ACUTE MEDICINE - QUO VADIS?

KGMM Alberti
National Director for Emergency Access and Service Design
HISTORY 1

- General Physician
- 3 or 4 per hospital
- Junior team
HISTORY 2

Radcliffe Infirmary 1965

» 5 teams

• Consultant
• Senior Registrar
• House Physician

N.B. No CCU. Direct referrals
N.B. Could not do much anyway
HISTORY 3

Freeman Hospital 1985

» 4 teams

- 3 Consultants
- Senior registrar
- Registrar
- 2 SHOs
- 2 House physicians
HISTORY 4

1990s

POPULARITY

Specialties ↑↑
General (acute) medicine ↓↓
RCP Action
Post-take ward rounds
THE CALL TO ARMS!

The NHS Plan
A plan for investment
A plan for reform

Presented to Parliament by the
Secretary of State for Health
By Command of Her Majesty

July 2000

Cm 4818-I
£15.00
Para 12.10

“By 2004 no-one should be waiting more than 4 hours in A&E from arrival to admission, transfer or discharge. Average waiting times ... will fall as a result to 75 mins.”

“By then we will have ended inappropriate trolley waits for assessment and admission.”
All the initial focus on A & E Departments and Acute Hospitals
THE PROBLEMS

• Waiting for assessment
• Hand-ons
• Waiting for a bed
• Waiting for diagnostics
• Waiting for a specialist
SOLUTIONS

- Rapid streaming
- Senior led decisions
- Skillmix
- Bed management
- Acute teams – see in 1 hour
- Assessment units
Key Recommendations

- Early senior-led decisions
- Assessment units
- On-take team with no other commitments
- Committed acute physicians based on AU
THE SIZE OF THE PROBLEM (1)

- 14 million attend A&E
- 2.5 – 3 million admitted
- 4 million seen at UCCs (WiCs and MIUs)
- 80 million attend GPs in hours
THE SIZE OF THE PROBLEM (2)

• 3 million admissions
• 2.3 million medical
• 1.5 million “elderly”
• Median age 77
WHERE ARE WE NOW?
MASSIVE IMPROVEMENT!

April 04 – Jan 08  97-99%

but only 80% for acute medical admissions
FUTURE ACTIONS (1)

COMMUNITY

Prevention
- education
- Proactive care of frail elderly
- LTCs
- Community matrons
FUTURE ACTIONS (2)

• ED bypass where feasible
• Early senior assessment
• Parallel C of E assessment
• Fewer, larger acute hospitals
THE ACUTE HOSPITAL

• Only for those who require the expertise and/or facilities

• Front door UCCs

• One per 500,000
ASSESSMENT UNITS

• Focus on diagnosis/early treatment
• Rapid Senior assessment
• Direct admission for GPs/Emergency Physicians
• Next day specialty triage
• Joint ownership ED/Acute Medicine

NB  Rapid throughput vital
THE ACUTE HOSPITAL

Key factors

» BED MANAGEMENT
» Freed up acute teams
» Early day discharge
INPATIENT MANAGEMENT

• Emphasis on speed of decision making
• Integrated inpatient acute care teams
• Major role for medical and surgical nurse specialists

[NB Trainees train]
RCP RECOMMENDATIONS

There should be three acute physicians in every DGH by 2008
ACUTE MEDICINE: THE WORKFORCE

- Specialist acute physicians
- Based on AMU
- Acute care of elderly team
- Nurse practitioners
- Acute general practitioners

How many consultants is enough?
ACUTE MEDICINE: THE FUTURE

New Role

» Inpatient care for newly ill
» Use of early warning systems
» Care of all surgical patients
ACUTE MEDICINE: THE FUTURE

• AMU as a conduit
• More direct admissions/rapid referrals to specialty units, e.g. stroke, AMI, respiratory failure, haematemesis, etc

What then for acute medicine?
THE FUTURE