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Introduction to Acute Medicine

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KEY POINTS

- Acute Medicine (or Acute Internal Medicine) is the specialty concerned with the initial assessment, investigation, diagnosis and management of adult patients with urgent medical needs.
- There is a broad spectrum of clinical work within the specialty, including the immediate management of life-threatening medical emergencies, the initial treatment (generally first 48–72 hours) of all presenting general medical ailments, and the provision of ambulatory care. More recently, acute medical care within the patient's home via telemedicine, Hospital at Home service and 'virtual wards' has also been implemented.
- The delivery of Acute and Internal Medicine care is dependent on the close working and interrelationship between members of the multidisciplinary team.
- Most physician trainees now receive much of their training in the care of acutely unwell medical patients while working in the Acute Medicine service.
- As Acute Medicine is an evolving specialty, and many acute medical services have a varied configuration and staffing model, the role of the Acute Medicine clinician varies across the UK.

Introduction

Acute Medicine (or Acute Internal Medicine) is the specialty concerned with the immediate and early specialist initial assessment, investigation, diagnosis and management of adult patients requiring urgent or emergency care for one or more of a wide range of medical conditions.

Acute Medicine evolved to provide patients suffering from a wide range of medical conditions who present to, or from within, hospitals requiring urgent or emergency management with the best quality care, in the right environment. These patients are often treated on distinct wards called acute medical units (AMUs) and patient care is generally led by consultant physicians, trained or with an interest in Acute Medicine. A patient admitted to the AMU will receive care that will include the necessary investigations and management required until the patient is discharged,

Acute Medicine: Lecture Notes, First Edition. Edited by Glenn Matfin.

transferred downstream to an internal medicine or specialty ward, or escalated to a higher level of care.

Acute Medicine and AMUs are relatively new innovations aimed at improving care given to patients with acute medical illness. Acute Internal Medicine was formally recognised as a specialty with defined training programmes in 2009, having previously been a subspecialty of General Medicine (now known as Internal Medicine) since 2003. The creation of Acute Medicine as a specialty has been a success in improving care for patients with an acute medical illness.

Despite its relative youth, the specialty of Acute Medicine has good support and advocacy from clinical professional bodies, such as Royal Colleges and the Society of Acute Medicine (SAM). This organisation and specialisation mean that most physician trainees now receive much of their training in the care of acutely unwell medical patients while working in the Acute Medicine service.

There is a broad spectrum of clinical work within the specialty, including the immediate management of life-threatening medical emergencies, the initial treatment (generally the first 48–72 hours) of all presenting general medical ailments, and the provision of ambulatory care. AMUs may be co-located with the emergency department (ED) and same-day emergency care (SDEC) areas. More recently, acute medical care within the patient's home via telemedicine, Hospital at Home service and 'virtual wards' has also been implemented.

Given the variety of patient presentations to Acute Medicine services, medical specialty in-reach or co-location with cardiology, medicine for care of the older person, stroke medicine and respiratory medicine is common. Ready availability of advice and management pathways from the other medical specialties is also critical. Some of this workload is performed by Acute Medicine physicians with subspecialty expertise. As well as medical specialties, Acute Medicine services need to work closely with other disciplines, for example surgical specialties, obstetrics and gynaecology, and psychiatry. Access to higher level care is also important – Acute Medicine specialists work closely with colleagues in high-dependency, intensive care and coronary care units. There has been a trend to having higher level of care provided on AMUs in enhanced care areas.

It is imperative to explore ways of incentivising doctors to work in the most challenging and in-demand areas of medicine, such as Acute Medicine. The rapid growth of hospitalists in the USA is a good example of attracting clinicians to an area of unmet clinical need. Bob Wachter (Chair, Department of Medicine, University of California, San Francisco) coined the term 'hospitalist' in 1996, more than 25 years ago. In naming a physician whose practice is dedicated to caring for a patient during the entirety of their hospital stay, he and his esteemed colleague (Lee Goldman) started a new movement. Hospitalists usually care for all medical inpatients and, in some organisations, every single inpatient, 24 hours a day, seven days a week. Hospitalists now number more than 50 000 in the USA and are more numerous than any subspecialty of Internal Medicine (the largest of which is cardiology with 22 000 physicians).

