

Scottish Covid-19 Inquiry Witness Statement

Statement of **FORD/Sandra**

INTRODUCTION

1. My name is Sandra Ford, and my date of birth is **Personal Data**. My details are known to The Inquiry. I am employed as a GP which I have done since 1996. In 1992 I obtained an MBCHB medical qualification and in 1996 I attained an MRCGP qualification.
2. I do not currently work in a GP practice, but I am a GP with special interest (GPwSI) in adoption and fostering services and I also work with out of hour's service at the weekends with Greater Glasgow and Clyde Health Board. This is my role now and was my role pre-pandemic. For the adoption and fostering role I work I compile health reports on adults who wish to adopt or foster children. I sit on adoption and fostering panels as medical advisor. I also support social workers and speak to prospective adopters about the health issues of children they are potentially adopting.

The Person to be spoken of **Name Redacted**

3. I wish to give a statement to the Inquiry about (my father). His name is **Name Redacted**, and he was 83 years of age **Personal Data** when he died on the 28 December 2021. He was in Deanfield Nursing Home in Glasgow which was run by Advinia Health Care. It comes under the Greater Glasgow and Clyde Health Board.
4. I would also wish to give a statement to the Inquiry about my role as a GP during the Covid-19 pandemic.
5. I have met today (31/08/2023) with witness statement takers from the Scottish Covid-19 Inquiry team, and I am happy to provide a statement about my experiences of the **Pandemic; Irrelevant**. I am willing to provide a statement, and for my statement to be published. I am willing to give evidence at hearings if required. I have completed the consent form provided.
6. Prior to going to the Deanfield Nursing Home in March 2021, my father had been on Balmore Ward in Leverndale hospital from August 2020. My dad had been diagnosed with Lewy Body Dementia in May 2019. The changes has started many years previously with changes in his personality and then he started having visual hallucinations and delusions as well as many of the other symptoms of dementia, although, unlike other forms of dementia, his memory remained relatively intact throughout.

7. My father was a very independent man and didn't accept help easily. At first, with the help of my five sisters we were able to care for my dad in his home. Before the pandemic he was able to go out short walks on his own and my mum could leave the house for short periods of time. He didn't get lost when out of the house but he started to lose the ability to track time and would stay out longer than planned.
8. When lockdown started in March 2020, we were not able to support my mum with visits, she was cheerful when we had our zoom catch ups and didn't let on that things were deteriorating. As we (my sisters and I) were becoming increasingly concerned we went around to their house when garden visits were allowed, and it was clear that dad's dementia had escalated markedly. My sisters and I would support mum and dad by visiting daily, but the situation became increasingly dangerous and we had to start staying overnight as that was when he was the most delusional and his hallucinations were very florid.
9. Eventually with the assistance of the psychiatric services dad was detained under the mental health act October 2020 and placed in Balmore ward at the Leverndale hospital. He remained there until March 2021.
10. Leverndale Hospital stuck by the Covid NHS restrictions rigidly, as he had a diagnosis of dementia we were allowed essential visits. This was one named visitor allowed to visit 2 times a week for 30-minutes. The level of communication was of very good, the nurses would phone my mum frequently and always answered the phone and spoke to her every day. Eventually I would join weekly Teams meetings with the medical team. Balmore ward had been working on a long term improvement plan which had included inviting a family member to the weekly team meeting. Prior to covid these would have been in person, as they moved to MS Teams during lockdown it actually meant it was far easier for me to join and I very much appreciated this opportunity to support my dad.

Moving from Hospital to care Home.

11. After a long assessment periods and trying various medications it was decided that dad's needs would be best met in a nursing home. We visited various care homes and eventually we chose Deanfield Nursing Home at Deanfield Quadrant, Penilee, Glasgow because it was close to mums Name Redacted home and they were confident they could meet my dad's needs. The care home manager spoke positively about family being central to residents care.
12. The transfer was delayed due to dad developing a non-covid virus and the need to wait on the results of at least 2 covid PCR tests before and then again after this virus. The nursing home agreed to take him on the

agreement that he would remain quarantined in his room for 14 days; we were very anxious about this arrangement but there fortunately was no deterioration in dad's dementia during this time.

Deanfield Nursing Home.

