See and Treat: a management driven method of achieving targets or a tool for better patient care? One size does not fit all

A M Leaman

We were very grateful to Leaman for his contribution that forms the first part of this debate. He is voicing concerns of many on the front line of A&E and feel we acknowledge his forthright and courageous approach. Equally it can be easy to criticise but difficult to be constructive, especially in such an onerous task as improving the UK emergency care system. We therefore have invited responses to the issues raised in the hope of stimulating debate on these critical issues for emergency care in the UK. We thank all the authors in this section for their hard work and well argued contributions to this debate. 

JW/PD

For anyone still uncertain about the concept, See and Treat is a process whereby patients with minor conditions are seen soon after they arrive in A&E by a senior clinician. Providing they have an appropriate problem such patients are given their definitive treatment straightaway and can then be discharged.

The Department of Health is very anxious that all A&E departments should adopt See and Treat and has organised a road show that has toured the UK spreading the word. Circulars and emails, arriving on an almost daily basis, have encouraged senior A&E staff to attend these meetings. One recent DoH letter even asked departments when, not whether, they would be introducing See and Treat.

The star turn at the See and Treat road show is the Kettering A&E Department. Kettering had its Eureka moment when it found that it’s throughput times were rising because all its cubicles (both major and minor) were blocked by patients waiting for admission. With the encouragement of its chief executive the A&E departments response was to employ its most senior doctors and nurses in offices close to the waiting room where they found they could See and Treat quite a lot of patients with minor problems. This improved their department’s deteriorating throughput times.

Many people might think that the proper response of the chief executive in this situation should have been to ask why his A&E department was being blocked by patients waiting for a bed. Furthermore, how representative is the A&E department in Kettering and are its solutions appropriate for more successful A&E departments? Is it appropriate for the most experienced A&E staff to see the patients with the least serious conditions?

The Department of Health’s uncritical promotion of the See and Treat concept is wrong and should be questioned by A&E specialists.

These considerations do not seem to have bothered the DoH, which, impressed by a few months improving figures, has decided that all departments should adopt the Kettering model. There has been no critical analysis of See and Treat. Nor have its principles been appraised in print by a major journal. Such disregard for scientific assessment is unfortunately all too prevalent in government circles. It should not however prevent A&E specialists from questioning the See and Treat concept.

Interestingly, much of the present waiting time problem is due to another concept that was introduced with little evaluation—triage. In particular the Manchester Triage Scale, with its notorious category 5 (or “wait until everyone else has been seen”), has encouraged excessive waiting times for those with less serious complaints.

In addition, A&E as a specialty has only itself to blame if it is now being told by others how to run its affairs. It was apparent at least 10 years ago that the chaos in most A&E departments could not go on but senior A&E figures failed to tackle this serious problem.

Before See and Treat is more widely introduced those organisations representing A&E in the UK should demand more evidence. An interesting study at Kettering would be to give the A&E department back its minor cubicles and to get the senior clinicians to use these spaces to see patients in the usual way. Would this produce a similar improvement in waiting times?

More information is needed about Kettering and the other exemplar A&E departments. Were their waiting times originally worse than average? Do they have above average numbers of GP type attenders for whom See and Treat can be used? Can their improved times be sustained or do the senior clinicians “burn out”? What has been the impact on SHO training? Will See and Treat encourage patients with GP type problems to attend A&E?

If the DoH really wants to help A&E departments most would be greatly assisted by an end to trolleys being occupied by patients waiting for admission. Minimal delays for radiographs would also speed throughput. Queuing theory and other business concepts may have lessons for those running A&E departments. However, patients, even those with minor complaints, are not “units” and should not be treated in this way.

Such an approach is contrary to the holistic and personalised care to which most A&E specialists aspire.

