

## Questionnaire

UK COVID-19 Inquiry: Module 2 - Rule 9 Request to Dr Helen Salisbury - Reference: M2/ISAGE/01/DHS

Please provide the following information:

1. A brief overview of your qualifications, career history, professional expertise and major publications.

BA Oxon Philosophy and Psychology 1986

MBBS Medicine London Hospital Medical School 1991

MRCP, MRCGP

I am a GP in a city practice in Oxford where I have worked since 2002. Details of my work in medical education are not relevant here (I led the communication skills course for medical students 2005-2018 and continue to teach at undergraduate and postgraduate level). My expertise is in general practice. The publications relevant to this enquiry are my weekly column published in the British Medical Journal - see below

2. An outline of when you participated in Independent SAGE, the role that you performed and any matters that you advised on.

I joined Independent SAGE in August 2021. My main role in the group is to bring clinical expertise to a group consisting of scientists and academic (although others are clinically qualified their field is public health). Other clinical members have since joined the group. I was able to comment on how policy was being enacted on the ground, and also to answer technical clinical questions as they arose.

3. A summary of any reports and/or articles you have written, interviews and/or evidence you have given regarding the work of SAGE and/or its subcommittees and/or the UK's response to the Covid-19 pandemic. Please include links to those documents where possible.

I have not written or broadcasted about the work of SAGE.

I was a witness at the 2<sup>nd</sup> session of the People's Covid Enquiry 10<sup>th</sup> March 2021 which focussed on the government's response to the pandemic. A video of my testimony can be viewed here <https://www.youtube.com/watch?v=ReR5LtgyPzk&t=5835s> and I append my witness statement to this questionnaire.

Throughout the pandemic I published a weekly column about General Practice in the British Medical Journal, which very frequently focussed on the pandemic. A small selection is pasted below

Salisbury H. Helen Salisbury: Is general practice prepared for a pandemic? BMJ 2020; 368 :m944 doi:10.1136/bmj.m944 <https://www.bmj.com/content/368/bmj.m944>

Salisbury H. Helen Salisbury: GPs still have no access to coronavirus testing BMJ 2020; 369 :m1881 doi:10.1136/bmj.m1881 <https://doi.org/10.1136/bmj.m1881>

Salisbury H. Helen Salisbury: Testing times for GPs BMJ 2020; 369 :m2180 doi:10.1136/bmj.m2180 <https://doi.org/10.1136/bmj.m2180>

Salisbury H. Helen Salisbury: Careless communication costs lives BMJ 2020; 371 :m4383  
doi:10.1136/bmj.m4383 <https://doi.org/10.1136/bmj.m4383>

Salisbury H. Helen Salisbury: Managing vaccine expectations BMJ 2020; 371 :m4448  
doi:10.1136/bmj.m4448 <https://doi.org/10.1136/bmj.m4448>

Salisbury H. Helen Salisbury: Poverty as a pre-existing condition BMJ 2020; 371 :m4607  
doi:10.1136/bmj.m4607 <https://doi.org/10.1136/bmj.m4607>

Salisbury H. Helen Salisbury: Prolonging omicron BMJ 2022; 376 :o191  
doi:10.1136/bmj.o191 <https://doi.org/10.1136/bmj.o191>

4. Your views as to whether the work of SAGE and/or its subcommittees in responding to the Covid-19 pandemic (or the UK's response more generally) succeeded in its aims. We have previously invited independent members of SAGE and its subcommittees to address this issue by reference to the matters set out below. You may find them of assistance, although we recognise that some are likely to be beyond your knowledge. Please address this issue as you see fit. a. The composition of the groups and/or their diversity of expertise; b. The way in which the groups were commissioned to work on the relevant issues; c. The resources and support that were available; d. The advice given and/or recommendations that were made; e. The extent to which the groups worked effectively together; f. The extent to which applicable structures and policies were utilised and/or complied with and their effectiveness.

I don't have information about this. I do wonder if they had any GPs involved, or public health doctors

The impression was given – although I have no evidence – that the questions considered by SAGE were controlled by government. Better advice may have been received if they had been given a freer rein to tell government what they considered the best course of action.

