Witness Name: David Bailey
Statement No.: First
Exhibits: None
Dated: 23 July 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DR DAVID BAILEY

I, David Bailey, will say as follows: -

1. My name is Dr David Bailey and during the relevant period for the Inquiry I was a full time GP partner at I&S Surgery in I&S Wales. This is a large training practice with 14 partners and about 20 nursing and ancillary staff in purpose-built premises. Throughout the relevant period I was also chair of Welsh council of the British Medical Association (BMA) the doctor's trade union and professional association. I was also an executive member of the BMA's General Practitioners Committee (Wales). I had been providing primary care on a full-time basis to my patients in the same practice for some 34 years when the pandemic started.

Changes to working conditions during the pandemic

2. When lockdown was announced on 23 March 2020, my General Practice partnership immediately altered our provision of GP care from a largely face to face service – both on the day and via appointment, plus home visits at doctor's discretion – to one which was entirely 'phone first', with patients able to have telephone assessments/consultations with doctors and other clinicians (such as nurse practitioners, practice nurses and physiotherapists) after booking slots with the front desk. As we had a single decision-making body in the partnership, this change was implemented virtually instantaneously.

3. In most cases, we found that GP care could be delivered over the telephone, by assessing the patient and providing advice with or without prescription. This could include advising to have a further discussion in, say, 36 hours, to reassess. For some

patients, however, they could not be reliably assessed without examination, and from the beginning of the pandemic, we continued to see patients face to face in the surgery where this was necessary. Most days, I saw two or three patients in surgery, who were brought in with appointment times after an initial telephone consultation. Before the pandemic, on an average day, I carried out between 28 and 40 face to face consultations with patients.

4. We rapidly added additional technical support to the practice within the first three to four weeks of lockdown. Bomgar was a programme allowing remote operation of the GP computer and printer from home and was prioritised early by Welsh Government for rollout. This enabled GPs who were feeling OK but had respiratory symptoms to continue providing remote care for patients from home and avoiding putting either staff or colleagues at additional risk. We could issue prescriptions which were printed at the surgery and either collected by the patient or sent directly to a local pharmacy. Any face-to-face consultations were transferred to other colleagues. This was, I think, a considerable aid to maintaining a fast level of service compared to other parts of the UK.

5. A second even more useful addition was AccuRx (again installed within the first three to four weeks of lockdown), which is a remote consultation system enabling patient-doctor contact via SMS, and the sharing of documents, written advice, and clinical photos. Any information shared on AccuRx, including any details from the consultation with the patient, was directly embedded into the patient record. Most patients have a smart phone and can send photos and text messages, and we found that high-definition photos were more valuable than a video consultation. We did not use video consultation as it added little to nothing to the telephone consultation and the sharing of photos via AccuRx. We tried video consultations on occasion, but found the connections were often unstable, and it was seldom a useful substitute for examining a patient in person. If we considered that we needed to see a patient to maintain safety (e.g., to carry out a chest or abdominal examination), they would be invited into the surgery for a face-to-face appointment.

6. AccuRx was useful for acute presentation and sharing information (e.g., patients could communicate temperature, blood pressure or blood sugar levels); however, it was not a tool to examine a patient. Some elderly patients had difficulties using the technology, and for these patients, we would often examine them in person, particularly as they were considered higher risk, and we had a lower threshold for examining high risk

patients in person. In general, very young, chronically sick or elderly patients had a greater likelihood of being examined in person when exhibiting similar symptoms to fit adults, because they were generally more likely to have a condition that could deteriorate quicker. These decisions were based on our clinical judgment as GPs on a case by case basis.

7. Intrinsically telephone consultations are less safe as they do not permit physical examination and some non-verbal communication is lost. Telephone consultations also took longer as clinicians were aware of the increased uncertainty in providing care. Although GPs are well accustomed to managing high levels of uncertainty - using less testing and relying on quicker review and assessment than, for example, secondary care - the increased uncertainty in providing care during the pandemic inevitably raised stress levels for GPs, including myself.