The Manchester triage category 5 should be abandoned. Such patients should be redirected to GP cooperatives, of which there are now many excellent examples. However, triage should not be completely abandoned. In addition to prioritisation, well trained triage nurses can start and complete many treatments, redirect GP type patients, and postpone minor A&E cases if waiting times become excessive.
Don’t throw triage out with the bathwater

J Windle, K Mackway-Jones

The concept of See and Treat has been heralded as something new and innovative that will ease the plight of emergency departments throughout England. However, anyone who has been in emergency care over the past 20 years will recognise this process as the norm during the early 1980s. Indeed triage was introduced to clinically risk manage this system of first come first serve and to re-direct the focus of scarce nursing and medical staff away from the most minor of presentations. For those who do remember these times there must have been a strong sense of déjà vu during their See and Treat workshop.

The Department of Health workshops focused on a series of exemplar hospitals who have introduced See and Treat. It is of note that they all appear to have a number of similarities, namely:

- streaming for major and minor patients did not exist before introducing See and Treat
- the waiting times did not appear excessive before See and Treat
- the case mix appears skewed to more minor cases

It would be appropriate to put this information clearly into the public domain so that others can see how close the situation in these hospitals is to their own. Once this is done it will be easier to judge how much of the apparent benefit can be attributed to streaming as compared with See and Treat.

We agree with Leaman who describes blocked beds and long trolley waits and questions the appropriateness of diverting senior clinical staff away from more complex cases in under-resourced and overstretched departments. It would be a great mistake to confuse See and Treat with a quality initiative. Let’s hold it up for what it is—a means to meet targets! To achieve the average wait of 75 minutes without solving the underlying problems of flow and resource the easiest group to “See and Treat” and get back in the street, has been singled out. A more sensible and quality driven initiative designed to improve the journey for patients requiring admission to hospital would be welcome. Rapid access to beds and the ability to divert patients away from demanding departments at present (then the limited resource was directed to the case with the greatest clinical need. It is inevitable that this will bring resources away from less urgent cases, however if we subscribe to the idea the most seriously ill and injured should receive the greatest resources, both human and environmental, then MTS priority reveals those patients safely and appropriately. The problem is not the triage priority or the system used to reach that decision, but the basic under-resourcing. In such a situation triage is just a messenger not a problem in itself.

The Manchester Triage Group would strongly reject the comment that MTS was introduced with little evaluation. While we acknowledge consensus view is the weakest form of evidence the process involved in developing the system took in excess of a 1000 person hours and that figure should be multiplied by the 20 strong group of contributors. The system was piloted and subjected to audit in the nine Manchester hospitals of contributors. The system was originally developed for. This was before the group were asked to teach the system across the UK. Additionally the words “not evidence based” are often used here without an understanding that until we agree a “gold standard” method of determining how urgent conditions are, it is not possible to prove that any system works. The MTS is an attempt to break this chicken and egg conundrum, and should provide a starting point for future changes.

The final paragraph of the paper throws up the issue of “the notorious category 5 patients”. If the author were well versed with MTS he might realise just how few patients could actually meet the...
Debate

K Castille, M Cooke

The advantage of having senior clinicians seeing and dealing with patients at the earliest possible opportunity is virtually uncontested across a wide spectrum of healthcare services. The concept of See and Treat is entirely based on this premise, and it is therefore not surprising that it works. The benefits of See and Treat, as part of an emergency department system are clear:

- Significant reductions in both the time that each patient has to wait and the total number of patients waiting at any one time
- Improvement in both patient experience and staff job satisfaction (concerns about staff job satisfaction emanate from those who have not tried it, rather than those who have)

Leaman offers a good description of See and Treat. His criticism seems to be mostly confined to the reasons for its introduction. We have therefore focused our response on his five main points which, in summary, appear to be that See and Treat:

1 was instigated by a Trust chief executive in response to deteriorating throughput times in A&E
2 was initiated as the incorrect response to bed blocking
3 is a single model, constructed from one example, that has been imposed
4 was not preceded by published research in a major journal. (This includes a perceived lack of a full understanding of the wider implications, such as impact on training, a potential rise in overall demand, etc)
5 uses modern operations management thinking that regards patients as “units” and, as such, depersonalises their care.

