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SUPPLEMENT

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Introduction to the JAEM Supplement

Welcome to the first issue of the supplement to the *Journal of Accident & Emergency Medicine*. This will appear with each issue of the journal and is designed to meet the need for a more topical publication to keep readers informed and up-to-date with those issues which affect us all but do not find their way into a scientific journal.

Among other items the supplement will cover medico-political issues, key points from association and faculty meetings, and relevant reports from the government and the colleges.

The publishing arrangements for the supplement will allow a short timescale of 4–6 weeks between submission and publication. This will ensure that issues are covered while they remain topical.

The supplement will be edited by Mike Beckett and Diana Hulbert who can be contacted at the West Middlesex University Hospital as detailed below. I am immensely grateful for their enthusiasm and hard work in driving this initiative. The supplement could not have appeared without the generous sponsorship of BOE whose support is gratefully acknowledged.

I am sure that this will prove to be a popular and important addition to the journal. Feedback on the content, letters for publication, and suggestions for future articles are welcome, and should be forwarded to the editors.

JOHN HEYWORTH

Editor, Journal of Accident and Emergency Medicine

Modernising A&E—an interview with Mike Lambert

The government's recent decision to invest £115 million to improve A&E departments has led to the establishment of the A&E Modernisation Group. We talked to Mike Lambert who chairs the group.

Tell us about your career so far...

I qualified from the Middlesex in 1981, and did an A&E SHO post working for David Williams. I started on a surgical career, but found I was in danger of becoming increasingly subspecialised, and realised what I really liked was the acuity of diagnosis and initial treatment. So after talking with David and others I carried out registrar training in Leeds. I then did a six month SHO post in intensive care before getting an SR post at Charing Cross and Central Middlesex. I was appointed as an A&E consultant at Norfolk and Norwich in 1992.

Why were you asked to head the Modernisation Group?

The short answer is I do not really know. I was already on a Department of Health committee advising ministers on emergency pressures, and when the initial £30 million was allocated for A&E modernisation I got involved advising the East Anglian region and looking at the bids coming in. When the government wanted to extend the programme, I understand soundings were taken and I was asked if I would like to be involved.

I am currently spending three days a week on the modernisation programme. I am fortunate in that my colleagues at the Norfolk and Norwich have taken on a lot of extra responsibility to let me do this because they recognise the potential importance of the work. I still have a clinical commitment to the department and still do some on call. I think it is important that when our group makes recommendations it is seen that they come from people who are active in the specialty.

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How representative of A&E interests are the rest of your team?
I think we do have a good spread. There is absolutely no point in us as a group coming out with views and opinions which are out of step with what consultants, nurses, and managers and all those who contribute to A&E would find acceptable—we would get rubbished by our own specialty. BAEM and FAEM are represented through the reference group. When the group was set up I had just been elected to the post of honorary secretary of BAEM and I was asked to stand down from that in case there might be any conflict of interest. We shall be holding regional workshops throughout the country, and other meetings are planned to engage the whole specialty.

How is the modernisation group structured?
The modernisation group itself consists of a number of A&E consultants, senior A&E nurses, a chief executive, and representatives from the Department of Health. In addition there is a reference group which has representatives from all interested parties: RCP, RCS, RCGP, etc as well as patients' groups. The association and the faculty are represented within the modernisation programme.

We report directly to the Secretary of State.

What is the group's remit?
There are three elements we have been asked to deliver.

First is to oversee the allocation of the £115 million modernisation fund. This does not mean we will do a detailed analysis of each individual case, but we will comment on the process by which money is allocated and look at the lessons that can be learnt from the expenditure and what it tells us about the future processes of A&E care—what problems were people trying to solve, and did the investment deliver the improvement they were hoping for. If it did not, we want to learn about their circumstances or their analysis of the problem, and whether perhaps they should have taken a different route.

Second is a shorter term project to look at good practice around emergency pressure this winter, particularly over the millennium. We know it is a whole system issue, from self help, primary care, and community services through medical care to rehabilitation. We also know that if any part of that system fails the pressure is declared in the A&E department. We will be looking at good practice and ideas from around the country that might be worth implementing in some departments before the millennium.

Finally, and potentially the most important area, is a remit to submit to ministers a strategic view for the development of A&E within the emergency care system as a whole. I think that should realistically be a 3–5 year view because life changes so quickly that grand schemes up to 20 years ahead are likely to be scuppered by events, so whatever we come up with should be deliverable within five years. We should look at the expectations and objectives of the specialty, as well as the public and government, the environment others are likely to create, and what resources we might reasonably hope to be given. With these three, expectations, environment and resources, we should be able to come up with a strategic view supported by a model of care. The final element of that strategic view would be to look at that model and define performance indicators to ensure the systems are delivering real benefits. If not we have got to ask questions about how the model is locally implemented. There is no guarantee we will get it right but what we have to do is challenge the accepted model.