13. On arriving at the nursing home in late March, we aided dad's confinement by purchasing an Amazon Echo Show device for his room which allows video calls, and it enabled us to virtually "drop in" to his room, which as my dad no longer had the ability to answer a call on a device, allowed us to have frequent communication with dad and support him through those very long, lonely days. I found about this from other members of Care Home Relatives Scotland (CHRS) Facebook Group. I can't emphasise enough how important this was to my dad and to us. Without it we have been cut off from him and him from us in the way that most care home residents were from their relatives during pandemic restrictions. Mum could speak to him every night and they could watch TV together. There were often lovely calls but at other times distressing calls, there were calls when we could see dad struggling to get dressed and people walking into his room and taking things.
14. The nursing home agreed for him to have the device but they were unaware of how it worked and some staff were suspicious of our freedom to "drop in" on the Amazon Echo device at any time but they did not prevent it. We did provide instructions of how to disable the device for privacy (personal care) but they often would not then switch it back on. It was a learning curve.
15. If my dad was upset, shouting for help etc my mum would phone the home to alert them to his distress, but they rarely answered which greatly increased her distress. The communication with the home was terrible and I complained about it on several occasions with no improvement.
16. On one occasion I could not get dad on our drop in (he was out of his room which was uncharacteristic for him) and was worried, it took me a long time to get through to staff on the phone. Eventually I was told that they had found him in another resident's room where he had been for quite some time. I was very concerned that my dad's whereabouts was unknown for such a long time and believe it was due to poor staffing levels.
17. It was generally accepted that the residents would be in and out of each other's rooms.
18. The nursing home manager was Name Redacted, and it was owned by Advinia Health Care. There was a qualified nurse on duty during the day, but I cannot say what was in place at night.

19. I had power of attorney for my dad and I objected strongly to the fact that when he was in the nursing home I was unable to adequately carry out this role due to not having access and not receiving adequate communication about my dad. Decisions were made about my dad's care that I was frequently not consulted about.
20. From the outset we requested phone calls to my mum from his keyworker to update and reassure her, these never happened despite repeated requests.
21. In October 2021 as my dad's behaviour dramatically changed. He became elated and disinhibited and some very distressing incidents happened. Through my professional knowledge I was able to understand what was happening and the extra support my dad needed. During this time he was a danger to himself and others and had we not mobilised extra support for my dad through social work and the psychiatry liaison CPN more incidents would have happened. It was a delicate situation and the home's lack of response was worrying. For a 'specialist dementia unit' their knowledge and ability to manage distress behaviours was, in my opinion, poor.
22. During this period the home shut to visits as someone tested positive for covid (I can't remember if it was a resident or staff member). I was very concerned about my dad's behaviour deteriorating. His elated behaviour meant he was often out of his room and I wasn't able to see him on the echo show. I needed 'eyes on' and requested an essential visit but was refused. I received a lot of support and guidance from CHRS about how to do this and what my rights were. I sent emails to [NR] stating that I was concerned about the lack of communication and essential visits. The response that I got was that public health had advised them to shut the home to visitors and did not acknowledge my request for an essential visits. My solicitor has possession of a number of emails that I have sent to [NR] and I am happy for the Inquiry to have access to them.
23. I want to emphasise how distressing this was. This was my dad who was very unwell and vulnerable and we were physically prevented from his giving him the love and care and support he needed. He was so much more settled and content when we were physically with him. Public Health were there to advise, not to make the overall decision about how care was given. The distress of other relatives on CHRS was awful. It was the only forum where people could get advice or support.
24. During the whole time Dad was in Deanfield Nursing Home there were no relatives meetings, which given online technology, there was no excuse. We, as the relatives, should have been approached as a group, to come up with solutions about how to safely visit our loved ones. Staff were

receiving twice weekly PCR's, why weren't we offered that? By October we were all doing lateral flow tests, why were visits stopped? It was obvious from the CHRS page that the practice between care homes was widely differing with some care homes having frequent relative zoom calls and creative responses to requests. Most, like Deanfield, were blindly following Public Health advice

