

The four hour target; problems ahead

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As the target rises, will EDs become nothing more than a queue processing machine?

Nobody likes to queue. Whether in a supermarket, an airport, a post office, or an emergency department, few of us wish to wait too long for service.

The clinical consequences of waiting too long for urgent treatment in an emergency department are all too obvious. The increased morbidity that can result from delayed transfer to a ward after assessment and treatment in the emergency department may be more subtle in manifestation but no less significant or serious. Sensational media headlines, combined with a powerful political agenda, led to the introduction of the four hour target for emergency department treatment, discharge, referral, and admission of patients. From a gentle beginning, with the target set at 90% for all ED attendances, the bar has risen higher and higher, currently resting at 98%. To some stressed staff it feels like the tightening of the screws on a rack of the Spanish Inquisition.

Few will disagree that NHS trusts, our specialty, emergency departments, and patients have all benefited from the investment and intense political and media scrutiny that has resulted from the target's introduction. The financial and political investment is welcome beyond measure.

What is interesting are the different processes introduced to meet the target. Solutions vary between trusts and are a

marker of human ingenuity and creative thinking. The Emergency Service Collaborative was a formal tool used to help introduce change, modify behaviour and improve team work between the prehospital and hospital communities. Less structured methods include the starting and stopping of the clock at different stages of the patient journey, the judicious use of the short stay/observation ward, and even just moving the patient to an in-patient ward as the clock ticks, even if their ED treatment or evaluation is incomplete. The debate on whether EDs are a treatment centre or a glorified triage station is one for another day.

Until March 2005, the target was audited quarterly. It was not unknown for trusts to hire extra staff at the end of an audit period to help meet the target. The audits did not thus accurately reflect care delivered outside the audit period. Now the data are continuously reported and the quarterly cycle abolished.

The pressure on ED staff to meet the target is fairly relentless. In many trusts, managers, who themselves report to a higher authority, cajole, harass, and even occasionally bully staff to ensure the target is met and there are no breeches. More often than not nurses receive the shop floor burden of this pressure. They may in turn extend or deflect the pressure to the doctors.

Regardless of what may be best for them individually, patients must be moved on within four hours. For many patients this is not a problem but others can languish in a medical or surgical acute assessment ward instead of an emergency department. This is not always the best place for them to be. The clock is becoming more important than correct clinical process. Perhaps the pendulum of change has swung too far. Is it time to reconsider lowering the target?

Are there any consequences that matter? Is the professional mentality changing? Will decisions be made that are not in the best interests of the patient?

This new philosophy, if unchecked, has long term professional risks. Doctors and nurses will feel undervalued and think they are automatons. They may even behave like automatons. Their clinical skills will deteriorate and diminish. Job satisfaction and professional pride will decrease. Retention and recruitment of skilled staff will be harder. Trainees may become disillusioned and turn away from the specialty. Burn out is manageable and reversible but attrition is permanent.

Are the time, energy, and investment needed to achieve and police the difference between, say, 95 and 98%, worthwhile? To use an over egged management phrase, is it cost effective? In the short term it is appealing to report that 98% of patients are seen in less than four hours. In the long term EDs may be nothing more than a queue processing machine with a diminishing skill mix of staff. The public and professionals will worry. The politicians may not.

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