BMJ Publishing Group

Emergency Medicine Journal

SUPPLEMENT II

November 2001

Reforming Emergency Care

This special edition of the EMJ supplement deals with issues arising from the department of health document *Reforming Emergency Care*. This is available in paper form, and also on their website www.doh.gov.uk/capacity planning. There is no doubt that this document is important for the specialty and will influence the way it develops over the next few years.

We welcome comments from all working in A&E, either relating to the government document, or the opinions expressed in this supplement. Letters will be posted on the EMJ electronic letters page www.emjonline.com, subject to editing. Emails to cclark@bmjgroup.com or write to the Editor, EMJ, Specialist Journals, BMA House, Tavistock Square, London WC1H 9JR.

The gestation of the document *Reforming Emergency Care* has been elephantine in duration. However, during this period there have been significant changes, not only in the title, but the tone and content have altered significantly. In earlier drafts, the role of A&E medicine was de-emphasised and there was widespread understandable concern among colleagues that this document may have represented an undermining or even dismantling of the specialty. In fact, there has been an impressive and gratifying response from those involved in the production of the report to the input of representatives of the specialty suggesting that, of course, A&E medicine is the very key to the successful delivery of an improved emergency care system.

Unfortunately, over a period of many years, emergency care has not attracted the focus or investment required and this has resulted in a system which has been inadequate to deal with the increasing pressures of patient workload and complexity. As a result, the opportunity for the specialty to demonstrate its full potential has been compromised and observers from outside the specialty have not been fully aware of the expertise available, given adequate investment and resources.

For many years, the political priority has been to focus on waiting list initiatives and the elective workload. Investment was required in this area but the ever increasing scale of emergency work has been secondary and overlooked. This has proved politically damaging with repeated reports in the quality tabloids and other media of prolonged waits and overcrowding in our departments. When the NHS Plan was announced, it was disappointing that emergency care was not identified as one of the major priorities, although the setting of new and more meaningful waiting time targets was an encouraging step forwards. Many of us believe that the targets of average time to be seen of 75 minutes and time from arrival to admission, transfer, or discharge of less than four hours, are reasonable but that the investment and change required to achieve these goals by the stipulated date of 2004 is very considerable and has been under-estimated.

Emergency departments act as the central hub of decision making and a bridge between expensive inpatient care and the community. We have a fundamental role in preventing unnecessary admissions and inappropriate discharges, thus optimising resource use.

In *Reforming Emergency Care* recommendations for improvement in the whole system of emergency care are set out.

The key points include the following:

- Recruiting an additional 183 A&E consultants by 2004—an increase of 40%.
- An additional 600 A&E nurses to deal with minor injury or illness.
- To run hospital capacity at around 82% rather than the current 90% to allow greater flexibility to emergency pressures.
- The provision of 24 hour seven day a week diagnostic and other services.
- Increasing use of near patient testing.
- Streaming of patients to separate the "minor" workload from the more major patients.
- The opportunity for "further developments in the specialty of emergency medicine".
- The establishment of 25 exemplar sites to test the face to face clinical assessment system based on NHS Direct decision support software.

- Appointing emergency care leads—we would hope that A&E consultants will be invited to take on this role.
- The establishment of emergency care networks.
- The development of standards and emergency care pathways.

We welcome these proposals, although have some concerns. The planned increase in consultant numbers is long overdue, but this expansion falls considerably short of the current proposals of the Association and Faculty designed to provide consultant presence on an extended but sustainable basis. Similarly, recruitment of this number of new consultants will be difficult given the likely output of registrars from existing training programmes.

With regard to the continued development of face to face decision support software, it appears that the lessons of the premature roll out of NHS Direct have been learned and we welcome the concept of the new system being tested and evaluated in 25 sites between now and 2003.

There is an urgent need to establish standards across the system of emergency care. However, the concept of emergency care pathways needs to be approached cautiously. There are some advantages but such pathways should not be regarded as a panacea.

The Association and Faculty believe this document represents a platform and opportunity for the continued evolution and development of the specialty. Clearly, there is much work ahead regarding the detail of this strategy. Emergency departments will have a pivotal role in coordinating and driving the recommendations in order to ensure that the potential of our departments to deliver prompt high quality care is realised at last.

JOHN HEYWORTH
President BAEM

IAN ANDERSON
President FAEM

* * * * *

Reforming Emergency Care—an important development

MATTHEW COOKE

Reforming Emergency Care was launched on Thursday 25 October 2001 by the Secretary of State. It recognises that staff in emergency care are dedicated and working under real pressure. It is appreciated that the system responds well to major incidents but is not so effective for the care of every day emergencies where patients experience long delays. But problems in A&E departments are often the result of problems elsewhere in the system. When asked what would solve the problems in A&E most staff give three common solutions: more beds, more staff, and more services available out of hours. I believe *Reforming Emergency Care* is addressing all these issues.

