Witness Name: Dr Michael Mulholland
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF Dr Michael Mulholland on behalf of ROYAL COLLEGE OF GENERAL PRACTITIONERS

I, Dr Michael Mulholland Honorary Secretary RCGP. will say as follows: -

Background to RCGP

1. The RCGP is a professional membership body of over 55,000 GPs. We are committed to improving patient care, supporting GPs to continually develop their skills and promoting general practice as a discipline. We support GPs through all stages of their career, from medical students considering general practice, through to training, qualified years and retirement. The RCGP is an independent professional body with expertise in patient-centred generalist clinical primary care.
2. We have 55,220 members in total 51,668 based in the UK; 43,491 are based in England, 1,467 in Northern Ireland, 4,590 in Scotland and 2,120 in Wales. 55% are female, and 27% are 50 years old or above. 51% come from minority ethnic backgrounds; 32% have an Asian identity, 12% black, 2% mixed or multiple and 5% other identities.

3. To become licensed to practise as a GP within the UK, doctors must pass the College's MRCGP examination, comprising the Applied Knowledge Test (AKT), Simulated Consultation Assessment (SCA) and Workplace Based Assessment (WPBA) (the latter of which is managed by local NHS Deaneries). The Simulated Consultation Assessment (SCA) replaced the Recorded Consultation Assessment (RCA) in 2023 as the final professional exam required to achieve MRCGP.
4. We also provide a one-stop-shop for CPD throughout a GP's career, enabling them to record and reflect on their learning journey and access high-quality CPD resources.
5. By harnessing the voice of our members, we help shape national policies and guidance in the UK that impacts how care is delivered in general practice, including engaging with

politicians and other national decision-makers in the health sector. We also deliver projects to help to identify and spread good practice.

6. The RCGP collaborates with the University of Oxford and the UK Health Security Agency (and previously Public Health England) in the running of the Research and Surveillance Centre (RSC), an internationally renowned primary care data informatics network and one of the oldest GP sentinel networks in Europe.

Summary of the RCGP's role during the pandemic in relation to the care sector

7. The College made the strategic decision to "pivot" RCGP outputs onto dealing with Covid-19 in March 2020. We established an internal clinical advisory group which included senior leaders from the organisation and key GP expertise. he group ensured we were across the emerging issues of the pandemic as much as possible, meeting at least weekly in the early stages of the pandemic and then regularly throughout the pandemic. This group considered a number of issues related to the care sector as part of their overall work. Care issues were considered as a key part of the College's overall aims to improve care in general practice, no matter where the setting.

8. During the Covid-19 pandemic, the RCGP delivered a vast amount of work to support GPs in providing the best possible care during extremely challenging times. The College followed the rapidly changing guidance given from national bodies and encouraged our members to do the same.

9. Throughout the pandemic, the RCGP-Oxford Research Surveillance Centre (RSC) carried out a range of activities such as Covid-19 surveillance virology and vaccine effectiveness. The RSC supplied Covid-19 testing kits to practices, and results to the Government that were unavailable elsewhere at the time. It underpinned the PRINCIPLE research trial – the urgent public health primary care platform trial that tested 7 different repurposed medications as potential acute Covid-19 treatments.

10. The Covid-19 resource hub, hosted in the College's eLearning platform, was created to support GPs in understanding and managing the pandemic. The hub was home to a range of resources to upskill and support GPs and their teams to respond to Covid-19. This included dedicated sections on supporting patients in community and care settings as well as information that was relevant for GPs no matter what settings they worked.

11. Each of these resources were developed by clinical leads and subject matter experts and were subject to a robust quality assurance process. The hub was updated on a day-to-day basis in accordance with changing member needs and new national policies.

12. The Covid-19 Hub was up and running by the middle of March 2020. Following the first week of the national lockdown (28th March – 5th April 2020) the hub had 90,000 visits. The College's eLearning platform saw a 170% increase in users between 23/03/2020 - 27/05/2020 when compared to the previous period 17/01/2020 - 26/03/2020. By April 2021, the Covid-19 hub had hit one million clicks.

RCGP's work with advisory bodies, government departments, agencies, arm's length bodies and professional organisations

13. From the onset of the pandemic, the College sought to engage constructively with politicians, decision makers and public bodies. This was largely at the national level with limited engagement with Health and Social Care Trusts. We do not have any records of engagement with individual local authorities although it is possible that there was some engagement at this level.

14. The level of communication between the RCGP and government and care bodies varied throughout the pandemic. We recognise that every organisation was dealing with a rapidly changing situation which impacted their ability to consult in the usual forms, and there were improvements to enable rapid two-way communications as the pandemic progressed.

15. Our engagement focused mainly on the delivery of primary care to patients in care settings rather than wider issues related to the running of care homes. When talking about infection controls in care settings, we would focus on the impact they would have on the ability to provide primary care support to patients.

16. For a significant period of the pandemic, our Chair Professor Martin Marshall joined a group of Medical Royal College leads to meet weekly with the Chief Medical Officer Chris Whitty for England and National Medical Director of NHS England Professor Steve Powis. They also met on largely two weekly basis with the Secretary of State for Health and Social Care.

17. Similar levels of engagement with politicians and NHS decision makers have been achieved in the devolved nations. These meetings covered the whole of the health and care response to Covid-19, including care homes, the discharge of patients from hospital and absence of PPE.

18. Representatives from the RCGP discussed with NHSE officials the development of the enhanced health in care homes programme that was launched in April 2020 and continued these discussions regarding the development of the October 2020 update. This was a programme run by NHSE launched before the pandemic and was adapted during the pandemic,

19. It is difficult to say whether the level of engagement with RCGP was sufficient with regard to the care sector. It was a very difficult time and there were a range of professional groups working in the care sector. What is clear, however, is that there was a general perception that social care is still seen by decision makers as less important than health care in the remit of DHSC. This may have meant that during the early stages of the pandemic social care considerations were not considered as important as those related to hospitals. With the messaging being "protect the NHS", it may be that social care considerations were deemed less important than those related to hospital in the early stages of the pandemic

The role of GPs in social care

20. GPs coordinate and deliver medical care and to access specialty community and hospital services for care home residents as part of their registered list of patients. The level of care needed can vary significantly depending on both the individual and the level of care provided by the home.