Do you worry that what works well in one department may not work everywhere?
I have absolutely no doubt that there is no single solution that will suit every department and system of care. I think we should like to come up with, if you like, a tool box of approaches—there are tools which you can use to analyse your particular problem, working out what you need and go into the tool box to look at what is good practice and might be a sensible way forward.

After years of presenting ourselves as a Cinderella specialty we have been given the opportunity to move into centre stage

When do you have to report?
The report on the millennium issue has to be with ministers in September. The main report is due in April of next year, and I anticipate we will still be doing some work around the modernisation programme to the end of 2000, beyond that remains to be seen.....

Do you think the government has an external agenda that they wish to impose?
There is an agenda—it is about modernising the NHS—making it more accessible, more reliable, more dependable, to quote the white paper. I think clinical governance is about getting rid of unacceptable variations across the regions. With the modernisation money there will be strings attached. When they give out the money they will expect to see that the process has improved—I have no problem with that. We have an opportunity to remove many of the barriers to good care that exist due to under investment. After years of presenting ourselves as a Cinderella specialty we have been given the opportunity to move into centre stage and show we can really deliver. I am sure we have been invited to do this because government sees A&E as a high priority for the future.

Consultant appointments, January to June 1999

Name	*Hospital*	*Previous post*
J Nigel Rawlinson	Bristol Royal Infirmary	Associate Specialist, Bristol Royal Infirmary
J Gavin Lloyd	Bristol Royal Infirmary	Locum Consultant, Bristol Royal Infirmary
Ffion Davies	Royal London Hospital	SpR, Royal Liverpool University Hospital
Jane Terris	Guy's & St Thomas's	HEMS
Olivia Dornan	United Hospital, Antrim	Consultant, Mater Infirmorum, Belfast
Michael Rickards	Gateshead Hospital	Senior Registrar, Queen Elizabeth Hospital, Gateshead
David J G Hall	Pinderfields Hospital	SpR, Pinderfields General Hospital
Deyhim Foroughi	George Eliot Hopsital	Consultant, Hospital of St Cross, Rugby
Alasdair Gray	St James's University Hospital, Leeds	SpR, St James's University Hospital, Leeds
Taj Hassan	St James's University Hospital, Leeds	Research Registrar, Leicester Royal Infirmary
Andrew Simpson	Hartlepool General Hospital	SpR, Northern General Hospital, Sheffield

The future of A&E medicine—a view from the terraces

A passionate crowd (representative of all the evolutionary stages of the A&E doctor) packed the Royal College of Surgeons for the combined BAEM/FAEM meeting "The future of A&E medicine".

The presentations (on care of the head injured patient, deliberate self harm, admission units, clinical decision units, rapid sequence induction, ultrasound) described a variety of clinical activities that some departments are providing over and above core A&E services. They also examined the interface between A&E and acute specialties. These topics had already been chosen in order to stimulate a broad and philosophical debate about the future of A&E medicine. The organisers were successful in achieving this as a lively discussion ensued.

It was acknowledged that most of the activities described had been initiated by clinicians with particular interests, in response to perceived suboptimal service and anxieties that some patient groups were being poorly provided for. It was appreciated that the maintenance of these services depends on the continuing enthusiasm of the participating clinicians as well as variable extra resources.

Some members of the audience clearly felt that A&E should concentrate on improving the provision of core service only (presumably as defined in *The Way Ahead*). It was argued that A&E is best at the initial assessment, diagnosis, and management of patients with acute injury and illness and that to broaden our horizons would inevitably dilute this expertise.

Others expressed the opinion that a controlled expansion of the clinical services provided by A&E, particularly the continuing care of patients with head injuries, was an opportunity to press for further resources, especially 24 hour middle grade cover. There was concern, however, that we should neither "cherry pick" extra clinical activities nor accept them by default.

The consensus appeared to be that in the short term there should be exploration and discussion concerning expansion of A&E services. Some departments will, however, chose to expand the clinical services that they provide depending on local requirements and resources available. Activities that expanded our diagnostic and interventional skills were to be encouraged as were admission avoidance schemes.

The long term future of A&E is undoubtedly more controversial. In his presentation "Aspirations versus reality" the president of the faculty cautioned the more junior members of the audience against seeking a significant expansion of A&E services and, in particular, adopting the Australian system that some favour. Such a development would obviously have tremendous training and resource implications.

Several speakers from the floor reminded us that A&E was conceived as a specialty because it was recognised that patients attending casualty departments were not getting a good deal. It was clear that the provision of a quality service for patients remains the main priority.