25. I did contact the Care Inspectorate in October 2021 to feedback what was going on at dad's care home regarding essential visits and the refusal to allow them by the care home manager; they were very unhelpful. Their response was that they would note my concerns but as it was Public Health guidance they wouldn't intervene. The interpretation of an 'essential visit' also widely varied, with many care homes restricting it to the last days and hours of life. The Care Inspectorate would not get involved in putting any pressure on care homes to vary this.
26. Dad's normal day in the home was boring. It revolved around the meals of the day, there was nothing else other than a TV in his room and in the communal area. Once dad's initial 14-day quarantine was over the staff at the home encouraged the residents to sit together because they could keep an eye on them. There was not enough staff to monitor them in their rooms. They did have an activities co-ordinator who would invite dad to do group activities, but my dad wasn't keen to join in.
27. I was insistent that if dad wanted to sit in his room he should as he was generally much calmer and more settled when he was there.
28. Dad's personal care was adequate. He often would not accept personal care, and he could get upset if pushed. I maintained my belief that his rights to refuse were more important than his personal care. It was interesting to me that this was the one area that NR was anxious about and contacted me frequently about initially. This is likely to be due to the care inspectorate getting involved if personal care or physical safety were below standard. My Mum continued to get upset over his personal as she knew that dad would be more likely to accept care if coaxed gently. Not all of the staff had skills to do this and would too readily give up when he needed personal care.

Infection Control.

29. Infection control was sloppy in the nursing home. An example of the sloppiness would be staff wear masks around their chin and varying enforcement of PPE for relatives when visiting. I personally didn't have an issue with this as I thought the PPE guidance was overly restrictive to providing care for people supposedly in their 'home', but it wasn't a

proactive decision for Deanfield, just more a reflection of their overall approach to care

30. Dad was never asked to wear a mask. I was happy with that. I wore one initially when I arrived because we were asked to wear one, but once in his room we removed them and no one ever asked me to put it back on.
31. Hand gel was readily available.

Care Inspection.

32. I believe the care inspection team had been at the care home prior to dad arriving.

Visits.

33. In April 2021 we were allowed garden visits and dad appeared to be bright and happy on the initial visit but his mood could be very variable after that. He was often very upset and tearful.
34. We had to pre-book visits, and we were allowed a 30 minute visit once a week at the start. This increased to twice a week. We had to do a lateral flow test on arrival but eventually you could do it at home before we attended and just record the result on a form. Mum and I would visit, and we had to wear full PPE and be stood at a distance.
35. In June 2021, we were allowed to visit dad in his room. We had to wear PPE and be distanced from him but it was good to see him. It was very important that I could see him personally and assess him physically. I could see that dad's feet were swollen which they had not told me about. If they had told me, I could have brought suitable footwear and socks which I then organised.
36. Dad did receive mental health services and they did visit him. He did however need podiatry services which he did not receive.
37. Dad's condition declined rapidly as the year went on, I cannot say it was directly attributed to the restrictions but it did not help.
38. The home was disorganised. I needed more communication but did not get it. We never had relative's meetings on Teams for the duration of his stay.
39. I received sporadic emails relating to the guidance on visits, but most of the time I found out from a staff member when visiting that they things were changing.

40. My Mum's health was such that she often couldn't visit at an allocated time. She needed the freedom to have rapid access when she was having a good day but the restrictions meant that she couldn't do this. As a result she had far fewer visits than she would have had had the restrictions not been in place. She felt guilty, frustrated and angry because she was not seeing him. Her grief has been intensified and she is still regularly in emotional pain as she recalls this time. Dad felt abandoned, he blamed me a lot and he was angry and frustrated.
41. On 21st October 2021, I wanted to go in and see him because his Amazon Echo was not working, and I wanted to re-set the device. I emailed my request to NR but she just ignored my requests by saying that public health guidance says you cannot come in despite the fact that dad was highly distressed.
42. Dad seemed to settle a little bit during November 2021.
43. Visits were reinstated in December that year. Dad has always disliked Christmas and Christmas celebrations started in Deanfield from the 1st of December. They had an event every day during December. He asked daily, 'is it over yet?'
44. Dad was due to come home for a visit on Christmas day, but my sister who was arranging this tested positive for covid. The rest of us already had made other plans for Christmas which we would have changed, but mum decided to cancel the visit and instead she and I visited on Christmas Eve. He was very tearful and felt very sore, he was struggling to walk. In retrospect this was the early signs of a condition which caused him to collapse the following day.
45. I received a call around 11 am on Christmas morning to say he was in a bad way. My mum had already been in on the echo show and had seen he was quite unwell. The nurse who called me had said she would have called an ambulance but knew the care plan said to call me first. This was because my dad did not want any hospital based interventions should he develop a life threatening illness, that his 'ceiling of care' was to be the nursing home. This was a decision that all the family agreed with.
46. I immediately visited and it was obvious that dad was very unwell, and likely to die from this illness. We requested an out of hours GP visit and they agreed that he was likely to die and that it wouldn't be in his interests to move him to hospital. They prescribed 'Just in Case' medications to deal with any distressing end of life symptoms he might develop.

