

Witness Name: Dr Michael Charles Prentice

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Dated: 9 May 2023

UK COVID-19 INQUIRY

SECOND WITNESS STATEMENT OF DR MICHAEL CHARLES PRENTICE

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I, Dr Michael Charles Prentice, of NHS England, Wellington House, 133-135 Waterloo Road, London, SE1 8UG will say as follows:

Introduction

1. High Consequence Infectious Diseases (“**HCID**”) services are part of a wider range of highly specialised services commissioned by NHS England.
2. HCIDs are highly transmissible infections that are rare in the UK, and typically associated with recent travel from countries where the infection is endemic or there is a current outbreak. They typically have a high case fatality rate and the ability to spread in the community and within healthcare settings if adequate precautions are not in place. Patients require careful management to prevent the staff caring for them from becoming infected and coordination is required at a national level to ensure an effective and consistent response.
3. An HCID is a different threat in comparison to an influenza pandemic. HCIDs are rare in the UK; with Ebola, for example, there was only one case every few years. Only diseases which are designated as HCID (by the Four Nations Public Health HCID Group) are managed through HCID protocols. These protocols do not apply to other types of incidents that require staff to be appropriately protected, in particular Chemical, Biological, Radiological and Nuclear (“**CBRN**”) (for example, the Novichok poisoning in Salisbury), which are managed differently, and do not invoke HCID protocols. There are many diseases which can cause serious illness which are not classified as an HCID.
4. An HCID is defined, by the UK Government and UK Health Security Agency (“**UKHSA**”), (formerly Public Health England (“**PHE**”)), according to the following criteria:
 - a. acute infectious disease;
 - b. typically has a high case-fatality rate;
 - c. may not have effective prophylaxis or treatment;
 - d. often difficult to recognise and detect rapidly;
 - e. ability to spread in the community and within healthcare settings; and
 - f. requires an enhanced individual, population and system response to ensure it is managed effectively, efficiently and safely.

5. HCIDs are then further classified based on their mode of transmission, **contact** and **airborne**:
 - a. contact HCIDs are usually spread by direct contact with an infected patient or infected fluids, tissues and other materials, or by indirect contact with contaminated materials and fomites e.g., Lassa fever, Crimean Congo haemorrhagic fever, Ebola and Marburg virus disease; and
 - b. airborne HCIDs are spread by respiratory droplets or aerosol transmission, in addition to contact routes of transmission e.g., Andes virus infection (hantavirus), Middle East respiratory syndrome (“**MERS**”), Monkeypox (Clade (variant) I only), Pneumonic plague and Severe acute respiratory syndrome (“**SARS**”).
6. The HCID Service is a response service which is required to be in a heightened state of preparedness. It needs to be ready and capable to accept relevant patients expediently and in a manner than contains the risk of further harm.
7. By its nature, it is a service where Emergency, Preparedness, Resilience and Response (“**EPRR**”) colleagues (often working at a national agency level), and highly specialist medical teams in Trusts, need to be in close co-ordination; in ‘incident’ mode. Due to the rarity of HCIDs, the service is not needed in every location.
8. The HCID Programme (the “**Programme**”) was initiated to put in place additional capacity and capability based on learning, from historical incidents with Ebola, MERS and SARS.
9. The Programme was a strategic piece of work, and once completed (in April 2018) the ongoing development of HCID provision became a business as usual activity – drawing on the experience of cases treated and further exercises. The key outputs of the Programme was the commissioning of four HCID Treatment Centres along with new national Standard Operating Procedures (“**SOPs**”); one for each mode of transmission; HCID-C (contact) and HCID-A (airborne).

Corporate witness statement

10. I have been the National Director of Emergency Planning and Incident Response for NHS England since April 2022. Through the pandemic I was Deputy COVID-19 Strategic Incident Director to Professor Sir Keith Willett, having been seconded from my previous role as Regional Medical Director and Chief Clinical Information Officer in the North East and Yorkshire Regional team. I attended the National Incident Response Board (“**NIRB**”) and a range of meetings as part of NHS England’s COVID-19 response, in addition to deputising at meetings with DHSC and UKHSA. My clinical background is in General Practice.
11. This corporate witness statement was drafted on my behalf, and with my oversight and input, by external solicitors acting for NHS England in respect of the Inquiry. The draft request received on 14 April 2023 pursuant to Rule 9 of the Inquiry Rules, specifically relates to Module 1 of the Inquiry, but raises supplementary questions (the “**Supplemental Module 1 Rule 9 Request**”) to NHS England about High Consequence Infectious Diseases (“**HCID**”).
12. The Supplemental Module 1 Rule 9 Request is broad in scope and time period and goes beyond matters which are within my own personal knowledge. As such, this statement is the product of drafting after communications between those external solicitors and a number of senior individuals (both current and former NHS England employees) in writing, by telephone and by video conference. I do not, therefore, have personal knowledge of all the matters of fact addressed within this statement. However, given the process here described, I can confirm that all the facts set out in this statement are true to the best of my knowledge and belief.
13. As this statement includes evidence from a breadth of sources, combined to represent the evidence and voice of NHS England,¹ references throughout to ‘NHS England’ and ‘we’ represent the voice of the organisation. I have referred to all individuals (including myself) in the third person, by job title and name where possible.
14. This corporate statement has been produced with input from a number of colleagues across NHS England, and following a targeted review of documents collated to date.

¹ This response represents NHS England as a legal entity prior to merger with NHS Digital (1 March 2023) and Health Education England (1 April 2023).

15. In the time available it has not been possible to review every potentially relevant document, and it is highly likely that relevant documents exist that have not been reviewed. This statement therefore provides a 'high level account', and is accurate to the best of our knowledge, but we cannot exclude the possibility that it will require updating as further evidence emerges through our ongoing process of internal investigation and document review. NHS England will of course notify the Inquiry as soon as practicable if information comes to light that would have been included in this statement if it was available before the deadline for its production.

