Health Perspectives
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Accident and Emmegency Services

Whether as a result of television dramatisation, newspaper headlines or their prominent locations in our cities and towns, accident and emergency departments have always had a high public profile. Every year 15 million patients in England and Wales use the 227 A&E departments[i] which (with few exceptions) are open 24 hours a day, every day of the year. The service is under increasing pressure and in the last few months there have been calls for fundamental change to the way it operates. This edition of Health Perspectives, looks at why A&E services are under such pressure and whether the proposed changes will benefit patients.

Increased demand

In the last decade, the number of people attending A&E has increased (by around two per cent each year) and, more recently, there has also been a rise in the number of emergency admissions through A&E departments. There has been little agreement about why this is happening but suggestions include: shortages in inpatient beds; more elderly people requiring care; GPs less able/willing to cope with seriously ill patients; increased patient demand; GP fundholders referring more patients to conserve their own resources.

Whatever the reason for this extra demand, there is little doubt that accident and emergency services have been stretched - in some cases to breaking point. At the same time, there have been problems with the recruitment of skilled staff to A&E, and inevitably in certain parts of the country the quality of patient care has suffered.

The Audit Commission report

In March 1996, the Audit Commission published a major report looking at these issues, *By Accident or Design - Improving A&E services in England & Wales.* The report recognised that pressures on A&E services have been causing problems - such as lengthy waits, inadequate supervision of junior doctors, and poor care for vulnerable patients such as children and people who are psychologically disturbed. The report included suggestions for improving care in A&E (see Box 1), a number of which address the concerns of Community Health Councils.

BOX 1

Key findings of the Audit Commission

Staffing

Although staffing has increased in recent years, there are still shortages. For example, there are huge variations in the length of time that a "more experienced" doctor is present at accident and emergency - 60 per cent of units only have one accident and emergency consultant. One solution is to expand the role of nurses in A&E and to make use of emergency nurse practitioners. Rostering can also be improved so that there is a better match between staff availability and patient demand.

Information to patients

Most patients will inevitably have to wait to be seen by a doctor in A&E. However, if they are kept well informed about the progress of their care and treatment, long waits can be made more "bearable".

Discharge

There are deficiencies in the accuracy and timeliness of information which is provided to GPs following discharge - frail patients are often discharged without next-day visits to check how they are coping. Information systems should be audited and A&E should ensure patients receive clear written instructions and information on discharge.

Children

Most units have a separate treatment room for children but less than half have a separate waiting room. Some children's units are staffed only seven hours a day, and 40 per cent of accident and emergency departments have no Registered Sick Children's Nurses. Trusts should ensure that there are properly equipped waiting and treatment areas for children available 24 hours a day and that a paediatrician is permanently available on-call.

Sensitivity to patients' needs

Psychologically disturbed patients should be cared for by specialist staff in separate facilities but often are not. In addition, many units have no policy on the care of anxious or bereaved relatives. Trusts should ensure departments have adequate access to psychiatric support and also establish a policy for the care of the bereaved.

Support from other specialties

Many accident and emergency units cannot deal with seriously ill or injured patients outside normal working hours because they do not receive sufficient back up from other specialties. Trusts should ensure that one senior manager is responsible for reducing delays in emergency admissions - but that support for this action should be joint responsibility of *all* hospital specialties.

Direct referral

Certain patients who have an established relationship with a particular specialty (*for example, in relation to asthma, early pregnancy or genito-urinary medicine*) could bypass A&E and contact the specialty direct in the event of an emergency. Some patients referred by GPs for emergency admission might be cared for in an admissions area separate from A&E before transfer to a ward to reduce unnecessary congestion.

END OF BOX 1

Waiting times and the Patients Charter

CHC surveys clearly show that the length of wait is one of the greatest concerns to users of accident and emergency services. In the words of one CHC, patients are frustrated at having to "wait to see the doctor, then wait for tests, again wait to see the doctor and sometimes face another wait for treatment".

It was these delays, together with the conditions within the local accident and emergency department which prompted Southwark CHC to set up *Casualty Watch* in 1994 to monitor problems within A&E. The project has grown to become a unique collaboration between CHCs providing high quality information about the length of waits and conditions in A&E departments at similar times but *in different parts of the country. It has also shown quite clearly that patients still* face unacceptably long waits - in a survey carried out in December 1995, over 26 per cent were made to wait for longer than four hours[ii].

