"See and Treat": spreading like wildfire? A qualitative study into factors affecting its introduction and spread

S Saint Lamont

....

Correspondence to:
Dr S Saint Lamont,
General Manager,
Northumberland, Tyne
and Wear SHA, Riverside
House, The Waterfront
Goldcrest Way, Newburn
Riverside, Newcastle upon
Tyne NE15 8NY, UK;
sharon.lamont@
ntwsha.nhs.uk

Accepted for publication
29 July 2004
....

Objectives: The aim of this paper was to explore key factors that influenced the spread of "See and Treat" in a range of accident and emergency (A&E) departments.
Methods: The study adopted a qualitative approach, and semi-structured interviews were undertaken with 21 key individuals working across 10 A&E departments operating See and Treat. Participants included clinicians, managers, and chief executives.
Results: Many factors influenced the spread of See and Treat. The initiative was well supported and monitored by external agencies, patients benefited and no staff groups lost out, waiting times were reduced, and Department of Health targets were achieved. However, this study indicates there were also a range of factors that limited the spread of See and Treat, including lack of additional resources and suitably experienced staff, impact upon quality of care, and no prior evaluation of its benefits. An interesting additional factor that may be both facilitating and limiting is the complexity of the A&E culture, in particular staff perspectives about working with minor injuries.
Conclusions: See and Treat was promoted as a solution to waiting times problems in A&E, without evidence from any national evaluation. However, many staff members referred to its usefulness as a tool to reduce waiting times and enhance the patient journey, although resource, quality, and staffing issues may mean such an initiative may be difficult to sustain in its present form.

See and Treat is an initiative designed to reduce waiting times and improve the patient experience in accident and emergency (A&E) departments. It is a simple technique that involves seeing patients when they arrive, assessing their needs, and providing treatment. Endorsed by the British Association for Accident and Emergency Medicine and the Royal College of Nurses, the initiative was presented at regional roadshows organised by the NHS Modernisation Agency. It also featured on a BBC television documentary[1] and formed the basis of an interactive CD.[2] Several trusts adopted the initiative in the summer of 2002, and See and Treat is now being disseminated by the NHS Modernisation Agency's Emergency Services Collaborative (ESC).

From a small start involving a few trusts, the technique has reportedly spread to over 160 of 202 Type 1 A&E departments.[3] Arguably, however, data from the Department of Health are limited, as Trusts are performance managed on this data and they are not audited. It is therefore not easy to confirm to what extent departments run See and Treat. There are also several variations of See and Treat in use; however, the underlying principles remain the same (box 1).

In recent years the process of managing emergency care has come under increasing scrutiny, and considerable diversity has arisen in the organisation of A&E care.[5–7] The NHS Plan includes a 10 year strategy, *Reforming Emergency Care*[8] and this strategy specifically targets waiting times in A&E:

> "By the end of 2004, no patient should spend more than four hours from arrival in A&E, to admission, transfer or discharge."

Various initiatives have been suggested to reduce waiting times, including the use of a separate stream of care for minor injuries.[6] This is not a new concept; Cooke *et al*[7] experimented with a system of fast tracking minor injuries

BOX 1 PRINCIPLES OF SEE AND TREAT
• On arrival, patients are seen, treated, and referred or discharged by one clinician.
• This clinician is able to make autonomous clinical decisions about treatment, investigations, and discharge.
• More seriously ill patients or those requiring in depth assessment or treatment should be dealt with in a separate area.
• Triage of minors is unnecessary when See and Treat is in operation.
• Dedicated staff should be allocated to See and Treat and only withdrawn in exceptional circumstances.
• Enough staff are needed to allow effective consultation without a queue developing (one doctor and one nurse has been shown to be effective for an arrival rate of up to 10 walk in patients per hour).
• Staff development should ensure that all staff members involved in See and Treat are able to make the system work effectively.
(Emergency Services Report[4]).

in 1999, and a consultant in Staffordshire developed a version of See and Treat over 10 years ago.[9] There are also examples of similar practices in the USA and New Zealand.[10] [11] Interestingly, it is also suggested that fast tracking was the norm at busy periods in many A&E departments prior to the introduction of the triage system.[12]

....

