SAMCoventry: Local organiser and acute physician Dr Tom Heaps shares what he is most looking forward to at our spring conference. (page 6)

Feature: Interview with Jan Basey on being a pharmacist on the AMU (page 10)

Latest updates in acute medicine (page 12)

Dr Nick Scriven writes about recruitment in acute medicine (page 9)
Contents

SAM News

3 Editorial
4 Acute Medicine Awareness Week
4 SAM & Social Media
4 Survey updates
5 SAM Secretary farewell note
5 SCE Update
6 Looking forward to SAM Coventry

The Francis Report

7 Acute Medicine and the Francis Report
7 Implications of the Francis report for nursing in the AMU
8 The Francis Report and the importance of the intensive care and acute medicine interface
8 The implications of the Francis report for pharmacy on the AMU

Feature

10 A day in the life of a pharmacist on the AMU
12 Managing the demand for emergency and urgent care

Acute medicine & more

6 SAMBA coming to a hospital near you
9 Recruitment in Acute Medicine
9 Making the most of AHPs
11 Revalidation: an update
11 Future Hospital Commission and the future of ‘Generalism’
11 RCPL acute care toolkit series
Welcome to the Spring 2013 edition of Acute News, SAM’s regular newsletter, designed to bring you up-to-date with all that is going on in the busy world of acute medicine. Our Coventry meeting is drawing closer, and local organiser and acute physician Tom Heaps whets our appetites with a summary of the sessions he is most looking forward to. The emphasis of this is meeting is, as ever, more clinical than the autumn meeting, and being a smaller event usually has a more intimate feel; however this also means that spaces are limited, so if you are keen to attend please ensure that you book in soon to avoid disappointment. This edition also includes a few topical articles relating to the Francis report – Liz Lees and James Allen have summarised some of the key points specific to acute medicine nursing and pharmacy, while our critical care representative on SAM council, Simon Fletcher provides his perspective on the need for change. Claire Charras, our media officer, has provided a short summary of the key points in the report, along with the government’s recent response. SAM will be issuing another formal statement in the coming weeks and we are still keen to get feedback from members, which should be emailed to acutemedicinecomms@gmail.com.

This newsletter also includes an article from our outgoing secretary, Dr Mark Holland, who will be replaced by Dr Hannah Skene, who was elected unopposed to the role. Mark has worked tirelessly over the three years of his tenure with SAM and his presence on council will be greatly missed. Hannah, who was a previous trainee representative on SAM council many years ago will have a tough act to follow. Congratulations also to Ruth Johnson who takes over from Amy Daniels as SAM Trainee representative, after winning the election earlier this year. Our thanks go to Amy for her excellent contribution to the society over the past two years.

I am grateful to all those who have contributed to this newsletter, and we would welcome contributions from members in the future, if you have items of news you think should be shared with a wider acute medicine audience. In addition we hope to include a ‘correspondence’ section in the future, with member responses to articles included in the newsletter. Please email these to the address above and we will hope to include in our next edition in late summer.
Acute Medicine Awareness Week
15th - 21st of July

This year, the Society for Acute Medicine has decided to run its awareness event over a week from the 15th to the 21st of July 2013. This will hopefully allow more AMUs to participate, offering more flexibility in the time and type of event you might want to organise.

Last year’s first ever ‘acute medicine awareness day’ was supported by 28 AMUs from across the UK. Many units raised money for their charitable funds with sponsored cycle rides, parachute jumps, cake sales and charity raffles, supporting local projects to improve the ward environment for patients and staff. Local celebrities and media were invited into a number of units which provided an opportunity to raise the AMU profile and share examples of good practice. The day also coincided with the national launch of our quality standards document.

Looking back at the feedback from those AMUs which took part in 2012, the most common comment was the sense of team work and staff engagement which their awareness day activities brought. We hope that even more will participate this year. More information will soon be available on the SAM website, where you will have the opportunity to register your interest in participating in this year’s event. In the meantime you can contact us directly if you would like more information on acutemedicinecomms@gmail.com

Surveys
The Royal College of Physicians is concerned about the potential impact on clinicians who have been involved in reporting of clinical incidents, and has compiled a survey to investigate further. We have agreed to help to publicise this – it will take only 10 minutes to complete and can be accessed via this link. Those SAM members who have not yet completed the SAM surveys on Quality Indicators or Echocardiography are encouraged to do so (please click on the highlighted links).

SAM & Social Media
SAM's social media presence on Twitter and Facebook has been steadily growing. We have now reached 560 followers on Twitter and 355 likes on Facebook. Each morning, @acutemedicine tweets the daily medical news from a wide sources of news publications from the BBC, the Guardian or the Telegraph to Nursing Times, the Lancet or the BMJ. This is a great way to keep up to date with the important healthcare stories of the day, which can be easily accessed via internet links with a smart phone, computer or tablet device.

