the long waiting commonly seen in A&E departments, first to be seen at all and second to obtain a bed if admission was deemed necessary, was totally unacceptable. The government introduced a target of four hours as the maximum time that a patient should spend from arrival to the department to being discharged or admitted. This above all has focused attention on A&E departments, although the point is increasingly made that emergency care is a whole system problem. It involves prehospital care and post-hospital capacity as well as the A&E department itself.

So where does skillmix fit in? It follows automatically from two facts. Firstly, there are too few doctors to deliver all the care that is required. This has been brought into sharp relief by the imminent introduction of the European Working Time Directive, which will cut drastically into the working time of junior doctors, as well as the demand, more and more, for consultant delivered care on the grounds of quality, speed, and safety. Secondly, and perhaps more important, is the result of putting patient needs first. Doing this one can work out a series of skills and competencies needed to achieve a timely, high quality outcome. The next move is to establish who has or could have these skills and competencies. Using this approach it is immediately apparent that much can be done well and competently without 10 to 15 years of medical training (and some perhaps better!).

The impact of these two factors—together with increasing skills of the nursing workforce—has been to cause radical rethinking by the A&E community of who should do what. There is still some resistance from those preferring to hide in their professional silos, but this is counterbalanced by management, politicians, and professional thinkers who have accepted that the status quo is not an option—and that patients deserve better than lengthy waits to be seen or to be admitted. The past two to three years have seen a dramatic rise in the number of emergency nurse practitioners undertaking a variety of tasks, generally involving minor injuries/illnesses, Walk in Centres, or triage. But more can be achieved. At present the position of the emergency nurse practitioner is hampered by the lack of clear definition of training needs and national criteria for training programmes. Emergency care practitioners are also being developed, so far on a pilot basis. Care facilitators are also appearing and having an important beneficial impact on patient flow, while physiotherapists are playing an increasing part with regard to the elderly population and orthopaedic problems. Many of the new developments in skillmix have come from emergency physicians and senior nurses working together in programmes such as IDEA, CWP, and the Emergency Collaboratives, all of which are accelerating change.

Obviously some control is needed to ensure that the quality of care matches the increase in quantity and speed of care. This is up to the emergency team as a whole. Equally someone has to lead and take responsibility for the work of the team. I would contend strongly that this should remain the domain of the consultant in emergency medicine, who has the breadth and depth of training to oversee all aspects of care.

The increased use of different people—that is, skillmix—is helping patient care. Even when we have sufficient consultants in post (six or seven for a 24 hour acute hospital) in 10 to 12 years time, the contribution made by non-medical clinicians will still be needed. Such clinicians have much to offer patients and complement doctors rather than replace them. Finally, we are moving to an emergency care system, which is both recognised as being of paramount importance to patient care and will be one of which we can be proud.

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Emergency care

Reforming the UK emergency care system

M W Cooke

Improving the care not just the figures

We are all too well aware of the problems of waits in emergency health care. They are consistently the issues that the public and media comment about when asked about emergency medicine. Delays in the emergency care system are invariably attributable to a complex mixture of problems before, during, and after the hospital episode.[1] Measures of performance in emergency care have focused on a few specific areas, for example, ambulance response to arriving at an incident and waiting times in the emergency department.[2] The blame for poor performance has often been cast on the area where the indicator has been measured rather than at the root cause. This has also allowed other areas to shy away from their responsibilities. These are all symptoms of an emergency care system that is fragmented,[3] with each component struggling to solve its own problems.

Some issues can be partially solved by one organisation working alone but this is rare.

An ambulance service could achieve an eight minute response for all category A calls by its own action. But this would be an inefficient method of achieving such change—how much better to look at joint initiatives. Rather than blaming hospitals, working with them to reduce turnaround times and free up ambulance resources. Looking at how they can take some patients to more appropriate destinations, resulting in a better service for the patient, and a more even spread of the workload. Within the hospital, the most important factor in preventing waits in A&E is the hospital bed occupancy.[4] But many colleagues will recognise that bed management is all too often a fire fighting function by comparatively junior staff not a predictive planning function with responsibility lying with an executive director. But the factors affecting bed occupancy are also outside the hospital. The ability of the community to accept patients back from the acute hospital is a key determinant of hospital length of stay, including availability of social care but also of primary medical care. It is however easy to use the whole system concept to blame others. None of us work in perfect systems and we can all make changes in our own areas to contribute to improved care. Ours may not be the biggest cause of delays in the system but, we have more influence to change our own area.