Abbreviations: A&E, accident and emergency; ESC, Emergency Services Collaboration; MA, Modernisation Agency

Criticism of See and Treat has emerged recently. Some authors[12] [13] suggest that See and Treat impressed managers and politicians and as a result was pressed into service prior to any detailed assessment of its efficiency or sustainability. Wardrope and Driscoll[9] call for evidence to show that the diversion of staff to deal with minor injuries does not compromise the care of more serious cases. Such criticisms are balanced, however, by those who believe that See and Treat is the best option so far and provides a base for continuing to improve patient care.[14]

The spread of this initiative throughout trusts in the UK is unquestioned. However, the question remains, why has this particular initiative taken off in the manner it has? This was asked by the Service Improvement Team within the NHS Modernisation Agency (MA), and the MA's Research into Practice team[15–17] was commissioned to undertake this study.

The aim of this paper was to explore key factors that influence the spread of See and Treat in a range of A&E departments.

METHODS

The study was part of a service evaluation undertaken by the NHS Modernisation Agency. A review of staff experiences was obtained using semi-structured interviews. The ESC provided details of all Trusts operating See and Treat. A convenience sample of 10 was selected, which included departments within large inner city hospitals and smaller rural hospitals. All departments were classified as "Type 1", as they had full A&E facilities and were consultant led. The departments were not representative.

In total, 21 interviews with chief executives, clinicians, and managers were electronically recorded (Appendix 1 and 2), and detailed notes produced. Ethical principles of confidentiality and anonymity were followed, although formal ethics approval was not sought as this was conducted as part of a service evaluation. The analytical approach broadly adopted a grounded theory model where, after some data collection and reflection, categories that fitted the data were generated.[18] The study continued until the categories were saturated— that is, the researcher felt assured of their meaning and importance.

RESULTS

This section introduces key themes that emerged during this study (further details can be found in the full report.[19]) Each subtitle in table 1 serves to categorise the themes into key questions that helped to analyse the data (for interview questions, see Appendix 3).

What is the problem?

The issue of waiting in A&E is a well recognised problem. Participants spoke of the constant need to reduce queues and waits, the increase in patient complaints and the inefficiency of existing practices. Queues and waiting time were issues for staff and patients alike. Staff talked about the anxiety they felt when faced with a full room of anxious patients, and the pressure they experienced.

The following quotation suggests that a definite catalyst was responsible for thinking about change, when a member of staff suggested the waiting room be extended to manage increasing numbers of patients waiting:

"We were finding we were under increasing pressure…it came to a head for me one day when A&E said to me that they needed to carry out a building scheme to expand the waiting room. It's like accepting you can't cope and making provision to not cope even more." (CE1)

Table 1 Key themes

Key question	Responses
What is the problem?	Waiting times
	Complaints
	Anxiety
	Inefficient working
Why now?	Targets
	Visibility
What facilitated adoption?	Mass media
	Roadshows
	ESC networks
	Near peer groups
	Leadership
	Enthusiasm
	Ownership
	Professional development
	Homophily*
	It matters
	It's adaptable
	It's simple
	It's testable
	It's observable
	Timing
	Type of decision
How was support organised?	MA
	ESC
	Existing networks
	Near peer groups
	Strategic health authority (SHA) reporting
What inhibited adoption?	Interpretation
	Inexperience
	Roles and resistance
	Quality and safety
	A&E mindset
	Demand
	Resources
	Existing performance

*Rogers[20] (p.19) maintains that "homophily" occurs when similar individuals belong to the same groups, live or work near each other, or share the same interests.

Why now?

Most participants maintained that there was a continual drive to improve patient care and quality (box 2). However, each participant also mentioned the importance of targets as a way of making change happen now. The introduction of the 4 hour waiting time target became a catalyst for change, and See and Treat was identified as an initiative to help achieve that target. The issue of visibility has also had an impact upon identification of the problem and the search for a solution. The structure of A&E departments is built around the waiting system, and patients and health workers see the queues.

What facilitated adoption?

Several factors aided the spread of See and Treat. The MA hosted regional roadshows, and See and Treat featured on a TV documentary called *The Service*. Several participants

BOX 2 WHY NOW?

- "The answer must be 'yes'. See and Treat is a way of addressing the targets." (Med4)
- "We did have to address waiting times so targets have had an impact." (Nur1)
- "There were two really (motivators to adopt). One was unquestionably the need to meet targets." (Man2)
- "A&E is a fine example of a process that involves lots of players and you see it there and then on the day. It's very visible to staff where the shortfalls are, much more in your face." (CE1)

mentioned the positive effect of the roadshows and the support and assistance provided by the ESC. There was also the perception that this support allowed departments to think of other ways to solve the problem, in this case to abandon traditional triage.

The roadshows, media, and networks were all important in raising awareness of See and Treat, but a more influential factor was the existence of informal group processes. Participants spoke of the need for good communication between peer groups, clear leadership and support (especially from lead clinicians), enthusiasm, and local ownership (box 3).