Hospital Medicine and Acute Medicine share a lot in common, both having core expertise in managing the clinical problems of acutely ill, hospitalised patients. However, the key lesson for the continued growth of Acute Medicine lies not in hospitalism as a suggested model of care, but in the process of how it became so successful – right leadership, financial impetus, workforce capacity and buy-in from other hospital specialties (e.g. offering co-management service, especially perioperative care).

As Acute Medicine is an evolving specialty, and many acute medical services have a varied configuration and staffing model, the role of the Acute Medicine clinician varies across the UK. However, it is critical that there is a multiprofessional approach to providing all the relevant knowledge and skills that the acutely ill medical patient may require.

The roles of the Acute Medicine physician include the following.

- Stabilise acutely ill patients, and then either discharge or transfer these individuals, when stable and if required, to the most appropriate acute care setting for their needs.
- Minimise length of stay by delivering safe and effective care for short-stay patients.
- Fully differentiate the presenting complaint or problem.
- Risk-stratify the cause of admission (i.e. 'assess to admit') to determine the best place for ongoing care and management (e.g. ambulatory, inpatient, home).
- Improve hospital patient flow, including reducing ED overcrowding.
- Provide leadership and guidance for the medical acute take.

In the UK, there is a shift from the terms *General Medicine* or *General Internal Medicine* to the more commonly used international term of *Internal Medicine*. Internal Medicine is the

specialty that encompasses the care, investigation, diagnosis and management of *all* medical needs, including acute medical problems, of both inpatients and outpatients.

Where is acute medical care administered?

The challenge for Acute Medicine is to provide a range of high-quality services to a heterogeneous group of patients across the acute care setting. In time-sensitive conditions where early intervention is paramount – such as sepsis, diabetic ketoacidosis and acute kidney injury – Acute Medicine clinicians can make a real difference to outcomes for patients.

In addition to the assessment and admission of adult patients, Acute Medicine clinicians also have an important role in developing services to enable the safe delivery of care in outpatient and home settings (Figure 1.1). Many patients previously admitted to hospital for investigation or treatment of conditions such as deep vein thrombosis, pulmonary embolism and cellulitis can now be treated safely as outpatients with the help of Acute Medicine-led SDEC services and follow-up clinics. Rapid-access ('hot') medical clinics also allow unwell patients access to specialist clinicians and rapid diagnostics without admission to hospital. Acute medical care within the patient's