8. Partners and staff continued to come into the surgery most days, although not all worked at the practice full-time. There was a large room upstairs where we could meet (albeit socially distanced and wearing masks). We had two trainees in the practice during the pandemic, although I was not one of their trainers. The work of the trainees was analogous to other colleagues, using Bomgar when they needed to work from home and AccuRx to support consultations with patients. Trainees continued to have daily de-briefs with their trainers, and I believe it worked well.

9. We had discussions early on at a national level in my BMA role about risk stratification for NHS staff to try and protect the more vulnerable. The upshot of initial discussions was the relatively rapid introduction of a stratification template, as all sides quickly perceived that the existence of a widely recognised risk template to protect the vulnerable staff in Wales was more important than the minutiae of its contents. The template was used in nearly all clinical environments in Wales, and it gave a weighting to factors such as age, gender, ethnicity, obesity, and the presence of chronic illness (particularly cardiac or diabetic conditions). Depending on the individual's score, they were given a grade: low risk (to observe normal precautions), high risk (to consider modified duties and avoid aerosol generating procedure environments) and very high risk (to avoid face to face contact).

10. By and large most staff at highest risk (mainly older men with medical risk factors) were able to reduce face to face contact to a large degree. Fortunately, despite being male,

over 60 and overweight, I was mercifully free of other risk factors and able to continue providing the same care as all my partners to our patients.

11. We met regularly as a partnership group and throughout the relevant period we were able to gradually flex our provision back towards more face to face consultations, particularly after immunisation became widespread and perceived risks reduced. By Summer 2022 we were almost back to our previous essentially face to face provision, although a couple of bookable slots for telephone consults remained as some patients requested that this suited them better.

Treatment of patients with suspected Covid-19

12. For query Covid patients, the key assessment was whether the patient needed to be sent to hospital, which did not usually require an in-depth assessment. In the early days, we attended patients in the practice car park, listened to their chest, and took temperature and pulse oximetry (which measured oxygen levels in the blood). If a patient needed a more detailed examination, we had a separate side entrance to the practice with cordoned off rooms for query 'hot' cases. After about a month, the practice obtained more pulse oximeters which could be loaned out to patients for ongoing monitoring. If their oxygen levels dropped, we would usually arrange transfer into secondary care.

13. In cooperation with other practices in the locality, we quickly established "hot hubs" where patients with likely Covid could be seen and examined by appointment. An old health centre that had been used for chiropody and other community health services up until the pandemic was converted into a "hot hub", with rooms solely used for people where there was a high risk of Covid. We recognised early that age was the biggest risk factor and we had early discussions about risk profiling. For this reason, it was usually the younger partners and those who were at lower risk from Covid, who attended the hot hubs. At the start of the pandemic, I was 63 years old, and one of the oldest members of the practice.

14. Most, if not all, of the partners and staff contracted Covid within the relevant period, and while some colleagues experienced severe symptoms, thankfully none of us were sick enough to require hospitalisation.

Infection prevention and control and protection for primary care workers

15. From the beginning, we used the full range of available PPE, both in surgery or on the rare occasions when we attended a patient at home. This included masks, gloves, and plastic visors. We also quickly moved to wearing scrubs rather than our own clothes while at the surgery. Early on, scrubs were not provided by the local health board, and ours were made by patients. We are a community practice covering approximately 14,000 residents across three villages, and the community came together making scrubs for us and homemade visors for eye protection. Although some eye protection was available through the Health Board, the patient made eye protection (worn in conjunction with a mask) was simple, cheap and did not interfere with our clinical activities.

16. PPE was initially from practice stocks and local patient support, although over time the practice was supported by the Health Board and Welsh government. At no stage did we experience any supply issues with Fluid Resistant Surgical Masks (FRSM) or latex gloves. Initially we wore plastic aprons over the scrubs, although it became apparent early on that they provided little additional protection. Scrubs were washed every evening.

17. Although there were early shortages of surface cleaning products these were quickly resolved (by our very determined practice manager). Certainly, I was aware from colleagues in other practices that there was a significant early shortage of surface cleaning products. After every patient, we cleaned off desks, keyboards, door handles and we washed hands and used alcohol gel. At the beginning of the pandemic, we mopped the floor between patients, as we were not entirely sure what worked and what didn't. As mentioned above, when we attended a patient where Covid-19 was suspected, we usually met them in the car park where there was plenty of fresh air and ventilation. Within the surgery, we had a Perspex glass barrier around reception, which was funded early on by the Health Board.