21. Prior to the pandemic, some care homes were overseen by one GP practice, while some were shared between practices. There was no national standard agreed and no universal agreement if GPs were providing regular visits to care homes or just reactive care. While many GPs did regularly visit care homes to provide check-ups and support there was no national funding for anything beyond standard reactive care a GP would provide to any patient.

22. GPs also play a key role in providing compassionate, high-quality end-of-life and palliative care, particularly for those receiving care in residential and nursing homes, as well as those being cared for at home by domiciliary and unpaid carers.

23. GPs are at the heart of delivering personalised, holistic care that supports patients and their families during this critical stage of life. Their key responsibilities align with the enhanced health in care homes framework, ensuring that residents receive proactive, coordinated, and integrated care. The enhanced health in care homes framework is an NHSE framework is for primary care networks (PCNs), providers, and commissioners of community health and social care services. It guides the commissioning of and delivery arrangements for health

and social care services in collaboration with care homes, so that the entire system works together to provide personalised care, improve outcomes and promote independence for people living in care.

24. Over the last 10 years there have been a number of pilots to look at how better care might be provided to this vulnerable group. The RCGP has been involved in discussions with NHS bodies and health departments across the four nations as part of these discussions on how to improve health in care settings. For example, GPs have been involved in the care home vanguards project which began in 2015 and the vanguard phase ended in March 2018. This lead to the implementation of the ageing well programme as part of the NHS Long Term Plan in 2019.

25. As part of the NHS 2019 Long Term Plan a more personalised proactive approach was encouraged and this enabled more care and support planning and advanced care planning for residents in care homes through the NHS England advanced care in care homes programme. This approach was promoted by the RCGP.

26. The Scottish Government requested GPs to have anticipatory care planning with people who had more significant underlying health issues about their treatment wishes, should they become unwell with COVID-19. This included DNACPR discussions where appropriate. Some members in Scotland told our officers informally that the ACP conversations landed very badly with the public who were anxious about the virus, and the fact that many of these conversations were having to take place on the telephone rather than in person due to infection control. On 2 April 2020 Chair Dr Lunan wrote to National Clinical Director Jason Leitch and Chief Medical Officer Catherine Calderwood seeking proactive communications to support both GPs doing the ACP work and patients understanding of the intention of the conversations (**MM/01/INQ000589793**). We asked for the Scottish Government to explain publicly that GPs had been asked to have these important conversations, which are actually a routine part of good care in non-COVID times, but this request was not met.

Pre-pandemic capacity of the adult social care sector in the UK

27. The RCGP, like most interested parties, had significant concerns about the state of the adult social care sector prior to the pandemic. As a membership body for GPs, our engagement with decision makers on social care largely focussed on the role of GPs in social care rather than wider issues such as bed capacity in care homes. For example, the RCGP often engaged with DHSC and NHSE on how to improve discharge from hospitals, focusing on the GP's role in providing support for patients being discharged.

28. As part of the 2019 Long Term Plan, NHS England had a programme to reform the policies regarding the provision of healthcare to older adults, including those in the care sector. RCGP were engaged in conversations with NHSE about the steps to create a more standardised plan. The first of three components, focused on urgent community response, was launched before Covid-19 became prevalent in 2019 **(MM/02/ INQ000589808)**. The pandemic had a significant impact on the implementation of these programmes leading to them having to be adapted to fit the current state of infection.

29. We also joined other health bodies in making clear that fixing social care should be a priority for governments and decision-makers.

30. Prior to the pandemic the RCGP had been very clear that general practice was close to breaking point. While the NHS was employing more and more doctors in hospital settings the number of fully qualified Full Time Equivalent GPs was falling, leading to a rising number of patients per GP. GPs were experiencing higher levels of burnout and stress than other doctors and patient care was suffering because of it. This made it particularly difficult for GPs to care for patients in care settings as they had higher needs and it was much harder for GPs to find the time to visit care homes when keeping up with an ever-increasing demand for appointments in their surgery.

31. One area that would have been helpful if GPs were better prepared for supporting patients in care settings during the pandemic was in their digital infrastructure. In 2019, the RCGP published reports demonstrating the need to invest more into the digital infrastructure in general practice and workforce. In response to a survey, GPs reported that the key barriers to adopting these newer opportunities were a lack of IT infrastructure, insufficient funding and training, not enough time to adapt, concerns about safety, effectiveness, quality and liability, unequal access and lack of a legal framework governing newer technology. This had significant implications for patients in care settings because of the difficulties of being able to see patients face to face.

32. The RCGP Scotland 'From the Frontline' report called for enhanced IT infrastructure, in order to support the integration of members of the wider multi-disciplinary team (MDT), and to improve interoperability with secondary care. In conjunction with the RCGP Scotland Patient Group, we called for the full evaluation of all new digital services before wider adoption, to assess them for impact on patient safety, health inequalities and clinician workload. There was concern that without adequate digital infrastructure to support these

new models, particularly in remote and rural areas where broadband speed and mobile signal may be poor, a new "digital Inverse Care Law" could result, with the use of such digital services typically being dominated by those with least medical need. RCGP Scotland called for Health Equity Impact Assessments where each new digital implementation is evaluated for its impact on practices and patients in more deprived and remote areas.

The impact of the pandemic on the work of GP's in the care sector

Home visits by GPs;

33. Many GPs provided home visits throughout the pandemic. This became significantly more difficult at different periods of the pandemic.

34. Early in the pandemic, GPs were trying to do home visits without adequate PPE and were unable to access testing. Those needing home visits were likely to be the clinically most vulnerable and there were significant dangers that GPs would be bringing Covid-19 into their homes if they had not been tested and could not access PPE. This meant that GPs had to make difficult decisions on whether to visit a patient or not, balancing the risks vs potential benefits.

35. Once both vulnerable patients and GPs and their teams were able to access vaccinations and PPE it became safer and more appropriate for GPs to provide home visits. However, no PPE or vaccination could make it completely safe, so GPs always had to weigh up the risk of visiting patients.

36. The RCGP provided guidance and support for GPs on how to do home visits as safely as possible, including publishing an infographic on our online Covid-19 hub – as outlined below in the section on how the RCGP supported members provide better care for patients in the care sector.

