

Module 3 Week 6

Dr. Sarah Powell

Dr. Sarah Powell detailed the challenges faced in accessing interpreter services during the pandemic. She recounted multiple instances where interpreters were booked but ultimately not allowed to attend appointments, leading to repeated cancellations and prolonged treatment. Dr. Powell expressed frustration over the advice to continue exercising during the onset of Long Covid symptoms, which exacerbated her condition. She detailed a harrowing emergency involving her husband, where inadequate communication due to the lack of interpreter services led to severe distress and delayed medical intervention.

Dr. Powell emphasised the need for automatic flagging systems in hospitals to identify patients who use British Sign Language (BSL) and require interpreters and highlighted the importance of making reasonable adjustments to accommodate patients with disabilities. She stressed that the lack of these accommodations prolonged her and her husband's symptoms and treatment.

Caroline Abrahams, Charity Director of Age UK

Caroline Abrahams discussed the increased risk of severe illness and death from Covid-19 among older people, exacerbated by pre-existing health conditions and socioeconomic factors. She emphasised the need for a rights-based framework within the healthcare system to combat age discrimination and improve care for older individuals.

Jackie O'Sullivan, MENCAP

Jackie O'Sullivan highlighted the disproportionate impact of the pandemic on individuals with learning disabilities, noting their higher likelihood of severe illness and death from Covid-19. She criticised the use of the Clinical Frailty Scale and DNACPR orders for people with learning disabilities and called for better data collection and reasonable adjustments in healthcare settings.

Prof. Philip Banfield

Prof. Philip Banfield addressed the physical and mental health challenges faced by doctors during the pandemic, including the heightened risk of Covid-19 exposure and inadequate protective measures. He advocated for a precautionary approach to infection control and better support for healthcare workers.

- Issues with underreporting of occupationally acquired Covid-19 infections among healthcare workers.
- The need for centralised guidance on resource rationing during emergencies.
- Concerns about the impact of institutional racism within the NHS.

Julia Jones (Co-founder of John's Campaign)

Julia Jones discussed the detrimental effects of infection control measures such as limiting visiting had on dementia patients. She emphasised the need for a legal right to a personal care supporter for vulnerable individuals. Julia highlighted the intense focus on infection control at the expense of other healthcare issues, leading to the deterioration and death of dementia patients when separated from their families. She argued that infection prevention and control should be more flexible and nuanced, taking into account the diverse needs of patients. Julia also stressed the importance of including patient voices in the drafting of guidance.

Nicola Ritchie (Long Covid Groups)

Nicola Ritchie works for NHS Scotland as a Physiotherapist. She contracted Covid at work and went on to develop Long Covid. She experienced inadequate PPE, challenges in accessing tests and treatment, and long-term debilitating effects. Nicola described the extreme exhaustion, brain fog, and other symptoms she experienced, which significantly impacted her daily life and career. She also highlighted the lack of support from her GP and the relief she felt when finally receiving validation and treatment from a private GP.

Professors Chris Brightling and Rachael Evans (Experts in Long Covid)

Professors Brightling and Evans provide insights into Long Covid, including its definition, symptoms, and prevalence. They discuss the challenges in treating and managing Long Covid, the lack of formal training for medical professionals, and the underfunding of Long Covid clinics. They emphasize the importance of multidisciplinary teams and the need for continued research and funding to support Long Covid patients. The document also addresses broader issues of infection control, the need for flexible and nuanced approaches, and the importance of including patient voices in the drafting of guidance. The testimonies and expert opinions underscore the significant impact of Covid-19 on vulnerable populations and the need for more inclusive and patient-centred healthcare policies.

Lesley Moore attended remotely and provided evidence on the impact of COVID-19 on clinically vulnerable families.

Lesley shared the challenges faced by her son, who has cerebral palsy, and the difficulties in managing his care during the pandemic. She highlighted the lack of timely information and support from the government, the issues with the provided FFP3 masks, and the overall lack of confidence in the healthcare system at that time.

Natalie Rogers, the founding trustee of Long Covid Support, discussed the struggles faced by individuals with Long Covid. She emphasized the lack of recognition and appropriate care for Long Covid patients, the damaging misconceptions about the illness, and the significant delays in the UK's healthcare system in responding to Long Covid. Natalie also highlighted the financial and psychological impacts on those affected by Long Covid, the need for prioritising biomedical research, and the importance of developing accurate diagnostic tests and treatments

Dr. Paul Chrisp from NICE explained the process of developing guidelines, the challenges faced due to the speed of the pandemic, and the importance of considering health inequalities in their recommendations. Dr. Chrisp also discussed the amendments made to the guidelines based on feedback from stakeholders and the efforts to ensure that the guidelines were clear and supportive of healthcare professionals.