47. The duty nurse was very good and pragmatic, and we were given lots of access to dad with no restrictions. We took it in turns to sit with him. He never regained consciousness. Our large family were all allowed to visit at any hour and say goodbye.
48. Dad died during the evening of the 28th of December 2021. The nursing home supported us and him during his final illness well. We were left to do what we needed to do. The priest also attended to see dad prior to his death. The on-duty nurse was very supportive, and the staff that we knew expressed their condolences. We never heard from the nursing home manager.

DNACPR.

49. Dad had a DNACPR in place, this would have been recorded on a care plan in the home and his medical records.
50. We did not want dad to be taken into hospital by ambulance if his health failed, we wanted to care for him in the home. I notified the care home of our request. This decision was made when he first entered the home and recorded in his notes under his 'anticipatory care plan' (ACP). I was very insistent on this because as a GP who visits care homes regularly, the ACP is essential to guide decisions on care.
51. One evening he was feeling dizzy so the care home phoned NHS 24 instead of phoning me as detailed in his care plan. NHS 24 sent an ambulance because his blood pressure was very high. As a GP I know that is often what happens when you phone NHS 24 as the assessment is made by a nurse following a flow chart. My mum phoned me to tell me what was going on as she had been aware of this through the echo. I spoke to the paramedics on the phone who wanted to take him to hospital as they were worried he was having a stroke. As a GP, I knew this was not the case and that my dad's dizziness earlier had been due to his Lewy Body Dementia and related postural hypotension. His high BP was long standing. They eventually agreed, reluctantly, not to take him in. Had I not intervened he would have been assessed in A+E, having probably been left alone in a cubicle for several hours being highly distressed by the experience. The assessing doctor would have confirmed he wasn't having a stroke and sent him back to the nursing home, but, as he has been in hospital for more than 2 hours he would have been restricted to his room for 14 days. This was happening to many care home residents during this time and I read many reports on CHRS of this. It was very, very distressing for people.

Impact

52. Dad's care in the home was much more stressful than it should have been. His illness was stressful, and it was made more stressful by the home and the restrictions.
53. The communication with the home was dire and it added stress to an already stressful situation.
54. Dad did not have access to his normal activities with no visits to the music shop and no access to religion. We asked about access to a priest and mass but again communication was poor with the home. We approached the priest and he said that he was not allowed into the home. We were unsure whose fault it was.
55. Mum felt very guilty which was compounded by the additional challenges brought upon by Covid and the care homes very poor response to the situation.

Lessons Learned.

56. We as a family should have been given free access to visit and support our dad in the hospital and care home.
57. The communication in this particular care homes was shocking. Staff should have been supplied with mobile phones
58. Technology such as the echo show should be standard for care homes and relatives should be made aware it exists and offered the use of it.
59. The restrictions brought in during the pandemic exposed how poorly care homes are run and how inadequate the staffing is. Care homes need more, better paid and better trained staff as well as improved facilities and the use of technology to support better communication and supervision of residents..

Role as a GP during the pandemic.

60. Just prior to the pandemic in 2020, I worked two to three shifts per week in the GP out of hour's service in Greater Glasgow and Clyde. I conducted home visits for those unable to attend and out of hours centre, but would also do and telephone consultations for patients and see them in the out of ours centres for assessment.
61. The clinical director was Name Redacted At the end of 2019 the out of hours service were on special measures from the health board as it was performing so poorly and there were serious patient safety concerns. NR from the health board was brought in to oversee this and Sir Lewis Ritchie and a team from Scottish Government was also

conducting meetings with the service. We were having lots of meetings to try and address these issues and our service was dangerously understaffed as many doctors were unhappy about working in such unsafe conditions.