More transparency early on about the composition of the group and the advice given to government would have aided public trust.

5. Your views as to any lessons that can be learned from the UK's response to the Covid-19 pandemic, in particular relating to the work of SAGE and/or its subcommittees. Please describe any changes that have already been made, and set out any recommendations for further changes that you think the Inquiry should consider making.

1) Be prepared – the failure to act on the results of previous pandemic preparedness exercises (eg Cygnus) put us in a very poor position at the start of the pandemic

2) Don't ignore the rest of the world – it was obvious to anyone with access to the internet or Twitter that a serious pandemic was on its way but the government appeared to ignore what everyone else knew until far too late.

3) Use the expertise that is already available. I cannot comment on how the expertise was used within SAGE, but in the community there was expertise in infectious disease management and particularly in contact tracing that was overlooked in favour of private sector contracts with unqualified providers.

6. A brief description of documentation relating to these matters that you hold (including soft copy material held electronically). Please retain all such material. I am not asking for you to provide us with this material at this stage, but I may request that you do so in due course

No relevant material held

Appendix

## **Helen Salisbury's witness statement to the People's Covid Inquiry**

### **Introduction**

From January 2020, the threat of a coronavirus pandemic was clear. Those of us who follow world events on social media watched in horror as the virus spread from China, to Iran and then to Italy. It was clearly only a matter of time before it reached the UK, but our government sat on its collective hands. I feel that I have been a member of a large and desperate chorus of Cassandras, who foresaw the effects of repeated inaction and mistakes but had no power to prevent them. There are many things we know now about the virus which were not known a year ago, and I will try in this analysis to distinguish between mistakes that are only apparent with hindsight, and those which were immediately obvious.

### **Preparedness**

As mentioned in the previous session, the Cygnus Exercise in 2016, a drill to explore pandemic preparedness, demonstrated that we were ill-equipped. We did not have enough personal protective equipment or ventilators, we risked running out of staff and our organisational and communications strategies were lacking. However, the report was not published until October 2020, by which time these deficiencies were already all too apparent. There was a stockpile of PPE but much of it was out of date, and some items – gowns, visors, swabs and body bags – were entirely absent.

### **Initial Response**

The early response of the government was to float the idea of 'taking it on the chin' – which meant allowing the virus to spread through the community until a natural herd immunity developed. The emphasis was on controlling the rate of spread to avoid hospitals being overwhelmed, and in particular to prevent scenes akin to those in reports from southern Europe, of desperate people lying in hospital corridors. It was immediately obvious, without any sophisticated mathematical modelling, that given a 1% mortality rate this strategy would result in 660,000 deaths which was unacceptably high, but time lost at this crucial juncture resulted in rates of community transmission which in turn led to the first wave of deaths.

### **The Role of General Practice**

General Practice was side-lined and ignored in the first wave. Parallel systems were set up for both the clinical and public health functions of GP, both of which performed poorly.

Patients were told to stay at home and only contact their doctor in an emergency and mostly they complied. Patients were directed to contact NHS 111 rather than their own GP if they had symptoms of coronavirus. It was unknown at the time how overwhelmed primary care might become, so the rationale for creating more triage capacity is understandable. However, NHS 111 itself lacked capacity to respond to calls, not only in an appropriate timeframe (1) but also with the necessary expertise (2,3). Some of the clinical features of Covid19 were unexpected and differed significantly from other respiratory infections: in particular, the lack of subjective breathlessness experienced by patients at rest, even with dangerously low oxygen levels, was entirely new (4). Subtle questioning involving assessments of fatigue and exercise tolerance were needed to form accurate judgements of disease severity over the phone (5). Although this was an evolving area of knowledge, I think it is fair to assume that fewer lives would have been lost in that initial wave if there had been more direct contact between patients and their GPs.

