Outline

• Past
  – How we got where we are
• Present
  – Values and Objectives
• The Future
The History of Acute Internal Medicine
The Past

• 1960s/70s
  – Acute medical receiving rotates round Consultant-led teams and general wards

• 1980s
  – Increasing Consultant specialisation
  – Increasing bed pressures

• 1990s
  – Acute care recognised to be substandard
  – Trolleys in corridors, safari rounds
  – AMUs (MAU, ARU, EAU, MAAU etc) developed
Late 1990s: A Time for Change


- But most importantly.....
The Albany, 2000
SAM is conceived
Support for Change

• 2000 The Society for Acute Medicine is formed
  – Inaugural President Professor Derek Bell

• 2003 Acute Medicine is recognised for Specialist Training as GIM (Acute)

• 2004 Acute medicine, making it work for patients. A blueprint for organisation and training. RCPL
2004

• Acute (internal) medicine is that part of general internal medicine concerned with the immediate and early specialist management of adult patients suffering from a wide range of medical conditions who present to, or from within, hospitals requiring urgent or emergency care

• 15 minutes per patient

• All new patients to be seen by a Consultant within 24 hours of admission
2007 Task Force Report

- Ambulatory Care
- 7-day Consultant rounds
- No other commitments
- Clinical decision maker
- MDT
- Capacity and flow
Change Complete?

- 2008 RCPE UK Consensus Statement on Acute Medicine
- 2009 Acute Internal Medicine recognised as a Specialty for CCT
2010 RCPL / SAM Survey

• An Evaluation of Consultant Input into Acute Medical Admissions Management in England, Wales and Northern Ireland
• Survey of 126 Acute Hospitals
• 98% of acute hospitals have an AMU
• 88% have a Clinical Lead for AMU
• 93% use an EWS
2010 RCPL/SAM Survey

• 91% operate Consultant of the Day model
  – But only 52% have no other commitments when on take
• 85% have Consultants in Acute Medicine
  – median of 3
• 73% do no weekend on call duties (!)
Present
What is Acute Internal Medicine about?

- Patient care
- Quality and safety
- Well run AMUs
- Multidisciplinary team
- 7-day working
- Training
- Quality indicators
- Quality standards
Example: Why

• Weekend mortality for emergency admissions. A large, multicentre study.
  – The overall adjusted odds of death for all emergency admissions was 10% higher (OR 1.10, 95% CI 1.08 to 1.11) in those patients admitted at the weekend compared with patients admitted during a weekday (p<0.001).

Example: Why

- *Hospital service patterns v clinical outcomes in England* RCPL Project Group

- Hospitals in which:
  - admitting consultants have no fixed other clinical commitments whilst on take had a lower adjusted case fatality rate
  - admitting consultants work blocks of more than 1 day had a lower excess weekend mortality
  - there were 2 or more AMU ward rounds per day (all patients reviewed) had a lower adjusted case fatality rate for patients with a hospital length stay of more than 7 days.
Core Values

• Acute Internal Medicine
  – Quality
Core Values

• Acute Internal Medicine
  – Quality

• What do we mean by Quality?
Quality
Core Values

• Acute Internal Medicine
  – Quality

• What do we mean by Quality?
  – Aspiring to excellence
  – Not settling for mediocrity
  – The standard of care you would want for yourself or your loved ones

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Core Values

• Acute Internal Medicine
  – Quality
  – Safety
Core Values

• Acute Internal Medicine
  – Quality
  – Safety

• What do we mean by safety?
Safety
Core Values

• Acute Internal Medicine
  – Quality
  – Safety

• What do we mean by safety?
  – A system designed to
    • Minimise error
    • Reduce harm
    • Provide consistency and reliability
Core Values

• Acute Internal Medicine
  – Quality
  – Safety
  – Teamwork
Teamwork
Core Values

• Acute Internal Medicine
  – Quality
  – Safety
  – Teamwork

• But how do we assure these things?
Quality Indicators and Quality Standards
Measuring Success
Clinical Quality Indicators

1. All patients admitted to the AMU should have an early warning score measured upon arrival on the AMU.

2. All patients should be seen by a competent clinical decision maker within 4 hours (maximum) of arrival on the AMU who will perform a full assessment and instigate an appropriate management plan.

3. All patients should be reviewed by the admitting consultant physician or an appropriate speciality consultant physician within 8 to 14 hours of arrival on the AMU.