62. The staff (doctors and nurses) at the coalface were aware that covid was more prevalent than official figures would suggest in the early days. We were aware that we were seeing more people with viral symptoms than we would expect and more unwell than we would expect.
63. The phone lines kind of exploded over March during out of hours and I was taken off home visits to staff the phones. As mentioned before we were a small team in special measures and understaffed. Things had to change very quickly. Many staff including myself volunteered to work many additional hours to meet the demand.
64. As March went on, the out of hour's service was tasked in creating Covid Hubs. These were centres where patients with suspected covid could be seen and examined safely. I was very impressed with the speed, dedication and willingness of staff with which this was done. Arnold Clark donated vehicles to assist in patient transport. We recruited a huge number of drivers. The good will of the NHS came out and colleagues filled shifts. Resource was made available. The phone triaging and home visiting cars were based at Caledonia House.
65. Covid centres were set up very quickly at Woodside Health Centre (at that time an unused building) and other centres in Inverclyde and Paisley and there were some others but I'm not sure where. The centres were to keep people with suspected covid away from GP surgeries and our own out of hour's centres.
66. Hospitals were also getting organised. There was a projection that the hospitals were going to be rapidly overwhelmed with people sick with covid. This was based on part on the experience of other countries. Decisions were made to discharge as many people as possible, particularly elderly people into any spare beds in care homes. I believe this decision was made to clear space in the hospitals but also to try and protect these elderly people as it was becoming clear that many people (patients and staff) in the hospital had covid. Sadly, many of these elderly people also had covid therefore accelerating the spread of covid in the care homes.
67. It is my opinion that we did fantastic job responding to the initial challenges of the pandemic. The good will of NHS staff came out and they went above and beyond. In particular our community based response with the covid phone lines and centres kept people away from the hospitals and stopped them from becoming overwhelmed.

68. My role was to give advice to patients on the phone and conduct home visits for the elderly and housebound, including the care homes. I increased my hours and was working around 24 hours a week for the service.
69. We were receiving complex guidance from Public Health. We received emails with changing information daily at times. The guidance was ever changing and not easy to understand. We supported and educated each other by holding webinars.
70. **NR** who is the Deputy Primary Care Clinical Director with the Health Board was involved in the setting up of the Covid hubs. **NR** was very visible in the out of hour's service at this time.
71. The team leaders in the out of hours were working many extra shifts and did most of the organising and set up. We worked together to ensure that information as it emerged was disseminated as quickly as possible.

PPE/Infection Control.

72. Infection control was unclear, and I recall a debate on masks. The FFP3 mask was recommended by Public Health but as very few were available guidance suddenly emerged that said we did not need them. Many of us felt this was not based on evidence but the fact that supplies weren't available. They recommended HASMAT suits but that was out of the question.
73. We got aprons reasonably quickly and eye protection which looked a bit like a diving mask, (you couldn't really see out of it as it steamed up), gloves and face masks. I initially got fitted for a special mask, but we were then told we did not need them. I always had access to PPE, and we set up our own hygiene practices from our own knowledge of infection control. We would all change and shower as soon as we got home. Most of us purchased our own scrubs.
74. We implemented a system that when people needed to attend an out of hours centre they were instructed let us know they had arrived and then go back out and wait in their car. We would phone them when we were ready for them to come in. This was to make sure people weren't sitting together in a waiting area.
75. The guidance was not clear as it changed so rapidly. We acted using our own infection control knowledge. I was involved in drawing up the guidance for infection control for home visits. **NR** had asked the

doctors carrying out home visits to do this. It wasn't really necessary as we all had good knowledge of infection control.

Adoption and Fostering Service.

76. At the very beginning, GPs were advised to stop doing adult medical reports for those fostering and adopting as it was deemed non-essential work but this continued for a long time and we were still basing our medical advice on people's own disclosures about their health well into 2021. This was dangerous because information may be concealed by people of a safeguarding concern to children and the GP is crucial in alerting us to that.
77. Social workers who would normally be making visits to houses were now only making phone contact. Adoption and Fostering panels stopped. Contact visits between children in foster care and their birth parents were stopped and children's relationships with their family were affected and I believe damaged the chances of rehabilitation to their birth families in some cases. Anecdotally I seemed to hear more reports of birth parents dying from drug overdoses. I'm unsure if there are any statistics to support this but I wondered if this was related to people injecting drugs alone whereas prior to the restrictions they would have been with other people.
78. There was anxiety amongst foster parents about their foster children bringing covid into their home. Quite a few of the foster carers were in the shielding group, or had elderly parents they also cared for so were very worried about contact visits being reinstated.
79. CoramBAAF (which is the UK's organisation for professionals working to improve outcomes for children and young people in care) started lobbying government to change policy for these specific groups. They had a Health Group which I sat on and we met more frequently to discuss what was happening in our areas and how we could go about making change happen. CoramBAAF approached the government and also got the BMA and Royal College of GP's to issue statements stating how important it was for GP's to restart doing these reports.
80. When adoptions were arranged we could not transition children into their new family in the usual gradual way. Normally, when it's time for a child to move their new home introductions are done gradually initially in their foster home with their foster parents present, and then short periods alone with their new parents and gradually built up, and adjusted to the needs of the child. During the pandemic transitions were done much more rapidly to limit the time people were together. It was an uncomfortable

phase and we were very worried about the negative effects on children and new families.

