



The London Review

Lord Darzi's review of London's health services is likely to influence policy far outside the capital. Inevitably many of the early reactions to this thoughtful review have been rather superficial. Julian Redhead represented the London emergency medicine consultants on the review group and we asked him for his personal assessment of the report.

In July this year a review of healthcare for London was completed by Lord Ara Darzi—*Healthcare for London: a framework for action*.¹ I was part of a review group providing emergency medicine input, but the final report represented Lord Darzi's recommendations after studying sometimes conflicting information from different sources.

A previous document had outlined his reasons for believing that healthcare in the capital needed to change. Here he quoted specific healthcare challenges for London, such as childhood obesity, substance abuse and mental health; health inequalities across London; reliance on hospital care, which, according to public consultation, is not what the public living in London would prefer although advances in medical care suggested that "centralisation" of some services would improve clinical outcomes; abilities of NHS staff not being fully recognised and that improved use of the NHS estate could be made. He was concerned that money invested in the NHS in London was not being used effectively. From these findings he proposed five principles for change:

1. Services focused on individual needs and choices
2. "Localise where possible, centralise where necessary"
3. Integrated care and partnership working to ensure maximum contribution from the workforce
4. A focus on prevention of illness rather than cure
5. Ensuring that health inequalities in London are removed.
4. Centralisation and the development of networks for the care of patients with strokes, acute coronary syndromes, severe injuries and patients requiring emergency surgery. This would require the ambulance service to "bypass" some hospitals for certain conditions and require the development of specialist transfer staff and resources.

The report was divided into six patient pathways: maternity and newborn care; staying healthy; planned care; long-term conditions; end-of-life care; and, most pertinent to us, acute care. Lord Darzi proposes:

1. Improved access for patients to their GP practice will ensure fewer patients will perceive an advantage to attending the local emergency department.
2. The development of a single number for telephone advice.
3. The development of "urgent care centres", both attached to all emergency departments and based in the community. These are described as the "front door" for ambulatory patients, suggesting that the majority of them would be attended to in this area with a proportion being "referred" to the main emergency department. The staffing of the urgent care centre would mainly be primary care with triage work being carried out by "experienced emergency department nurses or General Practitioners".

To support these changes and others in the report it is proposed to develop two new types of care systems: (1) to provide community-based care at a level that falls between the current General Practice and traditional district general hospital—the polyclinic; and (2) to develop specialist hospitals to improve the care of complex patients whilst linking with universities to foster research—the specialist hospitals and academic health science centres.

It is reported that since his appointment as health minister Lord Darzi has been asked to produce a similar report nationally.

Many of the changes proposed will have support from clinicians and some have already been proposed by emergency medicine consultants in the past, such as

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centralisation of trauma. However, even if all the proposed centralisation was to happen it would still only account for a small proportion of the workload for a single emergency department, thought to be around 2%. This is an encouraging figure when considering the potential complications from transfer of patients to the larger hospitals, but must also be considered in terms of training and continuing professional development for consultants working in the smaller hospitals. It is likely to result in a change in the way we are employed by a single trust and result in more split site working.

The London Ambulance Service will have a pivotal role in the prehospital triage of patients and the transfer of patients between institutions. They will need the resources to ensure that this role is fulfilled and protocols agreed across the health networks. The proposed specialist transfer teams from the receiving hospitals will be necessary to ensure continuity of service at the smaller hospitals and that high-quality care can continue to be delivered. The paediatric retrieval team, CATS, provides us with a working model but would need to be adapted for adult patients.

Many consultants will be encouraged by Lord Darzi's recognition of the emergency department consultant's skills in resuscitation and airway skills, and the need to ensure 24-hour senior cover within the emergency department. However, others will be concerned about the likely time lag before all senior doctors working in an emergency department will have these skills and the ability of those doctors working in smaller hospitals to maintain these skills. The move to 24-hour senior cover will require a large investment in consultant and training number expansion.