37. In our member survey, fieldwork from 6 to 23 July 2020, titled "GP activity/workload over the Covid-19 pandemic and now", we asked our members "On average, what proportion of your general practice appointments over the past week would you say you have delivered using the following methods?". Our members said that on average they spent 2% of their time on home visits.

Discharge of patients from hospitals to care settings

38. GPs were not normally the professionals responsible for discharging patients from hospitals or the ones running or overseeing the care homes.

39. The RCGP Covid-19 Advisory Group reported that when the first patients were being discharged from hospitals the RCGP team did not know that they had not been tested - the assumption was that patients admitted from hospitals were being tested. The RCGP therefore did not raise significant concerns around the discharging of people from hospitals to care homes without testing until it had been made public in the press. Once this issue was raised in the press our Chair raised it in his regular meetings with DHSC and NHSE officials. However, as GPs were not the main groups of professionals in either discharging patients from hospitals or overseeing the care homes it was not something we have records of writing to anyone about and it seems appropriate that we were not a key influencer on these decisions.

Care home visits by GPs

40. The same considerations GPs needed to work through before visiting vulnerable patients at home were an even more difficult balance for patients in care homes. The danger of GPs and their teams spreading Covid-19 in care homes was a much more significant issue. In April 2020 NHS England published advice on how to establish a remote 'total triage' model in general practice encouraging practices to significantly increase the number of remote consultations as part of their infection control. While this was not specifically about patients in care homes it would applied to them as infection control was particularly important in these settings. This guidance was updated in September 2020. These policies were changed at different times throughout the pandemic through the "NHS England COVID-19 Primary Care SOP GP practice" which were updated regularly as the pandemic changed and policy considerations changed. As these were NHS England published documents, we do not have the full records of each of the changes.

41. In our member survey, fieldwork from 6 to 23 July 2020, titled "GP activity/workload over the Covid-19 pandemic and now", we asked our members "On average, what proportion of your general practice appointments over the past week would you say you have delivered using the following methods?". Our members said that on average they spent 1% of their time on care home visits. In total, they said they were spending 87% of their time on some form of remote care – so some of that will be spent on supporting patients in care homes remotely, although we did not go into this level of detail in our survey.

42. The RCGP did significant work supporting GPs visiting care homes. The RCGP Clinical Advisors Network provided guidance and support for GPs on how to do home visits and care home visits safely, including publishing an infographic on our online Covid-19 hub. The

RCGP worked with NHS and government bodies to signpost and widely disseminate this work. We provided significant support for members on these issues, publishing webinars and supporting members with questions via our phone lines and via email. More details of our support and contents of our Covid-19 hub is outlined below in the section on "How the RCGP supported members provide better care for patients in the care sector".

43. In April 2020 the enhanced health in care home programme EHCH introduced the expectation of weekly 'home round' for every care home, organised by their local Primary Care Network (PCN). In April 2020 the expectation was that this would be virtual unless the patient needed to be seen for clinical reasons, because of the high rates of infection and danger of spreading Covid-19. At other points in the pandemic there was more flexibility for PCNs to carry out these home rounds in person. The RCGP updated their guidance for GPs to include reference to these new guidelines and expectations.

44. RCGP Scotland worked with the BMA Scottish General Practitioners Committee (SGPC) together to improve care home guidance for GPs. A Frequently Asked Questions document was developed which was sent out by the Chief Medical Officer Gregor Smith, which covered guidance on access, the availability of services, considerations for admitting to hospital, and when to visit a care home or someone shielding in a care home.

The provision of healthcare via remote and digital methods

45. During the Covid-19 outbreak, practices had to strike a delicate balance between providing face-to-face patient care where clinically necessary and minimising the number of face-to-face patient contacts in line with national infection control protocols.

46. In England, prior to the national lockdown in March 2020, just over 70% of GP appointments and almost 80% of appointments in general practice overall were delivered face-to-face. During the first national lockdown, these proportions changed dramatically, with data from the RCGP-Oxford Research and Surveillance Centre finding that approximately 70% of GP appointments and over 65% of general practice appointments shifted to being undertaken remotely by telephone or video.

47. In Wales, Scotland and Northern Ireland, prior to the pandemic, appointments were also largely carried out face to face, with a rapid shift to telephone consultations in 2020.

48. These changes were particularly important to patients in the care sector. GPs were given clear guidance early on in the pandemic that there were significant dangers to care home residents that could be caused by bringing Covid-19 into the care home.

49. These changes were not, however, made without significant difficulties. In our survey of members in March 2020, we found that 85% of respondents said that they wanted better guidance on how to best manage appointments with a mix of remote working and triage. In April 2020 NHS England published advice on how to establish a remote 'total triage' model in general practice using online consultations. This was updated on 15 September 2020. **(MM/03/INQ000589807)**

50. There were also significant technical difficulties for GPs working remotely, with our survey in field from 3 to 8 April 2020 finding that 50% said they were not working from home. This was largely because they could not access practice laptops (44%), patient records (34%) or software for online consultations (33%). The College raised these concerns publicly and directly with DHSC and NHS bodies.

51. To provide support to care homes, not only did the GP practice need the right technology and training but so did the care home staff. Most care homes did not have facilities or plans in place to support the delivery of remote care in their buildings. Learning from the lessons of Covid-19, this should be built into every care home's plan so that their local NHS services can quickly deliver the best possible remote health care in any future emergency.

52. GPs rapidly responded to NHS guidance to move to an operating model of largely remote consultations, with the then Secretary of State declaring that even after the pandemic, 'all consultations should be tele-consultations unless there's a compelling clinical reason not to'.

53. In August 2020 we worked with NHS England to jointly publish a document 'Principles for supporting high quality consultations by video in general practice during Covid-19' to support our members with video consultations. **(MM/05/INQ000589791)**

54. While GPs responded to the NHS guidance and understood the need to protect patients and staff by minimising chances for the disease to spread, a significant proportion expressed concerns about the potential impact of moving long-term to a largely remote service. In our survey of members on remote working (in field between 10 and 12 September 2020) we found that 58% of respondents thought a higher proportion of face-to-face appointments were needed to best meet patients' needs, and that high levels of remote consultations made them anxious about delivering good patient experience and health outcomes.

