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Interview with Stephen Bengier

Many hospitals facing increasing deficits are appointing Turnaround Directors with the perhaps unenviable task of setting the organisation on the road to profitability. The emergency department can seem to be the source of apparently uncontrolled expense and activity.

Newham University hospital in East London is trying to reverse one of the largest deficits. We talked to Steven Bengier, their Turnaround Director.

Q. Steve, what is your background and how did you become involved in the NHS?

SB. My original training was in engineering with the local electricity board in South Wales. I moved to a teaching company assignment, got some independent consultancies and joined a well known UK-based business with a £150 million turnover. When the company restructured I became involved in running their European operations. I developed a passion for change and became an associate member of the Society of Turnaround Professionals. A colleague was working with the Department of Work and Pensions and suggested I get involved in the NHS. I was selected by a panel at Newham Hospital in May 2006.

Q. What is the Turnaround process and how have trusts been identified as needing help?

SB. Turnaround is about financial recovery. You also need to look beyond the financial issues and get to the heart of the



Stephen Bengier

operation, the processes and the people that implement those processes. Turnaround should, if it is implemented properly, get the organisation to a point where it knows what it needs to achieve sustainability. All Strategic Health Authorities in the first phase of Turnaround process employed a director and focused on individual trusts with financial problems.

Q. How can clinicians effectively participate in and influence the Turnaround process?

SB. An organisation like the NHS is people-based and clinicians on the front-line dealing with patients are the focal point of the delivery of the organisation. But for them to be effective the rest of the

organisation and the processes that sit alongside them have to be effective. A key issue is about reducing variability. Unless organisations deal with variability around the mean they will always have peaks and troughs in performance. You can do very little about the things that are outside your control but it is important to address those in your control.

Q. What are your observations of the emergency department (ED) and what things can we improve, not just at Newham but nationally?

SB. EDs, by nature of the 98% target, have been given the most intense performance criteria. I agree with the need to set such a high standard because it is such a critical area. Focusing on targets forces all of the people in that part of a hospital to be more integrated and work together. What an ED cannot afford to do is allow an individual's view of what is required to dominate the way the service is delivered. The way you get a process operating efficiently is by having management rigour and people need to know what standards and processes they are going to be monitored against. If they are not then achieved the unit needs to understand why not and take corrective action—continuously.

Q. EDs have different case mixes and numbers coming through the door. Surely variability is not predictable like an operating list for example?

SB. In emergency medicine there is a view that demand is unpredictable but statistics actually show that emergency work is more predictable than elective! Too many organisations create a plan,

don't implement it and then want to create another plan with a whole lot of different actions. If you say you are going to do something, measure yourself against it and if you don't achieve it, then understand why not and put that right first before you look to move on.

Q. How do you think Primary Care Trusts (PCTs) and acute Trusts can work together to reduce emergency attendances and admissions?

SB. For unscheduled care the focus is on joint Walk In and Urgent Care Centres so that the point of entry for a patient is a joint

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Minor injuries Physiotherapist – A help or a hindrance?

Since the implementation of the 2001 Reforming Emergency Care plan, emergency departments (ED) across the country have been evolving in an attempt to meet the ever increasing number of patients and the standards set out by the plan. The number of people attending the ED rises by 2% each year.¹ In addition, patients' expectations regarding the speed of response and quality of service they receive are increasing. Some key principles were therefore set out in the plan to build an effective Emergency Care service which was patient focused and evidence based, namely:

- All services must be designed from the point of view of the patient
- Patients should receive a consistent response, regardless of where, when and how they contact the services
- Patients' needs should be met by the professional who is best able to deliver the service they need
- Assessment and treatment should not be delayed through the absence of diagnostic or specialist advice
- Emergency care should be delivered to clear, consistent, and measurable standards which cover each element of the service and the whole of the patient's journey.

SO WHERE DOES A PHYSIOTHERAPIST FIT INTO THIS VISION FOR THE ED?

Physiotherapists working in musculoskeletal medicine have been developing specialist skills in the assessment and treatment of this population for many years. More emphasis is being placed on

triage area. If patients don't need to be in a secondary care setting they shouldn't be coming into the hospital. The PCT and acute Trust can look at whether there are any specific issues in their community that make patients think they need to go the secondary care setting. It's also important to examine patterns of referral by GPs and why people think they might be seen at a hospital more easily.

Q. Is the future of the NHS rosy or bleak?

SB. My short experience in the organisation is proving to me that the vast

the use of research to develop a clear evidence based approach. With this in mind they are ideally skilled to act as a first line practitioner in the management of musculoskeletal disorders.