16. Within this witness statement, we refer to documents which are exhibited to support a particular point being made. These documents are exhibited as [MPxxx-08], followed by their NHS or INQ document number. In addition, we refer to documents that have previously been disclosed by us, as exhibits to the First Witness Statement of Dr Michael Charles Prentice. These are referred to as [MPxxx] followed by the INQ number which has been attributed to the exhibit by the Inquiry. Finally, we refer to documents which have been disclosed by other Core Participants in this Inquiry. These are referred to by their INQ number only.

Outline of this corporate witness statement

17. This statement contains responses to questions set out in the Supplemental Module 1 Rule 9 Request, received by email on 14 April 2023.
18. Some of the issues touched on in this statement have been addressed in greater detail in the First Witness Statement of Dr Michael Charles Prentice (the “**First Witness Statement**”), but this statement is limited to only addressing the Supplemental Module 1 Rule 9 Request.
19. The statement is structured as follows:
20. **Section 1** covers HCIDs generally; including the specific arrangements relating to HCIDs in England, including the HCID Programme and the evolution of this until programme completion (“closure”) in April 2018, when it was absorbed into business as usual (“**BAU**”).
21. **Section 2** covers the 2020 future HCID programme.
22. **Annex 1** sets out the key figures at NHS England in respect of HCID
23. **Annex 2** contains a view of NHS England’s specialised commissioning governance during the period of the HCID programme (2017/18)
24. **Annex 3** sets out the search parameters undertaken when identifying relevant documentation in support of this witness statement
25. In this statement I have referred to NHS England, DHSC and the Secretary of State for Health and Social Care (“**SSHSC**”) in accordance with how they are structured today, but such references include all predecessor organisations and roles as the context may require.

SECTION 1 : Highly Specialised Services: High Consequence Infectious Diseases (HCID) and NHS England's involvement in the HCID Programme

(a) HCID Overview

26. NHS England nationally commissions certain specialised services. What is meant by NHS England commissioning a service, is that NHS England develops and issues a service specification, which forms part of an NHS contract between NHS England and the provider. Under this contract, the provider agrees to deliver the specialised service (in this case the HCID service) in accordance with the service specification, in return for payment by NHS England.
27. Most other services (non-specialised services) are commissioned more locally by Integrated Care Boards (for the relevant period, by Clinical Commissioning Groups).
28. Within specialised services is a subset of services classified as 'highly specialised'. In the year 2019/20 there were 76. (There were 75 at the point of NHS England's inception on 1 April 2013). Each highly specialised service is provided to a smaller number of patients compared to specialised services; usually no more than 500 patients per year. They are typically delivered nationally through a small number of expert centres (**[MP0046 INQ000113285]**).
29. HCID services are one of the highly specialised services commissioned by NHS England.
30. Prior to NHS England's inception, England had two specialist centres for contact HCIDs, which, historically, were funded by DHSC. These were located at the Royal Free Hospital, London and the Royal Victoria Infirmary, Newcastle. Post inception, NHS England took over, from DHSC, responsibility for commissioning these two HCID specialist centres and assuring them operationally. Subsequently, NHS England also commissioned two HCID specialist surge centres, at the Royal Hallamshire Hospital, Sheffield, and Royal Liverpool Hospital. These two surge centres are brought online when patient numbers exceed the available bed capacity at the Royal Free Hospital and the Royal Victoria Hospital.

31. These specialist centres and services were commissioned to be in place for system readiness and for the treatment of patients with 'contact' diseases including viral haemorrhagic fevers such as Ebola.
32. Whilst NHS England had developed a commissioned pathway for some HCIDs which were a mix of contact and airborne, there was not a commissioned pathway and no specific contracts for the treatment of patients with high consequence 'airborne' diseases, such as SARS and MERS, leaving a gap in provision.
33. The Ebola outbreak in West Africa in 2014-15 challenged the ability of the NHS in England to provide appropriate, scalable care for HCIDs. Ebola-specific solutions were rapidly commissioned during the emergency, demonstrating the potential to find operational solutions within the NHS. However, the learning from this needed to be consolidated and incorporated into a long term resilience plan to enable the NHS in England to deliver care safely and effectively for a wider range of known and unknown HCIDs, within the existing specialised commissioning arrangements.
34. NHS England recognised this issue and following the Surge Capacity Exercise for Ebola in March 2015 ([MP0058 INQ000113299]) it was recognised that an HCID plan needed to be developed, based on key recommendations from this exercise.
35. The Surge Capacity Exercise for Ebola (March 2015) was designed to consider the current arrangements and capabilities of the four commissioned HCID surge centres in England and their options for surge capacity in response to multiple positive cases of Ebola. The four surge centres at the time were: the Royal Free Hospital London NHS Foundation Trust; the Newcastle upon Tyne Hospitals NHS Foundation Trust; the Royal Liverpool and Broadgreen University Hospitals NHS Trust; and the Sheffield Teaching Hospitals NHS Foundation Trust. Representatives from DHSC, PHE, NHS England, the National Ambulance Resilience Unit ("NARU"), appropriate Ambulance Services, some Local Authorities, the Health & Safety Executive, Public Health Wales and the Ministry of Defence took part. Recommendations were focused on improving the management of HCIDs, and led to the development of a HCID plan

(b) HCID Programme

36. In 2015/16, shortly after the Surge Capacity Exercise for Ebola, NHS England established the HCID Programme (the "**Programme**") which was a joint programme

between NHS England and PHE, with input from DHSC, to describe clinical and public health operations for the definitive HCID service for England. The overarching objective of this Programme was to develop an agreed approach to managing the end-to-end patient pathway for suspected and confirmed HCIDs (**[MP0047 INQ000113171] [MP0048 INQ000113292]**). This would ensure that a sustainable response was in place that could be efficiently and effectively actionable should the need arise.