81. Adoption applications from people wanting to adopt increased during the pandemic whereas foster carers resigned during the pandemic because of the need to shield and isolate and applications from people wishing to foster decreased.
82. June, July and August 2020 were extremely busy for me working with social work to try and address the issues that were emerging from the restrictions being put in place. I am not normally involved in contact arrangements or transitions but as the advice from Public Health was so black and white social work needed support to come up bespoke arrangements that addressed the complicated issues were arising. It struck me that as I reflected on this the restrictions placed on care homes were causing similar complexity and they too could have greatly benefited from extra support in addressing their residents and their family's needs.

Out of Hours – Care Homes during Covid.

83. In my role as a home visiting GP many of my visits are to care home residents. This was also true during the pandemic. I also volunteered for the 'covid' shifts, which were when a visit was required for a housebound patient with suspected covid. We covered the whole of Greater Glasgow and Clyde. I visited many care homes and in the initial weeks of restrictions they were in chaos.

Treatment and Care.

84. We would receive requests for a home visit from GPs who were doing telephone consultations in the covid phone centre or referrals from GP's in the practices who had carried out a phone consultation with a patient and decided they needed a face to face assessment. If a face-to-face consultation was required then a car containing a driver, a GP and equipment would be deployed on a home or care home visit. About 4 GP's were available to carry out these visits during most shifts.
85. At the very beginning, we were not admitting care home residents to hospital for treatment of covid. I cannot recall if this was official guidance.
86. Once an elderly person is at a level where their needs are such that they need to be cared for in a care home, the average level of life expectancy is around two years. The person is usually very frail and dependent with a number of health conditions that can deteriorate at any time. It is also generally accepted that your frailty is such are highly unlikely to survive

CPR in the event of a cardiac arrest. This is the reason that everyone on admission to a care home should have a DNACPR certificate. This is to allow people dignity in death and avoid unnecessary, distressing attempted resuscitation scenes. Once this has been explained to people and their family's they rarely refuse to have one.

87. It is a key role of care home managers and nurses to make sure care plans include conversations with the resident (if appropriate) and their family an anticipatory care plan. This is what is important to the person in the event of their health deteriorating. This is a delicate conversation and the person and their family need information and guidance on the likely outcome of a deterioration in their health as well as the benefits and potential adverse outcomes of an admission to hospital.
88. There were very few treatment options for an elderly, frail person with covid at the beginning of the pandemic. They would not be strong enough to respond to the more intensive measures that were being used with fitter people.
89. The patients in care homes predominantly received a GP level of medical treatment. Oxygen Concentrators were introduced sometime later in care homes, and we could give oxygen. I was concerned about the inability to give IV fluids. Many of the elderly patients with covid were extremely fatigued and unable to accept oral fluids.
90. By June, I became concerned about care home patients not being admitted to hospital. I was concerned that dehydration was a big issue. I can't remember now if there was written guidance but there was a general acceptance that it was not appropriate to admit a resident in a care home to hospital with covid

GPs and Care Homes during Covid.

91. Care homes rely on family to provide emotional support and company to their loved ones. Employed staff are there to provide medical, physical and personal care. If you cut out the family the care homes cannot provide the care that relatives require. There are activities coordinators but they generally only provide group based activities and have no knowledge of what that resident enjoys specifically.
92. This sudden exclusion of families, 'non-essential' staff and 3rd sector was very obvious when I made my visits. The distress levels of the residents increased as did distress behaviours. The staff in many of the homes I visited were distressed; they looked distressed, eyes glazed and tearful. They seemed overwhelmed and not in a good place.

93. The phrase used was "footfall". "We need to reduce the footfall in the care homes". All non-essential services stopped, such as physiotherapy, podiatry etc. Staff made do and used to do things like cut patients hair and cut toenails themselves. Care homes are usually full of activities for residents and their families to enjoy together; movie nights, concerts, gardening. All of these activities stopped and people with dementia were unable to understand why, or retain the reason if they did understand.
94. Practice GPs stopped doing home visits and care home visits in the initial weeks and dealt with everything over the phone. Many practices have continued to do this particularly with care homes. The workload crisis within General Practice has meant that GP's are scrambling to find time to do the work. Home visits are very costly in terms of time and many GP's are now relying on phone conversations with staff nurses to make their diagnosis and prescribe. This is a loss to care home residents and it is my opinion it has affected their quality of life.
95. Obtaining prescriptions, medication and administering end of life care was a challenge. We use syringe drivers to administer medications during end of life care, but due to then number of people dying we did not have enough, or, enough trained staff to set them up and monitor them. We were given guidance from palliative care on how to manage symptoms differently and how to overcome these challenges.