We have had increasing interactions on Twitter with medical organisations such as Sepsis UK (@sepsisUK), Royal College of Physician of London (@RCPLondon) and the British Geriatrics Society (@GeriSoc). A number of leading acute physicians regularly tweet updates relating to acute medicine, including the current SAM President (@croseveare), Dr Nick Murch (@AcuteMedEd) and Prof Derek Bell (@ProfDerekBell). The hashtag #TeamAMU is regularly used to share information of relevance to anyone working in the AMU setting. Trainees may also be interested in participating in the Twitter Journal Club (@twitjournalclub) which is organised by an ACCS trainee, Natalie Silvey (@silv24) on Sunday evenings and often discusses papers of relevance to an acute medicine audience.

SAM has officially registered the hashtag #SAMCoventry for the spring meeting, and would like to encourage those of you on Twitter to use it during our conference to share your views on the talks and workshops. Those who are not able to attend the meeting will be able to follow some of the key messages from the meeting on twitter by using this hashtag.

For those of you who have not yet explored the world of Social Media (and who are probably wondering what a hashtag is!), we will be running an interactive session at the Autumn meeting in Glasgow, which will provide a basic introduction; a number of top medical ‘tweeters’ have also agreed to attend and share their thoughts on the clinical, educational and general healthcare benefits.

The Royal College of General Practitioners (@RCGP) have produced an excellent Social Media Highway Code – this provides advice on the ‘do’s and don’ts’ of Social Media for Health Care practitioners, as well as a very helpful introduction and overview of how to make the best use of these resources.
End of an era: outgoing SAM secretary Dr Mark Holland reflects on his three year tenure
by Dr Mark Holland

Deciding if time has been well spent is easily measured by how quickly it passes and by this yardstick my time as SAM secretary has been very well spent and better very enjoyable. I commenced the role in January 2010 and started work within a matter of days by taking the minutes of a Council teleconference (think about it). Most of the secretary’s work is administrative, organising meetings and agendas, keeping minutes and running Council elections. Whilst other colleagues on Council debate, the more pressing issues of the day often forcibly and always for many hours, I quietly take the minutes, interjecting on points of fact or to clarifying constitutional issues.

During my tenure the administrative work has been particularly important as the two presidents, Phil Dyer and Chris Roseveare, worked tirelessly to raise the profile of SAM and acute medicine. Hopefully, when Hannah Skene takes on the Secretary role in May I will be able to hand over a well run society.

Looking back over three years affords the opportunity to reflect on how the society and acute medicine have progressed. Thanks to our treasurer, Deepak Bhatia, the society is now an incorporated company. SAM has taken the lead in promoting standards for quality of care in acute medical units. Not everyone will agree with me, but our push for 7-day working is definitely something to be proud of.

Improving quality still remains a priority, and like it or not, the Francis report is there for us all to reflect upon. At a time when the NHS is under huge pressure there are beacons of light. In Manchester, the acute medical unit at Salford Royal, led by my friend and colleague Richard Warner, provides a level of service and care that is truly inspirational.

Last year we had the first Acute Medicine Awareness Day. One thing I have learnt from the senior Council members is the gift of delegation. So, in the North West I was fortunate enough to dump the responsibility on Olivier Gaillemin, with the remit of organising a pan-Manchester sports event. Up for the challenge, Olly came on and did tremendous, all credit to him, with a rounders tournament won by the Royal Oldham Hospital.

To reassure people, there are no material benefits in being a SAM Council member, with the exception of the post-Council meeting/pre-conference dinner, where we meet our guest speakers. Apart from that, my moment of glory was being sent to Cardiff, by Phil Dyer, to represent SAM on the NICE neutropenic sepsis guideline group. My remit from Phil was simple, ‘make sure they call it AMU, not MAU’!

Lastly, Christine Lawson. It is hard to thank Christine in words for all her help and support. They gave me 450 words for this article so no space to tell you about the time that Chris Roseveare………

Speciality Certificate Exam Update
by Deepak Bhatia, Chair of Acute Medicine SCE Board

The next diet of SCE in Acute Medicine is scheduled for November, 2013. At the last examination, pass rate of UK based candidates was 86.4 % and 67.6% overall. You should refer to SAM and MRCP (UK) websites for details on the next exam. Shortly, a further set of sample questions shall be posted on both these sites. SAM aims to organise a session for examination preparation at each of its conferences; this year at Coventry and Glasgow. Should you have any feedback on the examination please write to MRCP (UK) and copy your letter to SAM admin office at Edinburgh. We want to support our trainees for success at this examination.
Spring is rapidly approaching (not rapidly enough I suspect for some of us), and with it comes the first of this year’s Society for Acute Medicine meetings. I was delighted to be given the opportunity to host this year’s spring meeting in the picturesque city of Coventry! Although Coventry perhaps does not carry the same cosmopolitan appeal as Dublin did for last year’s spring meeting, I am confident that the programme that has been put together will both inspire and educate at a similar, perhaps even greater, level.