37. The primary reason for establishing the Programme was the continuing threat of 'airborne' diseases, such as MERS, SARS and Avian influenza.
38. The Programme was designed to build additional capacity and capability within the NHS based on the learning from the previous management of patients with HCID and the ongoing risk that these diseases present. This additional capacity and the way it would operate was then commissioned from providers of service by NHS England (National Specialised Commissioning team). Once in place the commissioning team has continued to work with the providers of HCID services and others on the ongoing operational delivery of HCID services and their development. However once services had been commissioned the formal Programme had achieved its objectives and was ended.
39. The operational delivery of services to patients presenting with a confirmed or suspected HCID is co-ordinated by the national EPRR team working with a wide range of partners: Specialised Commissioning; HCID services; Ambulance Trusts; MOD; and PHE/UKHSA.
40. As part of the Programme, it was planned that assessment processes would be put in place to ensure that providers could meet, for example, the terms of new service specifications. The embedded assurance and BAU cycles within NHS England would ensure that the newly developed capability would be kept current/refreshed as required.
41. A copy of the NHS England [National] Known and Unknown HCID Project Initiation Document (PID) is exhibited (**[MP0217-08 INQ000184151]**). This was first published on 28 September 2015 but subsequently amended and updated, with the copy exhibited dated 7 July 2017. This set out the initial plan and purpose of the HCID Programme, including what the proposed Programme was; what it was aiming to

achieve, why it was required, where the Programme and its outputs would be developed, who was going to be involved and how and when it was going to happen.

42. A high level overview of the HCID Programme from 31 May 2016, (and another from February 2017) are exhibited (**[IMP0218-08 INQ000184174]**) (**[IMP0219-08 INQ000184147]**). In terms of governance, there was to be regular HCID Programme board meetings, where attendees included the SRO, programme directors, workstream leads and a PHE representative. Highlight and progress reports were to be presented at each board meeting and output assurance was to be provided by the Programme director (Mike Jacobs).
43. The workstreams agreed were (1) communications (2) command and control arrangements (3) response arrangements for first contact agencies (4) tiered operational response (5) governance frameworks for the use of novel and experimental therapies (6) standards and mechanisms for responsive clinical research (7) NHS contribution to a UK government response to overseas HCID
44. In terms of how the lines of responsibility within the Programme were split between NHS England, PHE and DHSC, it was envisaged that DHSC would provide the support and cross government decision making, PHE would have responsibility for horizon scanning, outbreak response, assessment of HCID threats to the UK, incidents management, command and control, management of epidemiology, IPC guidance, prevention, screening and diagnostics and NHS England would have responsibility for operationalising the response, including clinical management and clinical command and control. To be clear, this is consistent with the “DATER” approach (**D**etection, **A**ssessment, **T**reatment, **E**scalation and **R**ecovery), with different organisations being responsible for each phase consistent with their legal and statutory framework:
 - a. **Detect and Assess** phases: Led by PHE. This is when there are initial cases and small clusters of the HCID in the country and the focus is on understanding the epidemiology of the virus.
 - b. **Treat and Escalate** phases: The NHS take the lead for response during the Treat and Escalate phases when there is an increasing demand on services as the number of patients increases.
 - c. **Recovery** phase: Alongside planning for and delivering a response to the HCID, it is essential that the recovery phase is also planned and managed. It

is essential that plans are maintained after it appears the HCID has abated in the event that there is a further wave of disease.

45. The HCID Programme Board Terms of Reference (“TORs”) (**[IMP0220-08 INQ000184148]**) confirm that the overarching objective of the board was to set the strategic direction and provide approvals for the Programme, to provide advice and direction as necessary, to assure the delivery of the Programme and monitor achievements, have oversight of costs and ensure ongoing alignment with the overall objectives of NHS England and DHSC in relation to HCIDs. The Programme would run from November 2015 to March 2018.

46. The TORs also set out that the HCID Programme Board had overall responsibility for ensuring that the HCID Programme delivered its objective to develop an agreed approach to managing the end to end patient pathway for known and unknown HCID (including suspected and confirmed cases) to ensure a sustainable response is in place, and is efficiently and effectively actionable, should the need arise. The HCID Programme Board would achieve this by ensuring the following outcomes were delivered:
 - a. A defined, proportionate and tiered operational response including defined secondary/tertiary care units to be commissioned as first and second tier units for high hazard infections
 - b. Response arrangements for first contact agencies, General Practice, Ambulance and Emergency Departments
 - c. Defined arrangements for command, control, coordination and communication in the event of such an incident or outbreak
 - d. Protocols setting out communications arrangements with NHS professionals and the public in the event of an incident or outbreak
 - e. A governance framework for the use of novel and experimental therapies for treatment of HCID in line with NHS England governance policies
 - f. Standards and mechanisms for responsive clinical research protocols to be implemented rapidly and effectively

- g. Development of agreed protocols and processes in place to support the UK government response to a HCID in any overseas response, including; a coordinated response plan for health provision in the event of an HCID, and, agreed arrangements in place for the provision and governance of expertise to support events in the UK e.g. Mutual aid
 - h. Development of any associated commissioning products, including service specifications and clinical polices, dovetailing with the agreed NHS England governance arrangements
 - i. The production of clinical risk based standards, by the Infectious Diseases Clinical Reference Group, governing the provision of care for a range of HCID, grouped under two main headings relating to their mode of transmission: contact and airborne.
47. The inaugural HCID Programme Board Meeting took place on 25 November 2015 **[INQ000057000]** at which the Terms of Reference were agreed. The minutes from that meeting also underlined that the Programme was aimed to *“stop emergency responses [and] instead embed a strategy for dealing with risk and infection.”*
48. The inaugural meeting minutes set out the expected contributions from the relevant key stakeholders:
- a. NHS England - the expectation was that NHS England would operationally determine the end to end patient pathway, through to final discharge of patients with an infectious disease, including first line responders (A&E, ambulances etc). Although this was an NHS England programme board, a single unified HCID plan should be the output, aiming for a single document which is user friendly and operational, based on current organisational capacity, utilising current resources and each workstream should have a clear objective with an overall unified plan. A new standard of protection, training and disposal was to be developed. The commission would therefore need to include training as well as provision of healthcare. The essence of the programme of work would be creating actions and providing clarity on who responds in what way. The plan would not seek to name diseases but deal with them generically i.e. contact or airborne. There should be paediatric

representation in relevant sections of workstreams, recognising that they may have a different presentation and complex history. There also needed to be agreed a standard for PPE, training and methodology to allow staff to move between sites without issue.

