UK COVID-19 Inquiry: Module 2 - Rule 9 Request to Professor Allyson Pollock - Reference: M2/ISAGE/02/PAP

Please provide the following information:

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

BSc (Hons)Physiology, MBChB 1983, MSc LSHTM 1989, FFPHM 1993,

I qualified as a medical doctor in 1983. After a few years working in hospital medicine I undertook a further five year training programme and postgraduate examinations in public health and became a Fellow of Faculty of Public Health Medicine in 1990.

My current position is clinical professor of public health with an honorary appointment at (what was) Public Health England, now the Office of Health Improvement and Disparities.

As well as working in hospital medicine, I previously worked as a public health physician in several health authorities in London, and also at the Kings Fund and what was the Health Education Council. I also held a number of university positions. I was director of the Public Health Policy Unit at University College London, as well as director of research and development at UCL Hospitals NHS Foundation Trust from 1998 to 2005. From 2005 to2011 I was director of Edinburgh University's Centre of International Public Health Policy and honorary consultant in public health at Lothian Health Board. From 2011 to 2016 I was director of the global public health unit at Queen Mary University of London. I am currently at Newcastle University where I was director of its Institute of Health and Society (2017-19) and its Centre of Excellence in Regulatory Science (2019-2021).

My expertise includes health service and system changes such as marketisation, institutional and administrative arrangements; private finance; pharmaceutical regulation; injuries, and monitoring inequalities in access to treatments and care and in outcomes. I have for over three decades actively promoted universal public health care in the UK. In 2022, I was a member of the subgroup on Public Health and Administration for the Infected Blood Inquiry. In 2020, I was a member of the Independent SAGE, advising on covid in the UK. I was a twice elected member of the BMA Council, and was a founding member of Keep our NHS Public. I am also currently president of the Socialist Health Association.

Some key publications include *NHS plc: the privatisation of our health care* (Verso 2004); *Tackling rugby* (Verso 2014); and most recently with Peter Roderick describing the dismantling of the NHS in England.[1] A list of my publications by subject area or date can be found on my website, allysonpollock.com

[1] Roderick P, Pollock AM. Dismantling the National Health Service in England. Int J Health Serv 2022; 00207314221114540. doi:10.1177/00207314221114540

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

I participated in Independent SAGE from April to October 2020. My role was to provide expertise in public health.

I advised on principles and the need for evidence, especially in the key areas of Non Pharmaceutical Interventions (NPIs) such as mass testing, masks, school closures, and zero covid.

I contributed to a report on testing,[2] and I co-authored a report on inequalities with Prof Clare Bambra and colleagues.[3] I also asked Independent SAGE to commission advice notes from Dr NR on screening and testing[4] and from Prof NR, Prof Terry Wrigley, and Prof Aoife Nolan on reopening Schools.[5] I also corrected an editorial that misreported an Independent SAGE recommendation on return to universities for students in a letter to the BMJ.[6]

I include in an appendix to this questionnaire an explanation of the circumstances in which I left Independent SAGE.

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 was not involved with SAGE, although some members of Independent SAGE were either members of the committee or subcommittees, or in close contact with them. I did look at evidence and questions SAGE was raising as they became available and referred to them where relevant.

My interventions and publications largely concerned the government response to covid. From the outset of the pandemic I drew attention to the failings in the system for communicable disease control in letters to parliamentarians and local directors of public health (DPHs), and in editorials and articles for the British Medical Journal and mainstream media, in particular

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[2] Independent SAGE. Final integrated find, test, trace, isolate, support (FTTIS) response to the pandemic. 2020. https://www.independentsage.org/wp-content/uploads/2020/06/FTTIS-12.42-160620-names-added.pdf

[3] Independent SAGE. COVID-19 and health inequality. 2020. https://www.independentsage.org/covid-19-and-health-inequality/

[4] Raffle AE, Taylor-Phillips S. Test, test, test: lessons learned from experience with mass screening programmes. Advice note for Independent SAGE. 2020. https://allysonpollock.com/wp-content/uploads/2020/08/ISAGE_2020_RussellTaylorPhillips_AdviceLessonsFromScreeningProgrammes.pdf

[5] Independent SAGE. When should a school reopen? Final report. https://www.independentsage.org/wp-content/uploads/2020/06/Independent-Sage-Brief-Report-on-Schools.pdf

