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Emergency Medicine Journal

BMJ

SUPPLEMENT

February 2014

CEM News

Life in the parish has been busy of late, and activity has led to significant progress. As you will all know, we published our '10 priorities' document last Autumn and it has had a major impact. The top three issues currently being progressed are:

1. *Recruitment*. As I write, we are about to meet with the Secretary of State and the Medical Director of HEE to agree a fully funded expansion of ACCS posts. These will be emergency medicine posts and will be appointed from August 2015. There will also be a government/HEE/CEM initiative aimed at MTI and tier 2 recruitment offering overseas doctors at ST3 level and above the opportunity to train for 4 years. This will enable these people to obtain high quality training and sit the college examinations while not depriving their own countries of their long term expertise.
2. *Tariffs*. The need to reform the remuneration to trusts for acute work is essential if we are to overcome unsafe and inefficient excessive occupancy rates. This will enable acute work to be appropriately valued and improve flow through hospitals. The Keogh review has undertaken to lead to new guidance on both tariffs and commissioning arrangements, and the College welcomes this. We are meeting with Monitor, who are responsible for tariffs, and in our recent meeting with Sir David Nicholson and Sir Bruce Keogh, the importance of tariff reform was accepted.
3. *Terms and conditions*. Equity is our purpose in pressing our case with the BMA who are in negotiation with the employers, discussing both trainee and consultant contracts. They fully recognise the need to reflect both the frequency and intensity of out of hours work; the difficulties in recruitment and retention will not abate until these issues are addressed. Although terms and conditions have not alone caused this crisis, they will be a key component in resolving it.

Talking of the Keogh review, it is clear that although the evidence base identifying key problems is authoritative, the same cannot be said for many of the solutions. This of course is not the fault of the review team as high quality evidence relating to demand management in acute care would barely fill a very small book.

Nevertheless, there are a number of important opportunities within the report. The first is tariff reform. The report identified this as a key instrument of change and in this we are agreed. The second is the distinction between different types of emergency departments. This is really a formalisation of the existing situation and the recognition that in some cases this will be the clinical rationale for reorganisation. Put simply there are, and will be, those emergency departments which are supported by a wide range of specialist definitive care teams (stroke, PCI, major trauma, paediatrics) and those which do not have access to such teams, and from these about 2% of patients will need to be transferred in a safe and timely fashion to a unit with the appropriate definitive care team. This is what should happen now, but often the necessary networks and referrer driven pathways are absent or fragile. The College continues to engage at the highest level with the ongoing review teams and will press home our key concerns and proposals.

On a completely different note, it is great to be able to welcome the new editor of the *EMJ*, Ellen Weber. She is our first overseas editor and will continue to develop and expand the influence of the journal.

One key aim that she and I share is the development of *EMJ* associated media, including podcasts and blogs. These will be launched early in 2014 and will take a broad perspective on key emergency medicine issues. They will often include contributions from leading emergency medicine doctors in North America and Australasia, comparing insights into contracts, tariffs, emergency medicine configurations, work/life balance, medical training, competency assessment and alike. There will also be succinct summaries of key documents—for example, 'Shape of training', 'CEM 10 priorities' 'Seven day service', and many more that most would wish to read but may not have time to do so!

Clifford Mann

Should you have a Youth Offending Team?

WHAT IS YOT?

YOT is an acronym for Youth Offending Team, also known as YOS, or Youth Offending Service. YOT works with young people who are involved in crime, as a result of court ordered interventions, police ordered interventions (where the consequence of non-engagement is court action) or on a voluntary basis. The voluntary aspect of the work encompasses supporting both those involved in gangs/youth violence in making changes in their lives and support/signposting for young people who are victims of youth violence.

HOW HAS YOT BECOME INVOLVED WITH EMERGENCY DEPARTMENTS?

