



Notes from the Tsar

It is many months since I last wrote about life at the “centre”. At that time the world appeared relatively simple! We had spent five years working towards and attempting to sustain the 98% “operational standard” for Emergency Departments—and by and large were reasonably successful. Some departments found it easier than others, some found novel ways of achieving it (!), while a small number struggled. There were occasional efforts to have the target adjusted downwards but these were resisted centrally. It was felt that adjusting downwards to 95% would ensure that that became the norm—and that four hours was still quite a long time for many patients. I personally felt that it would give managers an excuse to restrict or remove resources from Emergency Departments. The pressure in fact worsened during last winter because of the impact of a continuing loss of hospital beds combined with the focus on 18 weeks for elective patients. Beds which previously had been available to deal with surges of emergency admissions were either not available or ring-fenced for elective surgery. That pressure has lessened a little and chief executives certainly know that the performance of their Trust will be judged not just on the 18-week performance but also on the operational standard being met.

Much else has however occurred in the last two years which provides and will continue to provide a whole range of new challenges. First came the London review led by Professor (now Lord) Darzi. This contained a range of new proposals. Many

of these are relevant to urgent and emergency care. Among these was the highly contentious proposal to establish “polyclinics” which would effectively be community health centres housing a relatively large number of GPs and offering a range of additional services such as therapies, outpatient clinics—and urgent care centres. The latter would be primary care led and would see people with less serious illness and injuries. The intent is to take pressure off Emergency Departments and offer a more convenient local service. There is also the suggestion that the Emergency Departments be front-ended by a primary care led Urgent Care Centre. This has already occurred in some hospitals. As far as “majors” are concerned it is proposed that there should be fewer acute hospitals in London than at present, with some becoming “local” hospitals which would take only highly selected medical emergencies (although they would still have an Emergency Department). Finally it was proposed that some services would be provided in a small number of more specialised centres. These include major trauma, primary angioplasty and strokes.

The next major event was the appointment of Lord Darzi as a Minister with the remit to review the whole of the health service. This has led to the so-called Next Stages Review. The focus was very much on clinical leadership and involvement. Local decision making was also a major emphasis. As you will all know, clinically-lead groups were established in each SHA in eight streams, one of which was Acute Care, encompassing urgent and emergency care. Many of you will have been involved

in these working groups, although there was considerable variation in the extent to which emergency medicine consultants were involved. The reports of the groups also varied greatly in the amount of detail given. Overall the principles were similar. There was an emphasis on integrated services, on clinical leadership, on safety, on quality and on focussing stroke, primary angioplasty and major trauma in a smaller number of centres. Not surprisingly there was little specific detail about which services would go where and which emergency departments might be downgraded to urgent care centre status.

So where do we go next and when? The next step will be in the hands of the commissioners and the SHAs. Presumably detailed implementation plans will be drawn up based on the Next Stages Review reports. In some places where two acute hospitals are relatively close together it will make sense for there to be one Emergency Department rather than two. We still have too many departments with too few consultants and where the back-up services, such as acute medicine, acute surgery, paediatrics, radiology and laboratory services, cannot guarantee a full service staffed by experienced clinicians on a 24/7 basis. Combining forces might well improve the overall safety and quality of service if the capacity is available to take the extra patients. With the changes involved in the EWTDC consultant involvement will be increased and we need to ensure that the critical mass of consultants is present. Combining forces will help in some places, but overall expansion of consultant numbers is vital.

It is also crucial that proper integration of services occurs and that the strife caused by, for example, unilateral action of commissioners is avoided. This is particularly

true at the front of the acute hospital where installing a primary care unit to deal with the less seriously ill without discussion with the Emergency Department just creates more barriers to care. There is certainly potential advantage to having people with experience of primary care and primary care skills but they should be part of an integrated team—as indeed does occur in some places—with a single point of entry into the hospital. This requires careful and open negotiation between all parties. A major problem here has been PBR which has encouraged PCTs to establish these primary care units as it saves money! We are now talking to the PBR team in the Department to see whether some arrangements can be made to deal with this perverse incentive.