[6] Pollock AM. An update to Independent SAGE's recommendations for student return to campus. BMJ 2020;371. doi:10.1136/bmj.m3849

- a BMJ editorial in March 2020 highlighting the absence of a strong local system for communicable disease control, and urging an immediate resumption of testing and tracing;[7]
- letters to parliamentarians and blogs in March and April 2020 urging caution on national lockdowns and especially with respect to school closures and highlighting the need for local public health teams and local data flows;[8] [9]
- a BMJ editorial in April 2020 drawing attention to the abysmal response to the crisis in social care and the need for an urgent plan of action, including relocation of care home residents to safe, infection-free accommodation allowing visitors and provision of covid-only facilities with extra staff;[10]
- an analysis article in the BMJ in June 2020 highlighting the ad hoc response to disease control, the failure of the statutory disease notification system, and the creation of a parallel privatised system for testing and contact tracing;[11]
- a BMJ editorial on mass testing in August 2020 highlighting the current problems with mass testing and the need for clarity of purpose and a good system, and to draw on successes of UK National screening programmes;[12]
- a BMJ editorial in September 2020 on the government's Operation Moonshot proposals, showing them to be scientifically unsound, which could do more harm to people, populations, and the economy, and pointing out that PCR tests are not tests of infectiousness, contrary to claims made by Liverpool DPH John Ashton;[13]
- a briefing in November 2020 on key issues for the Operation Moonshot testing policy;[14]
- a BMJ editorial in December 2020 challenging some of the claims made about asymptomatic transmission and the basis for the mass testing of asymptomatic people, whilst advocating a rational use of tests for symptomatic testing and reintegrating testing into clinical care;[15]
- A BMJ editorial February 2021 urging government to keep schools open as a top priority;[16]
- evidence to House of Lords Science and Technology Committee;[17]

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[7] Pollock AM, Roderick P, Cheng K, Pankhania B. Covid-19: why is the UK government ignoring WHO's advice? BMJ 2020;368. doi:10.1136/bmj.m1284

[8] Letter to Scottish and Welsh governments https://allysonpollock.com/?page_id=2906

[9] Pollock AM. Covid-19: local implementation of tracing and testing programmes could enable some schools to reopen. BMJ 2020;368. doi:10.1136/bmj.m1187

[10] Pollock AM, Clements L, Harding-Edgar L. Covid-19: why we need a national health and social care service. BMJ 2020;369:m1465. doi:10.1136/bmj.m1465

[11] Roderick P, Pollock AM, Macfarlane A. Getting back on track: control of covid-19 outbreaks in the community. BMJ 2020;369:m2484. doi: https://doi.org/10.1136/bmj.m2484

[12] Raffle AE, Pollock AM, Harding-Edgar L. Covid-19 mass testing programmes. BMJ 2020;370:m3262. doi:10.1136/bmj.m3262

[13] Deeks JJ, Brookes AJ, Pollock AM. Operation Moonshot proposals are scientifically unsound. BMJ 2020;370. doi:10.1136/bmj.m3699

[14] Deeks JJ, Pollock AM, Taylor-Phillips S, Raffle AE. Briefing on Operation Moonshot screening for SARS-CoV-2. 2020. https://allysonpollock.com/?page_id=3394

[15] Pollock AM, Lancaster J. Asymptomatic transmission of covid-19. BMJ 2020;371:m4851. doi:10.1136/bmj.m4851

[16] Lewis SJ, Munro AP, Smith GD, Pollock AM. Closing schools is not evidence based and harms children. BMJ 2021;372:n521. doi:10.1136/bmj.n521

[17] House of Lords Science and Technology Committee. The science of COVID-19. 12th evidence session 29 June 2020 https://allysonpollock.com/wp-content/uploads/2020/07/AP_2020_LordsSciTechCttee_C19_S12a.pdf

- an editorial and paper setting out why vaccine mandates for care workers were an unnecessary, disproportionate and unevidenced based policy;[18]
- a written submission by my colleague Peter Roderick to House of Commons All Party Parliamentary Group on Coronavirus.[19]

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 do not have any knowledge of how SAGE worked. My main concerns were that politicians, policy makers, and many of the scientists on SAGE had insufficient understanding of the institutional and administrative arrangements for health and social care, for local and national communicable disease control, and for testing and screening and the extent to which these had been eroded, fragmented and dismantled over time.

