such, often struggle to meet the medical, nursing, and social care needs of dying people and their families. These changes will greatly affect care for dying people and may increase the number of hospital admissions.

However, one important initiative is gaining momentum within primary care. The Gold Standards Framework is a resource for organising proactive palliative care in the community and is supported by funding from the Cancer Services Collaborative, Macmillan Cancer Relief, and the National Lottery.¹⁰ The framework provides a detailed guide to providing holistic, patient centred care and thereby facilitates effective care in the community. Other recently initiated mechanisms for developing primary palliative care include the training of general practitioners with a special interest in palliative care and the new end of life initiative in England to improve palliative care provision by generalists and to share examples of good practice.

To support such developments it is essential that primary palliative care is supported by an adequate academic base.¹¹ This is admittedly a challenging arena in which to undertake research, but progress has been made in recent years in developing conceptual models and research architectures for studying end of life issues. Now we need to build on this work to ensure that the understanding and insights gleaned can be translated into effective interventions.

Every person with a progressive illness has a right to palliative care.¹² Patients desire a reassuring professional presence in the face of death. General practitioners and community nurses are trusted by patients and are in a position to provide effective, equitable, and accessible palliative care. This will happen only if they have adequate time and resources and work in a system that encourages such care. Patients

who receive holistic support in the community may be less likely to require expensive admission to hospital and often futile treatments at the end of their lives.

Scott A Murray *clinical reader*

Kirsty Boyd *honorary senior lecturer*

Aziz Sheikh *professor of primary care research and development*

Primary Palliative Care Research Group, Division of Community Health Sciences: General Practice Section, University of Edinburgh EH8 9DX (Scott.Murray@ed.ac.uk)

Keri Thomas *national clinical lead palliative care*

Cancer Services Collaborative, Birmingham, B24 0DE

Irene J Higginson *professor*

Department of Palliative Care and Policy, King's College, London SE5 9RJ

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Emergency care networks

Are needed to coordinate the options available to patients in an emergency

Hospital based emergency care has been an integral part of the NHS since 1948. First medical and surgical emergencies were referred directly to the acute care firms and were seen initially by house officers. Patients with trauma, both minor and major, were seen by casualty officers in the casualty department. Over the next 25 years, "casualty" gradually evolved into accident and emergency medicine, which became an independent specialty in the 1970s. Since then the number of people attending emergency departments has inexorably risen, with a similar increase in the number of people "waiting for attention." The philosophy was "first come, first served," but with the most seriously ill patients taking precedence.

The situation changed dramatically in 2000 with the publication of the *NHS Plan*.¹ This contained two targets for emergency departments—that by 31 March 2003, 90% of attendees in emergency departments should be seen and discharged or admitted within four hours, and that this figure should rise to 100% (now amended to 98%) by the end of 2004. These targets were supported by a key document, *Reforming Emergency Care*, in 2001.² As

a result major changes and improvements have occurred, to the benefit of patients with urgent needs. Waiting in emergency departments has decreased considerably, with more than 95% of patients dealt with in less than four hours, long trolley waits down to a handful, and improved satisfaction of patients.³ But is that enough?

The success of emergency departments has led to new problems. A further increase in the number of people attending has resulted, presumably because patients find it easier to go to emergency departments than to make an appointment with their general practitioner and partly because arrangements for out of hours work in the community have changed. But could there be more appropriate and more convenient care for patients elsewhere? Pressure within the hospitals for more seriously ill patients has been increasing. Diagnosing the need for admission quickly is one thing, but finding a bed and a specialist team to deal expeditiously with the patient quite another.

The main focus so far has been on the emergency department, whereas emergency care is a problem for the whole system. If one starts with a person with an

urgent need in the community, many possible options are available to deal with the problem—not just telephoning 999. Patients can go to their general practitioner, telephone NHS Direct, treat themselves, call social services, or get help from a pharmacist. Often patients will not know that alternatives to telephoning 999 or seeing the general practitioner exist, and a single point of contact is needed where the patient could be put in touch with the most appropriate service.