I feel that it is critical that we/you re-establish urgent care networks. I personally feel that the networks should oversee ALL urgent care services in the area covered by a PCT and that clinicians should rotate between different parts of the service—and that emergency medicine consultants should play a major role in

leading the network. I would encourage all of you to be proactive and to speak to your PCTs and commissioners. Centrally I am talking to SHAs and, wherever possible, PCTs to emphasise the importance of integrated collaborative working and the need for effective networks.

Decisions will also have to be made about more specialised services. Major trauma centres will undoubtedly be established—the evidence supporting such centres is strong. Similarly primary angioplasty is already established in some places and will increase. Hyper-acute stroke centres are also likely on a regional or sub-regional basis. There are however many other aspects of acute care which might benefit from greater focussing. It is likely that not every hospital will accommodate acute paediatrics—with some having ambulatory care. Acute surgery may also be performed in fewer places, particularly as surgery has become more specialised. This has already happened with vascular surgery where regional clinical networks have been established. By contrast acute medicine is likely to remain in all acute hospitals, with

caveats and safeguards needed with regard to the presence of level 3 critical care, immediate availability of a surgical opinion, etc. All of these changes will require an increase in ambulance services, more critical care transfers and greater use of air ambulances. I personally would like to see the establishment of regional critical care transfer teams to ensure that the greater distances involved do not cause harm.

Much of this is still speculation but what we can be certain of is that change will occur over the next 12 months. I will continue to do my best to ensure that emergency care is not forgotten at the centre and that any plans that come my way place sufficient emphasis on safety and quality, and the availability of experienced clinicians to see ill patients. For your part I suggest you continue to raise the profile of emergency medicine locally and that you talk to commissioners and other providers to ensure that we continue to provide a safe, effective service for those requiring urgent or emergency care.

Professor Sir George Alberti

Emergency Care Tsar

Consultant appointments May 2008

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
Dr Mark Friederickson	Bristol Royal Infirmary	Locum Consultant
Dr Sarah Evans	Colchester General Hospital	SpR
Dr Sanjay Patel	Colchester General Hospital	SpR
Dr Mark Williams	Leicester Royal Infirmary	Locum Consultant
Dr Mark Buchanan	Clatterbridge Hospital (Wirral Hospital NHS Trust)	Unknown
Dr Dominic Jenkins	Clatterbridge Hospital (Wirral Hospital NHS Trust)	Unknown
Dr Owen McCormack	The Royal Bolton Hospital	Unknown
Dr Kissoon	Queen Elizabeth, the Queen Mother Hospital, Margate	SpR
Dr Hunt	Queen Elizabeth, the Queen Mother Hospital, Margate	Consultant
Dr Donna Wade	The James Paget University Hospitals NHS Foundation Trust	Unknown
Dr James Crawford	The James Paget University Hospitals NHS Foundation Trust	Unknown
Dr Sarah Pearson	Queen's Hospital, Burton on Trent	Unknown
Mr Victor Ameh	Royal Albert Edward Infirmary, Wigan	SpR
Dr Sanjay Ayathan	Derby Hospital	SpR
Dr Wendy Kuriyan†	Bedford Hospital	Consultant
Mr Stuart Lloyd‡	Bedford Hospital	Unknown
Dr Maria Smith‡	The Princess Alexandra Hospital, Harlow	SpR

*Above consultants have been appointed at various times between February and May 2008.

†Start in post 27 July 2008.

‡Starts in post August 2009.

Remember—during August you will be able to vote for some important roles in the College of Emergency Medicine. These include the election of the President-elect, the Chairs of regional boards, the Chairs of national boards, President of EMTA and Chair of FASSGEM. It is your college, you have a vote—use it!

Does your hospital have a Stroke team? Why you should ...

