Editorial

Emergency care—in and out of hospital

This edition includes a new section on prehospital care. The journal *Pre-hospital Immediate Care* has now merged with *EMJ*, a change that reflects the need for closer working between prehospital care and in-hospital emergency medicine.

The way in which the ambulance service operates can have a major impact on the workings of accident and emergency (A&E) departments. At present most UK ambulance services have a limited range of responses to a 999 call. Most such calls result in a paramedic ambulance response, which then only has three choices. The majority of cases are taken to A&E, some cases are referred to the general practitioner and some patients sign their own discharge. Not all 999 calls are for emergency problems. It has been shown to be safe to refer non-urgent calls to a nurse or paramedic working with decision support to carry out further interrogation and decide on what further care is required. This system also permits a wider range of services to be utilised. Community nursing and social services could have an important role in this type of system.

The role of the UK paramedic developed initially to treat cardiac emergencies and then other emergency treatments were added to their protocols. Very few ambulance services have developed protocols for not transporting patients, either because the patient have recovered after treatment or because they do not require emergency transport. The decision not to transport is however often more complex than the decision to treat. There are two ways in which this change can be assisted. Increased training of the paramedics will give them the skills to decide on “non-transport”. Secondly, the use of decision support would also help this process, this may be accessed by telephone (for example, contacting NHS Direct for remote support) or by the use of hand held computers at the scene. Use of this decision support could also enable more options than simply transport or not. Current decision support has been developed for use in telephone consultations and new systems will be required to be developed and evaluated for use when a professional is able to provide extra information from clinical examination. It would permit a choice of the destination. As well as A&E, patients could be taken to primary care centres, minor injury services, emergency psychiatric services, walk in centres or other locally available sources of healthcare.

All emergency departments in the UK suffer from predictable surges in activity. One such surge occurs in the early afternoon. General practitioners undertake their house calls mid-morning, after their surgery, they then contact the ambulance service. These urgent cases have to take second place to 999 calls and therefore usually arrive in A&E in the early afternoon. In some areas, ambulance services are now operating systems whereby they book non-emergency transport by time of arrival at each hospital. Ambulance services can also advise general practitioners of the relative workloads of various A&E departments and assessment units to spread the load between comparable units. In this way, the ambulance service has a pivotal role in controlling workload of urgent GP cases attending the hospital.

The discussion so far has centred on how the ambulance service can help the A&E department. There is a flip side to every coin. There are also ways in which the A&E department can help the ambulance service such as helping improve the turnaround of vehicles to maintain availability, training of paramedics and availability of online advice. Of course, far more important is that the two teams work together for their common goal. To the patient, at least, they should be one team. Sharing of information is a key element of this strategy, whether it is on an individual patient basis or by joint research and audit. Guidelines should be patient orientated and written to follow one continuum of care, being associated with common patient centred standards of care. An example of this is the new UK national audit of call to needle time replacing the door to needle time. We are seeing increasing numbers of paramedics train as nurses and vice versa; hopefully it will not be long before there can be a commonality of training and sharing of roles between all professionals.

The inclusion of a prehospital section in the *EMJ* will allow a cross fertilisation of ideas and bring these emergency care professionals close together. Hopefully, the editors will have increasing difficulty deciding whether an article belongs in the hospital or prehospital section. But I should not predict the end of the section before it has started, even if for the best of reasons.

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