### **Successes in Primary Care**

In most areas, local plans were put in place to assess of patients with possible Covid19 while also continuing to provide safe access to other primary care services. In some cases single practices divided into 'red' and 'green' zones with separate entrances. In others, GP federations or Clinical Commissioning Groups set up separate clinics to which patients with suspected Covid could be referred for immediate assessment. This was accompanied by a Covid19 paramedic visiting service for the housebound or those without their own car. In the most recent wave, our CCG, in common with others, has supplied each practice with home oxygen monitors (pulse oximeters) which can be lent to patients to be judged to be well enough to stay at home but in need of monitoring.

### **Lack of testing**

We were hugely hampered at the beginning of the pandemic by the lack of availability of testing. For other notifiable infectious diseases, there is a longstanding process whereby GPs suspect the illness, send off a test and alert the local public health department who will follow up and do contact tracing as appropriate. In the case of coronavirus, we had no access to testing and no way to request tests for our patients other than to suggest they go on the government website. Patients were often directed to testing sites which were hours' drive away, which were impossible to attend either because the patient was unable to take the time off work, did not have transport, or felt too unwell to make the journey. Patients could ask to be sent a kit by post but this further increased the delay in receiving a result. Apart from the lack of availability of testing, the restrictive criteria for being eligible for a test was, and still is, a major problem(7). Tim Spector's research group at KCL has produced excellent data on the range of symptoms that suggest Covid19 including early evidence that loss of taste and smell were highly predictive (6). Through his work and from clinical experience we now recognise that Covid19 may present with a range of gut, skin and cognitive symptoms, but I am still talking to patients who have applied for a test and been told that they do not qualify. Although I am highly suspicious that they do have Covid19, I still cannot provide them with a test.

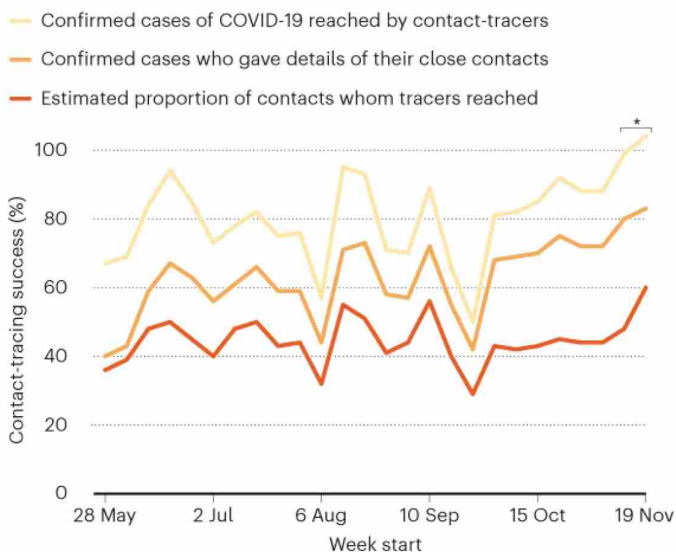
### **Contact tracing**

Other than vaccination, the key to control of infectious diseases is contact tracing. It is instructive to look at Vietnam, which has a death rate of less than 0.5 per million in contrast to the UK's 1,824 per million. There they contacted as many as 200 people per case, and extended to second and third order contacts. They closed their borders very early and concentrated on eliminating the virus. Effective contact tracing needs to be rapid and extensive. In the UK most of the tracing is forward looking, going back only 48 hours from a positive test result and mostly concerned with who this case might have infected. Looking back for up to 14 days, to find the source of the infection is equally important and in many cases has led to the discovery of super-spreaders (people who were highly infectious). The WHO's benchmark for a successful COVID-19 contact-tracing operation is to trace and quarantine 80% of close contacts within 3 days of a case being confirmed, a goal few

countries achieve, and even that may not be enough to reduce the spread of the virus. The graph below illustrates just how far off that goal we were in the UK with just 60% of contacts being reached in November.

### MISSED CONTACTS

Between late May and November, contact-tracers in England generally reached less than half of the close contacts of people who tested positive for COVID-19.



\*Number rises over 100% because some positive cases were carried over from the previous week.

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It is arguable that the battle for successful containment of the virus was lost with the first delay to lockdown in March 2020. However, rates of infection did fall so that by the end of August 2020, if we had had a functioning test and trace system in place, we could have avoided the second and third wave of infections.