'I don't believe there are any disability charities on that list of stakeholders. We do reach out to disability charities and engage with them on specific topics.' **BJC Note: This is the problem though – the unintended consequences are that guidance that is thought not to have specific impact on disabled people, inevitably does - as the generic guidance will not take the needs of disabled people into account and what adjustments need to be made. The perfect example is below.**

I agree that the Clinical Frailty Scale is not appropriate for use on people under 65 or those with stable disabilities. The consequence of applying the Clinical Frailty Scale for people with autism was not intended.

In April 2020 NICE issued guidance with respect to target oxygen saturation levels and with respect to the range for the most acutely ill patients and it reduced the target saturation level from 94 to 98% which was the standard pre-pandemic. First of all, down to 92 to 96% and then down to 90-94%.

- That particular piece of guidance was an NHS England piece of guidance that was published on the NICE website so it wasn't NICE guidance
- I don't know whether that was because of a shortage
- I don't know whether the guidance went back up to the pre pandemic level.

Expert in Emergency Prehospital Care and Shielding - Professor Helen Snooks:

She discussed the significant challenges faced by individuals who were shielding, emphasising the lack of clear guidance and support from the government. She pointed out that the psychological impact of shielding was profound, with many individuals experiencing increased anxiety and isolation due to the prolonged period of staying indoors. The lack of clear communication and support exacerbated these feelings, leaving many shielders feeling abandoned and vulnerable. Professor Snooks also addressed the practical difficulties faced by shielders, such as accessing essential services and healthcare. She noted that the fear of contracting COVID-19 in healthcare settings led many to avoid seeking medical help,

which in turn had adverse effects on their health. Overall, Professor Snooks' considered that there was no evidence that the Shielding program worked because the healthcare settings many vulnerable had to attend at were not safe.

Protocol 36

Protocol 36 was a specific protocol that was added in or brought into use within the pandemic to assess calls of patients with or patients with suspected Covid infection. It was brought in around early April of 2020. It was a specific way of asking questions to callers with symptoms that might be Covid-19 to assess their need for an emergency response. It was felt that the generic system wasn't able to take enough account of specific symptoms that were coming up in Covid-19.

It might be easy to think you should send the highest response to everybody, but that carries its own risks. It's very important to not over respond to people because that puts the whole system under pressure. If the patient has Covid-19 but it turns out they do not need emergency transportation to hospital, then it's exposing more people to the risk of transmission and the ambulance crew as well.

BJC Note: The evidence from Prof Snooks did not really explain what this meant, which was to reduce the target ambulance attendance time for a person struggling to breathe from 7 minutes to 18 minutes if the person had symptoms of Covid.

Expert on Colorectal Cancer - Professor Aneel Bhanu discussed the significant reduction in colorectal cancer diagnoses during the pandemic due to difficulties in accessing healthcare and the pause in bowel screening programs. He highlighted the importance of continuing diagnostics and screening programs during future pandemics to avoid similar issues.

Experts on Hip Replacement - Professor Andrew Metcalfe and Dr Chloe Scott emphasised the severe impact of delayed hip replacement surgeries on patients' health and outcomes. They have already got severe disease and a severe symptom burden which is why they've been offered a hip replacement in the first place. Whilst they wait for surgery, they continue to deteriorate so the longer they wait the worse they get and then the worse the outcome of their hip replacement is.

Children and Young People's Mental Health Services:

Julie Pashley discussed her daughter who was in a mental health unit when the pandemic hit. When she was suspected of swallowing a blade her parents were told they would have to take her to A&E but that she would not be allowed back into the unit because she would represent a Covid-19 risk.

Expert in Children and Young People's Mental Health Services - Dr Guy Northover - There was a concern that some young people were being discharged when perhaps their treatment hadn't been completed

and at a time when potentially the community intensive support teams were not in a place to manage all of the young people who might have been referred on to their services.

There were issues with PPE – items from masks could be used for self-harm and the wearing of masks can also prevent building relationships and trust.

The Covid rules impacted on children and young people in terms of reduced visits from families and carers, increased self-isolation periods and reduction in staffing levels and less continuity of care. I don't recall any guidance aimed at mitigating those impacts.

Counsel to the Inquiry

On 10 October Professor Jonathan Wyllie gave evidence. He was asked about whether the Resuscitation Council had received reports of inappropriate or blanket DNACPRs. He indicated he thought there had been reports of a Trust behaving in this way. We asked Professor Wyllie for further details about that evidence. He's provided an addendum statement in which he clarifies the example he was talking about in fact related to a restrictive approach to the circumstances in which CPR should be administered and not in fact to an example about blanket or inappropriate DNACPRs.