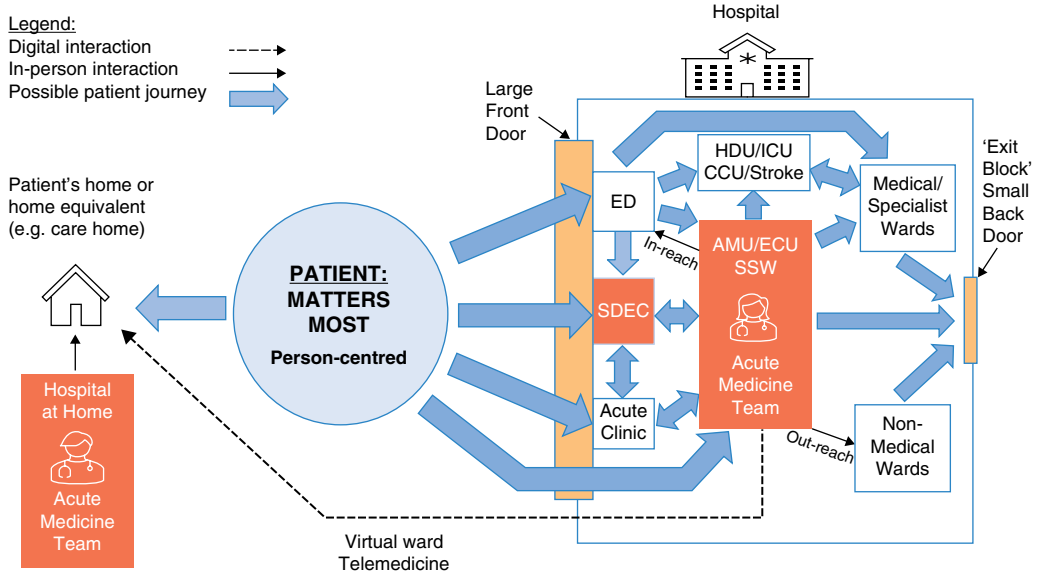

Figure 1.1 Changing landscape of Acute Medicine services. The circle in the middle of the figure represents the patient – who should be at the centre of all we do (i.e. person-centred care). The solid blue arrows represent the different directions of travel of possible patient journeys throughout the acute medical care setting. The solid orange boxes represent the major bases for the Acute Medicine team. On the left side of the figure, the patient can be managed by the Acute Medicine team at home, either in person by the Hospital at Home team or digitally via the virtual ward or telemedicine. On the right side, patients traditionally entered the hospital 'front door' – the point of arrival/entry to hospital – via the emergency department (ED). However, this leads to ED crowding. Front-door reconfiguration measures to reduce ED crowding and hospital admission include patients attending ambulatory care, such as acute clinics (e.g. rapid-access 'hot' specialty clinics) or same-day emergency care (SDEC). Alternatively, patients can be admitted directly to the acute medical unit (AMU) or short-stay ward (SSW). Acute medical patients needing more enhanced care can be managed in the Acute Medicine enhanced care unit (ECU) or transferred to critical care – high-dependency unit (HDU)/intensive care unit (ICU), coronary care unit (CCU) or stroke unit. The Acute Medicine service also offers specialty in-reach to ED and out-reach to the non-medical wards. The hospital 'back door' is depicted smaller than the front door in the illustration, which represents the functional reality that it is more challenging to discharge patients back home or into the community. This 'exit block' leads to overall hospital crowding (patient flow 'gridlocked') and unnecessarily increases length of stay.

home via telemedicine, Hospital at Home service and 'virtual wards' is rapidly evolving.

Acute care hub

The Royal College of Physicians (RCP) Future Hospital Commission describes the hospital footprint of acute medical services across five areas, termed the 'acute care hub' (see Figure 1.1).

- AMU
- Short-stay ward (SSW)
- Ambulatory emergency care (AEC)/SDEC
- Emergency department
- Enhanced care/Critical care

Acute Medicine in the in-hospital setting

- AMUs - defined by the RCP as 'a dedicated facility within a hospital that acts as the focus for acute medical care for patients who have presented as medical emergencies to hospital'. AMUs, as a base for the practice of Acute Medicine, have become integral to the care pathway of most patients who require hospital-based acute medical care in the UK. AMUs provide the initial treatment (generally first 48–72 hours) of all presenting Internal Medicine ailments. Those patients requiring longer hospital stays beyond 72 hours should be transferred to Internal Medicine or specialist medicine beds.
- SSW – bed base providing targeted care for patients requiring brief hospitalisation (estimated date of discharge of less than 72 hours) and dischargeable as soon as clinical conditions are resolved. Short-stay beds are based within the AMU or co-located with AMU in a separate ward-based environment.
- Frailty service – in-reach or embedded within AMU/SSW/SDEC and typically led by a geriatrician. This service may also provide emergency perioperative medical care (e.g. frail patient with fractured neck of femur).
- Enhanced care beds – enhanced care takes place in a ward setting (usually AMU) but provides ready access to the critical care team through established communication links. It is a pragmatic approach to reducing the risk of patients falling into a service gap: patients who would benefit from higher levels of monitoring or interventions than expected on a routine ward, but who do not require admission to critical care.
- Specialist out-reach – Acute Medicine outreach provides urgent and emergency acute care for the hospital, in collaboration with the critical care team. This can be as part of a *medical emergency team*.
- Acute Medicine in-reach to ED.
  - Review acutely unwell medical patients waiting for a bed in AMU or SSW.
  - Work collaboratively with the ED team to identify patients who attend ED and can be: 1. sent to AEC (SDEC); 2. referred to a rapid-access clinic or telemedicine; 3. referred to Hospital at Home or virtual ward service; 4. discharged back to the care of their GP; and 5. discharged home.

Acute Medicine in the ambulatory setting

- AEC/SDEC – AEC provides patients with the traditional aspects of acute medical care but avoids hospital admission.
  - The RCP defines AEC as 'clinical care which may include diagnosis, observation, treatment and rehabilitation, not provided within the traditional hospital bed base or within the traditional outpatient services, and that can be provided across the primary/secondary care interface.'
  - The underlying principle of AEC is to convert traditional inpatient care into same-day emergency care.
  - Acute and Internal Medicine teams deliver SDEC in AEC units.
- Acute care clinics – there are several types of acute care clinics.
  - Rapid-access ('hot') clinics are for patients accessing specialty care and usually offer same-day appointments. Can also be triaged via telemedicine.
  - Early-discharge clinics are for patients who do not need to remain in hospital but where early follow-up is best served by their discharging team as opposed to their GP. These clinics may be part of the SDEC services.