The emergency department receives the fallout of youth violence…the victims. YOT became involved with emergency departments as part of the 'Ending gangs and youth violence strategy'. Initially, about 3 years ago when looking at ways to engage young people in a creative and dynamic way and trying to impact on the tit for tat incidences of youth violence, we thought that engaging young people in the emergency department might be a good starting point. We piloted the idea for a 4 month period, during which time we saw a real value in engaging at that early point, with a much better take up rate in terms of the support we offered, than we had previously when approaching young people a period of time after the incident. Some of the barriers we faced were related to poor planning, and most of the staff did not know who we were. However, we received a very positive response once we explained what we were doing. It needed to be properly planned, targeted and resourced…so it was.

WHAT ARE YOUR AIMS WORKING IN THE?

The aims or idea behind the initiative is pretty simple: to offer support to young people involved in youth violence at the earliest possible opportunity as this increases the likelihood of engagement and gives the best opportunity to impact on their propensity to continue the cycle of violence through revenge or impact on the circumstances in their life that have led to them becoming a victim.

WHO COMES TO THE EMERGENCY DEPARTMENT AND WHERE DO THEY HANG OUT?

In Newham it is YOT staff who come to the emergency department, and you can find them at various different places in the hospital. On a typical day in the emergency department, we check in with the staff in majors, urgent care and paediatrics on arrival so they know we are on site and to see if they have any potential clients for us. Throughout the course of the evening, we continue to check in with the departments in the emergency department. We also engage with young people in and around the hospital site, so we can often be found in reception or outside, dissuading groups of youths from entering the emergency department on masse. We also have a dedicated Smartphone, so staff often call to alert us to potential clients in the emergency department. Hence regardless of where we are on the site, we are only a phone call away.

HOW DO STAFF GO ABOUT APPROACHING POTENTIAL CLIENTS?

In terms of hospital staff approaching potential clients, it has been as simple as them explaining to the young people that there are staff in the hospital who offer supportive services to young people and asking if they are happy for those workers to come and have a quick chat to explain how they might be able to help them. In terms of our staff, the approach usually focuses on what services are available to support them, before discussing the more difficult aspects of why they have presented at the emergency department, once a rapport has been established.

ANY SUCCESSES SO FAR?

Yes, we view all interactions with young people as a success as it means we have had an opportunity to offer support and make the young people aware of what is out there to help and support them. Sometimes that interaction alone can be the catalyst for impacting on an individual's propensity to change. The fact that so many have also accepted the support we offer is a bonus, and has led to some really positive outcomes.

ANY MISSED OPPORTUNITIES? IF SO, WHY?

Yes, all good things come with some limitations and ours are that we do not have the resources to be present in the emergency department 24 hours a day, 7 days a week. So initially there were a few young people who could have benefitted from our services who were missed. We remedied this by providing the emergency department with a referral form they are able to send to our secure email address with details of any young people who present when we are not on site but express an interest in hearing what we can offer. In addition to the referral form, we also have the dedicated Smartphone that staff can call, and we follow-up all these referrals within 24 hours.

HOW MANY TIMES DO CLIENTS REFUSE TO TALK TO YOU?

To be honest it is not very often. Even if they do not wish to accept the support offered, they usually want to hear what it is, which provides us with an opportunity to really sell ourselves to these young people, and we often manage to change the minds of the most stubborn individuals.

WHY SHOULD EVERY EMERGENCY DEPARTMENT HAVE YOU?

One simple reason is 'social value'. When I say social value I am referring to the

societal cost of not having us. I am talking about the cost of retaliation in terms of what the police will spend in investigating any further violence. I am talking about the healthcare cost in relation to any injuries sustained by both the victim and offender. I am talking about the cost to the criminal justice system in prosecuting, imprisoning and supervising convicted individuals. These reasons are those that you can attach a financial benefit to, but the biggest reason is the opportunity to change lives or even save lives by impacting on the cycle of violence.

Damien Cowie
Youth Justice Officer—Disruption Team, Youth Offending Service, Enforcement and Safety Division

How to take a sabbatical

Last summer, after many years as a consultant, I took a 3 month sabbatical. Since you ask, I and a few family and friends were sailing an elderly wooden boat around Britain in easy stages. Was this a good idea and what have I learnt from the experience?

WAS IT EASY TO ORGANISE?