55. The RCGP has supported members with significant advice and support on this subject through our Covid-19 hub. This included guidance for clinicians on the different modes of consultation, and when a particular mode of delivery may be better indicated than another, depending on the situation.

56. We published specific guidance around the use of remote consultations in care homes. This included consideration about how to work with staff who are already in the building, to support remote consultations. **(MM/06/INQ000589809)**

57. The RCGP was also represented on the NHSE groups writing guidance on how to manage safe remote consultations, both in home and care settings. This included the NHSE April 2020 advanced care in care homes programme, which proposed a significant expansion of the use of virtual visits.

PPE

58. There were challenges with personal protective equipment (PPE) provision for primary care in the early stages of the pandemic, and confusion around PPE guidance. In the early stages of the pandemic, there was a lack of clarity about how PPE should be used in both general practice and in care settings.

59. Some members reported that care homes and local GP practices pooled their resources of PPE, for example some care homes provided the practices with PPE to ensure they were able to visit the care homes.

60. Our survey of members in March 2020 found that 76% said it was very important to have more guidance on how to use PPE. We heard from members that this included a need for more information on fitting and training for use of PPE.

61. On 26 March 2020, the RCGP publicly expressed concerns about the availability of and guidance for PPE. We wrote to the Secretary of State for Health and Social Care saying that it was vital that urgent clarity was provided on whether GPs should begin wearing PPE for all face-to-face patient consultations. **(MM/07/ INQ000589805)** While this did not specifically refer to the care sector, the points made were particularly important in the care home sector.

62. At the same time, we wrote to the Minister for Health and Social Services in Wales raising the same concerns. **(MM/09/INQ000589810**) We also raised concerns that the release of PPE in Wales through the NHS Wales Shared Services Partnership had been based on an allocation of just 200 symptomatic patients per practice/Out of Hour centre, and that there was no option for practices to ask for further supplies. A response was received in early May which highlighted revised guidance on PPE use which had been issued in April

(MM/08/INQ000589801). The reply also referenced the four-nation approach to PPE procurement and the role of the Life Sciences Hub Wales in working with industries to develop the supply of PPE.

63. Following emergency guidance to hospitals in April 2020, against the backdrop of concerns that some items of PPE could run out, the College joined a number of other Medical Royal Colleges in writing publicly to the Secretary of State for Health and Social Care emphasising the importance of a transparent and open approach and calling on him to work more closely with the medical community to rebuild trust and confidence **(MM/11/ INQ000589795).** We also wrote in similar terms to Lord Deighton when he was appointed by the Health and Social Care Secretary to lead the national effort to produce PPE **(MM/10/ INQ000376188**).

64. Following our lobbying supplies for PPE did improve in Wales and Northern Ireland, which helped GPs when visiting care homes.

65. In Scotland, we received extensive media coverage after we wrote to the Cabinet Secretary for Health and Sport, jointly with Scottish Care and the Royal College of Nursing, to raise concerns over the level of PPE available for those delivering care in the community **(MM/12/INQ000589804).**

Infection control

66. Most care homes attempted to use a cohorting system to keep potentially infected patients separated from other residents. While of course this approach was viewed as the right thing to do at the time, the decision made it significantly harder for GPs and their teams to provide face to face care for different groups of patients without spreading infection.

67. Many GPs from across the UK expressed concerns about a general lack of effective infection controls within the care sector. These concerns were expressed informally by GPs to our senior officers and therefore were not specifically recorded. Our Chair Martin Marshall raised these concerns with national decision makers, including the Secretary of State for Health and the Chief Medical Officer, as part of their wider conversations about infection control in the overall health and social care sectors. However, as GPs were generally not in charge of running care homes, other organisations are likely to have taken a lead on this issue.

Testing of primary care staff entering care settings

68. Primary care staff visiting care settings were not able to access Covid-19 testing at the outset of the pandemic, and it took some time before a robust testing system for staff was in

place. Many staff were extremely concerned about infecting other staff members and their patients.

69. Once testing for NHS staff became available, there were issues with getting timely access to tests. It was almost impossible to get rapid test results, which were much more readily available to hospitals at earlier stages of the pandemic. In small or single-handed practices, this put patient care at significant risk.

70. During the early phase of the pandemic, an important focus of the College's campaigning was to push for priority testing for general practice staff and their families, so that staff who tested negative could return to frontline practice and maintain delivery of care for patients and their communities. This was rolled out in England in the second week of April 2020.

71. As part of this campaign the College also wrote an open letter on 14 May 2020 to the Secretary of State for Health and Social Care in England, calling for a comprehensive testing strategy for Covid-19 based on testing the 'right people at the right time', as a vital component of easing lockdown restrictions and protection against the risk of a second wave of infection. In our letter, we emphasised the need for GP records to be updated with test results and, following feedback from our members, a commitment to improving the sensitivity and specificity of tests. The letter generated extensive media coverage **(MM/13INQ000589802) [MM/14/INQ000280663]**, including an appearance by the Chair of Council on the Today Programme, and led to a meeting with Dido Harding, the newly appointed chair of the Government's "NHS Test and Trace" programme. We also had regular meetings with Lord Bethell, the Minister responsible for the Government's test, track and isolate policy.

72. On the 28 May 2020 the Government launched the Test and Trace strategy, which while not a perfect system, significantly expanded the ability to test the 'right people at the right time'.

73. In September 2020, we responded to the Chair of the Health Select Committee's comments on the need for weekly testing of all NHS staff. We talked about the need for strong, unambiguous guidance from NHS England, outlining how workforce capacity would be protected and the need for detailed plans on how these tests would be carried out in practice and assurance from the government that there was capacity to fulfil this initiative. In November 2020 NHS England introduced twice weekly testing for all NHS staff.

74. In Northern Ireland, we issued a joint media statement with other local Medical Royal Colleges, calling for better access to testing for healthcare workers. In Wales, the Government responded positively to our call for test results to be shared directly with GPs and we also pushed for faster processing of results and distribution of testing sites.

75. In December 2021, the Chair of the RCGP continued to express concerns that GP staff were struggling to access Covid-19 tests. This included that "we cannot afford for healthcare staff,

right across the NHS, to be unable to safely return to work simply because they cannot access a test".