Infection Control.

96. Infection control in the homes was initially variable. It was obvious from my initial visits, particularly in the residential homes, that staff did not have knowledge of how to carry out basic infection control. I spoke to social work managers about this and they organised for appropriate professionals to go into the homes and instruct as well as help the staff set up infection control stations. Homes with nurses were much better equipped.

Covid Testing.

97. When lateral flow tests were introduced, I tested myself on each day I was working. Most care homes were happy with this arrangement, but it did vary and many had additional arrangements such as questionnaires and temperature checks before I was allowed to enter the home which was time delaying and unnecessary. I was provided with plenty of tests.

Sedation of Residents.

98. The loss of crucial services such as day centres for people in the community with dementia resulted in a loss of routine and extreme

pressure on family carers. I witnessed this first hand with my dad that the impact of his dementia increased with the restrictions. The only option at times was to sedate patients. People were medicated more because of the isolation I would say.

99. In nursing homes I have a colleague who believes his mother died from dehydration secondary to sedation. She had Covid and was distressed so she was heavily sedated as they did not have staff who could sit with her.
100. It is not unusual for a person with dementia to become agitated when they are unwell, and covid was no different. If a resident with covid was agitated and wanted to leave their room they would be sedated as there wasn't staff available to give one to one supervision. Relatives were not given the option to sit with their relative.

End of Life Care

101. We as doctors were bombarded with guidance on how to manage the symptoms of Covid, and how to manage an end of life situation when we didn't have access to syringe drivers, but no guidance was given to care home staff on how to provide emotional and spiritual care in the absence of loved ones and spiritual teachers.
102. Generally care homes are excellent in supporting a resident and their family in their final illness but the government guidance did not acknowledge what good end of life care involved; freedom for family to be with their dying loved one, comforting them and cherishing final hours together. It can be painful time but also a very precious time. Family support one another and sit together. An 'essential visit' allowed one family member to visit for 30 minutes which was woefully inadequate. The interpretation of the guidance varied from care home manager to care home manager. Some were stricter, and others were more pragmatic.
103. It was not appropriate to stop visits, not the right decision. Many relatives, including me were prepared to take the risks. I could not understand that as a doctor I spent my day visiting people in care homes yet was not allowed access to visit my own dad.
104. The role of a GP was interpreted differently in care homes. Covid guidance which included restrictions could be interpreted using a more flexible approach if a GP advised it.
105. Guidance was not clear and not enough emphasis was placed upon being pragmatic and responsive to the needs of individuals.
106. I tried to feedback what I was seeing in care homes as a doctor but I couldn't seem to access a person or body who listened and could affect

change. I did not who to contact in Public Health to try and discuss the impact of the regulations on residents despite trying to. Other colleagues had the same experience.

107. I did phone a doctor called [NR] in the early days. [NR] at that time had a role within care homes supporting them with putting ACP's in place and I told her that it was awful in care homes. She arranged a group phone call with social worker managers she had contact with. They were keen to hear what I had to say and responded by arranging professionals to go into the homes to teach and support the staff with infection control as well as be more visible to the staff in a bid to boost their morale.

Transferring of patients to Hospital.

108. After a few months of the pandemic we understood covid much better and were able to predict more accurately those people who would deteriorate. Week two of Covid was often when patients would deteriorate. Covid pneumonia would kick in and we knew we could make a difference with oxygen and steroid treatments. Very quickly this treatment became available in the care homes. There was a dedicated Covid phone line and medication would be delivered to the home. I was delighted that these treatments were made available in care homes but hugely disappointed that care homes did not open up to relatives.

109. If a care home resident was admitted to hospital for more than four hours when they were discharged from hospital, they were expected to isolate in their rooms for 14 days and had a negative PCR test. This was unnecessary and it still existed in March 2021 when dad went into hospital. This was cut down to 7 days a few months later.

Home Visits/Care.

110. Before the pandemic my job was generally very enjoyable. Most people I visited got better. Those who were at the end of their life it was generally peaceful, long anticipated and well supported.