The type of innovation was also a key facilitating factor. Rogers'[20] five fold classification of innovation characteristics was used to explore perceptions about See and Treat, and the right hand column (table 2) represents some of the key messages emerging from the interview data.

The type of decision may also be a factor in the spread of See and Treat. Decisions range on a continuum from optional decisions where an individual has almost complete responsibility for the decision, through collective decisions where the individual has a say in decisions, to authority decisions where the individual has no influence in the decision. Generally, the fastest rate of adoption results from authority decisions, and optional decisions are made more rapidly than collective decisions. Although most participants said that decisions in A&E were very much a team affair involving all A&E staff, the decisions made to either adopt or reject See and Treat appear to be mainly optional as they were made by one or two key individuals in each trust who had the status and expertise to drive a decision forward.

How was support organised?

The main support mechanisms were the MA, the ESC network, existing A&E networks and the support of near peers. The issue of reporting mechanisms will also be introduced as a positive effect on spread.

The MA, or more particularly the ESC, continued its support of See and Treat through its involvement with subsequent collaborative waves. Good communication with existing networks enabled ease of access to various social and professional groups outside of the department—such as Emergency Nurse Practitioner training groups and A&E networks across the regions. Good and effective leadership was also a factor of ongoing support (box 4).

Despite the importance of support groups, the data would suggest that an equally important factor in the spread of See and Treat was the effect of the Strategic Health Authority

Table 2	Rogers' classification of innovation characteristics
Relative advantage	Triage does not work in the patient's best interests. It is another method of queuing, causes delays and promotes ineffective working practices. Some participants insist a form of triage is still needed.
Compatibility	See and Treat is compatible with the needs of patients and staff. It eradicates excessive waiting.
Complexity	See and Treat is simple to communicate and operate. Potential adopters do not need specialist equipment or expert knowledge.
Trialability	See and Treat can be tested over a short period with little pre-planning. The A&E consultant often adopts the role of lead person with the help of a senior nurse. The results are rapid in that usually the waiting room clears quickly.
Observability	See and Treat is particularly easy to observe and results are immediate. Positive observations include a less crowded waiting room, shorter waiting times, and improved staff morale.

(SHA) feedback reports. The 4 hour target was a key feature of these monthly reports:

> "There is a definite message to trusts to operate some form of See and Treat. We have to report See and Treat figures on a monthly basis. Previously the SHA asked you to tick a box on whether you had an ENP. Now they want to know what our plans are for See and Treat. The inference is we're expected to do it." (Man5)

If the question on this feedback form was answered in the negative—that is, the trust was not practising See and Treat, the subsequent question on the form asked what was being done in its place.

What inhibited adoption

How health professionals interpreted the principles of See and Treat had an impact upon its adoption, as it called for a shift in thinking about practices in A&E (box 5). Participants recognised that See and Treat required experienced front line staff capable of making decisions, and that the system could not be led by junior medical staff or nurses. However, there were examples where See and Treat was led by staff with various levels of skills and experience.

What may be more inhibiting to spread than lack of experience is the resistance perceived by some staff. Some stated doctors were unwilling to be involved in minor injuries and others suggested that clinicians often work in A&E because of the crisis element, the emergency, as opposed to

---

BOX 3 WHAT FACILITATED ADOPTION?

- "It escalated very quickly because of the consultant and nursing support for it. They began to see results very quickly and by eliminating the hands-offs in the system that triage created, they began to get through minors far more quickly." (Man4)
- "We're quite a high achieving department because of being a well-supported trust, and we've worked very hard at setting our systems up." (Med3)
- "Secondly the network empowered them to say they were no longer doing triage." (Man2)
- Get the SHA to sell it and the MA to work on it." (Nur1)
- "It's about players, it's about leadership, it's about support, and it's about good evidence." (CE1)

BOX 4 HOW WAS SUPPORT ORGANISED?

- "Consultants made it clear from the beginning that they wanted it to be successful…" (Man2)
- "Overall we started the process well as we had an enthusiastic manager who employed a G grade nurse from a minor injury unit who was very experienced and pro See and Treat. This set the scene for staff development and support." (Nur3)
- "It's a good feel team down here too. They were all very close and enthusiastic…a good team spirit." (CE1)

the sprains and strains of minor injury. A further limiting factor was the growing concern about the effects on quality of care as some participants were unwilling to abandon triage in favour of See and Treat, and there had been no formal evaluation of the benefits of the initiative. Another issue concerning risk was, ironically, a perceived downside to seeing and treating patients quickly. Some participants said that nurses were concerned that individual patients were not given enough time for a thorough examination, and would inevitably need to return.