Acute Medicine in the community

Interface Medicine: managing patients with undifferentiated illness who are at an interface between primary and secondary acute care.

- Hospital at Home – innovative care model that provides hospital-level care for acute conditions that would normally require an acute hospital bed, in a patient's home for a short episode through a multidisciplinary healthcare team.
- Virtual wards – observe and manage patients in their home supported with technological innovations that will enable monitoring of a person's vital signs and well-being through phone calls or other virtual technology from a team of clinicians, as well as patient monitoring apps.
- Telemedicine (remote) services.

Scope of Acute Medicine care – what are the common presentations or conditions?

The range of clinical problems encountered in Acute Medicine is very wide, which gives the work a great deal of variability. Examples of common Acute Medicine presentations and conditions are outlined in Table 1.1.

Table 1.1 Common Acute Medicine presentations and conditions (not including COVID-19)

Abdominal pain
Acute back pain
Acute confusion (delirium)
Acute kidney injury (AKI)/chronic kidney disease (CKD)
Blackout/collapse
Breathlessness
Chest pain
Cough
Diarrhoea
Dizziness
Falls
Fever
Fits/seizure
Haematemesis and melaena
Headache
Hyperglycaemia
Jaundice
Lethargy
Limb pain and swelling
Nausea and vomiting
Palliative and end-of-life care
Palpitations
Poisoning
Rash
Weakness and paralysis

Challenges in Acute Medicine

There is a crisis in acute medical care for multifarious reasons.

- Medical emergencies are the most frequent cause of unplanned hospital admission, and place considerable demands on acute healthcare services (Box 1.1). In the Getting It Right First Time (GIRFT) Acute Medicine national report (2022), approximately 92% of the inpatients on medical wards had been admitted as an emergency, and most of these were admitted via the AMU. This has led to rising acute medical admissions with increased bed occupancy levels and hospital crowding. During times of increased pressure, such as the perennial winter period or waves of the recent COVID-19 pandemic, increased unplanned admissions also negatively impact the delivery of elective services.
- Increasing numbers of older, frailer patients with complex, high-acuity illnesses. Frailty defines the

Box 1.1 NHS England and SAM (2022) 'six to help fix' areas to improve in-hospital flow

- Protect SDEC capacity and function.
- Diagnostics should be provided on the basis of clinical need, but areas such as AMU, SDEC and ED must have the same level of access in terms of availability, priority and reporting times.
- Ward rounds and handover. Twice-daily review on the AMU, seven days per week. Internal medical/specialty wards – daily ward and board round on weekdays and board round with targeted patient reviews at weekends.
- Workforce optimisation.
- Access to Acute Medicine. Develop services to enable direct access, ensuring clinical conversations are used to direct patients to the most appropriate service/areas to meet their clinical needs.
- Specialties and in-reach. It must be recognised that medical patients who present as an emergency admission are the responsibility of *all relevant* specialties working within the hospital.

group of older people who are at highest risk of adverse outcomes, such as falls, disability, admission to hospital or the need for long-term care. Nearly two-thirds of patients admitted to hospital are over 65 years old and around 25% of these patients have a diagnosis of dementia (with more than a third of people living in care homes having this diagnosis).