- b. PHE – the expectation was that PHE would bring together work already underway within PHE’s remit and new work specific to the Programme. Some of this would involve reframing work that was already ongoing. The workstream programme was set to be flexible but transparency was to be provided on how they interrelated. PHE also needed to look at funding and resources, particularly on horizon scanning which needed space, time and funding.
 - c. DHSC – DHSC’s interest lay in risk (and in relation to the National Security Strategy). A challenge of DHSC’s role was in stewardship over the operational programme and a key part of their role was to provide cross government assurance. It was also expected that DHSC would assist on legislation and would resource this.
49. Some examples of ongoing minutes from the HCID Programme Board are exhibited **INQ000057020**) (25 May 2016) and (**[MP0221-08 INQ000184149] [MP0222-08 INQ000184150]**) (24 April 2017). Typically Board meetings contained a review of the action log, an HCID update from NHS England, PHE and DHSC (with further actions for all three organisations being minuted).
50. In February 2016, NHS England was involved in Exercise Alice (for MERS) (**[MP0059 INQ00011329] [MP0060 INQ000113173]**). Exercise Alice was a tabletop exercise, commissioned by DHSC, to explore the challenges that a large scale outbreak of MERS-CoV could present nationally to health partners very early on in England. The exercise was prompted by a request from the CMO and was focused on two stages of response; initial actions and public health response and the health care aspects of a wider spread of cases.
51. Participants in Exercise Alice included representatives from NHS England (including representatives from the Highly Specialised Commissioning and EPRR teams), PHE and DHSC. Additionally, observers from the Cabinet Office, the Devolved Administrations and GO-Science attended.

52. Whilst MERS focussed, Exercise Alice provided a valuable opportunity for participants to explore the key roles and responsibilities of partner organisations in managing the response, and the wider health impact, beyond the initial outbreak, as well as providing assurance of the preparedness of health partners for an incident of this type. Learning from Exercise Alice, helped inform the wider development of the operational response to an airborne HCID, and the HCID Programme generally. Recommendations from Exercise Alice were divided between DHSC, PHE and NHS England, as appropriate. The actions were migrated into the Programme's different work streams and were operationalised ahead of the HCID Programme closure (or considered as part of the pandemic flu programme) ([MP0061 INQ000113259]).
53. At the HCID Programme Board Meeting on 25 May 2016 [INQ000057020] it was noted that there had been some slippage in the Programme due to other work priorities, including the Zika virus and industrial action. NHS England confirmed that whilst progress had been limited over recent months, the core team were now in place. The Programme had moved from concept stage to defining and designing tangible outputs to support the end product. The Programme could be described in three phases; commissioning, preparedness/planning and response.
54. PHE confirmed that it was behind NHS England in terms of implementation of its workstreams, due to some resource constraints. However, significant strides had been made with the appointment of a Project Management Office ("PMO") and it was envisaged that all project documentation would be agreed at its next meeting in June and the programme would start to pick up pace. DHSC confirmed that its current focus was on reviewing regulations for ships and aircrafts and medivac capabilities. It was also noted that the post exercise report, from Exercise Alice (MERS), had been produced with a number of action points for PHE, NHS England and DHSC but no briefing on the HCID Programme had yet been submitted to Ministers.
55. The NHS England HCID Programme Manager gave an update to the HCID Programme Board on 26 August 2016 [INQ000057044]. This confirmed that the Programme was to be finalised by end-March 2017 but the subsequent implementation of the proposed commissioning arrangements would not form part of the HCID Programme and would be subject to the Specialised Commissioning Team's business cycle with new commissioning arrangements being in place by April 2018.

56. During the HCID Programme Board meeting on 24 April 2017, the update from NHS England confirmed that an internal stocktake had taken place earlier that week and the Programme was still on target to deliver within the defined timescales. Some of the challenges within the Programme were identified, including making links between PHE and NHS England pathways and processes.
57. It was also confirmed that following discussions with key stakeholders in respect of Paediatric HCID, a parallel pathway would need to be commissioned; with the view being that paediatric services could not be an adjunct to the adult airborne HCID service. Consequently, the plan was that the Adult HCID service would be commissioned first and then Paediatric HCID would be commissioned thereafter. The Adult HCID and Paediatric HCID services needed to be clearly identified as two separate services.
58. An update was given on the Interim Adult HCID airborne specification, and an explanation was provided about the process it needed to go through before procurement.
59. The PHE update in the same meeting confirmed that significant progress had been made over the last few months, within all work streams. High level narrative had been produced for the Programme to support the overarching programme, with detail of progress made by each work stream. There were still various areas which needed to be resolved and were currently being worked on with some of the work streams. The 'Community Sampling' paper had not been completed and the issues of (1) Who does the sampling and (2) Who does the commissioning of this were queried. It was agreed: (1) that PHE were responsible for Community sampling and (2) NHS England were responsible for the commissioning aspect. Board members discussed issues relating to the issue of skills and capabilities of organisations to complete the commissioned aspect of the Community sampling.
60. The HCID Programme was closed down in April 2018 once delivery of the Programme had been achieved. The ongoing HCID programme was then absorbed into NHS England highly specialised commissioning business as usual.