111. During the pandemic, especially in the first few months, most of the people I visited died a few days or weeks later. I have never in my whole career experienced anything like that.

112. Social care in people's homes was drastically reduced, people were dying from lack of care. I admitted people to hospital at the beginning not for medical care but personal care as they were having difficulty with daily

living activities and were additionally struggling with mild covid or another illness.

113. Care packages changed dramatically which had a very bad impact on people's lives. I started submitting adult protection forms which I had not done before due to lack of social care.

General DNACPR Requests

114. GPs were asked to go through their patient lists and identify anyone who was vulnerable and should be on the shielding list. They were then required to phone the patient and check whether they knew about Covid and ask whether they would want DNACPR notification on their medical record. They would speak to the patient directly and not the family. I presume the directive came from clinical director level at the health board.
115. Vulnerable people were identified by the practice by age, underlying health conditions and if they were shielding.
116. The reason for doing this was that it was anticipated that the high numbers of people dying would trigger emergency response requests and that the ambulance service would be overwhelmed. Paramedics will start CPR in any person whose heart has stopped unless they are in receipt of a DNACPR form.
117. A clinical decision was made on admission to hospital under pressured circumstances. If it was judged that you would not survive a cardiac arrest a DNACPR was put in place. As doctors we are not required to get a patient's consent for this, it's a clinical decision based on the likelihood of you surviving a cardiac arrest but it is recommended and good practice to discuss it with the patient and the family. During the pandemic this practice was often dropped and patients and family were often quite shocked to find out it had been put in place.

Welfare Support for GPs.

118. I was given initial support from posters that were distributed and was told to go for a walk and do some mindfulness.
119. In December 2021, NHS Scotland signed up to Practitioner Health Services, which was an NHS England initiative where staff could access confidential mental health support from GP's, counsellors and psychiatrists. I accessed the service in April 2022 it was really good and helpful.

Impact.

120. I operated really well during 2020, but I was mentally and physically burnt out the following year. I'm still not fully recovered.
121. The impact on care homes was terrible. The atmosphere was desolate. Staff and residents were equally distressed.
122. Dementia in patients was accelerated due to the isolation. I saw this first hand with my dad and other residents who I was visiting.
123. Residents were lost and unsettled, the atmosphere was bleak and desolate. Residents were barrier nursed in rooms with an infection control station outside.
124. Because of Covid, and the neglect of family involvement, very often DNACPR conversations were not taking place with family and they were shocked to find out it had been put in place.
125. My colleagues and I were very upset. We felt that care home residents were an abandoned group of people. Staff sickness rates in care homes were high due to stress, needing to shield and being sick with Covid.
126. Medical staff sickness rates remain high. We felt for a long time that we had been firefighting, we were at times flat and irritable, but we battled through it but it has taken a toll.
127. Some GPs have not returned to the profession following Covid. GPs, like much of the NHS and social care sector are at breaking point. The long waiting lists for secondary care has increased the workload in General Practice as patients will continue to consult about symptoms they are struggling with and have not received an appointment for yet.
128. People's health has changed dramatically. Many children did not develop normally as a direct result of the isolation during Covid and the waiting lists for assessment at child development centres has increased dramatically. Children's mental health has deteriorated significantly and teachers are really struggling to educate with the increased needs of some children. Referrals have increased and all specialties have long waiting times.

Lessons Learned.

129. We need to have a better understanding of vulnerable groups and their needs. The soft stuff (emotional and spiritual care) is important, and we really only focused on the hard stuff.

130. The guidelines did not allow families to have access to their loved ones; to acknowledge that these were guidelines and not rules. We knew the impact on residents in April 2020 and isolation went on far too long. For those living in the community freedom was given to families to make their own decisions about breaking restrictions if a family member needed care.

131. Care Home Relatives Scotland was doing impressive work. I greatly valued the support and advice I received there. Their campaign to see Anne's Law passed is very important and I'm sorry it is taking so long.

132. Making this statement has made me realise that I didn't know who to raise my concerns with. In my fostering and adoption work CoramBAAF took on the role of lobbying on behalf of care experienced children and their families (birth, adoptive and foster). Residents in care homes need a similar group. Independent but funded.

133. Greater considerations and provisions to be made for homeless groups, looked after children, domestic abuse victims, asylum seekers and the elderly who were massively underrepresented.

Inquiry Hearings.

134. I am on holiday the 28th October to the 7th November.

Signed **Personal Data**

Date.....21/09/2023.....