4. All acute medical units should collect the following data:
   – Hospital mortality rates for all patients admitted via the AMU
   – Proportion of admitted patients who are discharged directly from the AMU
   – Proportion of patients discharged from the AMU who are readmitted to hospital within 7 days of discharge
Defining Excellence
Quality Standards

• SAM and West Midlands

• London

• CQC

• Sir Bruce Keough
The Future of Acute Medicine
UK Perspective

• Future Hospital Commission RCPL
  – Important - read it!

• NICE
  – Acute medical emergencies

• Shape of Training

• Francis Report

• NHS
  – For ever changing
Generalism v Specialism

Major and exciting medical advances

Becomes a sought-after speciality

Appeal of generalism diminishes

Accessibility to doctors prioritised

Hospitals & GPs surgeries 'open all hours'

Attractiveness of medicine as a career declines

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Medical Post Graduate Training

- Foundation 2 years (F1/2)
- Core (medical) training 2 years (ST1/2)
- Specialty +/- General Internal Medicine Higher Training 4-6 years (ST3-8)
- Consultant (30 years!)

- 2013 Shape of Training Review
Shape of Training Review

- Foundation 2 years
- Broad based specialty training (BBST)
  - 4-6 years
  - More Generalism
  - Less Specialism
- Post Consultant credentialling
RCP Edinburgh

• The option to “drop” training in General Internal Medicine should be lost.
• If most trainees contribute in general specialties, workloads for all will become more manageable, which will help these specialties regain their previous popularity and status.
• In promoting generalism, it is vital that the specialty of Acute Internal Medicine continues to develop to provide leadership within acute medical units.
• RCP London view? Read FHC
change in size of population, by age group (2010-2035)
Number of people with each disease
2002-2035, 000s

Source: British Household Panel Survey/English Longitudinal Study of Ageing/Trajectory

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UK Deaths/year (millions)

- 2010-15: 2.96
- 2015-20: 3.07
- 2020-25: 3.19
- 2025-30: 3.33
- 2030-35: 3.50
- 2035-40: 3.65
- 2040-45: 3.78
Frail Elderly vs Healthy Elderly

Health in old age

Unhealthy Old Age
- Impact on the public
  - Increase in comorbidities and chronic disease
  -Heightened awareness of impact of unhealthy lifestyles
- Impact on the healthcare sector
  - Massive increase in demand for generalists & geriatricians
  - Resources stretched and huge financial burden on health sector
- Impact on government
  - Political focus on social care and living standards of elderly
  - Social care legislation and increased funding for elderly care
  - Intergenerational tensions rise as younger people feel marginalised

Healthier Old Age
- Challenges of ageing society easier to meet
  - Reduced emphasis on generalists, geriatricians and community care
  - Appeal of specialisms and hyper-specialisms continues to rise in absence emphasis on generalism
  - Public satisfaction with public services – including health rise
  - Doctors’ working conditions improve
  - Public spending distributed more evenly across society
  - Increased funding for other areas of healthcare budget
  - Increase in public health campaigns
Consultant Expansion: AIM/GIM

Total number of consultants in acute (internal) medicine and general (internal) medicine

Consultant expansion in acute (internal) medicine and general (internal) medicine vs all specialties

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### AIM/GIM Consultant Workforce by Age/Gender

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
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<tbody>
<tr>
<td>% gender</td>
<td>Number</td>
<td>% age group</td>
<td>Number</td>
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<tr>
<td>34 and younger</td>
<td>8.0</td>
<td>30</td>
<td>60.0</td>
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<td>35–39</td>
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<td>87.5</td>
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<tr>
<td>60–64</td>
<td>8.2</td>
<td>31</td>
<td>100.0</td>
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<tr>
<td>65 and older</td>
<td>2.4</td>
<td>9</td>
<td>100.0</td>
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<tr>
<td>Unknown</td>
<td>0.3</td>
<td>1</td>
<td>100.0</td>
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<tr>
<td><strong>Total</strong></td>
<td>376</td>
<td>127</td>
<td>503</td>
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</table>
Acute and general (internal) medicine
Population served by each whole-time equivalent (WTE) consultant

RCP recommendation 1:47,600 (approx)*

*NThe RCP recommends 1,300 WTE consultants in acute and general (internal) medicine for the UK. The Office for National Statistics 2009 population estimate for the UK is 61,792,000. Hence the WTE population ratio is 1:47,532. This has been rounded up for the sake of the diagram.

Real AMU data

A&E referrals

% of all referrals

month

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Real AMU data

Ambulatory care

Direct discharges from AMU

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Making SAM Bigger

- Regional SAM
- Grass roots up
If Dennis Bergkamp were a doctor.....

he would be an Acute Physician
Thank you

Acute Medicine
a simple way to make things better

Questions Please