It has been estimated that up to 1.5 million people attend EDs in England each year with an exercise related injury, accounting for 2.7–8.3% of attendances.² This does not include work related and non-traumatic musculoskeletal problems, such as lower back pain and tendinopathies. Without specialist assessment and advice many conditions can go on to become recurrent or chronic problems affecting peoples' lifestyles and the economy. An excellent example of this is ankle sprain, which accounts for up to 7–10% of ED attendance³ and is often thought of as a simple injury requiring standard management. However, long term outcome studies have shown chronic symptoms to be reported in 40% of cases, including pain and functional instability.⁴ There is controversy about what constitutes best management for this complaint and a different approach is seen in many EDs. This is where a physiotherapy practitioner can play a vital role in developing and setting standards of care. This also meets

majority of people are committed because it is a passion and a vocation. If the organisation does not succeed with that commitment then you have to look at the structure by which it is being managed and question why it isn't more effective. It also strikes me that successive governmental structures have produced initiative overload. If there is consistency in an approach and support for a long enough period to drive forward an agenda, then I think there is a very strong future for the NHS. If the goalposts keep moving people will just say "why should I bother".

one of the key principles set out by the Reforming Emergency Care plan 2001.

The physiotherapist's main focus in the minors area is as a musculoskeletal specialist promoting the use of evidence based assessment and treatment techniques, based on clear standards. This is achieved by splitting the role into a number of defined facets, which include:

- Developing care pathways for specific populations (eg anterior shoulder dislocations)
- Opening communication pathways with the orthopaedic team and potentially decreasing unnecessary referrals to clinics
- Providing expert advice on individual patients, ensuring appropriate management and staff support
- Carrying out regular up to date in-service training, including assessment of competencies for F2 doctors

The physiotherapist also improves the skill mix in the minors area creating communication pathways to the therapy teams, which can assist the carry-over of patient care especially if physiotherapy or hand occupational therapy review clinics

Table outlining the strengths and weaknesses of an ED physiotherapy practitioner.

Pros	Cons
Increased staffing	De-skilling doctors
Musculoskeletal/orthopaedic/sports specialist	Cost
Training for staff	Efficiency (ie ability to see variety of patients)
Improved communication with ortho/physio team	Accessibility
Evidence based treatment	Expanding the role leads to potential loss of core skills
Setting standards of care for minors musculoskeletal patients	
Development of care pathways	
Skill mix/expanding roles	
Meeting NHS/reforming emergency care plans	
Development of physiotherapist	
Potential for decreasing recurrence/chronicity	
Patients seeing the right person at the right time	
Research in minors	

ED, emergency department

are used. The minors area is also an untapped resource of research potential. Physiotherapists working at this level should be carrying out or promoting research, thus boosting the department's profile and ensuring its continued strive for excellence in patient care.

There are potential weaknesses in having an ED physiotherapy practitioner. These include deskilling both junior and senior doctors in the ED, a problem already identified in departments with emergency nurse practitioners (ENPs). This can be addressed by appropriate training of the medical team and using the physiotherapist to consult on more complex patients. Physiotherapists have excellent anatomical knowledge and handling skills and so should develop competencies in shoulder and fracture

manipulations, joint aspiration and therapeutic injection. This type of progression would benefit both the emergency and orthopaedic departments, the patient and the physiotherapist, ensuring there is a first line practitioner with the appropriate skills to deal with as many musculoskeletal problems as appropriate without the need for secondary advice.

In summary, specialist musculoskeletal physiotherapists working in the ED minor injury areas have potential strengths and weaknesses, but if the role is defined correctly patients should receive a higher standard of care, not just from the physiotherapist but from all members of the team. This will ideally lead to a decrease in musculoskeletal chronicity and the prevention of long term conditions, one of the key Department of Health

targets set out in the White Paper 'Our Health, Our Care, Our Say' (2006) and the NHS Improvement Plan (2004).

PAUL HAWORTH

Emergency Department Physiotherapist

References

- 1 **Mason S**, Coleman P, O'Keeffe C, *et al*. The evolution of the emergency care practitioner role in England: experiences and impact. *Emerg Me J* 2006;**23**:435-9.
- 2 **Boyce SH**, Quigley MA. Review of sports injuries presenting to an accident and emergency department. *Emerg Med J* 2004;**21**:704-6.
- 3 **Kannus P**, Renstrom P. The treatment of acute tears of the lateral ligaments of the ankle. *J Bone Joint Surg* 1991;**73A**:305-11.
- 4 **Osborne MD**, Rizzo TD. Prevention and treatment of Ankle sprains in athletes. *Sports Med* 2003;**33**(15):1145-50.

