

Executive summary and recommendations

The purpose of this report is to improve the quality and safety of care of people who are acutely ill. Building on earlier reports,^{1,2} it marks a further stage in strengthening the care of acutely ill patients, by focusing on the new specialty of acute medicine and its place in service provision. The report examines the facilities and organisation necessary to support clinical services, and proposes standards of care. It also considers the education, training, careers and job plans of doctors who are drawn to this field, and the need for an academic base to ensure teaching and research of the highest quality.

In producing this report, the Working Party reviewed two previous Royal College of Physicians (RCP) reports, *The interface of accident & emergency and acute medicine*¹ and *The interface between acute general medicine and critical care*,² and we recommend that they are read in conjunction with this one (see Appendices 1 and 2 for their summaries and recommendations). As with the earlier reports, the Working Party has taken care to ensure that the recommendations are in keeping with current Department of Health policies on this element of service and in terms of Modernising Medical Careers.

We are grateful for the support of the Royal College of Physicians of Edinburgh and the Royal College of Physicians and Surgeons of Glasgow in developing this blueprint for managing acutely ill medical patients. While specific recommendations are directed to England, the report is relevant to the whole of the UK. *The recommendations below will need to be modified locally to take account of differences, for example in consultant contracts and methods of delivery of care, in different parts of the UK.*

Recommendations

- 1 We recommend the following definition of ‘acute medicine’:

Acute medicine is that part of general (internal) medicine concerned with the immediate and early specialist management of adult patients with a wide range of medical conditions who present in hospital as emergencies.

The following recommendations are addressed to medical directors and chief executives of trusts in England, to chief executives of primary care trusts, and to the Department of Health.

- 2 We recommend that all trusts admitting acutely ill medical patients have a dedicated area where they can be managed. Current terminology is confused, and we recommend the term ‘acute medicine unit’ (AMU). In some hospitals this may be a combined multispecialty unit for all acutely ill admissions.
- 3 We recommend that a network of advisers, including lead physicians, be established to take forward the development of acute medicine in England. This would involve:

- ▶ a consultant physician in acute medicine in every trust, who is given time to take the lead in the development and provision of acute medicine to ensure that this service, which is pivotal to the quality of care, is developed as a matter of urgency
 - ▶ regional specialty advisers appointed jointly by the three Royal Colleges of Physicians of the UK and the Society for Acute Medicine to work with postgraduate deans on issues such as acute medicine training and its funding. They should also support lead physicians in trusts on service delivery issues
 - ▶ a National Director of Acute Medicine appointed by the Department of Health to work with the Royal Colleges of Physicians, the National Director for Emergency Access and the regional specialty advisers in acute medicine.
- 4 **We recommend** that there should be at least three consultants with primary responsibility for acute medicine in every acute hospital, and more in larger hospitals, by the year 2008.
 - 5 **We recommend** that a contribution to the practice of acute medicine from appropriately trained consultants in emergency (A&E) medicine and critical care should be facilitated.
 - 6 **We recommend** that appointments in acute medicine should be developed that include commitments to accident & emergency (A&E) departments, high-dependency units and intensive care units, as well as AMUs.
 - 7 **We recommend** that the staff dealing with the acutely ill should be appropriately trained, and that staffing levels should be adequate to meet the needs of patients in an expert and timely manner.
 - 8 **We recommend** that an appropriately trained member of the clinical staff should assess according to clinical need, and certainly within four hours of arrival, all patients presenting to hospital as acute medical emergencies. This should include the development of a management plan.
 - 9 **We recommend** that a doctor with appropriate skills in acute medicine should be present at all times in all units receiving acute medical emergencies. This would usually be a specialist registrar or equivalent in medicine, or in a medical specialty, who should have the MRCP(UK) Diploma or equivalent, and two years recent experience in managing patients presenting as acute medical emergencies. A consultant physician who has no other scheduled commitments should support this doctor.
 - 10 **We recommend** that 15 minutes for each new patient should be available on a consultant's 'post-take' ward round. This equates to about one clinical four-hour programmed activity for a consultant to see 16 new emergency admissions.
 - 11 **We recommend** that each new patient admitted should be reviewed by a consultant physician within 24 hours. This will require the cancellation of other commitments by the relevant consultant. In all but the smallest trusts (those with less than 16 acute admissions per 24 hours), this will necessitate a consultant-led ward round at least twice in each 24-hour period.

- 12 **We recommend** that all trusts develop an emergency admissions policy. This policy should contain a plan of action to be taken in the event of insufficient acute medical beds, and a plan to provide a dedicated area, with identified medical and nursing staff, for the provision of acute medical care at times of extreme pressure.
- 13 **We recommend** closer collaboration between those working in acute medicine, staff in A&E departments, and those working in critical care units, in order to streamline care for the acutely ill. This would include sharing clinical guidelines and best practice, as well as integrating the work of medical and nursing staff, and facilitating staff rotation across the various aspects of the work. A single directorate of emergency care may facilitate this.

The following recommendations are addressed to undergraduate and postgraduate deans, and members of the Postgraduate Medical Education and Training Board (PMETB).

- 14 **We recommend** that deans of medical schools ensure that dedicated time in the undergraduate curriculum is devoted to acute medicine, and that formal teaching by consultants in acute medicine is provided. All medical students should have experience of acute medicine in AMUs as part of their medical studies.
- 15 **We recommend** that postgraduate medical training attachments to AMUs should last for one to four months. Rotas that provide experience in AMUs only in sessions of one shift, one day or one week, without such blocks, should be discouraged.
- 16 **We recommend** that the PMETB ensures that trainees in acute medicine receive dedicated experience in AMUs, coronary care units, high-dependency units, intensive care units, A&E departments and in geriatric medicine. We **further recommend** that trainees in acute medicine undertake the Royal Colleges' IMPACT[®] course (Ill Medical Patients' Acute Care and Treatment), and receive training covering the key clinical, management and organisational skills described in the acute medicine curriculum.
- 17 **We recommend** that clear pathways are developed to facilitate higher specialist training in acute medicine for doctors with a background in emergency (A&E) medicine and critical care, who have appropriate basic specialist training, but do not necessarily have the MRCP(UK) Diploma. Equivalence should be determined for other relevant postgraduate qualifications.
- 18 **We recommend** that the PMETB considers putting in place arrangements to facilitate the further training of consultants in acute medicine who wish to change career direction and re-enter specialty training.
- 19 **We recommend** that there should be an emphasis on opportunities for flexible training and flexible working in acute medicine.

The following recommendations are addressed to the three Royal Colleges of Physicians of the UK.

- 20 **We recommend** that the General (Internal) Medicine Committee of the Royal College of

Physicians of London be reconstituted as the Committee for Acute and General Internal Medicine.

- 21 **We recommend** that the three Royal Colleges of Physicians and the Society for Acute Medicine work together with the Council of Heads of Medical Schools to establish a secure academic base for acute medicine.
- 22 **We recommend** that the RCP Workforce Unit, on behalf of the three Royal Colleges of Physicians, collects and monitors accurate data on the numbers of consultants and trainees working in acute medicine and on the contribution from consultant physicians who also work in other specialties.
- 23 **We recommend** that RCP regional advisers and specialty advisers review and advise on job plans for new consultant posts in acute medicine in the light of the working patterns recommended in this report.