76. RCGP Scotland called for an evidence-based approach to Lateral Flow Tests in primary care, and a recommendation that PPE and social distance were still required despite routine screening tests. We also urged GPs to optimise their technique to maximise test performance, to use accompanying public health advice or epidemiological evidence, and asked for occupational 24-hour turnaround for PCR testing as the 'gold standard' for confirming COVID-19 infection.

Verification of death

77. The RCGP supported temporary legislative changes allowing for remote verification of death, reducing unnecessary in-person assessments while maintaining clinical and ethical integrity.

78. Before the pandemic if someone died in their home or in a care home, if their death was expected it could be verified by a range of professionals. However, the medical certificate of cause of death (MCCD) had to be signed by a doctor who has seen the patient within the last 14 days. The Coronavirus Act changed the law to allow remote certification of death and extended the time that the doctor could have 'seen' the deceased patient (including remote consultations) to 28 days prior to their death. There was significant confusion amongst professionals about how that would work in practice. The RCGP worked with the BMA to produce guidance on the remote verification of expected death**. (MM/16/INQ000589811)** This has been supported by NHSE and has gone on to influence the relevant government guidelines **(MM/15/INQ000589794)**.

79. In August 2020 we updated our online module and guidance on the Medical Examiner System and Death Certification Process.

How end of life care was impacted by the pandemic

80. Every aspect of healthcare was stretched to near or actual breaking point by the Covid-19 pandemic, and this includes end of life care.

81. The Covid-19 pandemic significantly impacted the way GP teams provided end of life and palliative care, requiring rapid adaptation to ensure that patients continued to receive high-quality, compassionate care despite unprecedented challenges. The Royal College of General Practitioners, in collaboration with national partners, played a leading role in

providing guidance and resources to primary care teams throughout the crisis. Key changes in GP teams roles included:

82. Increased use of remote consultations – To minimise infection risk while maintaining continuity of care, GPs rapidly expanded the use of telephone and video consultations. While face-to-face visits remained important for complex cases, remote consultations enabled timely symptom management, advance care planning, and carer support. This approach was reinforced through ethical guidance, including resources such as the GMC's Remote Consultations Hub (GMC Ethical Hub).

83. Enhanced Advance Care Planning (ACP) – The pandemic highlighted the critical importance of proactive Advance Care Planning, ensuring that patients' preferences for treatment and care were understood and respected. The RCGP Joint Statement on ACP and Universal Principles for Advance Care Planning, published on 01 April 2020, was instrumental in shaping discussions around preferred place of care and death, ceilings of care, and do-not-attempt-resuscitation decisions.

84. Rapid deployment of palliative care medicines – The pandemic necessitated urgent action to ensure timely prescribing and access to symptom control medications. Collaborative discussions with NHS England led to legislative changes allowing controlled drugs to be repurposed and used for patients who need them during the COVID-19 pandemic. This allowed medicines no longer needed by the person for whom they were originally prescribed and intended to be re-prescribed to be used by another patient.

85. Supporting care home staff and unpaid carers – In alignment with the Enhanced Health in Care Homes framework, GPs intensified their support for care home teams and unpaid carers. Weekly virtual and face-to-face rounds enabled proactive health monitoring, medication reviews, and education on recognising deterioration and managing end-of-life distress. To the best of our knowledge no GPs were able to carry out face to face rounds in care homes throughout entirety of the pandemic with all care homes limiting access during at least one point during the pandemic.

86. Inequality and culturally sensitive care – The pandemic highlighted disparities in end-of-life care access among ethnically diverse and socioeconomically disadvantaged communities. Particular inequities in access to this care were experienced by Black, Asian and Ethnic Minority (BAME) communities, people living in more deprived areas, people who do not live with a spouse or partner and people with non-cancer conditions. As shown in the British medical bulletin article "resourcing of palliative and end of life care in the UK during the

Covid-19 pandemic" (**MM/18/INQ000589789**). We do not however keep statistical evidence on this. This made it significantly more difficult to provide culturally sensitive care, as it was harder to consider different religious and cultural expectations of families following a patients death.

87. The pandemic fundamentally shaped learning on the delivery of generalist palliative and end of life care, reinforcing the importance of personalised, coordinated, well-planned and community-based approaches.

88. At different stages of the pandemic, the rules on the ability of families visiting changed which led to changes in how palliative care could be delivered. As explained above the Standard Operating Procedures and guidance for GPs also changed which meant GPs were encouraged to carry out more consultations remotely making it more challenging to deliver palliative care.

The role of the RCGP and Marie Curie Daffodil Standards in supporting end-of-life care improvements during Covid-19

89. The RCGP worked closely with other organisations working in End-of-Life Care including Marie Curie, Macmillan Cancer Support, Cruse Bereavement, and Compassionate Communities UK.

90. The RCGP and Marie Curie UK General Practice run the Daffodil Core Standards for Advanced Serious Illness and End of Life Care. The Daffodil Standards provide a free, evidence-based framework to help practices self-assess and consistently offer the best end of life and bereavement care for patients. The Standards offer a simple structure to enable practices to be proactive organisations in which continuous learning and simple quality improvement steps are an integral part of care. The standards operate across the **(MM/19/UKINQ000589792**) **(MM/20/INQ000589799**).

91. During the Covid-19 pandemic, the Daffodil Standards were promoted in order to guide and strengthen primary care responses, aimed to support patients, families, and carers to receive consistent, high-quality care despite immense pressures. Several targeted adaptations and developments were introduced to support primary care teams in navigating pandemic challenges.

92. We also worked with the Scottish Government and the BMA to produce a letter to practices designed to support them with Anticipatory Care Planning for patients in very high-risk

groups [**MM/021/INQ000280657, MM/022INQ000280664].** This support for Anticipatory Care Planning included guidance on how to update and use the Key Information Summary for 'at risk' patients on both of the leading and most widely used GP IT systems (Vision and EMIS), with a template for practice activity for people with severe frailty to enable discussions on patient preferences for active treatment. The Key Information Summary refers to a collection of information about a patient, extracted from their general practice record by the GP, which is available to other services, such as Out of Hours Services, the Scottish Ambulance Service, and NHS24.This was subsequently adapted by RCGP Wales and issued to all Welsh GPs, jointly badged with the Welsh Government, NHS Wales and BMA Cymru Wales.