### Missed Opportunities

General practice was struggling with workload at the beginning of the pandemic, with a steady decline in doctors in over the last decade, and a shift to a more diverse, less expert and cheaper workforce. Public Health, which has been serially reorganised and defunded was in an even worse state in terms of staffing. However, these two fields were where expertise lay at the beginning of the pandemic. It could be argued that GP was in no position to take on the challenge of coronavirus, but this ignores the crucial factor of funding. Very large amounts of public money (£37 billion including latest budget additions) has been handed to the Test and Trace service run by Dido Harding, and it would be very difficult to argue that we have had good value for money. If even a fraction of that money had been spent in primary care, we could have developed local testing which would have been faster, more accessible and better targeted. We could have worked in conjunction with public health colleagues to operate a more efficient contact tracing system. In areas of the UK where local systems have been developed (eg Ceredigion in Wales) they have achieved much higher rates of successful tracing. In general practice we have lists of all our patients and their contact details, we usually know who else lives in the same house, and crucially we have pre-existing relationships built on trust which help us with the difficult conversations that contact tracing involves.

### Contact Tracing Apps (I was asked to comment but not really my area of expertise)

Much time and money was spent on the development of a contact tracing mobile phone application which would alert you if you (or your phone) had spent 15 minutes within 2 metres of someone who subsequently tested positive for coronavirus. Electronic capture of contacts had been used in other

countries but I have seen little evidence that it has contributed much to overcoming the pandemic in the UK. It is interesting that all reference to the app has slipped away since October, which may be a tacit acceptance of its failure.

### Lack of support for patients who test positive for coronavirus

One of the key drivers for the failure of the track and trace program has been the lack of support for those who need to self-isolate. The support payment of £500 is available to very few and most claimants do not qualify. If people have insecure employment and are only paid for shifts worked, or have caring responsibilities, it is easy to understand why they might choose not to come forward for testing. Equally, they may be reluctant to name contacts who would then be forced to isolate without support. The inability to isolate safely, which has hit the least advantaged hardest, has been a key driver of the pandemic. The government advice to 'use a separate bathroom' where possible demonstrates just how out of touch they are with the realities of most people's lives.

### Public Messaging

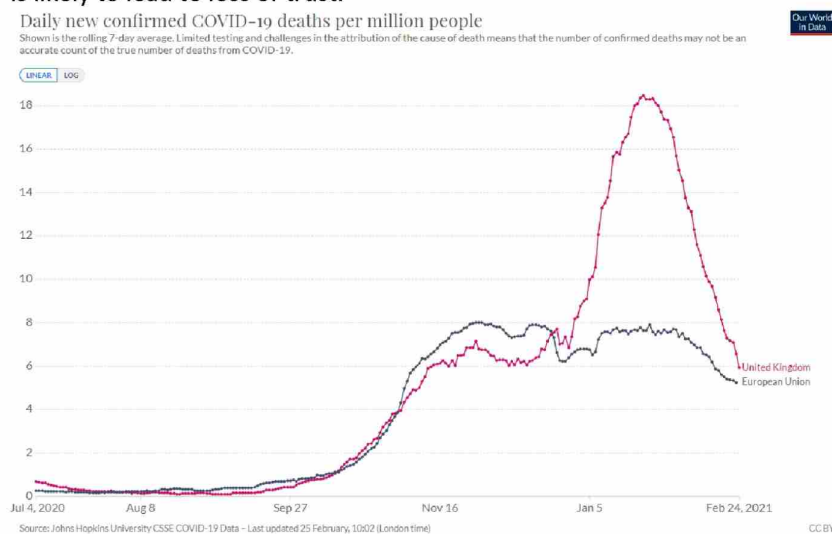
The effectiveness of the public messaging in reducing the severity of the pandemic was dependent on accuracy, clarity, consistency and trust, all of which were lacking.

**Accuracy** At an early stage in the pandemic, when we knew little apart from the importance of avoiding spread, the Prime Minister boasted about shaking hands with everybody in a hospital with coronavirus patients. Later, it became clear that coronavirus (SARS-CoV-2) is airborne and spread is through breathing in air that others have expired rather than being by droplet or touching contaminated objects. The messaging has been very slow to change and hence there is persistence of performative wiping of surfaces but lack of information about the importance of opening windows.