In my view, bad policy decisions stemmed in large part from a lack of understanding of the principles of communicable disease surveillance and control, the erosion and dismantling and fragmentation of systems for strong local systems for communicable disease control and health services. This was evidenced in the decisions to empty hospital beds and discharge elderly patients (including those infected with covid) to nursing homes and home; in failure to mobilise staffing and other resources; in failure of the disease notification system, which is the main statutory basis for communicable disease surveillance; in failure to establish a scientifically informed approach to contact tracing, mass testing, and laboratory services; in building the Nightingale hospitals, which were not used; in bringing in an inexperienced private sector to deliver services; in neglect, and inefficient deployment, of staff to the social care sector; and in the failure of public procurement in respect of PPE, testing, Nightingale hospitals, etc.

The loss of the institutional structures, memory and expertise in communicable disease meant that policy makers, including some SAGE scientists, were advising on policy in the absence of real world experience, and had failed to take on board lessons learned from previous outbreaks. The government appeared to base its policies on advice from

[18] Hayes L, Pollock AM. Mandatory covid-19 vaccination for care home workers. BMJ 2021;374:n1684. doi: http://dx.doi.org/10.1136/bmj.n1684
[19] Roderick P. Submission to All Party Parliamentary Group on Coronavirus. 24 July 2020. https://allysonpollock.com/wp-content/uploads/2020/07/APPG_2020_Roderick_Coronavirus.pdf

a small group of behavioural scientists and modellers, and the evidence upon which policies, eg, prolonged national lockdowns and school closures rested and NPIs such as masks and testing was insufficiently challenged by other experts. Media and public discourse, and apparently advice to government, were dominated by behavioural science, modelling and political science ie those with no hands-on expertise and experience of communicable disease control and public health including implementation of testing programmes . A key problem with the modelling was the extraordinary complexity of the models and neglect of the poor quality source data, eg, not having a clear definition of a case or a death, issues which I drew Independent SAGE's attention to on repeated occasions, as did others.

It's useful here to reflect on the findings of the "Lessons to be Learned" House of Commons report on the foot and mouth disease crisis:

> "At the height of the crisis … there was no senior group within government offering informed, but detached, advice that could challenge prevailing thinking."
>
> "In any crisis, especially one that mobilises the deployment of resources across Government, we perceive a need for detached, impartial advice at the most senior levels from individuals not directly involved in the emergency response. A **'senatorial group'** whose membership would vary depending on the nature of the crisis could provide this. Such a body could give a valuable independent view on the handling of future national emergencies.
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> "41. We recommend that the concept of a 'senatorial group' be developed to provide independent advice to the Prime Minister and Cabinet during national crises."[20]

In 2006 Hilary Pickles noted this point's relevance for planning for a future flu pandemic. "Setting up the potential for challenge may be uncomfortable for those giving mainstream advice, but it provides a potential safeguard for the public", and quoted the Canadian National Advisory Committee on SARS and public health in 2003: "There was much to learn - in part because too many earlier lessons were ignored."[21]

In March 2020, at an early stage of the pandemic, I was so concerned about the drive for mass testing and government failure to utilise the expertise of the UK National Screening Committee (NSC) that I set up a small informal group to look at mass testing. This group initially comprised: Dr Angela Raffle, an expert on screening and a pioneer in the delivery of screening/ testing programmes , Prof Jon Deeks, a statistician and expert in biostatistics, test evaluation and health care interventions, Dr Mike Gill, a former regional director of public health and long time member of the UK NSC, and Prof Tony Brookes, who has expertise in PCR, high-throughput genomics testing, and health data science. This small group was tenacious and prolific in raising concerns about the unevidenced and expensive approach to mass testing including with the MHRA and politicians. Their reviews including research and evidence were published in the BMJ,

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[20] Anderson I. Foot and mouth disease 2001: Lessons to be Learned Inquiry Report. London: House of Commons 2002, pp18, 107.

[21] Pickles H. Using lessons from the past to plan for pandemic flu. BMJ 2006;332:783–6. doi:10.1136/bmj.332.7544.783

and elsewhere,[22] [23] [24] [25] [26] [27] They mobilised their own contacts and experts in screening, including Sir Muir Gray who established the UK NSC. A meeting of the group planned with Lord Bethell, was cancelled by him with only a day's notice.

