



Dr David Williams

David Williams has recently retired from his post as Clinical Director of the Emergency Department at St Thomas' Hospital, towards the end of his 63rd year, after 28 years as an A&E consultant. We thought it appropriate to pay tribute to his role in the inception of the Faculty and the development of the specialty.

David occupies a unique place in the specialty for a number of reasons: he was a consultant at three London teaching hospitals, he is a fellow of five medical Royal Colleges, a man with a lecture named after him while still (very much) alive, and a man who has held office in the Casualty Surgeons Association, the British Association for Accident and Emergency Medicine, and the Faculty of Accident and Emergency Medicine.

The Faculty was conceived by a senior group of individuals, led by David Williams. One of the two seminal meetings was held by candlelight after an electricity

failure in the hotel in Leicester, the other was held in the wilds of Cumbria. Out of such beginnings was the Faculty born. The instigator and prime mover for its existence was David Williams and the next generation of emergency medicine specialists should be grateful for his legacy. He had the wise counsel and diplomatic skills to persuade the Royal Colleges that accident and emergency, even though a new specialty, could be allowed to determine its own destiny. Such changes do not happen without hard work and tenacity and only those very closely involved can fully appreciate the many difficulties and obstacles involved.

David has left clinical medicine but continues to work for the CICA and as clinical adviser to the NHS ombudsman.

We wish him and his family a happy and entertaining retirement.

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National Patients' Access Team: Emergency Services Programme

Patients often perceive the emergency care system to be characterised by restricted access, confusion, fragmented and disconnected services, and long waits. Consequently, the staff are frustrated and their morale is low. These factors epitomise poorly designed systems of care rather than a lack of interest, motivation, and ability of the workforce.

There is tremendous potential to redesign emergency care systems. This, in turn will reduce waits—increase accessibility, choice, and communication for patients—and support the delivery of clinically effective care. The result will be improved outcomes. To this end, the National Patients' Access Team (NPAT) Emergency Services Programme was launched in May 2000 to improve and modernise emergency services. NPAT is part of the NHS Executive and soon to be incorporated into the new Modernisation Agency together with the clinical governance team and the primary

care collaborative team. This new agency will create a major force for modernisation of the NHS.

The NPAT Emergency Services Programme will run for two years and initially involves 13 participating hospital trusts (16 A&E departments) working together to improve the patient's experience of emergency care. The participating organisations are working to improve the system of emergency care across their local health community. This will be achieved by testing new and different ways of working, and making changes to the way care is delivered. John Heyworth, president elect of BAEM, is the medical adviser to the programme and Andrew Kent, a senior A&E nurse, is the nurse adviser.

This national programme will use the experience of the participating organisations to develop transferable generic principles for improvement, by considering ways of

matching capacity and demand across an emergency care system. The learning from this will be disseminated across the wider NHS to achieve sustainable change.

The overall purpose of the programme is to redesign, modernise, and improve the system of emergency care throughout the patient's journey.

In particular the programme aims to:

- Support patients and staff to redesign and implement improved emergency care
- Ensure all patients are cared for in a suitable environment
- Identify, share, and disseminate good practice in emergency care across the NHS

The early goals of the programme have been shaped by the HSC/LAC on Winter Capacity Planning for Health and Social Care.¹ The ultimate aim is to eliminate all trolley waits. However, the target of no trolley waits is considered to be both challenging and ambitious given the starting point of many organisations. Therefore, this is regarded as a long term goal and will take considerably longer than the two year life span of this programme.

Although "trolley waits" are reported as an A&E service problem, it is now widely accepted that they are a symptom of a wider system problem. Therefore a whole systems approach, that cuts across the health and social services, will be taken to eliminate trolley waits.

The programme provides an opportunity to make major improvements in the delivery of patient care. Tools and techniques will be developed to improve emergency services across the NHS. To achieve this the programme will draw from a number of sources. These include:

- NPAT's redesign expertise and experience
- In-depth analysis of two local health economy sites
- The support and advice of an expert panel
- Nursing and medical advisers from A&E, primary care, surgery, and medicine
- Parallel work of the London regional office emergency care learning sets
- The work of the A&E Modernisation Programme

Each participating organisation has appointed a full time project manager to lead a local emergency services

improvement project. The project managers have received training and support in redesign and improvement methods and collectively form a learning set to share learning and development.

Each local project manager has set challenging but achievable aims that can be measured. Following identification of key principles for change, new ways of working will be tested, measured, and changes implemented. As the programme progresses, the principles will be tested and developed with the help of an expert panel.

The expert panel represents a wide range of perspectives from nursing, medicine, management, ambulance services, A&E, NHS Direct, walk-in centres, and social services. Thus it covers the whole spectrum of emergency care from primary and acute care through to discharge and social care. The aim of this panel is to maximise whole system working and ensure that the work is patient focused. Patient groups are also represented. The role of the panel is to provide advice, support, and guidance throughout the development of the national programme and the composite local projects. Alistair Wilson, A&E consultant from the Royal London Hospital, is a member of the expert panel and it is chaired by Sue Page, Chief Executive of Northumbria Health Care Trust.

