Emergency care

Turbulent times

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The pace of reform may exceed capacity

We thank David Lammy,[1] George Alberti,[2] and Matthew Cooke[3] for their thought provoking editorials. We also appreciate the contributions for the "For debate" section. Some may find the views of Leaman[4] extreme but we sense that he articulates the thoughts of many A&E clinicians concerning progress in reforming the emergency care system. "See and treat" is not a new idea. Professor Tony Redmond when he was in charge of North Staffordshire developed this model of a senior clinician at the front door.[5] It makes a lot of sense to bring forward some of the decision making and starting investigations as soon as possible.[6]

Leaman[4] and Windle[7] both make the important point that this is yet another initiative that catches the imagination of managers and politicians. As a result it is being pressed into service across the country without a detailed assessment of the efficiency, cost efficiency, or sustainability. NHS Direct, Walk in Centres, face to face computer triage are examples of other centrally driven initiatives that were implemented without adequate evidence. They certainly have been "successful" in that lots of people use these facilities. Unfortunately this has been due to the creation of *new demand* for NHS resource, rather than helping with the existing workload in A&E or primary care.[8 9] Instead this new demand has sucked up resource and staff that *might* have been more effectively employed in primary care or in A&E. We will never know the answer to these questions, for trials with adequate design have not been carried out.

As Leaman[4] quite correctly points out the main problem facing the NHS is lack of capacity to meet the demands of modern health and social care. The old NHS was based on the philosophy of the "greatest good for the greatest number". The aspiration of the new NHS is the best possible care for all, a laudable aim but hopelessly idealistic with current resources and staffing.[10] Add to this the huge new demands of the medico-social needs of older patients and the cracks appear in the emergency care system.

Lammy[1] assures us that new resources are being put into the NHS to try and provide better care. Alberti,[2] Cooke,[3] and Castille and Cooke[11] point out that new ways of working may help this problem. Things are improving, mainly for patients with minor problems but the intractable problems of lack of capacity to handle admission workload remain.

Long waits in A&E are the symptom of the malaise that is taking hold of our current systems. Dealing with symptoms rather than the root cause of the disease is like giving an aspirin for headache to a patient with a subarachnoid haemorrhage. This might improve the most pressing problem but leaves us with the potential disaster of system melt down as our departments struggle under the weight of acute medical admissions. Work by Cooke (Cooke MW, *et al,* annual scientific meeting Faculty of Accident and Emergency Medicine 2002) and Miro[12] show that the main determinants of A&E overcrowding are hospital bed occupancy and availability of medical beds.

If "See and treat" brings new additional experienced staff, more resources and more space to our departments, then it should be welcomed. We all want more staff. We all want to reduce waiting times. We all want to provide a good service. However, we cannot divert existing staff to deal with minor injuries without convincing evidence that it does not compromise care of the more serious cases or simply transfer the bottle neck of patient flow to another part of the system.

Operational research in A&E is often difficult and hard to fit into the "randomised trial" pattern but well conducted studies are possible but they need to be thought of as part of the implantation of a new initiative, not as an afterthought. In doing such studies we need to aim to improve all the aspects of quality of patient care—not just speed through the department. Consequently the in house clinicians, trust managers, and the A&E specialists all must be willing to change.

This edition of the *EMJ* brings together a huge amount of material on the organisation and delivery of emergency services. We hope it will provoke discussion and debate. The care we deliver to our patients is probably as dependent on sound managerial structures and processes as on individual clinical excellence. We await your responses to emjonline.

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REFERENCES

1 **Lammy D**. Reforming emergency care; for patients. *Emerg Med J* 2003;**20**:112.
2 **Alberti KGMM**. Skillmix: an advance or an excuse. *Emerg Med J* 2003;**20**:112–13.
3 **Cooke MW**. Reforming the UK emergency care system. *Emerg Med J* 2003;**20**:113–14.
4 **Leaman AM**. See and Treat: one size does not fit all. *Emerg Med J* 2003;**20**:118.
5 **Redmond AD**, Buxton N. Consultant triage of minor cases in an accident and emergency department. *Arch Emerg Med* 1993;**10**:328–30.
6 **Lindlay Jones M**, Findlayson B. Triage nurse requested x-rays. Are they worthwhile? *J Accid Emerg Med* 2000;**17**:103–7.
7 **Windle J**, Mackway-Jones K. See and Treat: don't throw triage out with the bathwater. *Emerg Med J* 2003;**20**:119–20.
8 **Munro J**, Nicholl J, O'Cathain A, *et al.* Impact of NHS Direct on demand for immediate care: observational study. *BMJ* 2000;**321**:150–3.
9 **Salisbury C**, Chalder M, Manku-Scott T, *et al. The National Evaluation of NHS Walk-in Centres. Final report.* Bristol: University of Bristol, 2002.
10 **Wardrope J**. Unlimited consumer demand would destroy the NHS. *BMJ* 2001;**322**:1369.
11 **Castille K**, Cooke MC. See and Treat: one size does not fit all. *Emerg Med J* 2003;**20**:120–2.
12 **Miró Ó**, Sánchez, M, Espinosa G, *et al.* Analysis of patient flow in the emergency department and the effect of an extensive reorganisation. *Emerg Med J* 2003;**20**:143–8.