- Multimorbidity. One in three patients admitted now has five or more health conditions compared to one in 10 a decade ago.
- Systemic failures of care, with lack of candour when things go wrong.
- Poor patient experience.
- Existence of racial, social and healthcare disparities.
- People who live in areas of higher than average deprivation are more likely to be admitted to hospital and to spend longer in hospital. This is independent of social class, educational level and behavioural factors.
- Alcohol and substance abuse. The UK continues to have high numbers of alcohol- and drug-related deaths, as well as associated morbidity. In addition, the COVID-19 pandemic has had a detrimental impact. For example, alcohol consumption has shifted more towards at-home, late-night drinking – and frequently alone. Drug decriminalisation, drugs consumption rooms, managing risky drug use behaviour and addressing the social determinants such as deprivation are all on-going debates and challenges.
- Unwarranted clinical variation – defined as 'variation that cannot be explained by the condition or the preference of the patient; it is variation that can only be explained by differences in health system performance'. Unwarranted clinical variation in NHS practice has long been accepted as a barrier to quality care.
- Healthcare workforce crisis. Healthcare is experiencing a global workforce crisis, with the World Health Organization projecting that an additional 40 million health workers will be needed by 2030. Approximately 13% of the total UK workforce is employed in the health and care sector. However, NHS currently has *130 000* vacancies. For example, 52% of advertised consultant posts were unfilled in 2021, with three quarters of these remaining unfilled due to having no applicants.
  - Poor workforce planning has resulted in inadequate numbers of medical, nursing and other healthcare professionals.
  - In addition, the current healthcare workforce is suffering from growing pressures with increased risk of burnout leading to physical and emotional exhaustion and drop in productivity. Working in depleted teams, facing daunting backlogs in patient care, and treating people with more advanced disease have become commonplace.
  - Workforce safety has also been a growing concern. In the context of COVID-19, persistent abuse and violence towards NHS doctors by patients and public compound the emotional toll on staff, damages morale and threatens patient safety.
  - All these factors have led to a potential mass exodus – '*the great resignation*'.
- Social and primary care crisis.
- Medical trainees are also under increased pressure and there is evidence that they do not get the mentorship or training that they deserve because of increasing demands on senior staff and the impact of the COVID-19 pandemic.
- Constant reconfiguration in health and social care delivery and legislation.
- Ever increasing costs of health and social care in a time of austerity and/or financial instability. Lack of modernisation of the NHS estate, rising energy costs, and cost-of-living challenges all impact negatively on healthcare provision.
- Overcomplex, slow, non-integrated digital health systems (e.g. electronic health records and electronic prescribing).
- The climate emergency is a health crisis. Climate change has worldwide effects on health, including Acute Medicine provision: heat waves (defined as ≥2 days of unusually hot weather) are increasing in frequency and intensity and can lead to heat-related illness; hypothermia (energy insecurity and fuel poverty); extreme weather events (e.g. floods); poor air quality and pollution (e.g. asthma); food insecurity (e.g. malnutrition and obesity); water insecurity and safety; vector distribution and ecology (e.g. mosquitoes, ticks); and social factors (e.g. increased risk of displacement).

Impact of COVID-19 on health and social care

COVID-19 has highlighted major issues in the capacity and resilience of the health and care system. Urgent and emergency care services remain under huge pressure with concerns regarding overcrowding, delays in patient care, exhausted staff with a worrying picture of rising burnout and unsustainable workloads exacerbated by the COVID-19 pandemic (e.g. staff sickness, isolation and long-COVID). Staff remaining in work

suffer 'left behind syndrome', where pressure to do more with less is even greater. Sustained moral distress (i.e. 'the psychological unease generated where professionals identify an ethically correct action to take but are constrained in their ability to take that action') leading to moral injury and impaired function or longer term psychological harm have also been common during the COVID-19 pandemic.

Opportunities in Acute Medicine

Academy of Medical Royal Colleges 'Fixing the NHS' report (2022) highlighted some of the key healthcare delivery challenges and solutions: Expanding workforce numbers; Improving patient access to care across all settings; Reforming social care; Embracing new ways of working; Grasping the digital agenda; Valuing our staff; Modernising the NHS estate; Revitalising primary care; Greater focus on prevention and tackling health disparities; Making better use of resources and ensuring there is adequate investment.

A new model of care for hospitals of the future has been proposed. The first principle is that of putting patients first (i.e. patient-centred). Patients should be treated with compassion and dignity. They should be involved in decisions on their condition and treatment (i.e. shared decision making), considering social and cultural norms, especially for multiethnic populations (i.e. cultural distinction).

There should be a medical division led by a chief of medicine (like the current practice in the USA) as the senior doctor responsible for making sure working practices facilitate collaborative, patient-centred working and that teams work together toward common goals and in the best interest of patients. Therefore, *effective leadership* is essential.

Patient safety is critical and having an open culture of providing safe care can help. Having real-time 'root cause analysis' ('huddle') when things do go wrong is desirable to prevent further occurrences. A duty of candour when problems arise is needed. Seven-day care is important too and there should be cover 24 hours a day, seven days a week; this should be across the multidisciplinary team, with nurses, pharmacists, discharge teams and radiology services, for example, required seven days per week so not just clinicians working in isolation.

