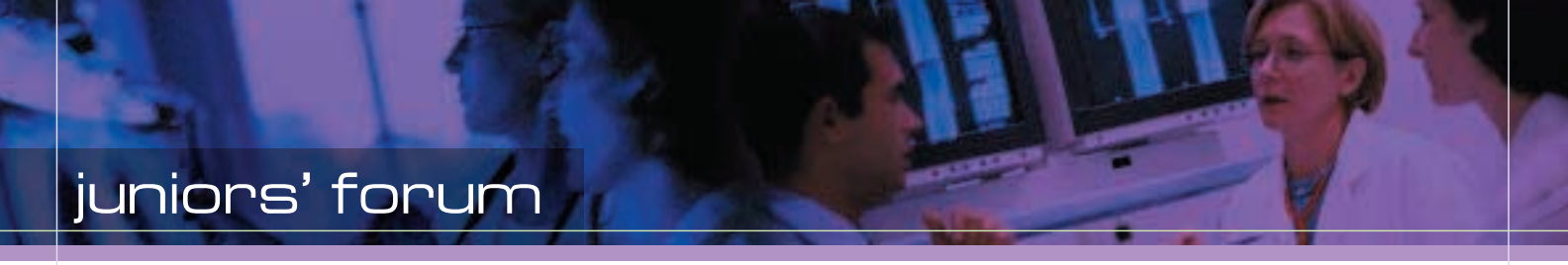

Four-hour **target**

The government target, that patients should not wait more than four hours in the Accident and Emergency Department before admission or discharge, has created great controversy. Does the four-hour rule just create extra stress and a distortion of clinical priorities or is it actually improving patient care? **Verona Beckles** and **Stephen Nash** give two different views on a divisive issue.

About to breach

Verona Beckles advocates prayer, planning, prioritising and, if necessary, politics

'It's just that she's about to breach!' How many times have you heard that line down the phone? Recently, during a week of days on call, I planned to count the number of times this familiar phrase came my way; after a couple of days, I lost count and gave up.

How do you respond when someone says that to you? Perhaps, like me, you almost bite your tongue off rather than sound annoyed. Or maybe you sulk and go round muttering like Muttley from Wacky Races! Should you protest? After all it's not your fault that she was referred three and three quarter hours after she arrived in A&E. Or are you resigned to the fact that four hours is the government's target and none of us would want our granny lying on a trolley for a minute longer than necessary? Perhaps you drop everything, dash down to A&E and see the patient.

She doesn't need admitting. What next? Do you join in the white lies by discharging her off the computer before she's got her clothes on, or before you've finished her GP letter? Or maybe you get down there, only to find that the admission decision has been taken out of your hands – the A&E registrar has fast-tracked to the ward! It can be really frustrating!

As Christian juniors, how should we manage this aspect of the day-to-day grind at the coalface?

Prayer

Ask God for help at the beginning of every day and throughout the day. He knows exactly what we

The other side of the coin

Stephen Nash argues for patience, constructive criticism and grasping the big picture

Back in 1993, I returned from the mission field and became an A&E consultant in a London teaching hospital. I was utterly appalled: daily press scandals, huge waits for beds and unbelievable A&E overcrowding with patients littered everywhere. Staff morale was rock bottom, patients weren't receiving good care, relatives were frustrated, and managers were impotent.

Why waits went up and care went down

- Reducing numbers of hospital beds
- More A&E patients but no more staff
- Poor A&E and hospital management
- Culturally accepted norm of long waits
- Out-of-date patient processing systems
- Slow access to investigations

A large plan

In the year 2000 *The NHS Plan*, with its promise of a maximum four hours' wait in A&E, was a central part of Labour's election manifesto.[6] So, having won a second term on the strength of it, they needed to deliver the goods. The public were getting impatient: drastic action was necessary or they would not get a third term in office.

Many things were tried and a stressful time followed for everyone concerned. 'Data sanitisation' occurred in many hospitals and Trusts got creative in order to get round the definition of a breach. Beds replaced trolleys, areas of A&E were relabelled 'wards', and decision to admit times were deliberately delayed to buy time. It was a scandal.

If you can do it once...