(c) Commissioning of HCID facilities by NHS England

61. As identified above, as part of implementing the Programme new pathway, NHS England needed to put in place a network of HCID centres which would provide a national system of service readiness, with the ability to cope with small numbers of patients in a safe, managed environment. It was also recognised that there was a need for a coordinated national plan to deal with HCIDs, particularly in terms of capacity and joined up thinking. This involved commissioning appropriate services by reference to agreed service specifications. The HCID network's creation brought together geographically separated centres and enabled them to be 'a network' and to share ideas and approaches.
62. On 5 September 2017, NHS England's Clinical Priorities Advisory Group prepared two HCID Summary Reports, one covering Adult services and one covering Paediatric services. These made proposals for development of an interim airborne HCID service specification that set out what an NHS Trust needed to have in place to be in a heightened state of preparedness in order to be able to treat patients with airborne HCIDs. The Summary Reports were not a service specification for direct patient care; that was to be developed in due course. NHS England were to use the planned service specification to select a small number of providers, probably around four, who could deliver this service. Ideally, providers would be able to deliver a service for both adults and children on the same site. The geographical distribution of those centres would likely be aligned to those cities that have the highest potential future number of suspected MERS cases. Actual patient treatment costs would be paid for through usual contractual processes in the NHS Standard Contract, i.e. respiratory intensive care followed by infectious disease tariffs.
63. The two proposals were supported by their own (1) Impact Assessment (2) Stakeholder Engagement Report (3) Consultation Report (4) Equality and Impact Assessment and (5) Service Specification Proposition; **[MP0223-08 INQ000184153] [MP0224-08 INQ000184154] [MP0225-08 INQ000184152] [MP0226-08 INQ000184155] [MP0227-08 INQ000184158] [MP0228-08 INQ000184159] [MP0229-08 INQ000184157] [MP0230-08 INQ000184156] [MP0232-08 INQ000184161] [MP0233-08 INQ000184160]**).
64. On 20 December 2017, NHS England's Specialist Commissioning Oversight Group prepared a Strategic Procurement Plan for HCID-A (HCID-A = airborne) (Adult and

Paediatric). This confirmed that interim service specifications for HCID-A services had been agreed and were awaiting publication. The services were interim as there was a national review of infectious disease which would lead to a national strategy and the HCID pathways would be part of this new configuration. Service specifications for a longer-term approach to HCID would be developed as part of the roll out of the national strategy.

65. The Patient and Public Voice Assurance Group (“**PPVAG**”) agreed that the service specifications did not need to go through a period of public consultation as there was an agreement with the High Consequences Infectious Diseases Board that provision for airborne infections would be in place for April 2018 and that these specifications were interim. When the national infectious diseases strategy was agreed, full service specifications would be developed for HCID and would go through a full public consultation.
66. To deliver HCID services national coverage, and ensure equitable geographic access to services, a geographical lotting strategy was developed which would minimise travel times for patients and provide access to a regional centre. Given that children were unlikely to present on their own, it was also important to commission a family centred approach, with adult and paediatric services co-located.
67. To achieve this, 3 lots were required across the country to meet the envisaged service needs:
 - a. Lot 1 – North (one centre)
 - b. Lot 2 – Midlands and East (one centre)
 - c. Lot 3 – London and South (two centres)
68. Units chosen as part of the service needed to demonstrate high quality standards, reliable assurance systems, integrated ways of working and value for money.
69. Key elements of the service to be commissioned were (**[MP0231-08 INQ000184162]**):
 - a. Service specifications for service readiness and staff training

- b. Ability to commit to being able to admit a patient with a confirmed diagnosis within six hours of notification
 - c. Adult services must be able to care for two patients at a time as a minimum and preferably up to four
 - d. Paediatric services must be able to cope with up to two children at a time
 - e. Interim service for two years; there is a national review of infectious diseases services, the long term approach for HCID will be part of the national strategy following on from this review
 - f. Co-location of adult and paediatric services
70. The commission set out that the purpose of the specialist isolation unit was the complete containment of any airborne HCID. For adults it was envisaged that the unit would be part of a specialist infectious diseases or critical care unit and for children, the unit would be situated in a paediatric intensive care unit, sited away from general circulation. In either case, patients were not to be admitted through the Accident and Emergency Department and there should be secure and direct transfer of patients from ambulance to unit. Units should allow delivery of level 3 critical care to patients.
71. Additionally, units needed to be able to maintain appropriate facilities and infrastructure for patient care, ensuring clear segregation of clean and potentially contaminated areas of the special isolation unit. Clear delineated pathways through the unit for staff, patients, visitors, supplies and waste needed to be integrated into the structural design. Patient isolation suites needed to be at negative pressure relative to the rest of the unit and the air needed to be High-Efficiency Particulate Absorbing (“HEPA”) or equivalent filtered before discharge into the atmosphere (and environmental monitoring was required to ensure performance). All surfaces were required to be easy to clean, impervious to water and resistant to damage from disinfectants.
72. Other requirements were that the unit should maintain a cadre of competent staff who have demonstrated through regular training and exercising that they are capable of operating a safe system of work while providing optimal care. Relevant staff groups should undergo regular training in the safe system of work, including PPE.

Sufficient staff needed to be trained and available to maintain an operational Specialist Isolation Unit for three weeks. Units must work closing with regional and national EPRR.

73. Through a five month process of determining the approach to the market, engaging with prospective providers and running procurement, NHS Arden and Greater East Midlands Commissioning Support Unit (GEM), on behalf of NHS England's Specialised Commissioning Unit (CSU)'s procurement team successfully secured the award of a two year contract to four providers (with the option to extend for a further year).
74. Consequently, four Airborne HCID Treatment Centres were commissioned. Airborne HCID units are located at St Thomas' Hospital, London (adult and paediatric services); Royal Free Hospital, London, with a paediatric service provided by St Mary's Hospital, London; Royal Liverpool Hospital, with a paediatric service provided by Alder Hey Hospital, Liverpool; and Royal Victoria Hospital, Newcastle (adult and paediatric services). Each centre routinely provides 2 beds (8 in total in England for airborne HCID). Specific service specifications outline the care pathway and unit requirements ([MP0232-08 INQ000184161] [MP0233-08 INQ000184160]).
75. Once the airborne HCID units were commissioned, they were absorbed into NHS England's business as usual. The ongoing assurance of these units is undertaken by NHE England's Highly Specialised Commissioning Team. This involves colleagues from the team visiting the units, to check various aspects against the specification: clinical facilities, systems and standards, training, routes for patient access and also to see how new capital investment had been utilised. This is not the same as a Care Quality Commission ("CQC") inspection, which looks at quality of care; it is a service commissioner check on performance.

(d) HCID Standard Operating Procedures (SOPs)

76. In January 2018, PHE and NHS England took part in Exercise Broad St (for Lassa and H7N9 Influenza) ([MP0067 INQ000113195]). Exercise Broad Street was delivered on 29 January 2018 and was part of PHE's funded programme directed by the Emergency Preparedness, Resilience and Response Partnership Group, which was chaired by DHSC. The exercise was sponsored by the HCID Programme Board and participants included individuals from PHE and NHS England (including from

NHS England's EPRR, HCID Programme and Highly Specialised Commissioning Teams).