Patient care should cross the boundaries of primary, secondary, postacute and social care with care pathways designed for each of the morbidities that a patient experiences. In this regard, as in all, *effective communication* is key.

There are important consequences of this and one is that there need to be more doctors trained and engaged in *generalist* medicine (including Acute Internal Medicine and Internal Medicine). This does not mean that specialist care is less important or less prioritised. This will remain essential and, indeed, the degree of expertise available in the specialties is ever increasing. Postgraduate medical education in the UK (i.e. 'Shape of Training') is trying to redirect toward more patient-focused, generalist training, and with more flexibility of career structure. It is also important to increase the number of medical and nursing students. Undergraduate medical education is also evolving, with greater focus on generalist training. Acute Medicine has been described as the powerhouse of undergraduate and postgraduate generalist training.

Healthcare workers are the cornerstone of health systems. Focusing on the 'three Rs' of the workforce – recruitment, retention and returners – is critical. In these challenging times, it is more important than ever to have working environments that are supportive, inclusive and safe. We need to:

- improve staff well-being by ensuring employers 'get the basics right', including providing facilities for rest (e.g. after night shifts), spaces to carry out non-clinical work, and easily accessible hot food and drink so staff can keep refreshed during their shifts
- ensure that job planning at all levels facilitates flexible training and working
- facilitate improved work–life balance which can be enhanced by the sessional basis of Acute Medicine clinical work, which lends itself to less than full-time working (improved rostering and use of shifts), and annualised job plans for consultants. It is important to incentivise senior doctors to continue working in our NHS.

The focus on *retention* must be matched by a commitment to sustainable *recruitment*. This includes both developing the next generation of UK-trained talent and *ethical* international recruitment (more than a third of doctors registered in the UK gained their primary medical qualification overseas). Overseas doctors, who continue to be an essential part of the workforce mix, must be given the tools they need to thrive (such as the new NHS standardised induction programme). Diversity, equity and inclusion (DEI) and antiracism in healthcare are top priorities in all our work. Promoting innovative models of medical staffing including nurse practitioners, physician associates and other mid-level clinicians is important.

Digital health encompasses the use of technologies such as telemedicine, smartphone apps, wearables

and artificial intelligence to deliver healthcare. These digital solutions have rapidly evolved during the COVID-19 pandemic and have the potential to improve patient outcomes and efficiency of care, which can further enhance safer patient care.

Health equity means that everybody should have the opportunity to lead the healthiest life possible. This requires removing obstacles to health such as poverty, discrimination and their consequences. Greater focus on prevention is also critical.

The world has changed due to COVID-19. This will undoubtedly influence all aspects of health and social care delivery for the foreseeable future. An appropriate legacy would be for co-operative working across hospital specialties to be retained. The additional skills obtained by many medical, nursing and allied health professionals need to be usefully retained, such as in enhanced care provision.

Realistic medicine

Realistic medicine recognises that a 'one size fits all' approach to health and social care is not the most effective path for the patient or the NHS.

- Shared decision making.
- Providing a personalised (individualised, patient-centred) approach to care.
- Reducing harmful and wasteful care caused by both overprovision and underprovision of care.
- Reduce unwarranted clinical variation.
- Managing risk better.
- Become improvers and innovators.

Getting It Right First Time (GIRFT)

GIRFT is a national programme designed to improve medical care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies, such as the reduction of unnecessary procedures, and cost savings.

The GIRFT Acute Medicine national report (2022) had 19 recommendations aiming to help trusts across England standardise patient care, and to introduce measures to help care for an increasingly older population (Box 1.2).

Training in Acute Medicine

The range of clinical problems encountered in Acute Medicine is very wide, which enables trainees to become experts in diagnosis, investigation and management across multiple disciplines (see Table 1.1). The practice of Acute Medicine requires the generic and specialty knowledge, psychomotor skills and professional attitudes to manage patients presenting with a wide range of medical symptoms and conditions. It involves particular emphasis on diagnostic reasoning, managing uncertainty, dealing with co-morbidities, and recognising when another specialty opinion or care is required. Doctors in training will learn in a variety of settings using a range of methods, including workplace-based experiential learning, formal postgraduate teaching and simulation-based education.

There is also significant overlap between Acute (Internal) Medicine and Internal Medicine training.