Since the implementation of See and Treat, participants reported an increase in demand for A&E services when See and Treat was in operation, and patients who would normally have left because they were tired of waiting ("did not waits", or DNWs), now waited to be seen.

Funding was a major issue, as almost all participants agreed that additional resources were needed to operate See and Treat efficiently. This had an impact upon staff stress levels, and meant See and Treat could not operate at weekends or night time, which arguably might be a high demand time for minor injuries. There was also a lack of dedicated space; all departments had triage rooms, but most were inappropriate for use in See and Treat.

A final theme is that of existing performance level. Participants saw See and Treat as a way of reducing waits for minors, but some believed they were already performing well. It was only thought to be of real benefit to those departments underperforming in minors.

Limitations of the study

As the focus of this study was on spread, only those departments operating See and Treat were selected. A sample of departments not using See and Treat might have raised some interesting issues. In addition, all of the departments had been involved in ESC improvement work, and therefore may not be representative of all departments. In qualitative research, discussions concerning objectivity continue.

CONCLUSIONS

Waiting times in A&E is an acknowledged and longstanding issue. Many participants believed that triage was no longer appropriate, and considerable work is currently underway to address inefficiencies. However, several participants did not see waiting times as the only issue to be addressed, and arguably, if current performance was acceptable, staff would have no need to search for a solution. If that was the case, why did See and Treat take off when it did? Although a key motivation was a growing awareness of inappropriate care in a very visible department, targets clearly featured strongly in its rapid spread. Targets may have encouraged exposure to potential solutions that would not have been adopted had it not been for that performance measure. They not only exposed individuals to the innovation, but created a need for See and Treat.

Regional roadshows and positive reporting on a TV programme were powerful vehicles to get the message of See and Treat across to a wide audience, and successful marketing and support by the ESC all added to its momentum. Personal and professional factors and characteristics of the innovation itself gave support to the adoption of See and Treat, and perhaps the timing was crucial in that the issue of waiting was being heralded as *the* issue in A&E. An interesting theme was the impact of SHA reporting on the continuation of See and Treat. This process encouraged trusts to consider this innovation, and perhaps gave little choice in adoption.

The key inhibitors are quality and resources. Issues of inexperience, safety, and resistance all have quality as a common denominator. The need for experienced staff to do the job properly, perceived resistance to changing practices, fear of working in unsafe practices, and the need to work in an environment that caters for individual needs and desires are all quality issues. Quality is linked to resources. Without additional funding, many individuals may not search for solutions and continue to accept existing performance levels. Lack of funding may mean that See and Treat can run on an ad hoc basis, but cannot operate full time, all of the time. Despite the barriers, participants in this study believe that See and Treat does reduce waiting times by speeding up the flow of patients with minor injuries. It is perceived as a solution to one part of the whole, and perhaps more importantly, it is seen to have a positive and measurable impact on the 4 hour target. However, research is now needed to explore the sustainability of this initiative and it may be that the barriers mentioned above may prove more influential.

BOX 5 WHAT INHIBITED ADOPTION?

- "One of the behaviours they had to overcome was that emergency medicine clinicians think too often that they're only about the emergencies, the 2%. We're looking at the margins rather than the bulk…people who work in A&E are gadflies. Their attention span is short and they quite like change and challenge. We're always up to having a go, but we get bored easily and it's fun to do something different." (CE3)

- "If you do psychological profiling on emergency medical staff, they're what's called sensation seekers. See and Treat is the most dull form of what we do." (Med3)

- "Nursing staff were sceptical at first. They were concerned about the quality of care. Were we pushing patients through the system too quickly, and not doing proper examinations? Would we get more returners because of this? What are the risks of not having triage and people having to wait 20 minutes to be seen?" (Nur1)

REFERENCES

1 **British Broadcasting Corporation**. *The Service*, BBC Political Documentary Unit, 2002.
2 **NHS Modernisation Agency**. *See and Treat*, Video produced by the Emergency Services Collaborative. London: NHS Modernisation Agency, 2002.
3 **NHS Modernisation Agency**. *Making See and Treat work for patients and staff. Emergency Services Collaborative*. London: NHS Modernisation Agency, 2004.
4 **NHS Modernisation Agency**. *See and Treat*. London: NHS Modernisation Agency, 2002.
5 **Byrne G**, Richardson M, Brunsdon J, *et al*. An evaluation of the care of patients with minor injuries in emergency settings. *Accident Emerg Nurse* 2000;**8**:101–9.
6 **Cooke MW**, Higgins J, Bridge P. *Minor injury services: the present state*. Warwick: Emergency Medicine Research Group, Warwick University, 2000.

