The ageing population in healthcare: a challenge to, and in, the workforce

Welcome to the August edition of Clinical Medicine. I think it would be fair to say that since I wrote my last editorial much has changed in the healthcare landscape and, despite many people’s misgivings about the recent general election, the outlook for patients and staff in the NHS may have unexpectedly been improved, with a government that is now mandated to listen, if it wishes to stay in power. We, the NHS, need them to listen, and more importantly to start responding, to our concerns.

In addition to the changed political landscape, the combined tragedies of the Manchester, Westminster and London Bridge terror incidents and the subsequent Grenfell Tower disaster have required all emergency services, including medical staff, to respond in terrible and tragic circumstances. This response is rightly described as heroic in the lay press, but, as we must continue to point out to ministers and those who control our purse strings, this is how we aim to respond to all our patients, providing life-saving and supportive care every minute of every day, not just in the nation’s darkest hours. Of course, we do this in the UK, for our own population, but as outlined in this journal, we also do so during international crises, such as the recent Ebola epidemic.

We all know that the NHS is under enormous strain, and will continue to be for many years to come. A publicly funded NHS model will remain under critical pressure with a government committed to austerity, but at least extra taxation to underpin its future was committed to by both opposition parties and is now forming part of the national debate. What is missing, however, is discussion on the additive effect of the ageing population, not just of the patients, but also the workforce.

In this issue, the excellent CME section focuses on the care of the older patient, highlighting the need to manage the complexity of this growing population with pragmatism, respect and dignity, focusing on frailty as the primary driver, rather than chronological age. Whether in the acute medical specialties, based on the evidence presented by Nitkunan et al, providing rapid access to specialist neurology advice, and this impacts adversely on both acute care and the discharge of less serious cases. The multidisciplinary example articulated by Nikkunen et al provides a potential model that could help upskill the entire acute medical workforce on the AAU, as well as providing immediate specialist reassurance to support early discharge, and filtered, but rapid, access to consultant level expertise when required.

With survival rates for cancer ever improving, the management of comorbid conditions takes on a greater importance; at the same time, maintaining knowledge of common cardiovascular conditions (such as heart failure and hypertension) is essential for all general physicians. These important areas are covered in detail within this edition in high quality and readable articles. Maintaining our clinical knowledge and how we would like to receive CPD to support our practice is highlighted in a fascinating article from Ireland, while the way we feed back to our trainees, via their online portfolios, could certainly be improved, especially in acute medical specialties, based on the evidence presented by Tham et al. The pressure of time and the multiple demands placed on a stretched workforce certainly play into this, but we owe it to both our trainees and our patients to ensure we take...
Editorial

the time to give meaningful, honest and actionable feedback to
the next generation of physicians.
In addition to the ageing and increasingly complex patient
population described above, and the relentless pressure on
the medical workforce, other government-driven agendas are
also squeezing our senior and overseas colleagues. The cap on
lifetime taxable allowance for pensions is, against a challenging
work environment, pushing some of our most experienced and
qualified colleagues to seek earlier retirement or return to work
in a less than full-time capacity. In addition, both the Brexit
negotiations and the government’s inflexible immigration and
visa policies mean that the ability of the NHS to recruit and
retain staff at this critical time (to fill an ever-increasing number
of consultant and training post vacancies) is challenging, with
rota gaps increasingly prevalent. This is not just true in hospital
medicine but also in primary care, where the NHS has relied,
to a large degree, on a workforce who came to the UK at a time
when we were more welcoming to those from overseas.
So, the ageing population is not an issue confined to those we
care for, but also applies to those who care. This is a looming
crisis and one the RCP is working hard to address both with
employers and at government level. Dealing with the issue of
ageing is essential for us and our patients if the NHS model is to
prevail in the 21st century.

References
1 Reece S, Brown C, Dunning J et al. The UK’s multidisciplinary
2 Conroy S, Parker S. Acute geriatrics at the front door. Clin Med
3 Gordon AL, Evans BJ, Dhesi J. The physician’s role in periopera-
tive management of older patients undergoing surgery. Clin Med
4 Khizar B, Harwood RH. Making difficult decisions with older
2017;17:360–2.
6 Offord NJ, Witham MD. The emergence of sarcopenia as an
7 Nitkunan A, MacDonald BK, Boodhoo A et al. A hyperacute
neurology team – transforming emergency neurological care.
8 Kapoor A, Prakash V, Sekhar M et al. Monitoring risk factors of
2017;17:338–40.
10 Callan PD, Clark AL. Heart failure – what’s new and what’s
11 Maher B, Faruqui A, Horgan M et al. Continuing professional
development and Irish hospital doctors: a survey of current use and
12 Tham TCK, Burr B, Boohan M. Evaluation of feedback given to

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