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SUPPLEMENT

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Final President's blog

This will be my last EMJ supplement as President. I have been reflecting on the three years and on the questions, I get asked regularly; have I enjoyed my time, and will I miss it? It is a huge honour to be elected President of your College and the role is unendingly interesting. I have had the opportunity to meeting a wide variety of people and have tried to influence for good. It will be up to others to decide how successful I (and my team) have been. Sadly, what I am aware of is that Emergency and Urgent care (my attempt to rebrand U&EC) is in a more perilous place than it has ever been. The whole of the NHS is under strain and there is a critical workforce crisis. I have been looking through what I have written over the last three years which document our concerns. So much of the current crisis has been a long time coming and its roots lie not in the pandemic but in the decisions and lack of actions of the last 12 years. I sit through meetings with NHSE officials telling me that ambulance handover delays are caused by exit block from Emergency departments! Really! Who knew? Oh, and patient care is compromised by ED 'congestion' No! Really? The lack of acceptance by these same people that they had been told years ago by the people closest to the work of Emergency departments- i.e. actually working in an ED and representing the professional voice of EM- that crowding and exit block create a pointless, harmful, inhumane and staff morale sapping, care disaster, is infuriating. I am delighted that this is now acknowledged but it appears we have had to go over the cliff to get them there.

I started as President in October 2019. In November 2019 I wrote in my newsletter

On the 14th of November, the 4-hour access standard figures for England were published. To no one's (working in A&E) surprise these were the worst performance results since records began at 81.4% (All Type). Meanwhile later in the month figures for Scotland, Wales and Northern Ireland all showed similar deteriorating performance generating national and local headlines.

I suspect we would all be pleased if we were making 81.4% nationally now. Back then Type 1 performance was a dismal 71.3%. In June 2022 Type 1 performance stood at 58.8% (the latest I have as writing this at the beginning of August) but as far as I can tell no one is paying any attention. Type 1 performance matters because Type 1 departments are where the sick patients are- I had to point this out to someone in a meeting the other day. Performance metrics do not exist in isolation – they represent the care received by actual patients and the patients I am (and they should be…) most concerned about are those who are ill and are likely to need admission) That 'All Type' performance currently is 68% is not a cause for celebration in any way. We have lost the confidence of the public that we will be there for them in an emergency.

AT THE END OF DECEMBER 2019, I WROTE

It is unbelievably tough out there at the moment and the news seems filled with one negative story after another. The glut of headlines so far this winter make for difficult reading but hopefully hammer home to policy makers and the government, just how stretched we are. Despite all this patients know the pressure staff are under and are incredibly supportive of us as a profession and the wider NHS. You are valued and patients are grateful for the work that you do. We know that demand is not going to go away so we continue to push for resources. You all appreciate the need for more staff, increased social care packages and more beds.

This is all pre pandemic. Lest anyone forget – pre pandemic messages about a system unable to deliver the care we should have been delivering because of staffing, social care, and bed capacity.

By February 2020 Covid was a thing, we were having to test patients on our ambulance ramps because nowhere else would and the newsletter said-

You cannot have failed to notice the operational stress and additional clinical pressures that the COVID-19 outbreak has created in our emergency departments. The College has been working, mainly behind the scenes, to offer sensible advice…… We have always maintained that bringing potentially infected people to a crowded emergency department that is full of elderly and frail patients, is extremely unwise.

By March we had cancelled our CPD event and then we entered lock down. We had our first national zoom call on March 26th and were pleased to have 176 people attend. This was the beginning of what has been a regular communication route. We were able to share practical information about sensible department reconfiguration and some early insights into the clinical presentation of Covid.

IN APRIL, THE NEWSLETTER SAID -

While for many people at home right now time may seem to be moving very slowly, for those of us on the frontline and tackling this pandemic

it continues to move very quickly indeed. Each hour seemingly presents a new issue, but the one that continues to rumble on, and will continue to be an issue is one about our very safety: PPE.

I still find it hard that we had to make such a fuss about what should have been obvious. Undifferentiated patients, agitated patients, uninhibited patients have always been an IPC risk in Emergency departments (and to paramedics). Our environment is open and busy. That we had to argue that the Resus room is a higher risk environment that an Intensive Care Unit is something I cannot forgive. The initial views on where PPE was needed related to concerns about supply not clinical risk. We now know that community carers going to vulnerable elderly, residential care home workers all should have had adequate PPE – both for themselves and for their clients. We managed in the end to get suitable PPE rules agreed but many had paid a price by then.

By May 2020 there was some relaxation of lockdown but there were some worrying signs. The collaborative working we had saw at the beginning of the pandemic was stopping.

We have worked very hard and then seen our normal workload go down which has given us much needed time to consider. We have had to adapt how we do everything, and we now see how worrying a return to the old ways of working is.