In March 2003 there was a two-week period when every Trust had to demonstrate the effectiveness of all the investments and efforts made so far. Although so many Trusts said it was impossible, most did achieve the target of 95 percent of patients seen and discharged or admitted within four hours! So how did the government respond? Predictably: if you can do it for two weeks, then you can do it all the time! This four-hour target became the government's top priority, and this was forced down to chief executives and onto managers, doctors and nurses. There was a lot of complaining but finally A&E waits were taken seriously.

All this worked very much to the advantage of A&E departments but there was much bullying, harassment and unreasonable pressure. However, after five years or more of sustained effort, I think the

need, and what our patients' real problems are. He is our provider God who carries us through the day.[1] Jesus too only had a few moments with his patients but still, divinely, he managed to get straight to the root of their problems.[2] And what about those in authority over us? We should pray for them and, when possible, obey them.[3]

Planning and prioritising

We all vary in how well organised we are at work. Have a long, hard think. Are you as organised as possible? Do you delegate whenever appropriate, for example using the emergency department technicians and anyone else who's around? Are you a team player and do your on-call team truly operate as a team?

How do you prioritise your patients? My tip is to find out what time each referred patient arrived in A&E and to ask where they will be. This way I can strike a balance between those who are sickest and those I must aim to see within the target. And when you are tied up with these more urgent patients, do get someone else to answer your bleep, and keep your team in the loop.

More senior juniors need to learn how to reallocate resources: follow Christ's example and ensure that everyone takes a break and has a meal.[4] It will certainly mark you out from other registrars!

Politics

It's so tempting to tap into and feed the continual moaning and groaning that prevails in the Mess Room. But we are urged to do everything without complaining.[5] So instead, why not repent of our apathy and turn our valid criticisms of the system into positive steps for change? There are many ways of helping to make Christian values an integral part of your hospital's ethos. Yes, a lot of Christian juniors do suffer from that deadly disease of busyness, but medical politics is a great way of getting your voice valued and heard. Pass on your concerns to your hospital juniors, BMA rep. Go one step further and get yourself elected onto a local policy making committee. Or dive in at the deep end by getting involved with the BMA yourself!

Verona Beckles *is Senior trauma and orthopaedic SHO in Barnet*

government just lost patience and decided enough was enough: 'Stop complaining! Just do it! We will help but you must do it!'

Whilst I do not applaud or approve of such behaviour, I do believe that there was no other way. The resistance to change was just too enormous. And as in war, drastic situations call for drastic solutions.

Every Trust had to participate in a programme that focused on minors, majors and the specialities. All our processes were reviewed. Good ideas were shared. A huge focus was made on A&E itself but a whole system approach was adopted. There just isn't enough space to describe all the changes.

Success at last?

I will never forget arriving at work one morning in May 2003. For several weeks we hadn't had any overnighters (that is, patients waiting overnight on a trolley for a bed the following day). The nurses were laughing and joking. It was a delight to come to work. The sun had finally come out.

It had worked. Yes, new problems were created but at last the problems in A&E became everyone's problem. Yes there were financial incentives but I don't believe they were the main reason for departments achieving the target. Rather I think it was the fear of not achieving and the consequences that would follow. Chief executives were under so much strain and this pressure was transmitted vertically downwards directly onto A&E and the various specialities.

Constructive not destructive criticism

Yes there are mistakes but I would emphasise that these are exceptions to the rule. The odd patient is admitted unstabilised and incompletely evaluated. Usually this causes uproar and is used as an excuse to rubbish the four-hour target. But what about all the correctly admitted patients? Without the target, most of these patients would still be on A&E trolleys, and the post-take ward round team would still be seeing patients in the A&E corridors. Such response to mistakes is not healthy. Instead we should be asking more constructive questions. Why wasn't this particular patient stabilised prior to transfer? Why wasn't the speciality doctor able to get down to A&E? Why were the investigations incomplete? And why did A&E refer so late? We should address problems regarding individual patients fairly and squarely, rather than using these incidents as excuses to rubbish the target.

Moving on

Now in 2006, there has been so much focus for so long on the four-hour target that I believe we have been neglecting the patient. We must move on and focus on providing excellent quality in four hours.

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references

1. Matthew 6:11
2. John 4:7-19
3. Romans 13:1, Titus 3:1
4. Mark 6:30-32
5. Philippians 2:14-16
6. *www.nhsia.nhs.uk/nhsplan/npch12.htm*