However, most of the audience seemed to agree that there are significant deficiencies in the current provision of acute care. They also appeared unconvinced that the relevant specialties would provide solutions to current problems. How long therefore before we seek further involvement in the process of organising, and perhaps ultimately delivering, acute care?

This meeting was the first in a series of debates and consultations that will undoubtedly occur.

I would like to acknowledge those people whose thoughts and opinions are expressed here without attribution.

A report of the proceedings will be issued by BAEM/FAEM.

ANGUS COOPER

Meeting with Frank Dobson

On 11 May 1999, Roger Evans and John Heyworth met Frank Dobson at the Department of Health. Mike Lambert was in attendance as leader of the A&E Modernisation Group.

The initial prompt for the meeting was the publicity surrounding the "winter pressures", although the officers took the opportunity to ensure that Mr Dobson was aware of a number of issues.

The key points from the meeting were as follows:

(1) The current initiatives of increased funding and the establishment of the Modernisation Group for A&E medicine were welcomed.

It was hoped that this represented a sustained raising of the profile and recognition of the importance of the specialty within government strategy.

- Most A&E departments are facing a steadily increasing workload. Initiatives such as NHS Direct are welcomed and show that the Department of Health is aware of some of the problems, although their eventual impact on A&E attendances is unknown.
- The concept of "winter pressures" is flawed—this is a year round problem with patients waiting for unacceptable lengths of time in many departments. This places immense strain on the A&E medical and nursing staff. The quality of care inevitably suffers. Privacy and dignity for the patients is often lost.
- Congestion in the A&E department often indicates a failure in the whole system to deal with the emergency workload. Improved resources and practice within A&E departments can help to ameliorate the problem but this will not be successful unless changes occur throughout the whole system of emergency care.
- There is concern that investment in this specialty at the local level by trusts and health authorities is affected by the pressure to achieve targets with regard to outpatient and waiting list times. The provision of emergency care should be at least equal in priority to elective work and the Secretary of State was urged to consider how this could be achieved.
- The specialty is unique in being SHO based. This provides an outstanding and unique training opportunity for junior doctors which should be continued, but the problems with regard to speed, use of resources and a tendency to over investigate and refer, were noted. The provision of greater numbers of more experienced medical staff

> The meeting covered a range of current issues including bed pressures, staffing, violence, and the millennium

at middle grade and consultant level was strongly recommended. A copy of *The Way Ahead*, outlining the staffing numbers which would allow such a service, was given to the Secretary of State.

- The potential for the specialty to provide the highest level of emergency care was emphasised. The current investment and interest was welcomed but will need to be continued if the specialty is to be able to deliver. This would be a much needed and popular political achievement.

(2) Issues surrounding the millennium were discussed. It was noted that much of the content of the BAEM millennium document had been incorporated in a HSC.

Concern was expressed that A&E departments might find that they had to provide a GP service over the long millennium holiday. The Secretary of State made it clear that he was expecting GPs to organise themselves to provide care during the millennium period, but did not give definite indication as to how this would be organised.

(3) Finally, the continuing problem of verbal and physical violence in A&E departments was raised. The Secretary of State made it clear that he believed that such behaviour was completely unacceptable.

Meetings with politicians rarely meet all expectations, but we were encouraged that Mr Dobson agreed to meet us—he could easily have delegated this to an official—and seemed knowledgeable and concerned about A&E issues. We are hopeful that this concern will prove beneficial to the specialty and to our patients.

News from BAETA

This is the word of BAETA. Here we hope to keep you up-to-date with the trainees' world of A&E.

The new BAETA committee was elected at Belfast in April this year and improved communication was our main aim. We have started as we hope to continue . . .

With current debates on "the future of A&E" including the meeting at the Royal College of Surgeons on 29 June, we decided that the trainees' voice needed to be heard—after all for the next two or three decades we are the future of A&E medicine.

A questionnaire has been distributed to all regional representatives in the UK to canvas the trainees' perspective on a number of pertinent issues. Please send any outstanding results or queries to Alison Smith or me and the results should be ready for the next supplement.

- Elspeth Worthington, president (tel: 0151 678 5111, long range pager via switchboard or secretary, extension 2080, e-mail: eworthington@ukonline.co.uk).
- Alison Smith, secretary (tel: 0114 243 4343, e-mail: alison@headland62.freeserve.co.uk).
- Adrian Clements, BAEM executive representative (tel: 0191 232 5131).
- Katherine Lendrum, faculty representative (tel: 01384 456111, e-mail: katherine.lendrum@dial.pipex.com).

ELSPETH WORTHINGTON

Next BAETA conference

Essential for education and entertainment, Cardiff 19–21 September 1999. For more details contact Mark Poulden (tel: 01792 703420)