What is required is a fundamental change in the way in which emergency care is organised. *Reforming Emergency Care* recommends just that. It builds on the work of previous reports, including those of the out of hours review (the Carson report), ESAT, WEST, and the work of the A&E Modernisation Programme.

The key problems of emergency care are identified as:

- Staff capacity in A&E departments is too stretched.
- Hospitals do not have sufficient capacity.
- Delays in discharge causing a log jam effect in hospitals.
- The needs of elective patients compete with those for emergencies both in terms of facilities and staff.
- Availability of diagnostic services does not match emergency care needs.
- Patients wait too long in the single queue system of A&E.
- Demarcation of professional working practices.
- Patients end up in the wrong part of the service.
- The system is fragmented.
- Standards vary across the system.

Staffing in A&E departments is to be increased with 183 of the NHS Plan's consultant expansion being allocated to A&E. These numbers will allow for further increases in senior presence in A&E departments. Now we need to work to ensure we have the ability to fill these funded posts. An additional 600 A&E nurses (£40m) are to be appointed. Work is not only needed on recruitment but also on retention—initiatives in Southampton have demonstrated the effectiveness of this approach to such an extent that they have a waiting list of applicants for A&E nurse posts. These new posts will also help the introduction of extra responsibilities for nurses, such as ordering *x* rays and providing initial pain relief. In time, this will build up to the provision of more nurse practitioners to care for minor injuries and for other advances such as nurses admitting medical patients, as is already done in Liverpool. Other changes in working practices are occurring around the country. Nurse supply of drugs, paramedic assessment of primary care cases, GPs working in A&E, increased senior shop floor working are all being used somewhere. We need to ask why they are not used everywhere. In my experience, it is often local bureaucracy and staff shortages that stops A&E departments introducing change, hopefully *Reforming Emergency Care* will provide extra strength to proposals for change.

All departments operate triage to determine people's position in the queue. *Reforming Emergency Care* suggests that this should be only one element of the initial assessment. The assessment should also look to develop streaming of patients. Those with primary care needs may be seen by a GP in the A&E department or referred to a local primary care centre. Those with minor injuries will be seen in a separate area with staff dedicated to that role. My research, soon to be published in *EMJ*, demonstrates that streaming of minor injuries decreases waits without delaying care of the seriously ill. Nurse practitioners may play an important part in this area but, like in other areas, *Reforming Emergency Care* does not believe that "one size fits all", so local decisions will determine how the service is delivered. Those needing further intensive investigation, before management decisions can be made, will form another stream. There are many models of how this can be achieved including services led by A&E consultants or by acute physicians. An important group are those who only need a rapid assessment and advice—at present, they wait a long time for minimal intervention. If the triage nurse

could be empowered to give that advice and discharge the patient, then some of the department's workload could be reduced and this group of patients could be out of the department very rapidly. One way that nurses can be empowered to undertake this new role is by combining their assessment skills with decision support software. *Reforming Emergency Care* announces an investment of £18 million to test this approach in 25 sites. Perhaps the biggest hurdle is answering the perennial problem—"well who will take responsibility?", the simple answer is "the NHS".

We are all aware of the delays produced because investigations are not available outside office hours or the on-call team is stuck in a clinic. On-take teams will be freed of other commitments, 600 of the NHS Plan consultant posts will be used to free up the on-call team, using new ways of working such as physician of the week rotas as are used successfully in Chester. But I suspect that changing the culture to one where emergency work is as important as specialty work will be a long battle. Radiology is having recruitment difficulties and so work will be undertaken to look at developments such as radiographer's assistants (as has occurred with mammography) and the use of teleradiology. Making investigations of all types available out of hours is a priority for improving the service.

It has long been recognised that many of the problems in the A&E department are due to difficulties downstream. A reduction in bed occupancy is required to reduce the times when beds are not available. Investment (£50m) is being made to buy additional operations, principally in the private sector, to free up NHS acute beds. The £300m announced recently to invest in social care is also aimed at reducing bed occupancy by enabling those who are medically fit but who need social care to be moved from acute beds. Diagnostic and treatment centres will also take these elective patients out of acute hospitals and free up more beds; this initiative has already started in London including the purchase of a private hospital by the NHS and the next ones are targeted for London and the South East, where waits in A&E are the longest. All these reductions will need to be accompanied by good bed management and an acceptance that high bed occupancy is not a sign of efficiency but a sign of failure to plan.

Above all, emergency care needs coordinating in each locality. Minor injury services and walk-in centres are often independent of A&E. Currently, patients may get seen by staff who are not adequately trained for their specific needs or may get passed from pillar to post. Local emergency care networks will be established to take a global view to coordinate systems to provide easier access to the most appropriate source of care. Money is being provided to free up time for clinicians to become local emergency care leads. Present standards focus on time of each stage in care. Future standards need to be more focused on evidence based clinical standards which apply across the whole emergency care system. We need to ensure that there is full consultation on these standards. A&E is all too familiar with the situation whereby other specialists impose their standards on A&E departments. The Department of Health will establish these new standards in conjunction with NICE and professional bodies. The BAEM/FAEM clinical effectiveness committee will have an important role in establishing these new guidelines.

