

PRIMARY SURVEY

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REFORMING EMERGENCY CARE

Reforming Emergency Care is a policy of the UK government aimed at improving emergency care systems. However, the challenges and problems facing emergency care are common throughout the world. This edition of the journal concentrates on some of the solutions to these challenges. It is clear that there is no magic bullet that will guarantee success. This will require team work, vision, and a large increase in resources to turn around the near melt down in emergency care that is the common experience of those of us working in emergency departments, the ambulance service, and primary care.

We publish a large number of editorials in this issue. UK readers will be only too aware of the great pressures being applied to meet targets for patient treatment. David Lammy, the Parliamentary Undersecretary for Health, points out that the government is reflecting the wishes of patients who demand improvements to our system. Some of the methods for achieving change are outlined in the editorials by Alberti and Cooke. The role of prehospital care is outlined in the editorial by MacFarlane.

Change is difficult and the methods of achieving change may sometimes conflict with the day to day reality of providing care for the critically ill and injured. The *Debate* section begins with such a contribution from the front line. The answers by Castille and Cooke and by Windle and Mackway-Jones should stimulate discussion and debate. Please send your thoughts to *emjonline*.

This themed edition has been led by Matthew Cooke and he has put a great deal of work into this project, Thank you Matthew.

See pages 112, 113, 114, 118, 119, 120

ALTERNATIVE RESPONSES TO TELEPHONE CALLS FOR AN EMERGENCY AMBULANCE

The demand for emergency ambulance services continues to grow at an alarming rate. Some of the less serious calls do

not require a "lights and sirens" response but it is difficult to identify those that do. The work by Dale *et al* provides some of the first evidence on the feasibility of this approach. They ran a trial of subjecting the less serious calls to further triage. During this advanced triage the clinicians assessing the call made a theoretical decision on whether an emergency ambulance was required. Of 635 calls in the intervention group 330 (52%) were triaged as not requiring an emergency ambulance. However, 30 (9.2%) of the patients triaged as *not* requiring an emergency ambulance were admitted to hospital.

There is a great deal of logic in this approach but the timely alternatives to an emergency response are not yet available. Research in this area needs to be taken forward as a matter of urgency. We need to focus emergency ambulances on those patients with time sensitive conditions where minutes matter. Equally we need to respond quickly to a patient group where 10% need an emergency hospital admission. See page 178

PROCESS DESIGN APPLIED TO EMERGENCY MEDICINE

Patients are not widgets. However, the analysis of the processes of care involved in the flow of patients through the emergency department may result in a more efficient system. Walley describes manufacturing design theory and applies this to the patient streams seen in emergency departments. Based on direct observation of real departments, he outlines the lessons that might be learned by clinicians using these techniques. He concludes that initiatives such as See and Treat are logical and should help cut waiting times. Is it time to swallow professional medical pride and apply these principles? Alternatively, if the NHS was simply a business, it would probably have "gone bust" years ago.

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GOOD PRIMARY CARE ACCESS REDUCES OUT OF HOURS A&E ATTENDANCES

One of the main determinants of rates of use of emergency care facilities is the ease of access. van Uden *et al* describe the differences between two healthcare systems and the impact that ease of access to primary care has on the use of the emergency department. One town had open access to a primary care centre next to the emergency department. The percentage of patients who self referred out of hours to the emergency department was 15.9%, one third of that in the town with a primary care centre where an appointment was needed for the primary care centre. As many emergency care systems seek to redesign their facilities this paper adds to the evidence that easy access to primary care is key to reducing demands on out of hours attendances at emergency departments.

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INCREASING SPACE AND RESOURCES CAN IMPROVE EMERGENCY DEPARTMENT OVERCROWDING

Miró *et al* show that patient throughput can be improved by increasing numbers of senior doctors and support staff. They also reformed working practice to place a senior doctor in the triage area of their medical emergency department. Patient treatment was faster, the emergency department was less crowded, and a higher percentage of patients were discharged. However, the main determinants of emergency room overcrowding were numbers of patients waiting for hospital beds and investigations outwith the department.

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