Editorials

The NHS Plan—the sound of cavalry or zebras?

The publication of the NHS Plan in August 2000 represents the first attempt by an administration of any persuasion to undertake a comprehensive review of the current state of play and propose reform. The plan has been pored over at length in the medical and lay press. The purpose of this editorial is to consider how the NHS Plan might influence day to day practice in our departments.

In publishing the plan, the government has provided a huge and unmissable target for cynics and sceptics alike. While some of this is justified and healthy, there is no doubt that the principles and developments within the plan represent a real opportunity for improvement. The plan covers all bases and, inevitably, lacks detail in how the changes are to be implemented. We must, therefore, seize any opportunity to influence the delivery of the plan. Of concern, however, is the paucity of specific comment concerning emergency care in general and the role of emergency departments in particular. This is surprising as the principal problem identified by consultation with NHS staff and the public was the need to reduce waiting times in our departments. It is equally disappointing that emergency care is not identified as one of the principal clinical priorities along with mental health, cancer care and heart disease. Although we are inevitably biased, emergency care is regarded by many health professionals and the public as being a fundamental component of the NHS that has consistently failed patients as a result of under-investment and under-staffing.

There is some solace to be found with important initiatives throughout the continuum of care that should have beneficial impact on our workload. For example, the recommendations that by 2004 patients will have guaranteed access to a primary care professional within 24 hours and a primary care doctor within 48 hours should help reduce some of our primary care workload. Similarly, the commitment to NHS Direct as a single point of contact for healthcare should help, although many still need to be convinced by evidence that this initiative will result in fewer emergency department attendances.

One example of innovation quoted in the plan is the Urgent Need Assessment Service project developed in North Tyneside. A number of triage nurses using NHS Direct decision support software are empowered to see and treat patients triaged into categories four and five (least urgent). This initiative has attracted great publicity and is reported to have found favour with the government attracted by the sound bite that this system provides a 30 minute turn around time for patients attending departments with minor conditions without additional resources required. The idea that this initiative is resource neutral may be mistaken. The concept of empowered triage nurses being able to redirect some patients is welcome and such innovative practice is invaluable. However, it would be unfortunate if this promising concept was damaged by imposition of the system nationally before full evaluation has occurred. It is essential to avoid some of the difficulties that have arisen with the rapid blanket roll-out of NHS Direct and Walk-in Centres.

The plan considers some anachronistic practices within the NHS, many of which date from 1948. In particular, professional demarcations and boundaries are rightly

regarded as an obstacle to progress. Emergency medicine has been pioneering and innovative in breaking down such barriers and, to many observers, represents an ideal example of the benefits that can arise from the multidisciplinary approach to enhance patient care.

It is disappointing that there is only brief mention of the need to provide high quality care 24 hours seven days a week. If the whole system is to change to deliver emergency care sensitive to the workload, then abolition of the office hours and the concept of seven days a week availability of staff and access to diagnostics, is essential.

The plan identifies shortage of staff as being a key deficiency in the current NHS. Surely, nowhere is this felt more acutely than in emergency departments. The commitment within the plan to a major expansion of the consultant grade, needing a significant increase in the numbers of specialist registrars, is particularly relevant. We very much hope that the current negotiations with the Department of Health and workforce planning in progress will convince the government of the need for such investment to be targeted in our direction.

In "Changes for NHS Doctors" options for senior doctors are considered. The two options identified are expanding the number of non-consultant career grade doctors or making hospital care a consultant delivered service. Inevitably, these proposals have generated a polarity of opinions. Within emergency medicine, however, there is a huge deficit in the numbers of senior medical staff available. A consultant delivered service may be an ideal but the huge workload in our departments means that this is not achievable within the 10 years allocated for implementation of this plan. However, a major increase in the number of consultants, registrars and non-consultant career grade doctors could ensure that all patients have experienced medical input into their care before admission or discharge. The clinical governance benefits are obvious. If such an initiative was combined with a reduction in overall attendances as access to primary care improves and NHS Direct delivers, then we would start to move towards the high quality service to which we aspire. Experience in emergency medicine would continue to provide excellent education and training for SHOs while avoiding their inappropriate workload, identified as undesirable within the plan.