18. Testing over the first couple of months was fairly haphazard requiring visits to distant testing centres and self-administering swabs using rear view car mirrors. We got proper personal testing kits relatively early on, which enabled early isolation for the protection of staff and patients. Once established until the pandemic waned this provision seemed pretty seamless.

19. An early concern was an inability, despite widely published evidence on physical droplet/aerosol behaviour, to upgrade in general practice from FRSM - widely available from the start and very cheap even when manufactured correctly - to FFP2 and FFP3 masks (Filtering Face Piece) which provided far higher protection. Despite several meetings and letters in my political role for the BMA, we were unable to persuade Welsh Government, the office of the Chief Medical Officer or the Local Health Boards to strengthen the four nation Infection Prevention and Control guidance and to more generally take up FFP2 masks in primary care settings.

20. We, and most GPs, bought FFP2 masks from our own money because they offered significantly more protection than FRSM, and while knowledge of transmission was developing, we felt it was appropriate to be cautious and to use FFP2 masks rather than FRSM. Towards the end of the pandemic, some locality GP clusters funded FFP2/FFP3 from Local Health Board money, however, this very much depended on the attitude of the Health Board and the persistence of doctors in that area. Many GPs felt the lack of support was emblematic of NHS Wales' valuation of GPs.

21. Staff and doctors were immunised early on and most of us received the first vaccination by January 2021. A rather more contentious debate related to the decision to delay the second Pfizer dose in early 2021 for NHS staff to allow earlier prioritisation of older people. This was in conflict with the published data from the company suggesting that there was no evidence at the time for the extension to a 12-week second booster. We were told that JCVI and the CMOs had seen unpublished data confirming the safety of this approach (indeed the same had actually been published for the AZ vaccine). I freely acknowledge in hindsight that this decision was correct and justified (unlike the decisions on FFP mask use) but sharing this unpublished data with the leaders of the unions providing frontline care at the time would have been far better for morale and cooperation, when frontline staff were justifiably concerned about their safety because of their far higher exposure and likelihood of contracting the virus. Given the subsequent difficulties with face protection, this decision increased the anxiety of every clinician I spoke to.

Impact on healthcare workers and patients

22. From a psychological perspective certainly in my practice, where there were a considerable number of us in appropriate premises every day, we managed reasonably well. While there was increased stress and worry, we were able to support

each other and maintain a relatively good level of morale. In this regard, I think we may have had a more normal experience than many others. Practices with much smaller numbers of partners, or unsuitable premises, may have found this period much more difficult.

23. Although some colleagues were significantly unwell with Covid 19 there were no hospitalisations or deaths of staff which clearly helped in this regard in contrast to some other practices. I feel that we were very lucky. Like all practices of course we had a number of hospitalisations and deaths amongst our patients, which undoubtedly had a detrimental effect on staff wellbeing and morale. The nursing home in our area avoided a Covid outbreak early on, although 15 months into the pandemic, we had six deaths.

24. Our patients were incredibly supportive, making scrubs and visors, and very understanding of the situation we were facing and the need to move to 'phone first'. However, I had the impression, particularly early on, that our patients did not want to bother us, and they may have held off or delayed contacting the surgery. There was a step change when immunisations were rolled out, and there was less of an issue around delayed presentation.

25. During the pandemic, the clinical content of our practice was 95% the same as before, although the precautions we took and the way we practised changed dramatically. Delays in presentation was an issue and delays in referral was an issue, but the vast majority of what we saw clinically was not pandemic related. In terms of Covid itself, most people were able to get better with little in the way of medical intervention, particularly in terms of primary care management.

26. As the pandemic went on, GPs saw far more people presenting with feelings of isolation, low mood and depression. Some patients had lost loved ones, and this had a profound effect. Undoubtedly the pandemic had a significant impact on mental health, and I saw this particularly in younger people. For most people, it seemed that the effects of isolation had more of an impact than Covid itself.

27. I retired from clinical practice at the end of 2022.

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.

Signed: Personal Data

Dated: 23 July 2024