Research subcommittee chair, Dr Philip Dyer and the Eventage team have been working tirelessly over the last six months to provide me with the support needed to bring together a plethora of excellent speakers from a variety of disciplines and backgrounds, some with international reputations and others with a more local experience to contribute. One of the themes running throughout the conference is the management of the acutely unwell and deteriorating medical patient and I am particularly looking forward to the infectious diseases symposium with respect to this. Once again, there is strong nursing representation both in the main plenary sessions (Rachel Binks, Critical Care Nurse from Yorkshire and Coventry’s own Chief Nurse, Mark Radford are both featuring) and in the parallel sessions where Liz Lees and Helen Pickard are organizing a stimulating debate on the 6 C’s of Nursing. The meeting is also particularly attractive for pharmacists with sessions on medical toxicology and novel anticoagulants to look forward to. Other highlights for me include the talks centred on the management of frail older patients with complex multisystem problems and a parallel session exploring education on the AMU.

As with all of SAM’s previous meetings, there will be ample opportunity to socialise, network and exchange ideas with acute physicians from across the country – on a personal note I am looking forward to sharing a few drinks with all my old colleagues from Yorkshire, where I spent many happy years training in acute medicine before moving back to the Midlands.

Finally, I would like to thank SAM for giving us the opportunity to showcase some of the work we are doing locally to improve the care of acute medical patients in Coventry, and I hope that as many of you as possible will be able to join us on May 9th and 10th. If you have not already registered for the conference, it is not too late – places are still available via the society’s website.

Keep the date: Society for Acute Medicine’s Benchmarking Audit 2013 (SAMBA ’13) coming to a hospital near you on 20th of June 2013

How good is our care? Does all the hard work pay off? Is Acute Medicine in the UK compliant with its guiding standards? Which units achieve care that is worth copying?

In 2012 we performed the first national benchmarking audit in Acute Medicine ever under the title “A day in the life of the Acute Medical Unit”. UK wide 30 units participated and submitted 24 hours’ worth of data from 1006 patients. The mean number of admissions per unit was 34. 28% of patients were seen within 30 minutes, 74% were seen by a consultant within 14 hours.

Nearly all patients had a full set of observations on admission, 115 triggered the local Early Warning Score, of these 82 had an appropriate response according to the local protocol but only 14 (1.4%) patients were admitted to Intensive Care units. In only 5 of the participating units 90% of more of all patients were seen by a consultant within 14 hours. Further results are being prepared for a paper in Acute Medicine.

On the 20th of June 2013, we would like to invite all members of the Society for Acute Medicine to join us for SAMBA ’13 and collect data from 24 hours of admissions. Registration, data collection and submission have been significantly simplified based on the experience from SAMBA ‘12. This will hopefully enable most Acute Medical Units in the UK to participate on the day.

We now need members of SAM who would like to help us and road test the data collection sheet prior to June. And we are looking for motivated consultants and SPRs who would be willing to head recruitment of further audit centres in their deanery area.

If you are interested please contact Chris Subbe: csubbe@hotmail.com.
The Francis Report

What the Francis Report means for acute medicine?

It is now two months since the publication of Robert Francis’ report into the events at Mid Staffordshire hospital. Much has been written about this in the medical and mainstream press; and most of the Royal Colleges and other healthcare organisations have now published responses. SAM published a short statement on the day after the report was released, along with a call for comments from members. Some of the key recommendations can be summarised as follows:

- Patients should be placed at the centre of everything which the NHS does;
- The need for a duty of candour: contractual and criminal
- Quality should be embedded into commissioning with greater input from clinicians
- Embed compassion into nursing training, with staffing level guidance and regulation of health care assistants
- Training should only take place where there is good care, with greater integration of deanship and regulators
- Fit and proper tests for managers should be introduced

On 26 March 2013, Jeremy Hunt, Health Secretary gave the government’s initial response to the Francis Report. The report, entitled Patients First and Foremost addresses five areas:

- Preventing problems
- Detecting problems quickly
- Taking action promptly
- Ensuring robust accountability
- Ensuring staff are trained and motivated

The government also announced the adoption of a Ofsted-style rating for hospitals and care homes, a statutory duty of candour for organisations which provide care and are registered with the Care Quality Commission and a pilot programme which will see nurses working for up to a year as a healthcare assistant as a prerequisite for receiving funding for their degree.

The Francis Report and the implications for nursing on the AMU

by Dr Liz Lees, nursing representative on the SAM council

Staffing level guidance: There is staffing guidance from the RCN which is used on general wards. In the case of acute medicine, specifically what would be of assistance is - support for nursing research to develop a bespoke dependency tool which is able to take into account differences we encounter in the patient profile on an AMU – namely: patient dependency, variable patient acuity, high patient turnover and increased ward rounds. This is captured adequately at present and requires utmost attention to detail to support the development of nursing within an AMU and safe effective care supported by appropriate staffing levels.