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Change management: a blinded clinical trial

OLD, NON-EVIDENCE BASED,
OUTDATED PROCEDURE

1. Submit CV with details of experience and qualifications
2. CV read by experienced consultants
3. Interview by expert panel:
 - Firm handshake?
 - Interesting hobbies?
 - Suitable old school tie +/- captain of rugby?
4. Unsafe, indefensible, elitist appointments to specialist training

NEW, MODERNISED, TRANSPARENT
ELECTRONIC PROCEDURE

(no control group needed in this trial)

1. Anonymised, applications ranked by computer
2. Competencies assessed
3. Multidisciplinary teamworking rewarded
4. Interpersonal skills scored
5. Substandard references deleted

BUT:

Trial terminated early... due to:

- Juniors revolt
- Overheated consultants flounce out
- Underheated consultants despair
- Deans become desperate

So.....

POST-MODERN, PRAGMATIC REVISED
APPOINTMENT PROCEDURE

1. CV submitted and read by consultants
2. Interview exploring experience and qualifications
 - Good eye contact?
 - Interests outside medicine?
 - Head girl +/- grade 8 cello?
3. Appointments in fair and open competition to specialist training

A consultation overheard

Emergency nurse practitioner: "Are you sexually active?"
Middle aged female patient: "No, I just lie there. My husband does all that."

EMTA update

I would like to take this opportunity to introduce myself. For those of you who do not know, I am Anna Forrest-Hay, the new EMTA President. My contact details are available on the EMTA website at www.emergencymed.org.uk.

I am a final year Specialist Registrar in the Southern Oxford Region. I have passed FCEM and am just completing my dual accreditation in Paediatric Emergency Medicine. Since 2005 I have represented EMTA members on the Training Standards Committee and am Vice Chair of the Academy of Royal Medical Colleges Trainee Group. The impact EWTD is having on training and assessing competencies in the workplace are two other groups I am currently involved in.

I sincerely hope my background will enable me to fulfil my duties as President in providing you with information, advice and feedback from the College on issues relevant to trainees in emergency medicine. My intention in telling you so much about myself is that you likewise, can know how best to utilise me in my role.

One of my first jobs must be to thank Ghufuran Syed, on behalf of the Committee, for all the hard work he did as President before me. He had plenty of ideas, always eloquently and enthusiastically portrayed and was dedicated to strengthening EMTA. We wish him every success with his future plans.

I cannot write this update without reference to the turmoil and change that has affected us all recently. What MMC

did enable, due to the positive and forward thinking consultants, was an opportunity to devise a much more logical and comprehensive training programme for Emergency Medicine trainees of the future. In line with the new curriculum, and paralleled with competency assessments, it will ensure a high standard of doctor, who is fit for purpose to take up a consultant post.

On the contrary, MTAS has made it one of the most difficult times in history for trainees trying to join a training programme to embark on a career in emergency medicine.

It is at times like this that a trainee committee is needed most. We should seize this opportunity to bolster our lines of communication and ensure that the EMTA Committee can fulfil its objective "to provide a structure for trainees to highlight issues specific to trainees and represent their views on senior CEM Council and National Committees".

Currently in existence in each region are Regional Representatives, often your STC representative, who automatically belongs to the EMTA council. They are an underused resource. You can speak to them directly and they will ensure that EMTA Committee members are voicing your opinions.

It is at times of crisis that strength in numbers is required. We would like to encourage as many trainees in Emergency Medicine in the UK to join and participate in EMTA and to attend the conference. I urge you to consult the College website on a regular basis and ensure that your details are up to date on the EMTA site

so that you can be fully informed and involved on important issues.

We wish you to get in touch with your recent experiences of MTAS, both good and bad. You should know that pastoral care is available to anyone from occupational health since the consensus that damage to the health of young doctors is attributable to the problems of the MTAS process.

Just to finish on a different note. As you know, PMETB has taken over the quality assurance of approving posts for training. A pilot takes place this June to include trainees on the Visiting/Assessment Panel. If deemed to be a success, a pool of experienced trainees will be required to volunteer themselves for intensive training to accompany future visits. Anyone interested in the improvement of training environments, resources and standards could benefit from this experience and should contact me via email.

Conclusions from the PMETB Trainee Survey should be available. 80% of you filled it in, but another will be distributed including more speciality specific questions. I would urge everyone to participate next time as you are aware that it replaces a large aspect of the quality assurance inspection of training posts previously achieved through the college visits and we would like the data to reflect trainees' situations as closely as possible.

I hope to meet some of you in person at the BAEM Annual Conference.

ANNA FORREST-HAY
EMTA President

Consultant appointments March 2007. The information for the consultant appointments is provided by the College and any errors should be notified to them and not the journal

Name	Hospital	Previous post
Andrew G HOBART	Princess Royal University Hospital	Consultant, Australia
James G M IRONSIDE	Maidstone and Tunbridge Wells NHS Trust	SpR, South Thames
Brendan P CONWAY	Darent Valley Hospital	SpR, South Thames