77. PHE and NHS England had developed protocols and plans as part of the joint HCID Programme to describe clinical and public health operations for the definitive HCID service for England. The Ebola outbreak in West Africa in 2014 to 2015 had challenged the ability of the NHS in England to provide appropriate, scalable care for HCIDs. The learning from Ebola had been the primary reason for the establishment of the HCID Programme and it needed to be consolidated and incorporated into a long-term resilience plan to enable the NHS in England to deliver care safely and effectively for a wider range of known and unknown HCIDs. Exercise Broad Street was designed to test HCID pathways and algorithms for the HCID service in England, which had been formulated as part of the HCID Programme. Both contact (Lassa Fever) and airborne (H7N9 influenza) HCIDs were used in the scenario. Findings from this exercise were incorporated into ongoing development of the HCID planned approach and standard operating procedures.
78. NHS England's HCID plan consisted of HCID Standing Operating Procedures for both modes of transmission (HCID-C = Contact and HCID-A = Airborne). These set out the internal process and actions for the National EPRR Duty Officer to follow when on-call and notified of a confirmed case. The same principles and structure applied for both HCID classifications but because there were two HCID networks governing the provision of care, grouped under two main headings relating to their mode of transmission: contact and airborne, there were two SOPs, which included activation arrangements for the respective HCID Network.
79. The first HCID-A SOP was published in August 2018. Copies of the HCID-A SOPs prior to January 2020 are exhibited at (**[MP0234-08 INQ000184173] [MP0235-08 INQ000184163] [MP0236-08 INQ000184164] [MP0237-08 INQ000184165] [MP0238-08 INQ000184166] [MP0239-08 INQ000184167] [MP0240-08 INQ000184168] [MP0241-08 INQ000184169] [MP0242-08 INQ000184170]**). The general procedure for a confirmed case of HCID (A or C) is described below.
80. If an HCID is identified, hospital clinicians seeking to transfer confirmed HCID cases, or discuss the transfer of highly probable HCID cases should contact the NHS England National EPRR Duty Officer, via PHE's Emergency Response Department ("ERD"). It is also expected that each case will already have been discussed with the

Imported Fever Service (a 24/7 clinical advisory and specialist diagnostic service for medical professionals managing travellers who have returned to the UK with fever, hosted by UKHSA, in partnership with the Hospital for Tropical Diseases, London and the Tropical and Infectious Diseases Unit, Liverpool) before discussing transfer, although decisions around transfer remain clinician led.

81. The activation process for a confirmed case of HCID should be through the NHS England National EPRR Duty Officer or via PHE but in practice, alerting may be from other routes, including members of the HCID clinical Network. The SOP includes the provision that the NHS England National EPRR Duty Officer may deem it necessary to convene a teleconference of the HCID clinical Network in response to other triggers. Triggers may include the following but each scenario will be assessed on its own merits:
 - a. In response to major or business continuity incidents that impact the network
 - b. Situations where a high number of presumptive cases are being tested

82. PHE could also activate, as they lead on the assessment of the risk and horizon scanning for emerging threats in relation to all public health including HClDs. Through national mechanisms, PHE would alert and consult with NHS England. The result of the intelligence gathered and PHE's recommendation may trigger the decision to convene a teleconference of the HCID Network to discuss readiness and capacity.

83. Once activation is confirmed, an incident management team is then established to ensure that the patient is admitted to the most appropriate clinical facility across England (devolved nations are dependent on HCID facilities in England). The incident management team would then agree admission and would coordinate transport from the location where the initial diagnosis has been made. Transport may involve the use of national assets such as the RAF Tactical Medical Wing (if overseas) and the Air Transit Isolator or specialist paramedic Hazardous Area Response Teams ("**HART**") in the UK.

84. On a practical level, NHS England has a contact within EPRR who is a bridge between EPRR and the Highly Specialised Commissioning Teams with a strong understanding of the process and can be called on to support on HCID incidents. The benefit is that additional support and advice can be provided to those addressing an

HCID when a call is received from PHE (now UKHSA) to EPRR, informing them that there is a confirmed case. These are picked up by NHS England's National EPRR Duty Officer, who then has to follow the SOP, triggering a conversation with the network lead. EPRR are the operation co-ordinators of the HCID networks (both airborne and contact) in this response. Decision making on individual patients is led by specialist clinicians across the network supported by PHE/UKHSA

SECTION 2 : 2020 Future development of HCID Services

85. As discussed earlier in this statement, the HCID Programme was formally closed down in April 2018, once its aims had been successfully achieved. The outputs from the Programme were absorbed into NHS England's Highly Specialised Commissioning ongoing BAU. This included the finalisation of the SOPs (published in August 2018) as discussed above.
86. It also included ongoing work from the lessons identified from Exercise Broad Street in January 2018, which, as set out earlier in this statement, was designed to test HCID pathways and algorithms for the HCID service in England, with a view to aid preparations for the future HCID service in England in 2020. The report, produced on 29 January 2018 following Exercise Broad Street, made the following recommendations for commencement of the 2020 service:
- a. Consider embedding subset HCID screening questions within current standard clinical algorithms for 111 / 999, primary care, ED and inpatient settings
 - b. Consider a mystery shopper concept to keep HCID awareness in Emergency Departments to an acceptable level
 - c. Promote awareness of HCID protocols and algorithms to the NHS
 - d. Consider the standard HCID pre-note criteria for priming appropriate professional partners
 - e. Consider the timescales an approach of the new BAU management of suspect HCID cases
 - f. Develop a definitive list of appropriate organisations/roles for alerting to ensure that timely targeted notifications are issued and include protocols for escalation
 - g. Review the wider HCID alerting mechanism including those currently used as part of the EU arrangements