Regulation of health care assistants: The regulation of care assistants has been debated for several years. The idea is to assure the quality of health care assistants through core national standards for training. This is excellent for any area of the hospital, but has particular importance in the justification of training of health care assistants within AMU. I suggest it is time for core areas of training to be identified and delivered within AMU but in order to do this – the release of the time required for training must be supported at a local level. Moreover, registered and non-registered nursing roles have to align and evolve, as part of a team which is multi-disciplinary (see Workforce toolkit – SAM).

Appraisal and revalidations system: Currently all nurses should be appraised at least yearly with revalidation coming in the form of self-assessed ‘Notification of Practice’ via the NMC. I have believed for a long time that both systems would benefit from an improved reporting structure. As a way forward for acute medicine, it is possible to develop portfolios which may encompass ‘experiential learning’; ‘accredited learning’; ‘relevant competencies’ and ‘clinical reflections’. This would place the emphasis on the individual but at the same time in partnership with the organisation to release time for CPD. There is no doubt that CPD is gradually being eroded in favour of ‘staffing the latest crisis’. Rockefeller famously said that he ‘always tried to turn every disaster into an opportunity’. It is vital now that we take this opportunity to learn from the mistakes of the past to improve our services.

It is hard to argue with the statement that ‘patients should be placed at the centre of everything that the NHS does’ - a principle which, I am certain, already applies to the practice of most of those working at the front line. Acute Medical Units are busy wards, and the pressures on staff can be intense; the workload is rising across the UK, and this winter many departments have struggled to maintain patient flow. Some will have been able to highlight these demands to argue for extra staff and resources; however, recruitment – particularly to senior medical positions in acute medicine remains a challenge for which there is no ‘quick fix’ solution. It is crucial that we don’t take our eye off the ball and start to accept substandard care as the norm. Ensuring that we maintain the highest quality of patient-centred care requires continued strong leadership and teamwork, which have always been key components of a successful AMU.

Many of the recommendations in the report focus on the care of older patients, who make up a significant proportion of the workload of the AMU. The report emphasises the importance of the multi-disciplinary team in caring for this patient group, which we have highlighted previously in our Quality Standards documents.

Liz Lees and James Allen have summarised, below, some of the key issues from a nursing and pharmacy perspective, while Simon Fletcher has written in this edition of Acute News regarding the importance of developing closer links between acute medicine and critical care.

Acute News | 7
The Francis Report

The Francis Report and the importance of the Intensive Care/Acute Medicine interface
by Dr Simon Fletcher, Critical Care Medicine Representative, SAM Council

Quality is the current (not for the first time) buzz word in health care and the focus on patient outcomes, as measured by Standardised Mortality Ratios has never been so intense. Although a whole system problem, it would appear that many of the issues detailed within both Francis reports were present from the first interactions between patients and Health Care professionals.

Thus acute medicine and intensive care will be identified as being part of the problems identified by Francis. In a failing system excess mortality will be concentrated in the sickest patient groups. If these are identified, managed in a properly resourced area by appropriately trained staff, they are far more likely to survive. Timely intervention has also repeatedly been shown (sepsis care as an example) to reduce morbidity and length of stay.

In a recent audit of more than 2000 acute medical admissions, conducted by Dr Huw Wilson at my own Trust during a designated month, 188 identified as having increased needs/risk (Level 1) and 72 with one of more organ failure (Level 2). These patients merit an enhanced level of nursing and medical care but clearly far outnumber the capacity to be cared for in designated critical care beds.

A similar, whole hospital, ‘point prevalence’ audit, conducted on two occasions, found that more than half of all inpatients had ‘unmet need’ as defined by a number of recognised dependency parameters. Critical care skills are essential for the acute physician; block placements on the intensive care unit are a part of the acute internal medicine (AIM) curriculum and many trainees also aim to attain dual accreditation with both AIM and critical care. However a significant proportion of those that have already undertaken joint training have been unable to obtain posts with joint AM/Critical Care responsibilities; however out audit suggests that the acquisition of these skills may be equally valued on the acute medical unit (AMU).

“Critical care skills are essential for the acute physician”

The Society for Acute Medicine has long advocated the development of Level 1+/Level 2 facilities within larger AMU’s. It is clear that our audit data justifies and supports this development, which will also be highlighted in a forthcoming ‘toolkit’ on the deteriorating medical patient, which is due to be launched during the opening plenary session at our spring meeting in Coventry. Both training in and delivery of care to sick, high risk patients requires a close relationship and understanding between those delivering acute care and critical care, within a hospital. Moves to enhance the capability of the AMU to manage for this vulnerable patient group would provide a patient focused quality innovation with real potential to reduce mortality and morbidity in our hospitals.