SADLY, BY AUGUST 2020 IT WAS CLEAR NOTHING HAD BEEN LEARNED-

Exit block is making a comeback. During the pandemic many of us were surprised and pleased to find ourselves practicing emergency medicine in uncrowded departments with good patient flow. In these most abnormal of times, it was an extraordinary reminder of how a normal emergency department should function. Most of us have not worked in these conditions for years. It was important to point out to others that the absence of crowding, corridor care and ambulance queues outside our departments was something we should reasonably expect always and not, as was often intimated, a sign we were 'quiet'

In October we published an updated version of RCEM CARES – the strategy document we had brought out pre pandemic. CARES stands for Crowding, Access, Retention, Experience and Safety. The document described the problems and proposed solutions. We could see the way things were going – all the same problems not being address and we were heading in winter with another Covid wave. And by Nov 2020 I was writing

I am worried and annoyed. I suspect many of you are too. We have seen crowding, corridor care and difficulties offloading ambulance patients come back. We have said how dangerous this is to everyone we possibly can reach- national politicians, health service leaders and indeed in the media in all four nations. If crowding and corridor care was unacceptable before the coronavirus pandemic, it is unconscionable now. This is all so depressingly predictable given the problems every winter but that there should have been so little action to avoid this coming into the second wave of the pandemic is upsetting

And so, it has continued ever since. Vaccination and pharmacological treatments have hugely improved the outcome for Covid patients. As healthcare workers we got out first vaccine doses in Dec 2020/ Jan 2021. The population has been able to be protected but what went before has meant a significant loss of life. We are all aware of the substantial number of people who have had their health care disrupted and the massive backlogs of known and unknow health care need but through this we have had an Emergency Care system that delivered care through difficult scary circumstances. This Emergency Care system was in trouble pre pandemic and so it cannot be a surprise that it would be very stretched. And yet despite this there has been next to no consideration as to how 'resetting the NHS' would need to involve strengthening the ambulance/ Emergency Medicine and acute care pathway of our sickest patients.

In April 2021 we put out a press release about our latest campaign – Summer to Recover. The message was - *To prevent another crippling winter we must use the summer to prepare our hospitals and Emergency Departments*

WHAT WE SAID WAS -

Governments and the NHS in all four UK nations

1. Embed Unscheduled Care firmly into recovery plans and allocate sufficient funding to support the whole Urgent and Emergency Care system
2. Expand capacity and restore acute hospital beds
3. Be transparent about the efficacy of the NHS 111 First and other equivalent phone-first services
4. Commit to using the 12-hour data from time of arrival for all Emergency Departments to drive plans for winter. All four nations must act now to stop long Emergency Department stays.

That campaign is as relevant now as then, but nothing moved.

IN SEPTEMBER 2021 I SAID IN THE NEWSLETTER

It is not enough to say the workforce is exhausted, NHS staff stepped up during the pandemic and we know it is going to be a really tough winter. We… have been worried for months and now see all our fears (and worse) coming to pass. Corridor care and exit block is endemic, we are all struggling to offload ambulances, and now see the additional failure of care of unimaginably long queues outside our EDs.

AND NOVEMBER 2021 -

At RCEM UK we are out there making the case yet again for what we all know; that crowding is bad for patients and staff, that not offloading ambulances is wrong and that the only solution to these two problems is to get rid of exit block by making beds available. Beds will only be available if we can get patients who have recovered from their acute illness back out into the community safely and if we stop doing something. In recent years this has been elective care. Currently many 'elective care' patients are becoming more unwell and so this becomes a very difficult area, but we must work out how to separate the unscheduled and elective streams before we do more harm to both groups of patients. Working the old way of flexing elective care in the winter around the emergency demand is not doable or right. For this winter we are, I fear, too late to get this sorted but if we have the same issues next year it must be seen as a scandalous planning failure.

So here we are about to enter another winter in 2022, but with the summer having been as bad as anytime we can remember (but with better weather). Ambulance delays are the most obvious casualty of the current situation. The number of 60 minutes + patient delays to ambulance handovers in March was the highest ever on record. Tens of thousands of patients are facing 12 hour delays in Emergency departments waiting for beds, in all four nations. The numbers are grim, they should shock all health and political leaders. There is no grand national plan and healthcare has not featured as a major issue in politics in recent months. I have enjoyed being President, it has been a privilege and to be in post during a national emergency has been incredible. I will miss the contact with clinicians from other Colleges. We found a great deal of common ground during the pandemic. I have been very lucky with my Exec and Council and seen the arrival of a committed Trustee Board. The RCEM team have been wonderful and for me as President the Policy and Communications team have been magnificent. I am grateful. What I will miss less is the feeling of being Cassandra.

Katherine Henderson

My personal Ukraine project

I was out in the Solent doing my Day Skipper course when the news about the war in Ukraine broke out. I had five days of sailing in rather freezing weather ahead of me. I found it very difficult to concentrate on navigation, tides, winds, tacking and gybing while scrolling through the news and talking and texting to friends and relatives who were spread throughout Ukraine. My wife's parents were escaping from Kyiv at the time, but we did not know what they were going through as the connection was poor, and they would not have told us all the details anyway. They finally did three months later when I recorded their story for my website.

