



The Royal College of Emergency Medicine

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Top 10 Emergency Medicine Research Priorities

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The Emergency Medicine Research Priority Setting Partnership, involving the James Lind Alliance and the Royal College of Emergency Medicine, started in September 2015 with the aim of including patients, carers and clinicians in a process to establish the research priorities in emergency medicine.

It has involved over 200 research questions, almost 100 mini-systematic reviews, a long list of 72 questions (which were prioritised by over 500 people), a shortlist of 30, and finally a top 10 research priorities for emergency medicine.

We wanted to share with you as soon as possible the results of this process, following our final prioritisation workshop on 19 January 2017 – our top 10 research priorities are as follows:

1. What is the best way to reduce the harms of emergency department crowding and exit block? We need a better measure of crowding that drives sensible improvements for the seriously ill and injured, adolescents and the frail elderly.
2. Is a traditional ED the best place to care for frail elderly patients? Would a dedicated service for these patients be better (involving either a geriatric ED, or geriatric liaison services within the ED), or given that this population is expanding should our current services be tailored towards this group?
3. How do we optimise care for mental health patients; including appropriate space to see patients, staff training, early recognition of symptoms, prioritisation compared to physical illness, and patient experience?
4. With regards to how ED staff development is managed, what initiatives can improve staff engagement, resilience, retention, satisfaction, individuality and responsibility?
5. How can we achieve excellence in delivering end of life care in the ED; from the recognition that a patient is dying, through symptomatic palliative treatment, potentially using a dedicated member of staff to work with palliative patients and their relatives, and handling associated bereavement issues?

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6. The effects of implementing new techniques in assessing patients with chest pain (which include new ways of using high sensitivity troponin tests, and decision rules such as the MACS rule and the HEART score) in practice. Would patients like a say in what is an acceptable risk, and should these tools be used alongside shared decision making to provide safe and appropriate care, minimise unnecessary risk and inconvenience for patients?
7. What is the ideal staffing for current UK EM practice, including doctors, nurses, healthcare assistants, porters, radiographers, clerical and reception staff?
8. Do early undifferentiated (broad spectrum) antibiotics in suspected severe sepsis have a greater benefit and cause less harm to patients than delayed focussed antibiotics in the ED?
9. In adults who are fully alert (GCS 15) following trauma does cervical spine immobilisation (when compared to no cervical spine immobilisation) reduce the incidence of neurological deficit, and what is the incidence of complications?
10. Which trauma patients should be transferred to a Major Trauma Centre rather than going to another hospital first?

We thank the hundreds of patients, their families, clinicians who work in emergency departments and everyone else who has contributed to this journey. Thank you for sharing your ideas and views with us - together we are shaping the future of emergency medicine.

Further details about these questions, the process by which we came to them, including the shortlist of 30 questions and longlist of 72 questions, are available via the RCEM website at www.rcem.ac.uk/JLAEMPSP and will be available via the James Lind Alliance website at <http://www.jla.nihr.ac.uk/priority-setting-partnerships/emergency-medicine/>.

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