93. In April 2020 RCGP Scotland was involved in writing the Scottish Academy guidance on end-of-life care and visiting patients in hospitals, in conjunction with Marie Curie and Scottish Care.

Key adaptations and resources developed in response to Covid-19.

94. Bereavement resources: Working with other organisations the College helped practical resources on bereavement support during the pandemic, these resources provided practical guidance for primary care teams on supporting grieving families and carers.

95. Evaluation and development of the standards: Work was undertaken to review and adapt the Daffodil Standards to improve their coverage, accessibility, and relevance within the devolved nations, supporting equity in end-of-life care.

96. Regular communication and updates: The RCGP and Marie Curie Daffodil Standards newsletters and targeted RCGP communications provided timely updates, guidance, and case studies to practices, ensuring they were supported with the latest evidence and policy developments.

97. Launch of the care home Daffodil Standard (2020): Recognising and responding to the increasing vulnerability of care home residents during the pandemic, the RCGP and Marie Curie developed and launched a dedicated focus of the Daffodils Standard for care homes. This provided a structured approach for GP practices to work closely with multidisciplinary teams (MDTs) and care home staff, enabling better end-of-life planning, symptom management, and family support. The standard operates at three levels, beginning with gap identification in care planning, progressing to MDT learning and quality improvement, and culminating in a focus on compassion, workforce wellbeing, and community support.

98. Refreshing and relaunching the Daffodil Standards: Work was undertaken to improve the navigability of the standards within this specific care home sector. This additional Daffodil Standard was launched in early January 2021 and combined the eight existing standards previously published for General Practice but tailored specifically to support General Practice to care for patients residing in care homes and support the clinical care home team to provide the best possible care for their residents. The prime emphasis of which was to improve communication between the GP, care home clinicians and community pharmacy teams to facilitate palliative care to take place with the care home setting and reduce further hospital admissions if they were not required.

99. Future development: Pharmacy Daffodil Standards: Acknowledging the crucial role of pharmacists in end-of-life care, particularly in ensuring timely access to palliative medications, work began on developing Pharmacy Daffodil Standards in collaboration with Marie Curie and Royal Pharmaceutical Society to share learning on the design and development of the RCGP Daffodil Standards in order for the RPS and Marie Curie Daffodil Standards to align in order to strengthen primary care-pharmacy quality improvements.

100. Collaborating on Advance Care Planning (ACP) tools: The RCGP and Marie Curie worked alongside national organisations to design and pilot a public-facing online ACP tool, aimed at supporting patients and carers in initiating and recording their care preferences in a structured and accessible manner. Champion practices using the Daffodil Standards piloted the prototype to share their learning and experience of using the tool.

101. Emphasising the use of the Daffodil Standards to review and reflect on the quality of care for minority groups: Informally our members told us that the pandemic highlighted inequalities in end-of-life care, by demonstrating that people with learning disabilities and those from diverse cultural, religious, and ethnic minority backgrounds often did not get the same quality of care tailored to their needs as white British patients in more affluent areas. As we do not hold or collect data on the delivery of end-of-life care other organisations may be better placed to spell out these impacts. The Daffodil Standards encouraged GPs and practice teams to reflect on care quality and ensure individualised care and support plans were developed in line with national joint guidance such as on ACP and DNAR decision-making. This included:

- Ensuring culturally and religiously sensitive end-of-life care, including early identification of specific needs.

- Encouraging conversations on personal beliefs and preferences, ensuring respect for religious, spiritual, and cultural values in palliative and bereavement care.
- Recognising and addressing inequities in access to palliative care and bereavement support.
- Supporting the early identification and communication of needs for rapid culturally sensitive burials, ensuring that faith-based practices were respected even during crisis conditions.

102. The pandemic underscored the urgent need for structured, evidence-based approaches to end-of-life care in general practice, particularly in community and care homes settings. The RCGP/Marie Curie Daffodil Standards played an important role in supporting GPs, teams, and patients through one of the most challenging periods in healthcare history. Moving forward, the ongoing evaluation and expansion of the standards will ensure that the learnings from Covid-19 continue to shape and improve the delivery of personalised, compassionate, and proactive end-of-life care.

Concerns and Advocacy on End-of-Life and Palliative Care During the Pandemic

103. The Royal College of General Practitioners and its members were deeply committed to ensuring that patients at the end of life received compassionate, high-quality care throughout the Covid-19 pandemic. However, significant challenges arose, necessitating rapid adaptations in service delivery, policy, and prescribing practices.

104. We had significant concerns about the quality of end of life care including how delivery of care was disrupted, challenges in receiving timely guidance and in relation to Advance Care Planning (ACP).

105. We were also concerned about the impact on bereavement support – we supported compassionate visiting policies and developed a bereavement resource hub for primary care teams.

106. There were also issues relating to the availability of palliative care medicines, caused by supply chain disruptions. At various points during the pandemic, there were shortages of key palliative care medications, including opioids, midazolam, and other symptom-control drugs.

107. This shortage of medicines led to regional variation in access. While some areas had effective local prescribing protocols, others faced delays in medication supply for

home-based and care home patients. With GP and community nursing teams overstretched, delays in medication administration were reported.

108. To help with these issues, the RCGP worked closely with partners, including the General Medical Council (GMC), to clarify safe and ethical approaches to remote prescribing (GMC Ethical Hub).

109. Palliative care was also made more challenging by the issues impacting care more generally, including lack of PPE, staff shortages and difficulties with infection control.

110. GPs reported challenges in referring patients to specialist palliative care teams, particularly during peaks of the pandemic. While some areas had well-integrated palliative care networks, others struggled with fragmented pathways with patients being passed between different providers who were all struggling to deliver adequate care in exceptionally difficult circumstances, exacerbating inequities in access.

Easing of restrictions on controlled end of life medicines

111. Throughout the pandemic, the RCGP raised concerns with the UK Government and Devolved Administrations regarding palliative and end of life care provision. This was largely through our regular meetings with key stakeholders. Advocacy led to temporary policy changes, including emergency legislation that enabled community pharmacists to supply end-of-life medications with fewer bureaucratic barriers and greater flexibility in prescription validity periods and remote prescribing protocols.