Each local project team could, potentially, make hundreds of different changes. The panel has been charged with the challenge of helping to identify the small number of potential changes that are most likely to yield the greatest benefit for patients. Thus, the panel has a key role in helping to maintain a clear focus for the programme. They draw from relevant existing knowledge and best practice across the health and social system. A key part of their role is also to help ensure that the programme remains patient focused, meets the needs of patients, and improves the patient's experience of emergency care.

KAREN CASTILLE

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¹ Department of Health. HSC 2000/016: LAC 2000/14, winter 2000/01 capacity planning for health and social care. Issued 23 May 2000.

The management of minor injuries—a personal view

Minor injuries make up at least 50% of the workload of most A&E departments, and the management of these injuries should therefore be of interest to all A&E specialists. Unfortunately any discussion of minor injuries is hampered by the lack of a clear definition. For the purposes of this article a minor injury will be defined as one which does not require admission to hospital but which cannot be treated in a GP surgery either because of the nature of the injury, for example, tendon injury, or because of the facilities required to manage it, for example, radiography.

There is also an unfortunate tendency for the general public (and many non-A&E health professionals) to assume that a minor injury is a trivial injury. This has tended to devalue the importance of minor injuries.

Recently a number of influential groups have suggested that minor injuries can be managed entirely by nurses and do not need to be seen in an A&E department. The purpose of this article is to question this proposal.

The development of A&E medicine as a specialty has brought about a great improvement in the care of injured

patients in the UK. Although much of the focus has been on major trauma, A&E specialists have also been interested in improving the diagnosis and management of minor injuries. Two good examples are minor head injuries and soft tissue injuries of the ankle. Research by A&E doctors has provided a sound scientific basis for the management of these common conditions and this is something of which our specialty can be proud.

A&E specialists have also emphasised the importance of holistic care even for those with minor injuries. By this is meant considering the cause of the injury and managing it in the context of the patient's medical and social background.

Now it is being suggested that A&E doctors do not need to deal with minor injuries and that these patients can be managed by emergency nurse practitioners. What are the motives for this change and will patient care suffer?

For many years A&E departments have struggled to cope with their workload and some have also found it difficult to recruit medical staff. In desperation this led a few departments to experiment with nurses doing the work of doctors. This was naturally welcomed by nurses who

wanted to extend their field of practice. However the motive for this development was a staffing crisis and not improved patient care.

From small beginnings more and more nurses wanted to become emergency nurse practitioners and some A&E departments set up emergency nurse practitioner training courses. Unfortunately the responsible professional bodies, including the Royal College of Nursing (RCN) and the British Association for Accident and Emergency Medicine, failed to regulate their training or define their field of practice. As a result ad hoc training schemes developed in various parts of the country with no standardisation or formal examination. The consequence is that the title “emergency nurse practitioner” now carries no reliable indication of that nurse’s training or of her/his area of expertise. This is a very unsatisfactory situation and one which puts patients at risk. Furthermore what research there has been on emergency nurse practitioners in the UK has tended to show only that they can perform as well as doctors who have just a few months’ experience in A&E. This is hardly reassuring. Nor is this an acceptable standard for practitioners who may work unsupervised, for example in a minor injuries unit.

In addition the published work also fails to indicate what happens to patients whose minor injury cannot be treated by emergency nurse practitioner protocol. Examples are those patients whose injury is a symptom of a tendency to fall, or those who have medical or social circumstances that affect the management of their injury. With an increasingly elderly population this is likely to become more and more important. Paradoxically the patients most likely to fit into inflexible management protocols are children—the very group many emergency nurse practitioners are not allowed to treat.

Despite all this the Department of Health, the RCN, and other influential bodies are now indicating that in future all minor injuries should be dealt with by emergency nurse practitioners. Why have A&E doctors not responded to this situation?

Firstly it has to be admitted that some older A&E consultants are not interested in minor injuries. They tend to be the same doctors for whom major trauma is the “raison d’être” of A&E. Their position has weakened recently with the decline in major trauma and as trauma centres have fallen out of favour.

Secondly, and more importantly, there is a new generation of A&E specialist, characterised by many of the registrars presently in training. Their interest lies in critical care and they see themselves as “emergency physicians”. They are not interested in minor injuries either. There are also a number of A&E consultants who have concerns about

emergency nurse practitioners treating minor injuries but who fear that their experienced nurses will leave if they are not allowed to do more and more.

Fortunately there remains a large body of A&E consultants who are interested in minor injuries and who realise their importance to our specialty. They understand that much can be done to improve the management of these common conditions, and that what appears to be a minor injury can have serious consequences if incorrectly managed. They also realise that good management of minor injuries demands a holistic approach (which only doctors can provide), and that many patients do not fit into inflexible protocols.