The implications of the Francis report for pharmacy on the AMU
by James Allen, SAM Pharmacist Representative

The report by Robert Francis QC in February 2013 includes some 290 recommendations, none of which specifically mention pharmacy. Does just a handful of mentions in the body of the document mean pharmacy can sit back an relax in the wake of the findings? In this case, the failings in the provision of care are so fundamental that all health care professionals should take stock of how toxic an approach to care can become within an organisation.

Ensuring the patient gets the right medicine at the right time is a fundamental principle of pharmacy. Whilst absent from the recommendations, the body of the report clearly highlights a number of key failings in medicines management. It is also obvious that a proportion of these medicines management issues played a significant part in the harm caused to patients. There had been warning signs of inadequacies highlighted by the strategic health authority and the report suggests their clinical pharmacy input and training were insufficient. Pharmacists on acute medical units will need to reflect on this and consider whether their units have the correct skill mix present, at the right times, to deliver the best for patients. Consideration should be given to the education opportunities provided to the wider healthcare team. Perhaps some of the cases could have been mitigated or avoided if adequate education relating to medicines had been provided.

In conjunction with our own professional duty of care, candour and competence clinical pharmacy service leaders will need to ensure the continual provision of core pharmacy standards. Over the coming years of austerity, providing high quality pharmaceutical care by appropriately trained pharmacy staff in the multidisciplinary setting must be a priority. Acute medical units certainly promote this approach but to safeguard services, in light of the failings highlighted in the Francis report, accountability in service provision and patient care will need on occasion to eclipse financial accountability.
Recruitment in Acute Medicine
by Dr Nick Scriven, Halifax, Acute Medicine Specialist Advisory Committee, Recruitment Lead

The mechanism for entering acute medicine (AIM) training has undergone almost as many changes as Acute medicine itself over the last ten years. For those of us old enough to remember pre-2007 we can recall the original method of recruitment that had been in place since medical training had been invented – i.e. individual deaneries all running their own recruitment at times to suit the posts available and following the well-worn process of application with a CV, long-listing by recruitment staff, shortlisting via clinicians and then an interview. Interviews were idiosyncratic and with absolutely no standardisation or co-ordination between deaneries. This continued with little central organisation through the dark depths of MMC with little in the way of competitive applications for AIM. In roughly 2009 AIM broke ranks and ran a national recruitment round co-ordinated by a lead deanery. This meant that practically all the AIM consultants of the time, met at Newmarket race course to interview prospective registrars using a ‘standard’ short listing and interview process – a very pleasant day out and actually successful in filling vacancies. In 2010/2011 the Royal College introduced a centrally co-ordinated application process for several specialties including AIM. This ‘single cascadable application’ system meant that candidates filled in one form to apply to their deanery of choice but initially could apply in several specialties in several deaneries and could be interviewed in virtually any or all of them. One aspect of the system was that CMT trainees could apply and be proleptically appointed without having full MRCP but with the final PACES exam result not being announced until late July a lot of trusts found them serves short of registrars with roughly five days’ notice, not ideal! Second rounds were run but at a local level.

We have moved on and refined the process to what we have today – a single application with interviews mostly in the first choice deanery with a transferrable score so that applicants only have one interview (per specialty applied for). The first round is held after Easter for all posts starting before Christmas with a second round co-ordinated and interviewed by one deanery (W Midlands for AIM). The problems with MRCP are still there but abated by alterations in the way PACES are run and results are reported.

For the recruitment cycle that started in spring 2012, 16 specialties used the system with 2600 applications from 1500 applicants for about 1000 posts. AIM advertised 82 ST3 posts in Round 1 and offered interviews to 96% of eligible applicants. We filled 82% at the first time – this compared to 90% fill for CMT Round 1 and 78% for endocrinology ST3. Round 2 was a little disappointing in that only 34% of posts were filled (against a national average of 58%) but this is mitigated by the facts that this was the same as 2011 when all deaneries ran competing R2, 78% of applicants had reapplied having been unsuccessful in R1 and there was a >30% of withdrawals from candidates offered an interview slot. However, this result was achieved for far less ‘consultant time/effort’ than for the same fill rate result in 2011. The AIM SAC surveyed all applicants for R2 and found that 72% had put AIM as first or second choice specialty with previous experience/role models being by far the most important factor in choosing to apply for AIM followed by geographical reasons.

For 2013 we are following the same model for R1/R2 with applications for R1 closing on March 20th 2013. To date we have had 250 applications for about 90 posts. This is with applicants being able to apply to two deaneries for up to six specialties. We have got a geographical distribution in applications with competition rates ranging from 11:1 (i.e. 11 applicants per number) in London through a median of about 2.5:1 down to 1:1 in two areas. Interviews are due to take place locally through April May with offers being sent by 20th May with a deadline for acceptance 24th May. Clearing follows this with interview scores being transferrable to deaneries with vacancies in June and a R2 to follow in September/October.