Several major players are involved, but all tend to function independently. These include general practitioners, ambulance services, social services, primary care trusts, acute trusts, mental health services, pharmacists, children's trusts, the voluntary sector, and so on. These, together with other local initiatives, have all added to the complexity of choices. What we need urgently is coordination of all these options with planning and prioritisation of services on the basis of local needs. One possible solution lies in the formation of geographically based emergency care networks. At present the evidence base in support of emergency care networks is non-existent, but networks have certainly helped in services for cancer and coronary heart diseases.

Networks can operate at two levels. The higher level would cover a strategic health authority and deal with broader aspects of policy and cooperation between partners, as well as covering clinical areas not represented in every acute trust, such as major trauma. The local networks would cover an acute trust, the appropriate primary care trust or trusts, the mental health trust, social services, the voluntary sector, and all other partners. The network would meet on a regular basis and would have senior representation from the parent bodies. A first task might be to review existing services and identify problems and solutions. One area, for example, is the development of urgent care centres outside acute hospitals convenient for patients, staffed by emergency nurse practitioners and perhaps paramedics, and acting as a base for services out of hours in primary care. This requires cooperation

between several of the partners. Staff could rotate between acute trusts, primary care, and the community.

Organising all this within the current organisational silos is difficult. Similarly, the current confrontational commissioning of services on a one to one basis between primary care trusts and individual providers does not help and interferes with a whole-system approach. The network could work out an appropriate service plan for the local community, set priorities, and then negotiate with the commissioner—ultimately itself becoming the budget holder. The final question is who should lead the network. Different models are already in operation. In some cases the primary care trusts lead. This is convenient but can also lead to competing interests as they are both commissioner and provider. In other places the chief executive of the ambulance trust has picked up the reins, which seems to be working well. Perhaps the chief executive of social services could fulfil this role—giving social services a greater role. Who leads the network probably does not matter so long as each partner organisation is committed to following the priorities chosen by the network as well as the overall model of care.

Much progress has been made in the past few years in developing and improving emergency care in England—but much more needs to be done. The next step is to establish empowered local emergency care networks.

K George M M Alberti *professor*

Department of Endocrinology and Metabolic Medicine, Imperial College, St Mary's Hospital, London W2 1NY
(george.alberti@ncl.ac.uk)

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Long term outcome of treating schizophrenia

Antipsychotics probably help—but we badly need more long term studies

Schizophrenia is one of the most disabling of mental illnesses, affecting one in 100 people in their lifetime, some 80% of whom will experience chronic or relapsing symptoms.¹ What do we really know about its long term treatment?

The guidelines on schizophrenia issued by the National Institute for Clinical Excellence (NICE) describe antipsychotic drugs as “an indispensable treatment option for most people in the recovery phase of schizophrenia,”² and a recent meta-review of depot antipsychotic injections considered them to be an effective maintenance treatment.³ Conventional antipsychotics (those acting via dopamine blockade, such as chlorpromazine or haloperidol), introduced in the 1950s, increased the proportion of patients who improved clinically noticeably from 35.4% to 48.5%.⁴

Because of their mode of action these drugs generated serious side effects, such as parkinsonism or hyperprolactinaemia; hence new generation, atypical antipsychotic agents (such as clozapine, olanzapine, risperidone, quetiapine) have been used (and sold) increasingly since the mid-1990s.

Acting more via 5HT blockade, but with interestingly variable biochemical profiles, these newer drugs have been shown to be as effective as the conventional drugs in treatment and relapse prevention.⁵ But they have yet to establish their longer term credentials in an illness that is usually lifelong.

The nature of schizophrenia as an illness (delusions, hallucinations, limited insight) leads to some 80% of patients relapsing within two years of a treated first episode (usually because of non-adherence to continuing

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