The management of Stroke has been neglected in the past but is now high up the agenda with the publication of the National Stroke Strategy in December 2007.¹ Every Emergency Department (ED) needs to review what they do for this patient group and engage with the improvement efforts. Stroke management, including the early management, is a team effort and what having a stroke team really means is that there is a multidisciplinary understanding of the processes and resources needed to manage these patients—a common language of care and the need for speed.

You receive a call from your local ambulance service saying that they are bringing in a 67-year-old man with a 90-minute history of slurred speech, and weakness of his right arm and right side of his face. They give a FAST score of 3. He has a history of well-controlled hypertension treated with antihypertensives and is on a statin for raised cholesterol. What is your department SOP in response to this call? It should be a team assembling in the Resuscitation Room to receive the patient, a quick handover from the paramedics, including confirmation of the time of onset of symptoms, rapid placement of monitoring and a brief structured clinical assessment, CT brain with report within a maximum of 60 minutes of arrival (and aiming for 20 minutes) followed immediately by an explanation to the patient and their relatives about the diagnosis and thrombolytic administration if indicated, Stroke Unit bed booked, transfer to the Unit for further assessment including swallowing assessment within 24 hours.

Chances are however that it is not as smooth as this. The national Sentinel Stroke Audit published in 2007 found that less than 50% of hospitals with stroke units have access to brain scanning within three hours of admission to hospital.² Only about 10% of patients are likely to be admitted directly to an acute stroke unit. Thrombolysis with alteplase in acute ischaemic stroke has been shown to significantly improve outcome in selected patients treated with three hours

of onset of symptoms but in 2006 less than 1% of patients received this treatment. So a lot has to change nationally to improve service delivery for the 110 000 patients who suffer a first or recurrent stroke each year in England.

From April 2008 the Stroke Improvement programme has become part of “NHS Improvement”. This comprises the merged Cancer Services Collaborative, Diagnostic Services Improvement and the Heart Improvement Programme. The strategy is to create Stroke networks with a hub and spoke model of service provision so a patient always initially goes to a centre that can provide “hyper-acute” stroke therapy. There will be different models of care but the fundamentals will be: a stroke triage system, expert clinical assessment, timely imaging and the ability to deliver intravenous thrombolysis throughout the 24-hour period. One of the markers of a quality service as defined by the strategy is “patients with acute stroke receive an immediate structured clinical assessment from the right people”. We are the “right people” but only if we improve our skills and engage with our Stroke colleagues or indeed get our Stroke colleagues to engage with us.

Forming a Stroke team is like pre-planning for major trauma. It gives everyone a chance to meet, to discuss the day-to-day practicalities of delivering a high quality service. It means that thrombolytic therapy is in a set place in the department with a pump available for rapid administration. It reduces the length of time needed to sort out the CT scan and it packages standard orders about patient positioning, the treatment of a raised temperature, raised blood sugar, raised blood pressure and fluid balance. It means that everyone knows what the pathway of care should be and works together to achieve it. It also means that roles in patient management become competency-based not title-based. Some ED doctors believe there is a battle to fight over who gives thrombolytic therapy and it should be the ED team. After all, we went through this with acute myocardial infarction (AMI) and showed without a

doubt that we were the right people to give the treatment—that was until we all realised that paramedics were also good and that in actual fact we would much rather the patient went to a catheter lab straight away for angioplasty. The same may well become true with stroke—a better technology may come along and intravenous thrombolysis will no longer be the gold standard.

But in the meantime should we give thrombolysis? Yes and no—there is no question that ED doctors can develop the skills but equally no question that the required skills are greater than those needed for AMI. There is also no doubt that the risks are greater. This should not be a battle about territory, but what is best for the patient. We should have a multidisciplinary team involving as many competent people as possible who all want to deliver great care. We need ED doctors who run departments where a stroke patient is rapidly identified and their brain imaged as quickly as possible. We need the best, most decisive CT scan reader immediately available—whether an ED doctor, radiologist or stroke physician or someone on a telemedicine link miles away. We need reperfusion therapy delivered only to the subsection of patients who will benefit whoever makes the decision. We want a system of clinical care that prevents the patient developing unnecessary secondary brain injury through hypoxia, hypovolaemia, sepsis or hyperglycaemia whether eligible for thrombolysis or not, and we want direct access for our patients to a specialist stroke unit.