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So what needs to be done? Firstly A&E specialists need to reassert their interest in minor injuries, and insist that these patients are seen in A&E departments. This will ensure continuing research in this field and maintain high standards of care.

Doctors who are interested only in critical care should become intensivists, and our specialty should retain the title “accident and emergency”.

Emergency nurse practitioners should be properly regulated and should have a clearly defined field of practice. An agreed course of training should lead to a nationally approved examination and qualification. There should also be a system of regular reaccreditation. It may be appropriate for emergency nurse practitioners to manage some minor injuries independently but the more serious injuries should always be supervised by an A&E specialist.

Finally A&E departments should concentrate on their core activity which includes all significant trauma. Conditions which can be treated in general practice should be strictly redirected and A&E departments should not be used as medical admissions units. Nor should the specialty take on additional roles, for example, the inpatient care of head injuries, until it is coping properly with its core activity. In this way patients with minor injuries can be given the attention they deserve.

ALAN LEAMAN

Princess Royal Hospital, Telford

Recent consultant appointments

The information for the consultant appointments is provided by the Faculty. Any errors should be notified to the Faculty and not the journal

<i>Name</i>	<i>Hospital</i>	<i>Previous post</i>
Angela C Dancocks	Kettering General Hospital	Consultant, Northampton General Hospital
Richard P Irons	Bridgend District General Hospital	SpR, Northern General Hospital
David Parkins	Wansbeck General Hospital	Consultant, Sunderland Royal Hospital
Michael M S Tan	Burnley District General Hospital	SpR, Bradford Royal Infirmary
Simon J Ward	King George Hospital	Locum Consultant, King George Hospital, Essex
Elspeth Worthington	Whiston District General Hospital	SpR, Warrington Hospital

News from BAETA

There are a few changes to report after the recent business meeting at BAETA 2000 in Liverpool in November. But first a quick account of the conference itself attended by a record 70 delegates this year. There was an interesting and varied academic programme incorporating topics such as child protection, some of the new boundaries and working patterns likely for the future of emergency medicine, illicit drug use in the 21st century, with a little nightclub medicine thrown in for extra measure and that was before we hit the social programme for real. The standard of free papers was reported as excellent by our consultant adjudicators and the winner was Miss Anne Weaver, SpR at Whiston Hospital, Merseyside with a presentation called "Boil in the bag—use of microwave ovens to warm IV fluids for the pre-hospital setting?"

Twenty eight hardy BAETA members braved the intemperate weather for the inaugural BAETA five-a-side soccer tournament. Some people had obviously played before, but the standard of play did not suggest that any participants had taken performance enhancing substances. There definitely seemed to be a culture of drinking and smoking between games and fitness proved a problem for many. In the end, the Alan Shearer influence was evident as a professional Geordie outfit defeated a Mersey selection in the final. On present form they are clear favourites for next year.

Various resignations and elections took place and the new committee members are detailed here:

President, Jason Smith; Secretary, Chris Biggin; RSM representative, Andy Stearman; Trainee representative on Faculty, Jonathan Bengier.

Unchanged:

Treasurer, Paul Baylis; BAEM executive representative, Adrian Clements; Examination and Education Committee, Sunil Dasan; Central Clinical Services Committee, Andres Izquierdo-Martin.

Currently vacant posts:

For postal votes from Faculty members, Research Committee JCHT(A&E) and for BAETA vote, Central Consultants Committee.

Other posts likely to be available at next BAETA meeting (BAEM 2001 in Bournemouth):

BAEM executive representative, BAETA treasurer, representative on Central Clinical Services Committee.

BAETA's financial situation: negotiations are still continuing though not without a few obstacles. We have approached Faculty as well as BAEM and if nothing is confirmed by BAEM 2001 then further action is planned.

Over the next six months the new president and I will be working together to ensure continuity of care for BAETA members and so if anyone has any other news or queries then please contact either of us.

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Jobshare register

We would like to set up a register of part time consultants and flexible trainees. This will facilitate networking and can be used to contact anyone, male or female who is interested in setting up a job share. If you are working part time, or would like to do so, please contact the Supplement editors (Mike Beckett and Diana Hulbert, Accident and Emergency, West Middlesex University Hospital, Twickenham Road, Isleworth, Middlesex TW7 6AF; tel 020 8565 5486, fax 020 8565 2516).

Did you know.....

Boerhaave's syndrome (spontaneous oesophageal rupture) was first described by Hermannus Boerhaave (1668–1738), a Dutch physician and one of the most famous doctors of his time. Like many physicians he did not believe in unnecessary interference—which was sensible as many of the treatments of the day would probably have done more harm than good. It is said that he carried everywhere a large book, which was supposed to contain all the secrets of medicine.

After he died there was great anticipation as the book was opened. It was found that every page was blank, except the last. There he had written "keep the head cool: keep the feet warm: keep the bowels open".

Emergency Medicine Journal

The journal will be launched in full text online this month, January 2001.

Full text features include fully searchable archive, customised email alerts, direct access to Medline, and more!

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