This shows good news for both deaneries in that there are plenty of trainees applying for acute medicine posts but also for trainees the message should be that there are jobs available throughout the country and that those committed to a career in AIM should find a suitable training post in the UK (even though it may be outside the M25!) – good luck to all those involved!

“Making the most of allied health professionals”

To coincide with NHS Change Day on Wednesday 13th of March, the Centre for Workforce Intelligence (CFWI) released a new paper with the latest insights into making the most of the allied health professionals (AHP) workforce. The report complements the AHP QIPP toolkits produced by NHS London and demonstrates how AHP interventions can reduce costs and improve outcomes for people along each major stage of various pathways.

Dr Rhidian Hughes, CfWI Head of Social Care said: “Our collaborative paper supports the collective energy and creativity being harnessed on NHS Change Day. The paper emphasises the crucial role of the workforce in supporting service innovation and development. We need to ‘think workforce’ to fully realise the opportunities in delivering the QIPP transformation agenda. “Our focus on the allied health workforce is an important one. This workforce delivers care across a wide range of health and social care pathways and are well placed to ensure the ambitions for integrated and joined up care truly become a reality."

The paper considers how best to organise the allied health professionals’ workforce across care pathways, considering factors such as optimum skill mix, education and leadership.

The full report is available on the CfWI website.
A day in the life of a pharmacist on the AMU

Jan Basey, consultant pharmacist on the Royal Liverpool University Hospital AMU since 2009 does everything in life very quickly. She did a degree in pharmacy at Aston University and passed the College of Pharmacy practice exams before becoming a non-medical prescriber. She is now five years into her PhD as well as being the lead pharmacist for AMU. Jan tells Acute News why acute medicine is the specialty for her.

How did you start in acute medicine pharmacy?
When I came to the RLUH in 1998 they asked me to cover the acute medical unit and I’d always been interested in all aspects of medicine so I agreed. Having an AMU in 1998 was quite unusual! I do everything in life very quickly and I get bored easily so I enjoy working in a very busy unit where there is lots to do and lots of challenges. There’s a good mix of patients and it’s always different so it keeps me interested.

What differences have you notice between working in AMUs and other type of hospital settings?
From pharmacy point of a view, the AMU is always a busy environment; it’s where you get the most medication errors, because errors occur at the boundaries where patients move from one care setting to another. We know that most medication problems in hospitals occur on admission. We probably also have more sick patients, proportionally than the wards. We have more people on IV antibiotics and IV treatment in general and it’s a very high turn-over. Our AMU has an average length of stay of about 18 hours so every morning I have at least 37 new patients if not more, whereas on the general ward a pharmacist wouldn’t have that many new patients in a day.

How much contact do you have with patients on the AMU?
We have several simultaneous ward rounds going on so I’m always kept pretty busy! I see patients independently from the medical consultants but if I find problems I will discuss it with the relevant consultant and make an entry in the case notes if appropriate. I work closely with all nine consultants from our AMU. When patients come into hospital, we try to make sure their medicines are correct and accurately prescribed, withheld or stopped because a patient might be admitted as a result of side effects and the doctors can’t assess the patients properly unless they know which medicines they were taking at home.

What is a typical day on the AMU?
When I start at 8am, the nurses usually have quite a few problems ready for me; it can be a medication chart they can’t read, medicines that a patient needs that haven’t been prescribed, medicines that they’ve tried to administer to the patient and the patient has said ‘I don’t take that one in the morning I take that one at night’, etc. Then for most of the early part of the morning I usually try to do medicine reconciliation, check the patients’ medicines and prescribe if needed. The medical consultants might have questions for me during their ward rounds. The junior pharmacists will also bring me problems that they found when doing the medicine reconciliation such as discrepancies which takes quite a lot of time because we have to look at the reasons for admission, check through the notes and check the blood results before I prescribe for the patient. Then by the later part of the morning we’ll start doing discharge prescriptions. That’s probably mainly what goes on all morning. You barely have time to breath.

What attracted you to join SAM?
I didn’t know about SAM until I was contacted to give a talk in London in October 2011. James Allen contacted me to give a presentation¹ at the conference and then I decided to join. I really enjoy the conferences and the journal is interesting to read. It’s also interesting to know what’s happening in the wider world of acute medicine like the issues around 7-day working.

“You have to have an interest in a broad range of medical specialties; you have to be enthusiastic, not get flustered easily, be able to cope with pressure, be able to interact well with people”

Jan is currently researching the challenges in implementing government-directed VTE guidance for medical patients² and medicines reconciliation.