Internal Medicine stage 1 training (2019)

Internal Medicine stage 1 (IM stage 1) will form the first stage of specialty training for most doctors training in physicianly specialties. The purpose of the IM stage 1 curriculum is to produce doctors with the generic professional and clinical capabilities needed to manage patients presenting with a wide range of general medical symptoms and conditions. They will be entrusted to undertake the role of the medical registrar in NHS district general and teaching hospitals and qualified to apply for higher specialist training.

IM stage 1 will normally be a three-year programme that will include mandatory training in geriatric medicine, intensive care, outpatients and ambulatory care. The scope of Internal Medicine requires diagnostic reasoning and the ability to manage uncertainty, deal with co-morbidities and recognise when specialty opinion or care is required. There will be a critical progression point at the end of the second year (IMY2) to ensure trainees have the required capabilities and are entrusted to 'step up' to the medical registrar role in IMY3. For most, the trainee will be entrusted to manage the acute unselected medical take and manage the deteriorating patient with indirect supervision in IMY3.

At completion of IM stage 1, trainees will be required to meet all curriculum requirements, including passing the summative 'high-stakes' assessment – Membership of the RCP diploma examination – by the time of completion.

Box 1.2 GIRFT Acute Medicine national report (2022) recommendations

Acute medical units (AMU)

Ensure the acute medical pathway is adequately resourced to manage the projected patient need in a safe, effective and efficient manner, 24/7.

Ensure there is seven-day access to medical specialties and services for all patient needs.

Ensure that there is cross-trust consistency in the use of acronyms when referring to acute and general medicine services (i.e. at least 30 different names are being used across England for the units that care for acute medical patients when they are first admitted to hospital: the AMU).

Ensure that the AMU is sited appropriately in relation to other parts of acute care hub.

Ensure the AMU is appropriately resourced in regard to time and space to train all healthcare staff in both acute patient care and the use of relevant equipment.

Ensure the AMU is resourced with the appropriate space and equipment to manage unstable medical patients (e.g. enhanced care unit interventions such as non-invasive ventilation, use of vasopressors).

Ensure there are systems in place to track patients and ensure good communication between staff, including handover and referral.

Act to improve and repeatedly monitor processes of patient care in the AMU.

Same-day emergency care (SDEC)

Ensure the SDEC pathway is adequately resourced to manage the projected demand in a safe, effective and efficient manner, including prompt access to diagnostic and specialist services.

Patient pathways

Ensure that evidence-based pathways are used optimally within trusts.

Ensure admission and readmission data is routinely and accurately recorded and monitored, and used to inform the provision of safe, effective and efficient pathways.

Ensure that the outcomes for sentinel conditions (e.g. chest pain, headache, pneumonia) are regularly monitored to identify any deterioration in performance and provide feedback to medical teams.

Ensure that patients presenting with sepsis are identified accurately and treated safely, efficiently and effectively.

Activity data and clinical coding

Ensure physicians and clinical coders improve the accuracy of data collection and ensure that all coding is undertaken consistently.

Ensure that services are provided in a cost-effective and efficient way.

Workforce planning

Ensure the workforce reflects the requirements of the Acute Medicine and Internal Medicine service.

Acute (Internal) Medicine curriculum (2022)

Training in Acute Medicine will take trainees who have completed IM stage 1 (or equivalent) to the level at which they have the capabilities required to acquire a certificate of completion of training (CCT) in Acute Medicine and are thereby deemed capable of working as independent practitioners in this specialty. All trainees will undertake Acute Medicine training alongside training in stage 2 of IM.

The purpose of the Acute Medicine curriculum is to produce doctors with the generic professional and specialty-specific capabilities needed to manage patients presenting with a wide range of medical symptoms and conditions. Acute Medicine training will be a four-year programme in combination with IM stage 2 training. The programme will include mandatory training placements in geriatric medicine, intensive care, respiratory medicine and cardiology, in addition to dedicated training on AMUs and SDEC units.

Training in Acute Medicine produces clinicians who are comfortable managing a wide range of medical conditions, with a particular focus on risk assessment and ambulatory management. Critical care competencies form part of the programme and Acute Medicine trained clinicians will be able to manage critically unwell patients in conjunction with critical care teams. Acute Medicine trained clinicians will be able to understand the importance of flow through acute services and also the integration of these services within the wider healthcare community. There will be a critical progression point at the end of the training programme to ensure trainees have the required capabilities and are entrusted to undertake the role of the Acute Medicine consultant.