This edition of *EMJ* highlights many projects across the whole system of emergency care and confirms the enthusiasm for change.

Emergency care networks are now being established in the UK, bringing together all organisations involved in emergency care in one locality. Their aim should be to look at issues across the whole system. In the past, such groups looked at contingencies for when the system was overloaded. This needs to change to looking at how the system can be changed to improve care at all times. By undertaking patient tracking, networks can rapidly discover where the system faults lie. Personal observation has shown how often the faults lie in organisations working independently without appropriate mutual respect and trust. I believe there should be a lay person on each network group, perhaps chairing it, so that vested interests and perverse incentives are overruled in favour of quality of care.

But performance indicators can also deceive. A patient may get their ambulance in eight minutes and be through A&E in less than four hours and still have a poor experience of emergency care. Often too much effort is focused on improving the figures not the care. At worst, this is demonstrated by the time invested in defining, interpreting, and manipulating the figures rather than investing it in patient care improvement. Examples that I have witnessed include hospitals not allowing ambulances to unload as they believe A&E time starts when the patient is unloaded from the ambulance trolley, or declaring certain areas of A&E as a ward so the patient is considered to have been admitted. Fortunately clinical staff still act as the champions of quality care and highlight these problems, but we need to ensure their voices are heard and acted upon. More commonly the effort to improve a performance indicator has focused on establishing new systems simply to improve the performance indicators results, for example moving patients direct to coronary care unit when A&E is delivering better door to needle times than the coronary care unit. The goal is not improved performance indicators, it is improved care. The best judge of care is the patient. Why do we not have patient representatives on our emergency care management groups? Why do we not use patients to monitor the performance indicators and the patient experience?

Emergency care is a complex component of health care. If I could change one thing to help emergency care, it would be to include a user and a junior member of nursing and medical staff on every committee that talks about emergency care. In my experience of visiting many emergency care communities, they know the problems and, very often, the solutions.

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Prehospital care

The advances and evidence base for prehospital care

C MacFarlane

Validation is needed to determine the true effectiveness of perhospital care

Prehospital care is a developing and exciting area of emergency practice. It comprises a variety of emergency care domains, including ambulance and emergency medical services (EMS) practice, medical rescue, prehospital physician response and medical direction, retrieval medicine, (including aircraft and seaborne activities), dispatch and communications, telemedicine, disaster medicine. Increasingly, there is greater interaction between various emergency authorities, including fire service, police, civil defence, military authorities. Greater interaction with hospital emergency departments is also being encouraged.

The major problem has been auditing the effectiveness of prehospital care and whether it is cost effective, or even worth the effort at all! Strong emotions and forcible opinions exist among both supporters and detractors.

The fundamental problem has been the lack of evidence based assessment of prehospital practice. The paucity of prehospital care in Cochrane reviews is evidence of this. A fundamental part of the problem has been the lack of reliable indicators to measure effectiveness, commonly because of the large variety of variables operative in this area. Attempts have been made to develop indicators, mainly in North America,[1–3] but there has not been general acceptance of appropriate indicators. In many EMS systems response times and on scene times are used as standards of system effectiveness.[4 5]

As a result of all this, there have been reports questioning the effectiveness of prehospital care.[6–9] Other reports, supporting the value of prehospital care, especially Advanced Life Support, have emerged.[10–12] Commonly prehospital care providers see their end point as the delivery of a live patient to a hospital. There is often little attention paid to the final outcome of the patient, and whether or how prehospital care influenced this. Much work needs to be done still on the development of accurate indicators for prehospital emergency care, and the development of these is, surely, fundamental to the evolution (and indeed, survival) of prehospital care systems. Attention to this is one of the most important activities in which prehospital care providers can engage.

Another problem is the tendency to consider prehospital care to be a homogeneous entity. It certainly is not! However, important papers by eminent personalities in large North American trauma centres of international repute are being regarded by many as "the law" as regards prehospital care. The edicts emanating from these excellent institutions may well be correct and appropriate in such well equipped centres, served by first class EMS, with short prehospital times. They may, equally, not be valid in rural practice, in small community hospitals, in developing countries, or in systems not modelled on North American