¹Masterclass on Developing a Consultant Pharmacy Framework in Acute Medicine

Does the pharmacy on the AMU operate on a seven-day basis?
Ever since I started we’ve provided a weekend service on the AMU because we could see it was an area where there was a big risk. We visit the AMU on a Saturday and Sunday but we don’t have the staff to provide quite the same level of service as during the week. We try to see as many of the patients as we possibly can and also resolve any problems which the nursing staff tell us about. We are a bit compromised by the fact that GP surgeries aren’t open at weekends. However, in Liverpool we can access a lot of the GP information about patients’ medicines electronically using EMIS web.

What is the required skill mix to become a pharmacist on the AMU?
In terms of individual skills, I think you have to have an interest in a broad range of medical specialties; you have to be enthusiastic, not get flustered easily, be able to cope with pressure, be able to interact well with people because there is an awful lot of staff on the AMU. I also work with all sorts of visiting consultants and nurse specialists. You have to like being busy and be very organised. If you like working in a pressurised acute environment then the AMU is for you.

“From pharmacy point of a view, the AMU is always a busy environment; it’s where you get the most medication errors, because errors occur at the boundaries where patients move from one care setting to another.”

Acute News | 10
Revalidation: an update

Revalidation has now started and all physicians should, by now, have received notification of their revalidation date from the General Medical Council. SAM has been working closely with the Royal College of Physicians to develop specialty-specific guidance for acute medicine, and this will soon be available on the SAM and RCP websites. SAM has been receiving a few specific enquiries from members about revalidation, in particular relating to the need to provide a Patient Survey. This may be a specific challenge for acute physicians who do not do outpatient clinics, particularly for those who work in small AMUs with a very rapid throughput of patients. I raised this issue at the recent RCP revalidation advisors’ meeting – there is clearly not going to be an easy solution, and it may be that the questionnaire will need to be delivered to patients on another ward, if they have already been transferred. Ambulatory Care physicians who are going to be coming back to the AMU for daily review would clearly be ideal candidates to receive a survey questionnaire.

The Quality Standards documents and AMU Quality Indicators should form part of the regular audit process for revalidation of acute physicians, and the figures in the recent SAM / RCP Toolkit ‘Delivering a 12/7 consultant presence on the AMU’ should be used as a guide to activity. The RCP is keen to collate all revalidation enquiries via its revalidation online helpdesk, so please direct any questions initially to them on revalidation@rcplondon.ac.uk.

Our previous Revalidation specialty advisor has recently stepped down from the role. Any acute medicine consultant who is interested in becoming our new Advisor should contact the SAM office, enclosing a copy of their CV. The RCP provides training for this role, which is going to be crucial as increasing numbers of acute physicians approach their revalidation dates.

RCPL Acute Care Toolkit Series

Following the joint RCP and SAM launch of the fourth in the Acute Care Toolkit series at our autumn meeting last year, many of you will have seen the fifth RCP toolkit ‘Training on the Acute Medical Unit’, written by SAM member Dr Nicola Cooper. The toolkit provides some practical advice on how best to use the rich training opportunities which the AMU provides, while recognising that the busy ward environment does not always lend itself to traditional teaching methods. The sixth toolkit: ‘The Medical Patient at risk’, written by past SAM President Dr Rhid Dowdle, is expected to be launched at our spring meeting in Coventry on 9th May.

This toolkit examines important aspects of the recognition and treatment of unstable medical patients, both on the AMU and elsewhere in the hospital, making reference to the National Early Warning Score which has been adopted by a number of units across the UK. Copies of the sixth toolkit will be available for delegates at the Coventry meeting and all available via our website.

Future Hospital Commission and the future of ‘Generalism’

The Royal College of Physicians of London’s Future Hospital Commission is expected to publish its report in the summer. This commission was convened to try to produce some practical solutions to many of the challenges which are facing hospitals at the moment. The Society for Acute Medicine has been strongly represented, both within the commissioning board and individual workstreams. A number of themes have been emerging in discussions and are likely to feature in the final document. Of particular concern is the need to reduce the numbers of transfers of consultant care and internal hospital moves which currently take place during a patient’s stay.

There is a strong view held within the RCP that a patient’s care should be allocated to the most appropriate consultant as early as possible during their hospital stay and that internal transfers after leaving the AMU should only occur if beneficial for the patient’s care. In some cases the most appropriate physician will be a specialist in respiratory medicine, cardiology or gastroenterology, but for many patients the skills of a geriatrician or general physician will be required. This will require a greater number of consultants to maintain skills in General Internal Medicine (GIM), and dually accredited acute physicians will often have the necessary skills to provide on-going care from admission to discharge, providing that adequate numbers can be trained and recruited.

Next month we will be circulating a survey to determine how many existing acute physicians are accredited in GIM, how many trainees are expecting to attain dual accreditation in AIM / GIM. We would also be interested in your views on whether on-going care beyond the AMU is something that you would be keen to provide within the constraints of your job plans. Please respond to this survey which will help to shape SAM’s official response to the Future Hospital Commission and how our specialty develops in the future.