- h. Consider options to reduce turnaround times in particular sample transport options
 - i. Ensure sample courier requirements and mechanisms have been reviewed and agreed
 - j. Review the UN category based requirements for transporting samples from suspected and confirmed cases of known HCIDs
 - k. Develop the future HCID diagnostic service considering options for sample testing locations
 - l. Consider the process to transition from current HCID programme and processes to future service
 - m. Develop a core standard for the transfer of a HCID patient
 - n. Revise the relevant communication algorithms and protocols for HCID threats
 - o. Develop a communication implementation plan to transform current arrangements to the definitive 2020 service
 - p. Develop trial and launch the HCID digital tool in advance of the 2020 service to establish the tool with professional partners
 - q. Consider how to support the local operationalisation of the HCID response from the HCID algorithms and pathways
87. The Exercise Broad Street report also confirmed that some next steps had been identified, including the need for development of HCID SOPs, but that there were still areas of work to be done before the 2020 service came into service. As discussed at paragraphs 78 and 79 above, HCID SOPs for both HCID-C and HCID-A were subsequently developed in August 2018, but continued to be consulted upon and revised into 2019.
88. Work around preparing for the commencement of the 2020 HCID service continued in the lead up to 2020 (including the engagement process and contractual arrangements), but thereafter, events were then largely overtaken, in early 2020, with what would eventually become a global pandemic. When SARS-CoV-2 was identified

in early 2020, little was known about the novel coronavirus; how it would affect the human body; what might be effective in treating it; how quickly or in what ways it could be transmitted; and to what extent it would impact on individuals and countries around the world.

89. When the potential for transmission and severe disease was unquantified, on 16 January 2020, the UK Four Nations Public Health High Consequence Infectious Disease group made an interim recommendation to classify COVID-19 as an HCID in the UK. The UK Four Nations public health service agencies (in England, PHE) then classified it as such.
90. Following the temporary designation of SARS-CoV-2 as an HCID, confirmed or suspected cases were channelled to the HCID-A centres across England for treatment. As more and more cases were identified, even with urgent expansion (NHS England also brought on board Sheffield Teaching Hospitals NHS Foundation Trust (adults only), which is routinely commissioned as a 'contact' HCID centre), plus assistance from several specialised Infectious Diseases services providing surge capacity, diagnosed cases exceeded the available specialist beds in early March 2020.
91. However, as cases increased still further, the model going forward was for the HCID/Infectious Diseases ("ID") units to provide support and advice to other hospitals through a structured geographical approach, with patients treated in their own healthcare systems.
92. The HCID/ID beds were then used as part of the overall bed base in the HCID/ID providers, with some sicker patients being triaged to these beds. They were also being used, as would be usual practice, to treat patients with other infectious diseases. In the event that a patient with another airborne HCID (such as Monkeypox or Ebola) needed treatment, capacity would be secured in one of the HCID centres. **([MP0244-08 INQ000184172]).**
93. Learning from COVID-19, and more recently Monkeypox, had demonstrated the need for networks of infectious disease provision. These formed organically during the early period of COVID-19 (when it was classified as an HCID); during outbreaks of new variants of COVID-19 (such as the 'mink' variant) and; the ongoing response

to the Monkeypox outbreak. This specialised ID network, involving almost all of England's ID units (with embedded research capabilities and academic links) was successfully assembled as a temporary arrangement. It was recognised that there was a need to capitalise on these arrangements and formalise these networks to ensure geographically equitable provision across the country.

94. In the early stages of the COVID-19 pandemic and in response to new variants, the HCID centres managed the cases and provided significant system leadership, training and support to infectious diseases centres and hospitals without infectious diseases centres.
95. In addition to the HCID Centres, there were also around 20 adult Specialist Regional Infectious Disease Centres (“SRIDCs”) that offered more specialist provision and advice than that offered in local infectious disease services, as follows:
 - Barts Health NHS Trust
 - Brighton and Sussex University Hospitals NHS Trust
 - Cambridge University Hospitals NHS Foundation Trust*
 - Hull University Teaching Hospitals NHS Trust
 - Imperial College Healthcare NHS Trust, London (adults; HCID for children)
 - Leeds Teaching Hospitals NHS Trust
 - London North West University Healthcare NHS Trust (Northwick Park Hospital)
 - Manchester University NHS Foundation Trust
 - Nottingham University Hospitals NHS Trust
 - North Bristol NHS Trust (adults in conjunction with University Hospitals Bristol and Weston NHS Foundation Trust)*
 - Oxford University Hospitals NHS Foundation Trust*
 - Royal Devon and Exeter NHS Foundation Trust
 - South Tees Hospitals NHS Foundation Trust
 - Southampton University Hospital NHS Foundation Trust
 - St George’s University Hospitals NHS Foundation Trust
 - University College London Hospitals NHS Foundation Trust
 - University Hospitals Birmingham NHS Foundation Trust Trust*
 - University Hospitals Bristol and Weston NHS Foundation Trust (in conjunction with North Bristol NHS Trust)*

- University Hospitals of Leicester NHS Trust
- University Hospitals of North Midlands NHS Trust
- * SRIDCs that are proposed as HCIDs

Future provision / planning

96. A paper was prepared for the NHS England's National Commissioning Group (NCG) for Specialised, Health and Justice and Armed Forces Services board meeting on 23 August 2022, which set out future plans for mobilisation of infectious diseases networks (**[MP0243-08 INQ000184171]**). Inevitably, this was informed in large part by learning identified from the COVID-19 pandemic, as discussed above.
97. The paper explained that NHS England had previously agreed that a review of specialised infectious disease provision should be undertaken. The first phase of the review proposed a model as follows:
- a. High Consequence Infectious Disease (HCID) Centres (centres that treat patients with HCIDs but also provide regional services for their catchment areas)
 - b. SRIDCs (centres that offer specialist infectious diseases advice and provision)
 - c. Local infectious disease services
98. The proposed model was as follows:
- a. The seven existing HCID centres
 - b. Four new HCID centres covering adults and paediatrics in, respectively, South West, Thames Valley, West Midlands (East Midlands covered by Sheffield) and East of England (all of which would be selected from the SRIDCs)
 - c. Designation of the remaining SRIDCs and confirmation of their network arrangements with local ID services; further work is needed on paediatric only ID centres