At present, there are few drivers or penalties for Trusts and others to ensure that adequate investment occurs in emergency care, particularly compared with the penalties that apply to chief executives should they fail to meet elective targets. If a change in the culture of investment is to occur, then this must be driven from the centre. It is proposed that workforce plans provide the numbers of staff needed to achieve the new standards of care, and that NHS Trust performance will be managed against these standards, indicating that incentives will be put in place to meet these targets.

The plan correctly identifies the lack of national standards and resultant wide variations in quality of healthcare. This is particularly relevant to our specialty. National Service Frameworks and NICE will have some impact on our practice. However, we have an urgent responsibility as a specialty to define those standards by

Box 1

"Patients with minor injuries will often be treated by appropriately trained Primary Care staff working in Accident and Emergency Departments."

which performance may be judged. These should reflect what we believe is good practice, ensuring that such targets are then used as levers to obtain resources, not sticks to beat those failing due to inadequate resource provision. The Clinical Services Committee of BAEM is currently developing such standards.

The issue of primary care and its relation to emergency medicine needs further discussion and clarification (box 1). A confounding factor in the debate is the lack of a universally agreed definition of a "primary care" patient. As a result, the estimates of such patients attending emergency departments vary widely, and there is a danger of misinterpretation of the published work available suggesting that a major proportion of emergency department workload is primary care. There is a population of patients who could be equally well managed by primary care doctors although the evidence is mixed on the efficacy of this strategy. Without wishing to deny the benefits available for some departments in employing primary care practitioners, it is perhaps simplistic to suggest that this is a panacea. There is probably no single model that is applicable nationwide. However, a system that provides rapid access to primary care in the community, a single point of contact using NHS Direct to ensure that patients are directed to the appropriate facility, empowered triage nurses using NHS Direct algorithms, emergency nurse practitioners and emergency department medical staff will provide the comprehensive response to this workload without having to impose rigid and possibly unworkable patient definitions.

Box 2

"by 2004 no-one should be waiting more than four hours in Accident and Emergency from arrival to admission, transfer or discharge. Average waiting times in Accident and Emergency will fall as a result to 75 minutes. By then we will have ended inappropriate trolley waits for assessment and admission." "This will involve major changes to the way that hospitals work. It may require more staff..." "It will require new working practices with nurses taking on new roles including the right to admit patients and order diagnostic procedures."

No one would dispute these principles (box 2), which are important and long overdue. A four hour wait is an attractive option in a culture where much longer waits to

admission are common place. Similarly, reducing the average wait to 75 minutes is laudable and correct.

Many of us believe that all trolley waits are "inappropriate" and the indication from this document that long waits will have ended by 2004 is encouraging, although bound to attract a modicum of eyebrow elevation at least. Again, this will need to be driven from the centre. The National Patients Access Team is currently considering emergency care and their first priority is trolley waits, both in terms of providing a definition of absolute clarity and proposing strategies to ensure that prolonged waits achieve only nostalgic status in the future.

The waiting times to admission, transfer or discharge are, of course, mostly out of the control of emergency departments but the perception remains that this is our responsibility. It is encouraging that the plan recognises that such improvements will require major changes in the system and new working practices. However, there remains a fundamental inadequacy with regard to capacity for emergency patients. The current widespread belief that emergency departments provide infinitely elastic accommodation for patients awaiting admission, causes huge frustration and tension. The proposed 30% increase in the number of critical care beds by 2003, should help and the emphasis on improving Social Services care by additional investment and tackling the "fault-line between health and social care" may help to dismantle the daily log jam. This is a classic example of the need for joined up practice driven by the government, colleges and Trusts committed to changing a system that has often proved resistant to such developments.

The target to reduce waiting times in emergency departments to an average of 75 minutes is ambitious but desperately needed. Achieving this will require significant investment in medical and nursing staff, review of their respective roles and a commitment to a team approach in order to deliver a high standard of emergency care. For many years, we have been frustrated by a system that has not focused on emergency care and, in particular, has neglected the contribution of emergency departments to the NHS. There are real signs that that culture is now changing and it may not be naively optimistic to consider that this represents a real opportunity and turning point. We know that medical and nursing staff are eager for change and capable of delivering, given adequate resources and a system that is responsive to emergency pressures.

The need for a combination of major investment and reform is long overdue. The initiative of significantly improved funding and modernisation of the system is welcome and should be embraced. The government have boldly attempted to tackle a huge agenda but the provision of emergency care is the pivot upon which the reputation of the NHS balances and by which its success will be judged.

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