112. The RCGP engaged in discussions with NHS England, the Department of Health and Social Care and the General Pharmaceutical Council to accelerate access to essential palliative care medications.

113. In April 2020, we wrote to the Home Secretary Priti Patel, calling for a temporary easing of restrictions around controlled end of life drugs to avoid delays in administering these medications to patients in need whose Covid-19 symptoms deteriorated rapidly (**MM/23/INQ000589798**). We flagged our concern that the NHS risked running out of essential medications unless there was a temporary ‘urgent relaxation' of the legal restrictions that meant controlled drugs - such as morphine, which is used to help control severe breathlessness and pain in patients - could only be given to named patients, and then destroyed if not used. Our concerns were highlighted in mainstream media by the Financial Times and Channel 4 News.

114. We were pleased that partially in response to these calls the Government introduced new emergency legislation at the end of April 2020 (The Misuse of Drugs (Coronavirus) (Amendments Relating to the Supply of Controlled Drugs During a Pandemic etc.) Regulations 2020). The Government also published a new standard operating procedure on running a medicines re-use scheme in a care home or hospice setting, which was an important change to government guidance **(MM/24/INQ000589812**).

Systematic bereavement response and ethical guidance

115. The RCGP and other organisations raised with key decision makers the need for an improved national bereavement support strategy.

116. We were pleased that joint lobbying efforts with the National Bereavement Alliance resulted in bereavement guidance being included in national pandemic response frameworks.

Do not attempt cardiopulmonary resuscitation decisions (DNACPR) in care settings

117. The RCGP had significant concerns about reports on the blanket use of 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions.

118. We were concerned that there was a delay in issuing central guidance for GPs on DNACPRs and how best to implement the policy.

119. We heard reports from GPs who were asked to carry out frailty scores for care home patients and the elderly, to document escalation plans, and use this information to complete DNACPR plans. We do not have full information on exactly how many GPs this applied to and which areas this happened in, but the CQC reported that there was a significant increase during this time of people reporting concerns about DNACPR.

120. We heard nationally that GPs were pressured to make these decisions at speed and without time for adequate discussion with patients and families, especially those without capacity.

Joint statement on advance care planning

121. In March 2020, due to our concerns, we wrote a joint statement on advance care planning with the BMA, CQC, and the Care Providers Alliance **(MM/17/INQ000589796).** The

statement set out the importance of having a personalised care plan in place, especially for older people, people who are frail, or those with other serious conditions. We stressed that it remained essential that 'do not attempt cardiopulmonary resuscitation' (DNACPR) or Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms were made on an individual basis. We made it clear that it is unacceptable for Advance Care Plans, with or without DNACPR form completion, to be applied to groups of people of any description. This document was intended to reinforce the importance of personalised shared decision making in Advance Care Planning. This was in response to uncertainty we had heard from GPs in parts of the country, where frailty scores and other measures were being used to make advanced care planning decisions. The intention was to support existing national guidance on shared decision making published by the NHS and to clarify that we believed some local interpretations of the NHS guidance were incorrect.

122. The guidance was produced rapidly in very difficult circumstances to deal with an emergency situation, and to ensure that we could quickly and clearly communicate messages to our members to provide clarity on this matter. The guidance was formulated by GP experts and was approved by our senior management and Officer team. This was in consultation with our Ethics Committee, which includes ethicists and clinicians.

123. The RCGP does not have a record of specific feedback from members following the publication of the joint statement. However, informal feedback from our members was that the joint statement we wrote provided helpful information and clarity for them to ensure patients were given the best care possible in difficult circumstances.

The provision of medication in care homes

124. GPs were involved in prescribing the medication but do not manage the dispensing of this medication. Pharmacy bodies therefore will be better placed to provide information on any possible shortages in medication and what impact they may have had.

How the RCGP supported members provide better care for patients in the care sector

Workload prioritisation guidance

125. While there was an overall drop in patients contacting practices in the early days of the pandemic, this trend soon reversed and there was a significant increase in demand for general practice appointments, including patients who were more unwell because they had

not sought medical attention sooner. There were also significant fluctuations in workload during the onset of different waves of infection and across different parts of the country.

126. During the Covid-19 pandemic, we regularly heard from our members that they were struggling with unprecedented workload demand and that there was a lack of guidance centrally on how to handle balancing the pandemic and business as usual. In March 2020, 92% of our members said that they were concerned about their practice's ability to provide business as usual services.

127. This had a particularly large impact on supporting patients in care settings as they were often those who needed the most support, often complex needs, and required dedicated time set aside to visit the home.

128. Given these challenges and the lack of guidance nationally available, the College decided to work rapidly with the BMA GPC to produce guidance to help clinicians make difficult decisions on which activities they should prioritise when it became challenging to deliver and fulfil each of the demands facing stretched GPs and their teams. We worked quickly with the BMA to develop and distribute the guidance, using the expertise and knowledge we had available to us at the time, and tapping into our clinical expertise. **(MM/25/INQ000280653]**

129. RCGP first published workload prioritisation guidance in March 2020.

130. In the April 2020 version of this guidance, we recommended that 'lower priority routine work' such as 'Over 75s annual health checks', "could be postponed in the event of a high prevalence of Covid-19 in your patient population, aiming to revisit once the pandemic ends, ensuring recall dates are updated where possible." However other issues that would be vital to patients in care homes, such as Remote Long-term Conditions (LTC) and ongoing reviews for those at higher risk, were considered as the most important category. For these activities, we recommended that GPs "aim to continue regardless of the prevalence of Covid-19 for the duration of the pandemic".

131. As the pandemic progressed, we sought to co-produce updates to this guidance with NHS England. However, while NHSE said they saw the benefits of the RCGP and the BMA developing this guidance, and fed back that they were broadly content with our overall approach, they were not able to co-produce or endorse guidance from an organisational perspective. This meant that the risks associated with deprioritising work sat with the RCGP and the BMA in publishing the guidance, and ultimately with individual practices for implementation. Anecdotal feedback from our members was that the lack of public endorsement caused confusion, and it meant that some practices were concerned about using the guidance for fear of being criticised by NHS bodies or regulators at a later stage.