There has long been the perception that a large proportion of emergency department patients could be better cared for by trained General Practitioners. Given that a majority of our patients are treated by junior doctors in training, then this is likely to be true. However, this proportion is likely to vary between departments and depend on the skills of the individual General Practitioner. Some will be confident in interpretation of radiographs and the suturing of wounds etc, but many will not. The development of an adjacent primary care led service will be an advantage to some patients; however,

the size and staffing of these new departments will need to be carefully modelled at a local level to ensure value for money, both in and out of hours.

These new departments must be located adjacent to the emergency department with easy access between them and the main emergency department. This will facilitate the single point of triage for all areas of urgent and emergency care. Lord Darzi is very clear that the triage work will be carried out by "experienced emergency department nurses or General Practitioners". This will be vital for the safety of patients.

The development of the polyclinic is a major change in the way that primary care and some hospital outpatient care will be delivered. Examples of polyclinics are available in Germany; there are few, if any, in the UK. It is interesting to await the views of General Practitioners on the benefits of such institutions. However, concern must be raised as to the cost involved in the building and relocation of practices, which is likely to divert funding away from the hospitals and the removal of vital staff in order to support services such as imaging. The British Medical Association has already raised concerns regarding the removal of local General Practitioner services to polyclinics.

The single telephone number for accessing healthcare information may be of benefit to some groups of patients, but it is unlikely to be a significant help in reducing the attendances at emergency departments; I am not aware of any study that has linked NHS Direct to a reduction in attendances at a local hospital. However, the proposed new service will have General Practitioners providing immediate advice with the ability to book patient's appointments with their local primary care service and have access to other local services such as social services. This may provide an improved telephone service but it will be important that a cost-effective analysis is carried out to ensure value for money for such a service.

The funding of the proposed new services is dependent on a number of assumptions about the success of the new services. If there is a significant movement of ambulatory patients to primary care it will be important that Primary Care Trusts do not destabilise the emergency department by removing a large proportion of funding. It is important that all the local healthcare systems are

viewed as a continuum and as a single economy.

Lord Darzi's vision for the future of healthcare in London is an important document for all clinicians working in the NHS. The proposals are a long-term vision, and detailed trials of parts of the new systems will need to be studied carefully. The report concludes with a challenge to NHS London:

1. Provide examples of polyclinics to model the new service by 2009.
2. Undertake a review of stroke and trauma services across London.
3. Rapidly improve the skill and capacity of the London Ambulance service.

I would conclude with a challenge to emergency medicine consultants to become involved in shaping how acute care will be managed across the country. We need to lead the process to ensure the best care for our patients. We need to ensure that quality of care is maintained and improved for those patients attending smaller departments, while gaining the benefits of centralisation for some acute conditions. Departments need to identify how many patients would require transfer or diversion for strokes etc and work with other departments in networks to coordinate this important data to inform local and national decision making. We need to discuss with our PCTs how an urgent care centre would work with the emergency department to ensure improved quality of care and not just recreate a "minors" area in a separate unit. We need to ensure that at all stages of implementation a thorough cost-benefit analysis is carried out so that the public can be confident we are investing their money in proven benefits. The report will have significant impact on the working practice of the emergency consultant and we need to consider this nationally and provide guidance on how we can ensure sustainability of work practice and maintenance of core skills. We need to ensure that we are leading the changes rather than the changes leading us.

JULIAN REDHEAD

REFERENCE

- 1 Darzi A. Healthcare for London: a framework for action. July 2007. <http://www.healthcareforlondon.nhs.uk> (accessed 20 August 2007).

The Tribulations of Trials in Orthopaedic Surgery: The UK Heel Fracture Trial



ISRCTN37188541: A multi-centre randomised controlled trial of operative versus non-operative treatment of displaced, intra-articular calcaneal fractures.

