Emergency care

Reforming emergency care; for patients

D Lammy

Working together for the benefit of patients

Emergency care is important to me for lots of reasons, but for one in particular: it's important to patients. We know that A&E services—and by implication all the components that make up the whole emergency care system—are among patients' top concerns.

Within A&E I believe a critical concern for patients is how long they have to wait for clinical care, and I can't blame them. When you are in pain, frightened, or with a sick child each hour you wait feels like purgatory. And when patients get stressed the staff can suffer too.

We have a target for waiting times in A&E—by the end of 2004, no one (unless it's clinically advisable) should spend more than four hours between arrival and admission, transfer or discharge. I think that is reasonable and achievable, even modest in some ways, but I don't expect it to happen by magic. The way we organise and cooperate across the whole emergency care system has to change.

See and Treat wasn't the government's idea but, having taken clinical advice, we do think it's a good one. There is a growing body of evidence indicating that it can cut waiting times for patients with minor problems without adversely affecting times for others. The guidance on how to make See and Treat work was developed in conjunction with the BAEM and the RCN and endorsed by them, but it's not a strict blueprint that we expect to see implemented to the letter everywhere. It can only work properly if it's applied in a flexible and open minded way that reflects local conditions. What matters is that it makes a real difference to patients' experience of A&E.

See and Treat works, but we know that it isn't the whole answer. Staff working in A&E are very busy people, and it isn't always easy for them to stop and think about how they do their jobs. That's where the emergency services collaborative and local emergency care networks can help—by giving staff from across the whole system the time and space to get together, iron out problems, and spread good ideas and practice.

Next we will turn our attention to all the other factors that can keep patients waiting in A&E, especially those patients who may need to be admitted. Things like bed management, diagnostics or admissions and discharge procedures can present more complex and awkward problems but that doesn't mean they are insoluble. The NHS Modernisation Agency is already doing good work that I hope can continue and develop through the emergency services collaborative and networks.

While a lot of this can be done without extra money, I don't want progress to be held back by a lack of resources. The NHS is receiving historically high increases in its funding, and have made specific allocations to Trusts and PCTs towards the cost of emergency care leads, emergency care networks, and more nurses in A&E. PCTs must make their contribution to meeting one of the most important challenges now facing the NHS. That doesn't mean tossing money around like confetti in the hope that some of it does some good, but it does mean we need to be receptive to well thought out ideas that can deliver demonstrable benefits to patients.

I hope you'll forgive me for concentrating on what needs to be done rather than on what has been achieved already. It doesn't mean that I don't understand the progress that has been made or that I don't appreciate it. I do, and so do my colleagues in government, but it is a fact of life that there is always more to be done. If it delivers an emergency care system that staff and patients can really be proud of, it will have been worth it.

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Emergency care

Skillmix: an advance or an excuse?

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Over the past five years there have been many changes in the way that emergency medicine departments work. This has been given recent prominence and encouragement by the recognition of the government—finally—that emergency medicine was in difficulty. There is also the recognition that the A&E department is the shop window of the NHS. A long trolley wait today is a newspaper headline tomorrow—particularly in London and the south east.

So why do we have a problem? Much is historical. Many A&E departments changed little for several decades after the birth of the NHS. A large, unattractive waiting room was the norm with all sorts of patients mixed in together. There was tacit acceptance that one would wait—sometimes for several hours. A&E had neither the glamour of surgery nor the academic backup of internal medicine. It was looked on as a necessary evil—a carbuncle on the side of the hospital. A&E consultants and SHOs worked hard and well, as did the A&E nursing staff, but opportunities to change practice were in short supply.

The past two decades have seen a gradually accelerating change in work, attitudes, and staffing. There has been an increasing number of consultant appointments with a new breed of energetic, committed individuals coming from a predominantly medical, rather than surgical, basic training background. Emergency medicine is now looked on as an attractive specialty without particular recruitment difficulties.

A breakthrough came recently with the publication of *Reforming emergency care* from the Department of Health—but with important input from Royal Colleges and Faculties. This pointed out that