132. The guidance was regularly updated, with versions published in March 2020, April 2020, June 2020, November 2020 and January 2021 We updated the guidance to adapt to the evolving situation, using the information we had at the time about the impact of the pandemic and the intelligence we had about the major challenges faced by our members and their patients (**MM/26/INQ000280655, MM/27/INQ000280656, MM/28/INQ000280660, MM/29/INQ000280654)**.

Guidance on caring for patients in care homes

133. The RCGP did significant work to support our members provide the best possible care to patients in care homes. This included publishing "Top tips for GPs visiting care homes" which covered issues like carrying out virtual ward rounds with care staff going around the care home with a video calling technology, advising care homes on correct PPE usage where problems have been identified, and advice on the delivery of end-of-life care. This was supported by the inclusion of case studies of work being carried out in different parts of the country to deliver better care in care homes.

Guidance on oximetry in care settings

134. The RCGP promoted pulse oximetry in October 2020 as we believed it was clinically the right thing to do, based on the information available to us at the time, to ensure more reliable measurements to help promote patient safety in care homes and other patients outside of hospital settings.

135. We published video webinars we made freely available on our Covid-19 hub on 'Covid-19: Patient Assessment – the role of physiology and oximetry' on 30th April 2020. This was viewed 11000 times in the first week. The webinar was led by Dr Jonathan Leach, RCGP Honorary Secretary and Covid-19 Lead, Dr Alison Tavaré, Primary Care Clinical Lead at West of England AHSN and Dr Simon Stockley, RCGP Lead for Acute Deterioration and Sepsis. The webinar covered Clinical features of Covid-19, the importance of oximetry in Covid-19, Clinical judgement and physiology in patient assessment, the role of NEWS2 in general practice and Care Homes and remote oximetry in the assessment and management of Covid disease in the community.

136. We used the Covid-19 hub to link to the NHS England guidance 'Pulse oximetry to detect early deterioration of patients with Covid-19 in primary and community care settings' on 23rd June 2020.

137. We published 'Covid-19 Oximetry @home webinar: an overview for primary care' on our Covid-19 hub on 12th January 2021. This webinar highlighted the association between

oxygen saturations and Covid-19 which underpins the need for the Covid-19 Oximetry @home pathway.

Guidance on end of life care

138. The RCGP worked closely with other Royal Colleges, NHS England, and palliative care charities to develop and disseminate joint guidance. The RCGP launched a Palliative, End of Life Care, and Bereavement Resource section on our Covid-19 hub. This included:

- The RCGP Joint Statement on Advance Care Planning (ACP).
- NHS Universal Principles for ACP (ACP Guidance) to promote a standardised, person-centred approach.
- Remote consultations and prescribing ethics (GMC Ethical Hub).
- End of life care for patients with COVID-19.
- Ethical guidance for primary care teams, including ACP, triage decision-making, and symptom control.
- Training materials for remote palliative care delivery and virtual consultations.
- Resources to support primary care in delivering bereavement care and compassionate conversations.
- Nationally endorsed bereavement commissioning guidance in collaboration with the National Bereavement Alliance.
- We created a webinar on basic life support in the context of the pandemic jointly with Resuscitation Council in 2020

139. Multiple bespoke masterclass webinars on end-of-life care: Created and delivered in response to emerging challenges, these provided practical, real-time support to GPs and primary care teams, covering issues such as:

- Remote symptom management in palliative care.
- Advance care planning under Covid-19 restrictions.
- Managing bereavement and grief in primary care settings.
- Ethical decision-making in resource-limited scenarios.
- Old age, frailty care and care in care homes: Focused on frailty management and medication safety in the context of increased vulnerability among older adults.
- Consideration of Guidance on Domestic Violence and Abuse in the context of end-of-life care in the Covid-19 pandemic.

BJGP Open article - Risk of Covid-19 in shielded and nursing care home patients: a cohort study in general practice”

140. The BJGP Open article titled "Risk of Covid-19 in shielded and nursing care home patients: a cohort study in general practice," published on 26 August 2021, analysed data from five general practices in west London between 1 February and 15 May 2020, focusing on Covid-19 infection rates among shielded individuals and nursing home residents **(MM/30/INQ000589806).**

141. Key findings include:

141.1. Higher Infection Rates in Shielded Individuals: The study found that 6.5% of shielded patients contracted Covid-19, compared to 1.8% of non-shielded individuals. This elevated risk persisted even after adjusting for factors such as age, sex, ethnicity, and comorbidities.

141.2. Significant Risk in Nursing Home Residents: Residents in nursing homes experienced a sevenfold increase in Covid-19 infection rates compared to those living in private residences.

141.3. Impact of Socioeconomic and Ethnic Factors: The research also highlighted that individuals from ethnic minority backgrounds and those residing in economically deprived areas faced higher Covid-19 infection rates.

142. These findings suggested that shielding measures at the time alone were insufficient to protect vulnerable populations, particularly nursing home residents. The study claimed to emphasise the necessity of comprehensive strategies, including vaccination and community infection rate suppression, to effectively safeguard these groups.

Final thoughts and recommendations

143. The care home system as a whole was underprepared for a pandemic when Covid-19 hit, and this included the delivery of primary care support services to their patients. The social care system has lacked the same levels of consideration and investment that the NHS and healthcare system have received for many years prior to the pandemic.

144. This unfortunately seemed to have carried on into the early stages of the pandemic, where the core focus seemed to be on hospitals rather than the wider health and care system.

145. The delivery of general practice services to people in care settings were seriously impacted by the pandemic. GPs and relevant organisations or providers struggled to get the balance right between providing the vital care that patients needed and limiting the accidental spread of Covid-19 by face-to-face contact.

146. This balance was made harder to achieve by compounding issues including the lack of adequate PPE, neither care homes or GP practices having the right technology to provide effective remote care, and a lack of Covid-19 testing availability.

147. The RCGP would like the inquiry to make the following recommendations:

147.1. All care homes need to work with their primary care providers to devise a plan for how they would deliver care to their patients in an event of another pandemic, including expanding the use of safe and effective remote care.

147.2. Governments and other key decision makers must ensure that the care sector is treated as importantly as the NHS and health sector in any future pandemic.

147.3. No patient should be discharged from a hospital to a care home without first being tested to ensure they are not infectious.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

PD

Signed: _____

Dated: 06/05/25