Clinical trials in emergency medicine are notoriously difficult. Not many have been done, and with good reason. The hurdles of obtaining informed consent from patients in an emergency setting are

well documented. However, recent changes in legislation have meant that some of these difficulties are now easier to overcome. The story is similar when thinking about running clinical trials in surgery. If the most reliable source of evidence is provided by a high-quality randomised controlled trial, then surgeons are being asked to sign up to something that questions whether their preferred method of treatment is the best, and to be willing to randomise their patients either to a non-operative or alternative operative strategy to the one they prefer. Perhaps not easy for characters who are used to having their clinical decisions accepted without question.

Treatment of calcaneal fractures, an important cause of hind-foot osteoarthritis, is generally surgical, but Cochrane reviews highlight a lack of evidence of a benefit of operative compared with non-operative treatment, and continuing uncertainty as to whether the possible advantages of surgery are worth its risks.

The aims of the UK Heel Fracture Trial are two-fold: to estimate the effect on

functional outcome of surgery for calcaneal fractures compared with non-surgical treatment, and to establish a nationwide network in orthopaedic surgery capable of running future randomised controlled trials.

So far, 15 UK hospitals are taking part, and seven centres are actively recruiting patients. One hundred and fifty patients will be recruited over 18 months and followed up for 2 years. The primary outcome measure, obtained at 2 years after injury, is the Kerr Calcaneal Fracture Score, a validated, patient-derived outcome measure of pain and function following calcaneal fracture.

If your hospital is taking part in this trial, please support your surgical colleagues, so that surgery may join emergency medicine as one of the up-and-coming evidence-based medical disciplines. The UK Heel Fracture Trial is being coordinated by Dr Rose Jarvis (R.M.Jarvis@warwick.ac.uk).

Full details of the study are available at <http://www.warwick.ac.uk/go/heelfracture>.

MATTHEW COOKE

Consultant appointments August 2007. The information for the consultant appointments is provided by the College and any errors should be notified to them and not the journal

Name	Hospital	Previous post
Miss Claire L SUMMERS	West Cumberland Hospital, Whitehaven	Consultant
Dr Rod MacKENZIE	Sen Lec (Clin) A&E, University of Leicester	Unknown
Dr Nicholas D G PAYNE	Frimley Park Hospital	Unknown
Dr Juan A BALLESTEROS	Doncaster Royal Infirmary	Associate Specialist
Miss Joan M P CLANCY	Darlington Memorial Hospital	Consultant
Miss Catriona J THOMPSON	Peterborough District Hospital (Foundation Hospital)	SpR - Trent
Ms Sally-Anne WILSON	The Calderdale Royal Hospital, Halifax	SpR - Yorkshire

Apology: In the August Supplement we listed Mike Fenwick as a new consultant appointment at Whitehaven. This was a mistake for which we apologise. Mike was the College rep on the appointment committee and remains a consultant in Middlesbrough.

Autumn meeting of the Emergency Medicine section of the RSM

The Emergency Medicine section of the RSM celebrates its 20 year anniversary this autumn. The next meeting of the section takes place on 15 November 2007 and is entitled Emergency Medicine Clinical Excellence Series 1, featuring cutting edge adult and paediatric emergency medicine.

Speakers include Kevin Mackway-Jones, Ffion Davis, John Heyworth and Frances Morris. For full details of the programme please contact lauren.wynn@rsm.ac.uk

Registration of the meeting is from 10 am and the day will include a champagne lunch

Come and be informed, entertained and challenged

EMTA update

Just over a year ago I took up the position as the members' representative on the College research committee. Prior to the vacancy being advertised I had no idea that such a post existed. In my application for the post I wrote that I would publicise my role and act as a resource for all trainees interested in research. In November, EMTA held a meeting for trainees at the CEM conference where we discussed the purpose of trainees sitting on the College committees. We are only of use if the UK trainees know that we exist, who we are and how we can be of use to them, otherwise how could we represent them? This article serves to fulfil part of this aim.

