BRITISH JOURNAL OF HOSPITAL MEDICINE

Dismal performance in response to coronavirus: the problem no one wants to discuss – the NHS

The UK death toll from COVID-19 is currently the fourth worst in the world behind the USA, Brazil and Mexico. Possible reasons include delays in lockdown, the provision of scientific advice to government and the decisions that government made based on the information they were given. When we review our performance and plan for the next public health crisis, we need to be brave enough to dare to challenge the NHS and its advisors.

Anthony Bleetman[1]

Author details can be found at the end of this article

Correspondence to:
Anthony Bleetman;
a.bleetman@gmail.com

How to cite this article:
Bleetman A. Dismal performance in response to coronavirus: the problem no one wants to discuss – the NHS. Br J Hosp Med. 2020. https://doi.org/10.12968/hmed.2020.0438

As an experienced consultant in emergency medicine, I believe it is time for us to critically discuss the NHS' handling of the COVID-19 pandemic. The UK death toll is the fourth worst in the world, over 46 000 at the time of writing (Statista, 2020). We could not have done much worse.

The reasons for our poor performance are many and include: data collection; advice provided to government; government decisions; lack of sufficient quantities of personal protective equipment and uncertainty as to which type to use in different clinical areas; public health measures; protection of elderly and vulnerable people living in care homes; the 'track and trace' programme; and the huge elephant in the room – what actually happened when a COVID-19 patient got to hospital. Critics have so far steered clear of levelling criticism at our country's sacred cow – the NHS.

I speak as a doctor with decades of experience and as an expert with 7 years' experience serving on the Department of Health's emergency planning group, the Emergency Planning Clinical Leadership Advisory Group, the Scientific Advisory Group for Emergencies' predecessor. More importantly, I speak as a doctor who cherishes our NHS. This is precisely why I feel we need to dare to consider the NHS' performance in working out why we did so badly with our health response.

As COVID-19 spread, we watched with some concern and aloof pity as the virus killed our European neighbours in the thousands. We reassured ourselves that it could never be as bad in the UK because we have the NHS. But, as it turned out, our mortality rates rapidly overtook those of our European neighbours. I believe that, in part, this was a result of deficiencies and inconsistencies in the delivery of health care in our hospitals. Specifically, the absence of a uniform and consistent approach to disaster management, policies for admitting patients to intensive care units and management of patients with COVID-19 once they got to hospital.

As a locum consultant, I worked in the emergency departments of five hospitals over the pandemic. The observations presented here serve to allow us to reflect and dare to ask 'could we have done better?' Nothing in what I have to say is a criticism of the majority of NHS staff with whom I worked. They did everything they could with what they had.

Who gave the scientific advice?

We all heard that directions given by the Prime Minister were prefaced with 'we are following the scientific advice'. So, who gave the scientific advice?

Back at the start of the millennium, the Department of Health relied on a number of clinicians to assist in emergency planning and inform policy making. I was one of those clinicians who assisted in providing solutions to the threat of chemical terrorism, which had been identified as a vulnerability.

Following the 9/11 attacks, we produced the initial guidance on requirements for personal protective equipment for chemical protection and wrote the first manual for health staff. More clinicians joined the group and we became the Emergency Planning Clinical Leadership Advisory Group, masterfully managed by a medically-qualified senior civil

servant, Dr Penny Bevan. Over 7 years the group assisted in developing policy, bringing the 'keeping it real' element to the table. We were active clinicians translating policy aspirations into practical and workable solutions for the NHS. You could walk into any emergency department and the equipment available for and approach to emergencies would be identical. The country had a unified, clinically-led response to disaster.

In 2012, the Emergency Planning Clinical Leadership Advisory Group was disbanded as government thought it prudent to engage academics and statistical modellers instead of clinicians. Scientific Advisory Group for Emergencies superseded the Emergency Planning Clinical Leadership Advisory Group. Before COVID-19, some clinical input was provided by the Emergency Preparedness, Resilience and Response group, which I am informed by one of the members has met fully only once since September 2019. The reliance on academic science and the lack of experienced operational clinical input into Scientific Advisory Group for Emergencies contributed to a chaotic response as each hospital tried to interpret government advice as best they could.

Each department had a different arrangement for patient reception and flow. All had 'red' (suspected COVID-19) and 'green' (unlikely COVID-19) areas; some also had an 'amber' area (not sure). The type of personal protective equipment available and its use varied from hospital to hospital. Each department had different approaches to patient containment and flow. Hospitals were initially given general guidance only, without specific 'this is what you must do and this is how it's done' advice (NHS, 2020).

The role of intensive care

Another issue to consider is access to intensive care. In contrast to many overseas health systems, emergency physicians in the UK do not routinely initiate intensive care-level treatment in the emergency department. Undertaking emergency anaesthesia and ventilation for the sickest patients attending the emergency department without the involvement of intensive care is, at best, frowned upon. The sickest patients with COVID-19 who failed to respond to non-invasive treatment often needed emergency anaesthesia and ventilation.