Surprisingly easy at first. About a year beforehand I put in a request to my consultant colleagues, clinical director and medical director, in that order. I was asking for 3 months of unpaid leave, and all agreed so readily I suspected they might think life would be quieter without me. As the departure date approached it became rather more difficult. Consultants accumulate all sorts of varied commitments and responsibilities, almost without noticing: tidying these up or delegating them became quite time consuming. The last 2 weeks or so before I left were spent in a frenzy of activity tying up loose ends. People began to suggest I should delay my departure to help meet various deadlines but we had agreed to join a group of other old boats with a prearranged start date so I had a good reason to stick to the agreed timetable. I was grateful for this, as otherwise I began to think we might never get away. As a compromise measure, I arranged with the IT department to be able to read my hospital emails on a mobile phone while I was away. This was quite helpful for the first couple of weeks. After that I began to feel out of touch with what was going on at work and unable to comment usefully, so I found other things to do with the time.

I set up a daily blog so any interested colleagues and friends could see how I was getting on. This showed them that sailing small leaky old boats is not all pleasure and can be hard work. It also saves on postcards.

WAS IT WORTH IT?

Marvellous. Highly recommended. It gives you a different view on life, the British Isles and the work treadmill. It makes you think about what you value in your work and what you don't miss, and that can be very positive. The usual fortnight holiday simply doesn't give you time to do this.

If you go away for a couple of weeks, many tasks just get left for you to sort out when you get back. If you go away for a long time, other people have to deal with these problems, so actually you come back to an emptier desk than after the usual short break. Sometimes you find that the people standing in for you have done a better job than you would have done, so maybe there is an opportunity to unload a few commitments.

DID IT COST A LOT?

Three months' loss of income far outweighed any direct expenses incurred on the trip. Houses and families cost much the same to run whether you are at home or at sea hundreds of miles away.

DID YOU THINK ABOUT MEDICINE MUCH?

Hardly at all. There were far too many other things to think about. My medical experience on the trip consisted of removing a fishhook from a seagulls leg and calling an ambulance for an elderly lady who had collapsed in a pub. The newspapers were full of headlines about the problems afflicting the nation's hospitals but I found these easy to ignore.

WAS IT DIFFICULT COMING BACK?

Everyone suggested it might be, but many colleagues who have been off on maternity leave or sick for longer periods manage without too much trouble. Most of the junior doctors had changed, but a lot of the hospitals problems appeared much the same as before I had left. After a few years' practice, many of the basics of clinical medicine have become hard wired into the brain and soon come back. My consultant colleagues who so generously made it easy for me to take the time off were very welcoming on my return.

WHAT NEXT?

Work, boat, house, bank account and working relationships all need a period of recuperation and consolidation, so the next trip is still a long way over the horizon.

Mike Beckett

COLLEGE OF EMERGENCY MEDICINE CPD EVENT 2014

The College of Emergency Medicine's fifth annual Spring CPD event takes place from March 17-19 2014 at the Mercure Hotel, Cardiff.

The programme is diverse and it is designed to reflect the CPD curriculum; it will also include a series of interactive sessions. Regular registration will run from 1 February to 14 March. The event is an excellent opportunity to boost your CPD portfolio with sessions including emergency medicine in practice, poisoning, trauma, sports medicine and paediatrics.

Images in EM

The sick berth on HMS Victory - an answer to overcrowding in the ED?

Forthcoming meeting
The Emergency Medicine Section of the Royal Society of Medicine
June 27th 2014 Acute Medicine

GETTING THE NEEDLE

Deep enough? Too deep?

Our Department recently treated a top level athlete from the Far East. He had gone to the team acupuncturist for some treatment for backache a couple of days before a big international track event. Unfortunately the needles must have gone in a bit deep as we found he had sustained a pneumothorax on the same side. Acupuncture may not show up on the drug testing but it still can have its disadvantages.

Fortunately he settled with simple aspiration. Informed consent might have been a bit difficult due to the language barrier. Its not easy to explain that the correct treatment for a needle in the chest is another needle in the chest. There were no medical complications but missing a major event is a big deal for a serious athlete. Perhaps there is now one team acupunturist who won't be going to the Rio Olympics in 2016?