So having a Stroke team should be shorthand for a multidisciplinary group having worked out a seamless pathway of care delivered by trained clinical staff with access to appropriate facilities. This group of patients deserve much more than they have been receiving up until now.

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The author was a member of the Emergency Response group for the National Stroke Strategy.

REFERENCES

1. **Department of Health.** *National Stroke Strategy*. DH, December 2007.
2. **Clinical Effectiveness and Evaluation Unit Royal College of Physicians.** *National Sentinel Audit, 2006*. RCP, 2007.

Emergency toxicology

The Cardiff diploma in medical toxicology runs every year from September to June. It is a taught postgraduate course in all aspects of medical toxicology. It can be extended by a second year to become an MSc, the second year consisting of a dissertation and three long essays. The candidates are mainly doctors, with emergency medicine being well represented, although there are other professions and specialities represented.

STRUCTURE OF THE COURSE

The course comprises six modules lasting five weeks each. Each week there is reading material, which is provided, and two tasks. These are a written task and a case study, which may be short answer questions, MCQs, or essay type questions. These tasks can be completed by reading the supplied reading alone—however, reading around the subject is encouraged, and gains extra marks. All materials are supplied online, and all work is submitted online. The modules cover drug safety and pharmacovigilance, mechanisms of toxicity, major toxins, management and prevention of toxicity, poisoning and toxicovigilance, and occupational and environmental toxicology. This is

followed by an exam consisting of an MCQ paper and an OSCE. The three-day update course in toxicology at Llandough hospital is included in the price of the course (approx £2500), and is worth attending but not compulsory.

WHAT IS IT LIKE TO DO IT?

There is a lot of work in this course. To get the maximum amount of benefit from it, eight hours per week would be the minimum. Evenings and clinical governance days tend to get swallowed by it. However, the course material is well written and interesting, with the modules being written by people expert in those fields. The written tasks are well structured and ask questions relevant to the subject being studied that week. To get good marks extra reading is important. Feedback is provided on all marked work, and this can be useful in future work. Doing this course has required a lot of commitment, and I would recommend that it shouldn't be done concurrently with other major projects (for instance FCEM). There are short breaks in the course (a week at a time) for Christmas and Easter, and the course organisers are

understanding of the need for extensions on deadlines for annual leave, etc.

WHY DO IT?

All emergency departments see a large number of toxicology patients. These consist of deliberate self harm, adverse drug reactions (iatrogenic, OTC, alternative, herbal, or illicit), or environmental/occupational. In my department, over 20% of all observation unit admissions are deliberate self-poisonings, with a further 20% being illicit drug and alcohol related. This is a large group of patients that we as a speciality see, and increasingly we are not sending any of these to the inpatient physicians. This group of patients can sometimes be seen in a negative light and present a real challenge in management. I feel that we should be becoming expert in their management. Doing this course has helped me several times in the course of a shift, and has given me a lot more confidence in discussions with others over the management of these cases.

In summary I highly recommend this course to other emergency physicians. It is interesting and relevant to our work, and is an area otherwise neglected.

Stephen Haig

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Course details and application forms can be obtained on a first come, first served basis from: FCEM Course Secretary Miss Lara Higginson; lara.higginson@wmuh.nhs.uk; tel: +44 (0)20 8321 5406.

Forthcoming MCEM Part A revision course, Royal Society of Medicine, Friday 17 October 2008.

Places are limited to 30 to enable small group work.

For further details please contact Lauren.wynn@rsm.ac.uk