### Clarity

Messaging was often unclear, and Downing Street briefings were illustrated with impenetrable graphs, entirely unfit for communicating with a public audience.

**Consistency** There was a repeated theme of mixed messages and U-turns which probably reflected the lack of agreement within government about the appropriate course of action. These included whether or not people should go back to work in the summer, the safety or otherwise of meeting family at Christmas and whether schools should return in January 2021. These last two decisions arguably led to the biggest loss of life, the third wave (see graph below). As well as being poor in themselves, they added to the impression that the government had no idea what it was doing, which is likely to lead to loss of trust.



**Trust** People can cope with changing rules if they can see a clear rationale, but there were multiple occasions when that was not the case, or the rule change was far too late. The other factor which undermined trust was the inconsistent application of rules. In the first lockdown, many people made huge personal sacrifices to stick to the rules and were rightly outraged when a prominent employee at 10 Downing St flagrantly flouted them. He compounded the insult with a ludicrous set of excuses and the failure of government to censure him further destroyed trust.

It might be expected that this poor and inconsistent messaging would play a large part in our failure to control the virus. On the whole, people have been remarkably obedient: it has sometimes been difficult to know exactly what the rules are, especially when they changed so rapidly, but there has not been large scale disobedience. The blame for our desperately sad position near the top of the world table of deaths, is more rightly placed with the rules themselves, and therefore the decision makers in government.

1)<https://www.independent.co.uk/news/uk/home-news/coronavirus-uk-symptoms-nhs-111-phone-line-nurse-a9400351.html> Jane Dalton The Independent 13<sup>th</sup> March 2020 Coronavirus: Callers to NHS 111 phone line wait hours and get cut off without being able to speak to nurse

2)<https://www.theguardian.com/world/2020/oct/12/nhs-111-call-centre-was-unsafe-says-worker-who-nearly-died-from-covid> David Conn Guardian 12th Oct 2020 NHS 111 call centre was unsafe, says worker who nearly died from Covid

3)<https://www.theguardian.com/world/2020/oct/01/nurses-barred-from-nhs-111-covid-clinical-service-after-60-of-calls-unsafe> **David Conn 1st October 2020** Nurses barred from NHS 111 Covid clinical division after 60% of calls unsafe

4) <https://onlinelibrary.wiley.com/doi/10.1002/jmv.26172>  
Allali, G., Marti, C., Groscurin, O., Morélot-Panzini, C., Similowski, T. and Adler, D. (2020), Dyspnea: The vanished warning symptom of COVID-19 pneumonia. *J Med Virol*, 92: 2272-2273. <https://doi.org/10.1002/jmv.26172>

5) <https://bmjopen.bmj.com/content/10/11/e042626>  
Greenhalgh T, Thompson P, Weiringa S, *et al*  
What items should be included in an early warning score for remote assessment of suspected COVID-19? qualitative and Delphi study  
*BMJ Open* 2020;**10**:e042626. doi: 10.1136/bmjopen-2020-042626

6) [https://www.nature.com/articles/s41591-020-0916-2?fbclid=IwAR3F7tMT9V8Saa3ol-Wv4B7pQ88jIAM\\_tz351sJHb1iuDmxnPcuhWSNpJel](https://www.nature.com/articles/s41591-020-0916-2?fbclid=IwAR3F7tMT9V8Saa3ol-Wv4B7pQ88jIAM_tz351sJHb1iuDmxnPcuhWSNpJel)  
Menni, C., Valdes, A.M., Freidin, M.B. *et al*. Real-time tracking of self-reported symptoms to predict potential COVID-19. *Nat Med* **26**, 1037–1040 (2020). <https://doi.org/10.1038/s41591-020-0916-2>

7) <https://www.bmj.com/content/369/bmj.m1881> Salisbury H. Helen Salisbury: GPs still have no access to coronavirus testing *BMJ* 2020; 369 :m1881 doi:10.1136/bmj.m1881