In response to long waits, the Government introduced a Patient's Charter standard that patients can "expect to be seen immediately and have their need for treatment assessed". Some critics say that this, in reality, is little more than a cosmetic exercise, and this is backed up by the Audit Commission report which found that those accident and emergency units successfully meeting the Patient's Charter standard, did not necessarily provide the quickest treatment - in fact, some departments "that returned comparatively 'good' Patient's Charter ratings were found to be amongst the slowest in actually treating and discharging patients".

ACHCEW believes that it is the actual time taken to see a doctor (or nurse practitioner) who is able to provide treatment, which is of greatest concern to patients. It is this figure which, for the purposes of the Patient's Charter, should be recorded and published.

Alternatives to A&E

A range of alternatives have been proposed to ease the pressure on A&E, for example the use of Minor Injury Units (see box 2). Other options include the

development of pre-hospital care, which aims to treat some seriously ill patients before they reach hospital.

Suggestions have also been made that primary care out-of-hours centres might have a role in reducing pressures on A&E and some large GP practices are investing in X-ray equipment and other diagnostic facilities. A number of trusts are considering setting up primary care centres next to A&E departments, others employ GPs within A&E to see patients who are identified as requiring primary care.
ACHCEW believes that these developments are useful to as long as they are *additional* to the level of support patients are entitled to expect from their GP. Patients should not have to travel when they need to see their GP out-of-hours and primary care centres should be located in the community - not next to a major hospital.

BOX 2

Minor Injury Units

Minor Injury Units (MIUs) are being developed as a half-way house between A&E departments and primary care. MIUs are designed to treat simple injuries such as cuts, broken bones, burns, scalds, bites, stings and sprains. The care is often provided by nurse practitioners but sometimes GPs attend.

MIUs are sometimes set up in place of A&E departments which have been closed. In these cases, there is a danger that local people will see the unit as a second-rate alternative. But some MIUs have become very popular and well-used.

The success of MIUs depends on:

- good publicity - it is important that local people are aware the MIU and its purpose
- access - MIUs vary in their opening hours and some are closed at weekends
- waiting times - MIU staff may be able to treat minor injuries much more quickly than is possible in a busy A&E department
- transport - some people attending MIUs will need attention at an A&E department so it is important that they can be transported there quickly and safely
- competence - staff must be fully trained and treatment guidelines should be agreed with representatives of doctors and patients
- service quality - those providing a service at MIUs should respect good practice in equal opportunities, confidentiality and privacy and dignity.

In any case, MIUs should not be used as an excuse to turn people away from A&E departments. Very long waiting times at A&E departments should not lead

to "victim-blaming" - the attitude that patients are using the service "inappropriately".

END OF BOX 2

The case for reconfiguration

The most contentious aspect of the Audit Commission report was the assertion that the solution to these problems was to *rationalise* provision: reviewing and possibly closing down "small A&E departments (with fewer than 50,000 new attendances per year) where there is good access to alternative facilities (say, within ten miles)". The Commission suggests that "If these reviews were to result in the amalgamation of 50 per cent of such small departments, this would mean closing 31 A&E units in England and Wales".

Relying on fewer, larger units would obviously restrict access to services but the Audit Commission claims the reasons for doing so are based on quality of outcome rather than cost (ie larger departments would have better access to specialist staff, better training, flexible rostering and better support from hospital services).

ACHCEW believes that the case for fundamental change to accident and emergency services is strong and that the majority of the recommendations put forward by the Audit Commission would bring about major improvements if implemented. However, the closure of existing facilities on the scale proposed does not seem either sensible or necessary:

- the Audit Commission's analysis deals only with the service experienced by patients from the point at which they arrive at the doors of A&E. The reduction in the length of wait which might be achieved at a larger, better equipped A&E department may be of little consequence if it takes injured or seriously ill patients twice as long to get there;
- although the Commission claims that the arguments for rationalisation are not based on cost, the definition of a "small" A&E (those which may be under threat of closure) is one in which services cannot be provided "cost-effectively". The Audit Commission has provided sensible, detailed recommendations, but in the final analysis they are making the best of an under-funded service.

Earlier this year, the Secretary of State for Health acknowledged that emergency and intensive care services are under considerable strain and announced that an action plan was needed. However, he guaranteed no extra funding or beds[iii].

There is a limit to what can be achieved by staff, by managers, by GPs and by campaigns to ensure patients make "appropriate" use of the NHS. It may be that

accident and emergency services have already reached this limit and cannot continue to cope without adequate financial investment.

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i i Audit Commission. By Accident or Design - Improving A&E services in England & Wales. 1996. HMSO.

[ii] Southwark CHC *Casualty Watch Survey - Bulletin*. December 1995.

[iii] Health Service Journal 14/3/96