The author concludes that See and Treat should not be introduced and that, instead, the solutions lie in abandoning Manchester triage category 5; using triage nurses to carry out treatments; and postponing minor A&E “cases” when waiting times become excessive.

We will briefly consider each of the criticisms and evaluate the conclusion drawn.

The first of the five points is factually incorrect. The chief executive, while supportive, had no direct involvement in the introduction of the See and Treat system. It was devised and implemented by the A&E consultant and her clinical team, resulting in a demonstrable improvement in the patients’ waiting times.

A key feature of See and Treat, as both a concept and a working system, is that it originated, and continues to be developed and tested by clinicians. It is insulting to clinicians to suggest that they might have responded to “being told by others what to do”.

Other emergency departments have introduced systems with senior clinicians assessing and treating patients. There are also examples of clinicians implementing similar principles in America and New Zealand.

Interestingly, about 20% of A&E departments are known to have introduced some form of See and Treat before the Modernisation Agency’s workshops were held. Hence the clinician to clinician networks were already in operation. The role of the NHS Modernisation Agency is to facilitate and support such ventures by enabling clinicians and managers to work together and find solutions that are workable, and beneficial for patients.

The second criticism is that the issues that need to be tackled lie outside of A&E, so why are we concentrating on patients with minor problems?
We agree that there are a number of issues that need to be tackled outside of A&E and to this end the Emergency Services Collaborative (ESC) has been established to tackle waits and delays across the whole system of emergency care. See and Treat constitutes only a small part of this work. The organisations involved in the first wave of the ESC are already helping to develop both local and national plans to tackle the complex problems related to patient flows, such as improved bed management. This is being done with the whole system in mind. Furthermore, one of the principles behind See and Treat—getting senior expertise at the front end of the patient episode—can be applied to patient flows where the patient has more serious and complex problems. This has been shown to benefit patients. Specifically, the impact of the use of a clinical decision unit (Hasan) and the review of the role of an assessment ward are highlighted elsewhere in this edition of EMJ.

See and Treat is therefore only one aspect of the work of the ESC. It can be introduced comparatively quickly and effectively compared with some of the more complex issues that surround bed management. See and Treat is not the solution to all emergency care problems. However, it does provide the opportunity for A&E clinicians to exercise control over the issues that are within their direct domain.

With regard to the third point, guiding principles for the introduction of See and Treat were published in October 2002. These principles were collated from all the known existing models of See and Treat. A consensus group of experienced A&E clinicians, was used to draft the principles, which were further developed and endorsed by the RCN and BAEM. There are several published studies that have described the impact of the application of similar principles in improving patient waiting times without detriment to major injury patients. There are also examples from experiences in UK emergency patients.

The NHS Modernisation Agency has recently completed a series of national workshops in which a variety of different models of See and Treat were presented by clinicians from across the country. The Kettering model was one of a variety of examples presented to show how clinicians had tackled the issues in different ways, and in response to local needs. Hence, we promote the importance of designing a local model to meet local needs.

It is important to emphasise that See and Treat is not regarded to be the domain of A&E consultants alone. The author endorses and speaks positively about “well trained triage nurses who can initiate and complete many treatments”—this is, in fact, a model of See and Treat. Most of the known models use a combination of team members to deliver the most appropriate service to meet patients’ needs. The focus should be on competence and skills and not professional backgrounds or job titles.

The issue of evidence based practice is raised with regard to the third point, guiding principles. These principles, which were further developed and endorsed by the RCN and BAEM, are based on sound operational principles. It is not the best alternative we have. We could however decide to retain the current system, which manifests as full waiting rooms and the ensuing oppression that this induces in our A&E departments. Alternatively we can choose to actively take steps to improve the current system. See and Treat provides us with such an opportunity.

REFERENCES


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