It quickly became very clear to me that the most effective way of fighting this very personal war was to transform my passive, emotional responses into practical actions, even on a small scale. Of course, it had to have a real value to the people on the receiving end. There was not a shortage of Ukrainian names on my contacts list – since the start of the war in the eastern Ukraine in 2014 I had been involved in a few educational projects there. I had attended conferences, and conducted seminars, and training sessions in a few cities there, as well as brought Ukrainian colleagues over here for short-term clinical attachments. I was able to contact them directly and find out what was needed the most. I also managed to get in touch with a few anaesthetists who volunteered to go to the frontline and were involved in setting up tactical medical services, as well as training centres for combat medics. The ground was set for my personal humanitarian project aimed at helping my Ukrainian colleagues.

I set up a crowdfunding page and have been truly touched by people's generosity. I was able to prepare for my first trip to Lviv within a couple of weeks. I bought tactical medical supplies, as well as some bulletproof vests and ballistic helmets for several teams of medics that I was in contact with. It turned out that body armour of high quality was, and still is, in short supply among them as the army prioritises it to the combat units, so the incidence of injuries among frontline medics is disproportionately high.

I arrived in Lviv, a beautiful city in the Western Ukraine in mid-March, less than a month after the start of the war. It was a visit marked by a contrast of how the city looked during the day with people enjoying sunny weather outside with bars, and restaurants open, before everything was put on hold when air raid sirens were going off, and everyone was rushing into bomb shelters. Besides the sirens, checkpoints spread around the city, and the curfew – the war there was not visible at the time.

With soldiers and medics from the Lviv Territorial Army battalion in front of the 4x4 that I delivered to them

Apart from delivering the medical supplies, I met new friends, and visited some old ones. I also visited a large hospital and delivered a few lectures on trauma-related care to their anaesthetists and intensivists. I was able to get a pretty good idea of what was in greatest demand both in hospitals, and on the frontlines.

For my second trip, I sourced tactical medical stuff such as anaesthetic disposables, and a box of much needed pain killers, which I collected on my way from my friend, a Ukrainian anaesthetist working in Germany. I also bought a 4x4 for my new friends from a territorial army battalion stationed in Lviv. It was a quick "in-and-out" mission, and I was pleased with its outcome.

Those missions have been very effective and satisfying on many levels – I have been able to help real people with what they needed the most; I connected with people in ways only possible in times of war; I have been inspired to continue helping them in various ways. Coming back from my trips, I experienced a cognitive dissonance, a disconnect between my experience, and understanding of the Ukraine war, and its often over simplified portrayal by the British media. After hearing a lot of stories of surviving not only physically, but mentally through the horrors of war, I felt that there is so much we could learn from those people's stories if we could only stop and listen to them through all the noise of superficial reporting, scare-mongering, and propaganda.

I decided to start recording those stories which you can find at https://www.ukrivski.com/stories/

I first talked to my in-laws, which was the first time they were able to rationalise their harrowing experience of getting out of Kyiv under a heavy Russian bombardment on the first day of the war. It was clear that they wanted to tell their story, both to be heard, and to rationalise their painful experience. I wrote the first draft, but they did not like it. They wanted me to include some details, which they thought will make their story more visual, more vivid for the readers. They wanted to connect with potential readers on a human level. When they were getting out of Kyiv they did not use their GPS, but got their "traffic updates" from a local radio station, which kept broadcasting the exact locations of advancing Russian troops. When they were staying at the border town there was a big field where men were teaching their wives, and teenage children how to drive their cars before they could leave for the border. Men themselves were not allowed

In a bomb shelter with the family I am as staying with during my first trip

to leave the country due to new mobilisation laws. Those powerful images were important to our parents. They thought that without them my story would be too dry, too incomplete

It is impossible to see what is really happening, the whole truth through "the fog of war", the sheer hatred, horrors, war crimes being committed by the invaders on an industrial scale right now. However, it is quite possible to see what is happening through the eyes of the people living through it, their different angles of vision, a collection of aerial photographs forming a composite picture of a large area on the ground.

Also, despite their sadness, the stories contain hope for the humanity. All the heroes of the stories survive their battles in spite of a temptation to turn into their enemies, to become fearful monsters full of hatred. A lot of the Russian tactics – bombings of the cities, war crimes against civilians, tortures, and executions of Ukrainian prisoners of war – are aimed at causing hatred towards themselves as a nation and parading the results of that hatred on Russian media both inside Russia and abroad, to make it easier for their leadership to maintain the narrative about "Ukrainian Nazis" and "Russophobia". Therefore, it is heart-warming for me to listen, and be able to record the stories of people who resist the temptation of turning into the monsters they are fighting, who survive unimaginable horrors not because of hatred towards those who hate them, but because of love of their families, their land, their home. Read the story about a marine POW, who spent 16 days in Russian hospitals with a broken pelvis, without any pain relief throughout his stay. He did have a lot of hatred against his enemies, for sure. But, when asked what had helped him to survive his ordeal, he did not hesitate – "I did not want to let my brothers-in-arms down, I wanted to survive so I could live in my beautiful free Ukraine, and I was praying hard".

I hope that after reading these stories you will be inspired by them as much as I have been.

You can find them at https://www.ukrivski.com/stories/

Leo Krivski

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