As further documents are produced with more detail of the planned reform (they will all be available at www.doh.gov.uk/capacityplanning), further work will be needed. A&E needs to ensure it takes up every opportunity to be involved in these changes. For the first time, the Department of Health has a full time A&E advisor; BAEM and FAEM are key stakeholders and will be actively involved in the implementation of the reforms. I believe that *Reforming Emergency Care* offers great opportunities to advance our specialty. We need to grasp this opportunity.

Matthew Cooke is Senior Lecturer in Emergency Care at University of Warwick and Consultant in A&E Medicine in Coventry. He is currently seconded to the Winter and Emergency Services Team (WEST) at the Department of Health as their A&E advisor and is part of the Reforming Emergency Care review team.

The views expressed above are personal views of the author and not those of the Department of Health.

* * * * *

We asked Professor Jon Nicholl, Director of the Medical Care Research Unit at the University of Sheffield to give a wider view of the thinking behind Reforming Emergency Care.

The long awaited Department of Health review of emergency care services has at last been published—at least in outline. Entitled *Reforming Emergency Care* it is essentially about "modernising" emergency care services and as such fits directly into the wider NHS modernisation agenda.

The review reiterates many of the key promises in the NHS plan, for example for eight minute emergency ambulance responses, average waiting times in the A&E department of 75 minutes, and 75% of patients needing thrombolysis to be treated within 20 minutes of arrival in A&E. There are also some new promises and new ideas. There are to be an extra 183 A&E consultants by 2004 and an extra 600 A&E nurses by March 2003. Depending on how close you are to the struggle to deliver emergency care it will either amuse or irritate you to know that these 600 nurses will almost exactly replace the nurses lost from A&E to NHS Direct.

Indeed, the capacity to see the emergency care system as a whole, and not in isolated parts, is the key to improving rather than merely reforming emergency care. The review acknowledges this idea and it is reflected in some important initiatives. First, £10m is going to be invested in developing emergency care leads by March 2003 to "coordinate the system of emergency care within their organisation". Second, these emergency care leads are to get together to develop an emergency care network to coordinate "all aspects" of the local emergency care system.

Those of us who have been arguing for this development for a long time should be hopping with excitement, however the outline review does leave open many questions about how the emergency care network will be funded, and about which organisations will have an emergency care lead and from which group the emergency care lead will be drawn. The role of A&E, at the heart of the emergency care system, suggests to me that the emergency care network should be organised and led by A&E medicine. This may be a critical issue for the development of the A&E specialty.

One other important development for A&E is flagged in the review. It suggests that the 600 extra A&E nurses (an average of three per A&E department) will enable patients attending A&E to be split into two parallel streams, one will be nurse-led treating minor injuries and illnesses rather as minor injury units and walk-in centres already do, and the other will be lead by senior doctors. Each stream will have its own resources. It is hoped that this will lead to a reduction in waiting times, presumably by reducing waiting times for many patients with minor conditions, and the extra 600 nurses may enable this to happen without penalising those patients with serious problems. However, the benefits of this approach will depend on the extent to which these two streams of patients and their dedicated resources support each other. If they "separate" into two streams which, no matter how busy or quiet they are, do not support each other then this could worsen average waiting times. In fact seen as a system there are no more differences between the A&E department, the walk-in centre, and the local minor injury unit, than between the two "separate" streams of minor and major patients in A&E proposed in this review, and it is this separation of the emergency care system into different services which lies at the heart of the problem of delivering the best possible emergency care.

It leads to patients attending services which are not best placed to treat them, and because they are separate services with separate budgets, accountability, professional allegiances, and interests it leads to duplication, repetition, and inefficiencies if they do not support and communicate with each other. In an earlier, widely circulated, and discussed version of the review the first of these issues was addressed by proposing that all patients entering the emergency care system, wherever they entered, should be assessed by the same NHS Clinical Assessment System. This proposal has been quietly downgraded. Now this idea will be tested in 25 A&E "exemplar" sites using a system "developed from" the NHS Clinical Assessment System. We must hope that this idea will be properly evaluated, preferably in a cluster randomised trial, since it may have widespread implications for the whole local emergency care network.

Let us also hope that the emergency care leads are A&E specialists who can take in hand the task of creating a coherent system or network, and ensure that streaming—which can lead to improved care for those patients in the right stream—doesn't simply lead to the development of a new, separate, nurse-led A&E service to add to the proliferation of other new nurse-led emergency care services.

JON NICHOLL

The *EMJ* supplement is edited by Diana Hulbert, Southampton General Hospital and Mike Beckett, West Middlesex University Hospital.