Online

E-news: Sign-up today to SAM’s weekly e-news round
Every Sunday you will receive a summary with the latest headlines in acute and medical news.

Twitter: @acutemedicine
Hashtags: #teamAMU #SAMCoventry #AMU

Facebook: The Society for Acute Medicine
LinkedIn: SAM—Society for Acute Medicine

Acute News | 11
Managing the demand for urgent and emergency care: First emergency care ‘summit’ 21st March 2013 by Dr Chris Roseveare

The first of two emergency care summit meetings, hosted by the Royal College of Physicians in association with the NHS Confederation was held on the 21st March. The meeting, held in the Dorchester Library, was attended by senior representatives from a number of key organisations including SAM, the College of Emergency Medicine, BMA, NHS Commissioning Board (NHSCB) and Royal College of General Practitioners.

The meeting was chaired by Intensivist and former RCP Academic Vice President, Tim Evans; opening the meeting he introduced the two key questions which were to be addressed:

1. What alternatives to A&E can be provided to deliver effective seven day assessment and treatment for people who become unexpectedly unwell?
2. What can the system, working together, do to reduce the number of people who need urgent or emergency care?

Simon Pleydell, associate director of the NHS Confederation and Prof Keith Willett, director for Acute Episodes, described some of the work which is already being embarked upon to address these issues at the NHSCB. The need to re-define the relationship between the Royal Colleges and the NHSCB, to improve the degree of collaboration was clear. Prof Willett stated that the government had ‘called our bluff’ by giving clinicians greater responsibility for commissioning care – now it was time to demonstrate that we are up to the challenging of delivering this.

Mark Docherty, chair of the National ambulance commissioners group presented data on non-conveyance of patients by paramedic crews following 999 calls. These data suggested that there was considerable variation in the proportion of patients conveyed to hospital in different parts of the country, with rates of around 50% in the South West comparing to >80% in the North West. Understanding the reasons behind these variations was key to identifying solutions to the problem; although this was likely to be multi-factorial, the lack of community based alternatives was a significant factor in those areas with high conveyance rates.

Prof Martin Roland, an academic GP from Cambridge described five common misconceptions in managing demand for emergency care:

1. Overestimating the importance of ‘frequent flyers’
2. Forgetting about regression to the mean
3. Assuming interventions are beneficial
4. Ignoring supply-induced demand
5. Forgetting about random variation

A link to his slides can be obtained by clicking here.

During the panel discussion the importance of senior clinical engagement in the triage process for patients presenting to emergency care was recognised. This led into an interesting presentation from Dr David Staples, acute physician from Derby, of their model of consultant-led triage for GP referrals. Combined with a well developed ambulatory care service, this had led to a 37% reduction in admissions and, specifically, almost 50% of GP-referred patients could be managed without overnight hospital stay. Of note the consultant taking referrals did not need to be based in the hospital while undertaking phone triage, but an appropriate level of seniority, general medical skills and broad knowledge of available services were vital. Other models of integration of hospital and community services were presented from Hampshire and Whittington, demonstrating the importance of working across traditional boundaries.

Sir John Oldham highlighted the confusion which commonly arises amongst patients when seeking urgent care, due to the vast array of options which currently exist. His work had identified 28 different places to which patients could present, in addition to the ED; however none of the models to date had managed to reduce emergency department attendances. He proposed that we need to define an urgent care system around models which patients understand – recognising that patients often choose to use Emergency Departments, but also that they represent a spectrum of different services.

The theme of cross-boundary working was continued by Prof Mike Pringle, President of the Royal College of General Practitioners in his closing address. Impressively speaking without notes or PowerPoint slides he articulated the importance of the primary-secondary care interface in achieving the necessary improvements. It was crucial that we do not ‘put barriers in place which make systems less responsive to patients’ need’; breaking down such barriers is the ‘Holy Grail which we should all be seeking’. While recognising that improvements to the community out of hours services were necessary, he also emphasised that this would not provide the sole solution; were this the case patients who arrive in emergency departments after hours would not end up staying in hospitals. The whole system needs to be addressed to effect a positive change.

Clearly much work still needs to be done. The key messages from the meeting are being collated and there is a forum on the RCP website where comments are encouraged which will feed into the next stages of this process; SAM will be working closely with the NHS Commissioning board’s review of urgent care services and acute medicine is already recognised as a key player in delivering solutions to the current pressures. SAM will be co-hosting the next acute care summit, on 25th April, which will focus on how improving patient care pathways after their arrival in hospital.

“... breaking down such barriers is the Holy Grail which we should all be seeking...”
Meetings 2013
SAMCoventry 9-10 May
SAMGlasgow 3-4 October

SAMCoventry
Registration and Call for
Poster Abstracts open now

To Register
www.acutemedicine.org.uk

Learn
Network
Enjoy