In most other parts of the world, delivery of invasive ventilation is part of the everyday workload of the emergency physician and is undertaken without any prior communication with intensive care. The emergency physician is relied upon to recognise the need for invasive ventilation and to undertake it safely, contacting intensive care once the patient has been stabilised. Intensive care then finds a bed for the patient. Services are resourced to provide this facility.

In the UK, it is the intensive care doctor who determines the thresholds for initiating emergency interventions in the emergency department and who is the gatekeeper of the intensive care unit. A decision not to escalate a patient to intensive care will result in a patient being admitted to a general medical ward or lead to an end-of-life care plan. The fate of a critically ill patient is therefore determined by the decision of an intensive care registrar called to the emergency department to assess these sickest of patients. Provision of intensive care beds in the UK is very low in comparison to other world health economies (Prin and Wunsch, 2012).

The pandemic led to many patients attending hospital with respiratory failure. As the influx increased, overworked intensive care doctors left their saturated working environment to assess new patients in the emergency department. Their mindset was often that they had no capacity for new patients and their no escalation decision had been taken before they answered their bleep. I believe we lost a fair few patients because they were denied access to intensive care. And this at a time when Nightingale (Covid-19 intensive care) hospitals stood largely empty (Bowman, 2020).

But what happened to those who did make it to intensive care? There are some reports that extracorporeal membrane oxygenation might improve survival in the sickest patients with COVID-19 (Zeng et al, 2020). Access to extracorporeal membrane oxygenation in the UK remains fairly limited. In the debrief, we need to reflect on whether greater access to extracorporeal membrane oxygenation might have saved more lives.

Patients with COVID-19 who were not sick enough for (or denied access to) intensive care were admitted to designated wards. Here, they were offered oxygen and care informed

Key points

- The UK's mortality rate from COVID-19 is among the worst in the world.
- Any inquiry into the UK's performance in managing the pandemic will need to consider many factors including the provision of advice to government, government decision making, public health measures, lockdown, provision and use of personal protective equipment, care home management and border control. To date, no one has questioned whether the NHS could have performed better.
- There was seemingly a lack of practical clinical input into advice provided by the Scientific Advisory Group for Emergencies to government, which contributed to inconsistencies in hospital preparedness and response in the initial stages of management of the COVID-19 pandemic.
- NHS staff did the very best they could with restricted access to intensive care beds at a time when the Nightingale hospitals stood virtually empty.
- It is possible that more lives could have been saved by greater access to intensive care beds and extracorporeal membrane oxygenation.

by the limited and evolving knowledge at the time. Access to non-invasive ventilation was limited, greater access might have saved more lives. In some units, the increase in oxygen demand led to falling pressures in the oxygen system (Lintern, 2020).

Learning the lessons

The lessons learned from this pandemic will be many. By knowing where we went wrong, we can build a better response to future public health emergencies. How many deaths from COVID-19 could have been prevented if we had provided clinical input into government advice, untied the hands of emergency physicians, provided more intensive care resources and extracorporeal membrane oxygenation, allowed greater access to non-invasive ventilation or provided enough oxygen on the wards? Very many, I suspect.

Author details

[1]Locum Consultant working in a number of NHS hospitals, UK

Declaration

The views presented in this article are my own and not of any employer or of the *British Journal of Hospital Medicine*.

References

Bowman V. Why do so many NHS Nightingale hospitals remain empty? 2020. https://www.telegraph.co.uk/news/0/do-many-nhs-nightingale-hospitals-remain-empty/ (accessed 30 July 2020)

Lintern S. Coronavirus: hospitals warned to have oxygen cylinders on standby as Covid-19 pushes systems to the limit. 2020. https://www.independent.co.uk/news/health/coronavirus-uk-oxygen-hospitals-nhs-cases-a9451751.html (accessed 30 July 2020)

NHS. Operating framework for urgent and planned services in hospital settings during COVID-19. 2020. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/05/Operating-framework-for-urgent-and-planned-services-within-hospitals.pdf (accessed 30 July 2020)

Prin M, Wunsch H. International comparisons of intensive care: informing outcomes and improving standards. Curr Opin Crit Care. 2012;18(6):700–706. https://doi.org/10.1097/MCC.0b013e32835914d5

Statista. Number of novel coronavirus (COVID-19) deaths worldwide as of August 3, 2020, by country. 2020. https://www.statista.com/statistics/1093256/novel-coronavirus-2019ncov-deaths-worldwide-by-country/ (accessed 3 August 2020)

Zeng Y, Cai Z, Xianyu Y et al. Prognosis when using extracorporeal membrane oxygenation (ECMO) for critically ill COVID-19 patients in China: a retrospective case series. Crit Care. 2020;24:148. https://doi.org/10.1186/s13054-020-2840-8