- “Improved care on wards – daily whiteboard meetings, day two review meetings, producing day of discharge, more discharge coordination, point of care testing.”
- “Reconfiguring staffing model – acute physicians, geriatricians and nurse practitioners, more partnerships GPs.”
- “Want to establish frailty unit, further expand ambulatory care, work more closely with GPs, recruit more physicians associates.”
- “Aiming to improve streaming from ED to specialty wards, bypassing AMU, using advance nurses to support.”
- “Plan to have geriatrician working at front door.”
- “Gastroenterologists likely to come off medical rota.”