After leaving Independent SAGE in October 2020, with Prof George Davey Smith and the then editor of the BMJ, Dr Fiona Godlee, I ran a series of BMJ webinars on covid entitled 'Covid-19: known unknowns'.[28] They were intended to inform the scientific discourse and to show the latest developments and knowledge about science. They also highlighted where there was uncertainty and a need for evidence.

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.**

My views from a public health perspective on the lessons to be learned draw on a lifetime's work on the NHS and more recently my work for the Infected Blood Inquiry's Public Health Administration group,[29] specifically in relation to communicable disease control. The report which the group produced includes material relevant to the covid inquiry.[30]

Disease surveillance starts with local disease reporting from clinical reports of suspected and laboratory reports of confirmed disease or causative agents. The response to the pandemic was less than optimal. Below I outline six factors that were crucial in this respect.

First, the steady erosion, fragmentation and dismantling of the systems for communicable disease control over decades resulted in a lack of expertise in communicable disease control on the ground and particularly in local authorities and in

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[22] Deeks JJ, Brookes AJ, Pollock AM. Operation Moonshot proposals are scientifically unsound. BMJ 2020;370. doi:10.1136/bmj.m3699

[23] Deeks JJ, Pollock AM, Taylor-Phillips S, et al. Briefing on Operation Moonshot screening for SARS-CoV-2. 2020. https://allysonpollock.com/?page_id=3394

[24] Deeks JJ, Raffle AE. Lateral flow tests cannot rule out SARS- CoV-2 infection. BMJ 2020;371:m4787. doi:10.1136/bmj.m4787

[25] Deeks JJ. Too many corners are being cut in the race to find a Covid-19 antibody test. The Guardian. 2020.https://www.theguardian.com/commentisfree/2020/aug/27/covid-19-antibody-test-coronavirus-corners-being-cut

[26] Raffle AE, Pollock AM, Harding-Edgar L. Covid-19 mass testing programmes. BMJ 2020;370:m3262. doi:10.1136/bmj.m3262

[27] Raffle AE, Taylor-Phillips S. Test, test, test: lessons learned from experience with mass screening programmes. Advice note for Independent SAGE. 2020. https://allysonpollock.com/wp-content/uploads/2020/08/ISAGE_2020_RussellTaylorPhillips_AdviceLessonsFromScreeningProgrammes.pdf

[28] https://www.bmj.com/covid-19-webinars

[29] https://www.infectedbloodinquiry.org.uk/news/update-public-health-and-administration-expert-group

[30] Expert report to the Infected Blood Inquiry: public health and administration. Infected Blood Inquiry 2022. https://www.infectedbloodinquiry.org.uk/evidence/expert-report-infected-blood-inquiry-public-health-and-administration

health bodies. The centralisation of infectious disease control, the loss of local health protection capacity in local authorities and local hospital laboratories, and the carving out of public health from the NHS in England in 2012 meant that the systems for disease notification, testing, and contact tracing could not be operationalised properly on the ground. The consequences of abolition of the Public Health Laboratory Service (PHLS) and its regional and local networks of laboratories in 2003, were profound, leaving the NHS floundering during the pandemic. The further abolition of HPA and weakened Public Health England (PHE) and now its replacement the newly created UK Health Security Agency (UKHSA) in the DHSC have centralised functions. UKHSA is an opaque and non-transparent organisation with almost no information on its website about how it is organised, what it does, and the arrangements and staff belonging to it. This contrasts with the detailed written accounts given by Dr N Spence Galbraith and others in the medical journals and elsewhere in the 1970s and 1980s about PHLS and CDSC.[31] [32] [33] [34] [35] [36] [37] [38] [39] [40]

Second, the inability to share information was part of the reason for the failures in the track and trace system to the extent that statutory requirements for disease notification were not followed, and/or data were not shared with public health departments in sufficient detail to undertake contact tracing.[41] A key problem for directors of public health in local authorities was the inability to obtain data on cases for purposes of rapid contact tracing and outbreak control. GPs also did not receive reports on hospital cases or laboratory reports.