7 **Cooke MW**, Wilson S, Pearson D. The effect of a separate stream for minor injuries on accident and emergency department waiting rooms. *Emerg Med J* 2002;**19**:28–30.
8 **Department of Health**. *Reforming emergency care—faster access to the right treatment*, www.doh.gov.uk/emergencycare/index.htm Last accessed December, 2003.
9 **Wardrope J**, Driscoll P. Turbulent times. *Emerg Med J* 2003;**20**:116.
10 **Portovi SN**, Melson BK, Bryan ED. Faculty triage shortens emergency department length of stay. *Acad Emerg Med* 2001;**10**:990–5.
11 **Ardagh MW**, Wells JE, Cooper K. Effect of a rapid assessment clinic on waiting time to be seen by a doctor and the time spent in the department, for patients presenting to an urban emergency department: a controlled prospective trial. *NZ Med* 2002;**115**:U28.
12 **Windle J**, Mackway-Jones K. Don't throw triage out with the bathwater. *Emerg Med J* 2003;**20**:119–20.
13 **Leaman AM**. See and Treat: a management driven method of achieving targets or a tool for better patient care? One size does not fit all. *Emerg Med J* 2003;**20**:118.
14 **Castille K**, Cooke M. One size does not fit all. *Emerg Med J* 2003;**20**:120–2.
15 **NHS Modernisation Agency**. *Research into practice. Sustainability and spread in the National Booking Programme*. Research into Practice, summary report no. 2. London: NHS Modernisation Agency, 2002.
16 **NHS Modernisation Agency**. *Research into practice. Spreading and sustaining new practices: sharing the learning from the Cancer Services Collaborative (CSC)*. Research into Practice, report no. 3. London: NHS Modernisation Agency, 2002.
17 **NHS Modernisation Agency**. *Research into practice. spread and sustainability of service improvement: factors identified by staff leading modernisation programmes*. Research into Practice, report no. 4. London: NHS Modernisation Agency, 2003.
18 **Glaser B**, Strauss A. *The discovery of grounded theory*. Chicago: Aldine, 1967.
19 **Lamont SS**. T*he spread of See and Treat. Research into practice.* London: NHS Modernisation Agency, 2004.
20 **Rogers E**. *Diffusion of innovations*, 4th ed. New York: Free Press, 1995.

Appendix 1 Interview participants

Job title	Collaborative wave	Interview code*
General Manager in A&E	6	Man1
Chief Executive	6	CE1
Chief Executive	6	CE2
Head of Performance Improvement	1	Man2
Group Manager in A&E	1	Man3
Executive Director of Operations	1	Man4
Lead Clinician in A&E	6	Med1
Chief Executive	5	CE3
Consultant in A&E Medicine	5	Med2
Chief Executive	5	CE4
Lead Clinician in A&E	5	Med3
Consultant in A&E Medicine	4	Med4
Patient Services Manager	4	Man5
Lead Nurse in A&E	4	Nur1
Consultant in A&E Medicine	6	Med5
Chief Executive	6	CE5
Modern Matron in A&E	1	Nur2
Consultant in A& E Medicine	1	Med6
ESC Manager		Man6
Sister in A&E	1	Nur3
Consultant in A&E Medicine	4	Med7

*Man, Manager, non-clinician; CE, Chief Executive; Med, Consultant/ lead clinician; Nur, Nurse/matron/sister.

Appendix 2 Interview participants by role

Role	n
Chief executives	5
Clinicians (medical and nursing staff)	10
Non-clinical managers	6
Total interviewees	21

APPENDIX 3 THE INTERVIEW SCHEDULE

Introducing the concept

- What did you know about it?
- How had you heard about it?
- Who was the initial enthusiast here?
- When did it start?
- What were the initial reactions of staff?
- How involved were staff in the programme design?

Implementation

- How does it work?
- What support /training was offered?

Influences

- What has enabled or prevented the spread of See and Treat?
- How has national policy influenced change?
- What impact did the NHS targets and political pressure have on the adoption of new practices?
- To what degree has the new practice become assimilated into core working patterns?

Impacts

- What effect has the programme had on waiting time targets?
  - On patient experiences
  - On staff
  - On budgets
  - On anything else
- Has it been a success, if so why?
- What are your plans for See and Treat in this Trust?

Lessons learned

- How can the Modernisation Agency learn from See and Treat as it promotes the spread of other initiatives?
- Is there anything else you'd like to add that might help us to understand the spread of See and Treat?