UK emergency medicine has great potential to produce high-quality, internationally recognised research. The high patient turnover makes our departments the ideal setting for studies and provides a source of evidence base that is relevant to our patient population. How does research affect trainees? All too often I hear groans of "research is not for me". However, I would argue that we all use research skills on a regular basis. We pride ourselves in keeping up to date in daily clinical practice. Each day we have conversations about the latest medical equipment or new changes in emergency treatment. Often the change has been instigated by evidence review. Whether we like it or not, our practice is influenced by research. Some emergency departments are not satisfied by changing practice solely in accordance with guidelines and hold their own journal clubs. Analysing published studies enables trainees to decide for themselves. Most regions hold a yearly research meeting where trainees present research they are currently conducting. Despite lack of time and resource I am constantly impressed by the number of studies presented at our meeting, and it seems research is alive and well among trainees. We use critical appraisal skills in at least three conferences a year (BAEM, CEM and EMTA). Even those who claim to have a genetic repulsion to research are urged to

demonstrate on their CV that they have participated in a study. But perhaps the most important aspect to an emergency medicine trainee is critical appraisal review. Each of us must demonstrate that we can formulate a clinical question, produce a search strategy, appraise the evidence and come to a conclusion.

So what help is available? For those who want education on the basics of literature searching and critical appraisal, the universities of Oxford, York, Leeds and Bristol run courses, as do SIGN, BMA, UK clinical research network and BestBETs. The College website has a comprehensive document covering all aspects of critical appraisal that can be used as a resource for reference, personal study, group study or local courses. Both the CEM and EMTA conferences have workshops on reviews. Practise makes perfect. Departmental journal clubs are ideal preparation for the FCEM exam and serve to spread the workload over the year. Ask your peers to review the CTR in its early stages and throughout. Don't put your head down and find out the week before completion that you've missed central publications on your topic. The best systematic reviews are independently checked at all stages.

For those trainees motivated to design a research study, what help can you get? The most important resource is a supervisor experienced in the same type of research. Don't settle for second best. If there is no-one locally, why not contact someone elsewhere? Has anyone else published the same type of study? As for funding, BAEM awards the Maurice Ellis prize (up to £3000), a travelling scholarship to facilitate education or research. The College awards the Alison Gourdie prize (up to £1250), and research grants (amount may vary) are advertised twice per year (March and September).

What about trainees who have a desire to experience research in more depth? This is where the greatest changes are taking place. The National Co-ordinating Centre for Research Capacity Development (NCCRC) now manages an Integrated

Academic Pathway for England and Wales. Foundation doctors wishing to advance their understanding of emergency medicine research can now apply for an Academic Clinical Fellowship (ST1-2) post. These posts provide the opportunity for the trainee to spend 25% of their working time exploring research ideas with a view to preparing an application for a research training fellowship or PhD at the end of ST2. Currently there are emergency medicine Academic Clinical Fellowship posts in Sheffield, Manchester, St George's Hospital London and Bristol. NCCRC does not manage academic pathways in Scotland.

If the trainee is successful in obtaining funding for a postgraduate degree, they would spend a further 2-3 years conducting research and preparing a thesis. If they are unsuccessful they join a standard clinical training programme.

For trainees who have completed higher degree postdoctoral research, the Clinical Lectureship Programme offers academic and clinical training (ST3-6) with opportunities to develop an application for a Clinician Scientist Award or project grant. These posts offer 50% time in research and 50% in clinical training for a maximum of 4 years. Clinical Lectureship posts will be advertised this year in Sheffield and Leicester. Specialist registrars with appropriate research experience can apply for these posts.

This is an exciting time for emergency medicine research with the prospect of increasing our international recognition. For the first time the NHS will be directly funding emergency medicine academic training. With this may come improved national networking, support and collaboration, facilitating improved research experience for all emergency medicine trainees.

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representative

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