Third, the increasingly independent operation of the NHS in England, and disruption of information flows that began with the creation of trusts and the internal market in 1990, and was furthered in 2003 by the creation of NHS foundation trusts, and in 2012 by the disestablishment of services from area bodies, the abolition of the minister's duty to provide key services, and the introduction of virtually compulsory tendering, and has been taken yet further in 2022 by the creation of 42 integrated care systems.[1]

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[31] Bartlett C. The Communicable Disease Surveillance Centre 1977-2002: an overview. Commun Dis Public Health 2003;6:87–96.
[32] Berrie JRH. National surveillance and control of infectious diseases. Health Trends 1977;9:19–20.
[33] Duerden B. Twenty-first-century medical microbiology services in the UK. Nature Reviews Microbiology 2005;3:979–83. doi:10.1038/nrmicro1291
[34] Galbraith NS. A national centre for the surveillance and control of communicable disease. Proc R Soc Med 1977;70:889–93.
[35] Galbraith NS. A national public health service. Journal of the Royal Society of Medicine 1981;74:16–21. doi: https://doi.org/10.1177/014107688107400105
[36] Galbraith NS. CDSC: from Cox to Acheson. Journal of Public Health 1989;11:187–99. doi:10.1093/oxfordjournals.pubmed.a042467
[37] Galbraith NS, Young SEJ. Communicable disease control: the development of a laboratory associated national epidemiological service in England and Wales. Journal of Public Health 1980;2:135–43. doi:10.1093/oxfordjournals.pubmed.a043298
[38] Howie J. Training of epidemiologists for control of communicable diseases. Proc R Soc Med 1970;63:519–21.
[39] Howie J. Threat to the PHLS. Br Med J (Clin Res Ed) 1985;290:579–80. doi:10.1136/bmj.290.6468.579
[40] Howie J. The Public Health Laboratory Service. The Lancet 1965;285:501–5. doi:10.1016/S0140-6736(65)92013-1
[41] Roderick P, Pollock AM, Macfarlane A. Getting back on track: control of covid-19 outbreaks in the community. BMJ 2020;369:m2484. doi: https://doi.org/10.1136/bmj.m2484

Fourth, the marketisation in relation to the constant reorganising since 1990 and the ideological drive for privatisation of health services and health care costs included the high costs of private finance, which resulted in a nonsensical and sustained belief that services including beds could be run at maximum capacity. This dogma drove the closure of services and beds and loss of expert staff throughout the last three decades. The consequence was that during the pandemic there was no surge capacity generally for community services, for ITU beds, or for acute hospital beds, nor for communicable disease control. The NHS became a covid service for more than two years.

This ideological drive during the pandemic resulted in billions of pounds being spent on procuring private companies that had little or no expertise in delivering services, eg, PPE, test and trace, the Lighthouse Laboratories, Nightingale hospitals, and masks, consultancies etc.

Fifth, the shift of care from NHS to individuals and local authorities and neglect of the social care sector, which cares for the most vulnerable in society, older people and people with disabilities, resulted in unnecessary distress and suffering and death.

Sixth, the lack of professional expertise in communicable disease control left a vacuum in policy and evidence. There was a failure to call on the relevant expertise that did exist and a failure to recognise lack of expertise at the operational and implementation level. For example, the failure to ask the UK NSC for advice resulted in billions of pounds being spent on NPIs such as masks and mass testing without the necessary evaluations being put in place. In contrast, the workforce shortages in nursing homes and residential care were ignored. Similarly, decisions about school closures and lockdowns should have been made drawing on a wider range of expertise and opinions within public health and across the child health community to consider the harms and benefits to children. Instead of recognising uncertainties and advocating on the basis of scientific principles there was unnecessary political polarisation, and this resulted in those people, including scientists and doctors, who did have expertise being pilloried and attacked and marginalised. Government communications did not highlight uncertainties or absence of evidence,[42] nor did they adapt their communications when new evidence became apparent. As a result, risks were long exaggerated for some groups and settings (particularly children, young people, and schools and nurseries) and failed to take account of other risks, including residents in long stay institutional settings, obesity and ethnicity, and for mental health.

Summary (see also Appendix E of the Public Health and Administration report to the Infected Blood Inquiry).[43]

The tragedy is that the structures for effective collaboration and information sharing for communicable disease control – between the local and the national, and between health authorities – were there and carefully built up over time but have been eroded,

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[42] McCartney M, Sullivan F, Heneghan C. Information and rational decision-making: explanations to patients and citizens about personal risk of COVID-19. BMJ EBM 2021;26:143. doi:10.1136/bmjebm-2020-111541

[43] Expert report to the Infected Blood Inquiry: public health and administration. Infected Blood Inquiry 2022. https://www.infectedbloodinquiry.org.uk/evidence/expert-report-infected-blood-inquiry-public-health-and-administration

defunded, or dismantled, and replaced by marketised public bodies, or private companies pursuing their own strategies and interests. Similarly, structures and mechanisms for and expertise in workforce and service planning and for ensuring public accountability of services to patients and the public have also been systematically dismantled.

If the necessary systems, capacity, and expertise had been in place and lessons from previous epidemics had been learned, the response to the pandemic would have been more coherent and far less costly to the public purse and society as a whole.

In my view until and unless local public health and communicable disease control capacity and expertise is rebuilt and the NHS in England reinstated as a publicly provided, funded and accountable system, the system will never be prepared. However this cannot be achieved without further legislation.

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.**

At https://allysonpollock.com/?page_id=2903 my website has copies of most letters to ministers, parliamentarians, chief medical officers, and Liverpool University, evidence to parliamentary committees, FoI requests including to the MHRA, and publications etc. I also have electronic records of emails and WhatsApp messages and texts. These were used extensively by members of Independent SAGE in communication with each other and external parties.

Appendix

I was invited by Sir David King to join Independent SAGE in April 2020 and was disinvited in October 2020 (see emails below).

I cautioned against adopting overly zealous policies, such as a zero covid policy, prolonged lock downs and school closures, and mass testing. Sir David asked me to leave the committee because I was unable to reach consensus with members on many issues, and I had a serious disagreement with them over some policy statements on testing (schools, universities), masks, school closure, and zero covid, and as a result my name was not included on some reports. There was no room for disagreement and I was not allowed to write dissenting notes. I became increasingly concerned that Independent SAGE did not have sufficient scientific expertise within the group, was engaged in group think, and was unwilling to consider and discuss alternative scientific opinions and evidence. In my opinion, its desire to drive the policy agenda often trumped the absence of good evidence.

Sent: 05 October 2020 19:04
To: Dave King ...
Cc: ...
Subject: Re: IndieSAGE membership

Dear Dave,

I am sorry it has come to this. I have learned a lot from the group. I look forward to continuing engagement, for example on the planned inequalities report which Clare and I will send to you all for approval and presentation next week

As you know I have voiced concerns about how the wish to respond rapidly can lead to not always following the science. In the spirit of being constructive, I would like to suggest that when considering policy recommendations, the group gives more consideration to the need to:

i) provide a clear evidential basis and grading for any recommendations, identifying the uncertainties in the science and the areas that need further enquiry,
ii) advocate for robust studies of harms and costs and benefits of complex public health interventions, such as masks and mass testing, before making any such policy recommendations for the population,
iii) acknowledge and consider other views and scientific opinions on interpretation of cases, hospital admissions and deaths,
iv) pay more attention to the heterogeneity of immunity and endemicity of the virus before advocating elimination and suppression (i.e., Zero COVID and the particularly restrictive measures which follow from this),
vi) adopt a whole system approach to finding symptomatic patients and focusing efforts on clinical integration of testing as well as reinstatement of health and social care services, and
v) see opposing scientific views and opinions as a gift and an opportunity to be sceptical and learn, rather than as a 'rival camp'.

Best wishes,

Allyson

From: Dave King
Sent: 03 October 2020 11:54
To: Allyson Pollock
Cc: ...
Subject: IndieSAGE membership

⚠ External sender. Take care when opening links or attachments. Do not provide your login details.

Dear Allyson,

I said that I would contact you after a discussion with the Executive Committee of IndieSAGE.

As I said in my last email, we are refreshing membership, bringing on one or two new people, particularly to share the burden of data collation and presentation, and we are keen to avoid group expansion.

We have decided that your own membership ends now. I do want to thank you on behalf of the Executive for all of the work you have done with us over the past six months. As I have already indicated to you, we would be very happy if you would like in the future to contribute in particular areas of common interest to members of IndieSAGE, such as the impact of COVID-19 on deprived, including BME, communities.

Once again, many thanks. It has been a pleasure to get to know you.

With my best wishes,

Dave