- d. Regional Infection Groups (next proposed phase of the service review)
99. In conjunction with colleagues in Regional Teams, four new HCID centres would be selected from existing SRIDCs. Ideally these centres could treat adults and children. The most likely scenarios are (not tested with providers):
- a. *South West* – North Bristol Trust (NBT)/University Hospitals Bristol and Weston NHS Foundation Trust [For the adult service, NBT has the infectious diseases ward and the expectation would be that consultants from both Trusts would support the ward. UHBW would offer the paediatric service. Royal Devon and Exeter Foundation Trust could possibly argue that they should be considered, but they do not have a paediatric infectious diseases service.]
 - b. *Thames Valley* – Oxford University Hospitals NHS Foundation Trust have an adult and paediatric service and there are no other viable providers in the vicinity.
 - c. *West Midlands* – University Hospitals Birmingham NHS Foundation Trust in conjunction with Birmingham Women’s & Children’s NHS Foundation Trust. University Hospitals of North Midlands NHS Foundation Trust could possibly argue that they should be considered, but they do not have a paediatric infectious diseases service.
 - d. *East of England* – Cambridge University Hospitals NHS Foundation Trust have an adult and paediatric services and there are no other viable providers in the vicinity.
100. Recent experience of the Monkeypox outbreak in particular identified the need for a dedicated Network Manager, who would work on behalf of the national network but be hosted/employed by one of the HCID Centres. This would be an additional resource that would be required to be drawn from the service review budget.
101. The paper also confirmed that there was a proposal from NHS England’s National EPRR Team to undertake a learning exercise, based on the experiences of Monkeypox in particular. This in turn would provide a valuable opportunity to review and test exiting procedures for managing HCIDs and inform ongoing training and

development of the response to significant outbreaks of infectious diseases in England, into the future.

Statement of Truth

I believe that the facts stated in this Statement are true. I understand that proceedings for contempt of court 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 in its truth.

Signed

Personal Data

Position or office held

National Director of
Emergency Planning and
Incident Response

Print Full Name

Dr Michael Charles
Prentice

Date

9 May 2023

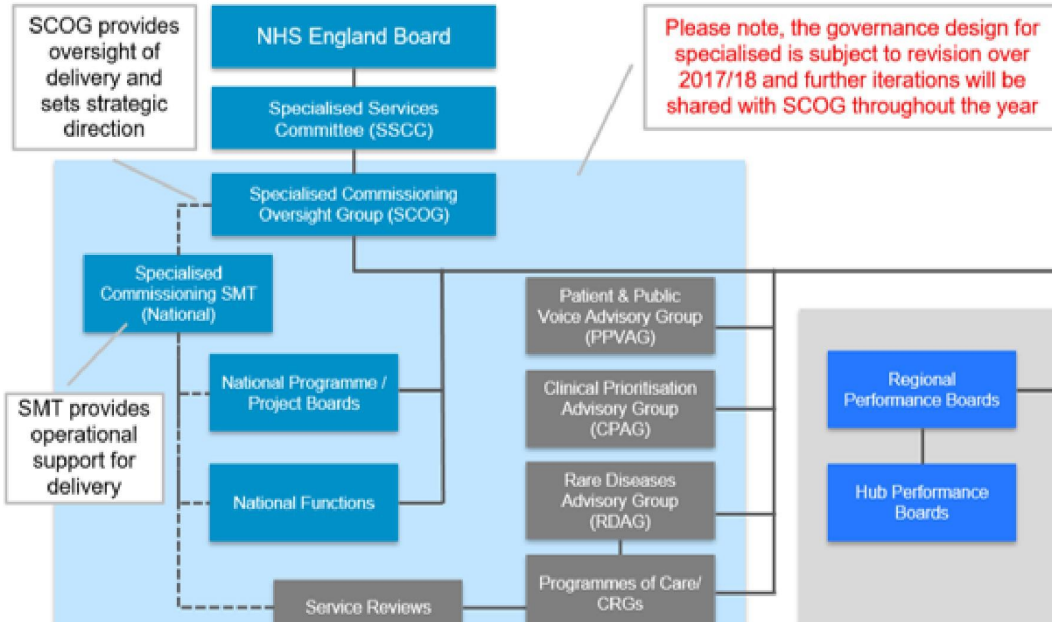
ANNEX 1 – Key Figures¹

Key Leader	Role
NHS England Board	
Paul Baumann	Former Chief Financial Officer (1 October 2012 until 18 November 2018)
Matthew Style	Former Interim Chief Financial Officer (19 November 2018 until 31 March 2019)
Julian Kelly	Chief Financial Officer and Deputy Chief Executive (since 1 April 2019)
Professor Sir Bruce Keogh	National Medical Director (1 April 2013 until 29 January 2018)
Professor Sir Stephen Powis	National Medical Director of NHS England (since 30 January 2018) Interim Chief Executive Officer NHS Improvement (1 August 2021 until 30 June 2022 (when NHS Improvement was abolished))
EPRR and EU Exit	
Bob Winter	National Clinical Director for Emergency Preparedness and Critical Care and Chair of EPRR CRG (2014 until October 2018)
Professor Sir Keith Willett	National Director for Emergency Planning and Incident Response (September 2019 until 4 July 2021) COVID-19 Strategic Incident Director (January 2020 until 4 July 2021) Strategic Commander for EU Exit (December 2018 until July 2021) SRO for pandemic flu preparedness programme Medical Director for Acute Care (since October 2012)
Dr Mike Prentice	National Director for Emergency Planning and Incident Response (since April 2022) Deputy National Strategic Incident Director, COVID-19 (February 2020 until April 2022) Regional Medical Director (North) (June 2016 until April 2022) Medical Director, Cumbria Area Team (April 2013 until June 2016)
Stephen Groves	Director of EPRR (National) (since April 2020) Head of EPRR (National) (since April 2013) Strategic Incident Director
Professor Chris Moran	Deputy National Strategic Incident Director (March 2020 until April 2022) Chair of Clinical Reference Group Strategic Incident Director
Dr Chloe Sellwood	London Deputy Head of EPRR (since March 2017) Acting Deputy Head of Emergency Preparedness, Resilience and Response (London) (November 2016 until February 2017)

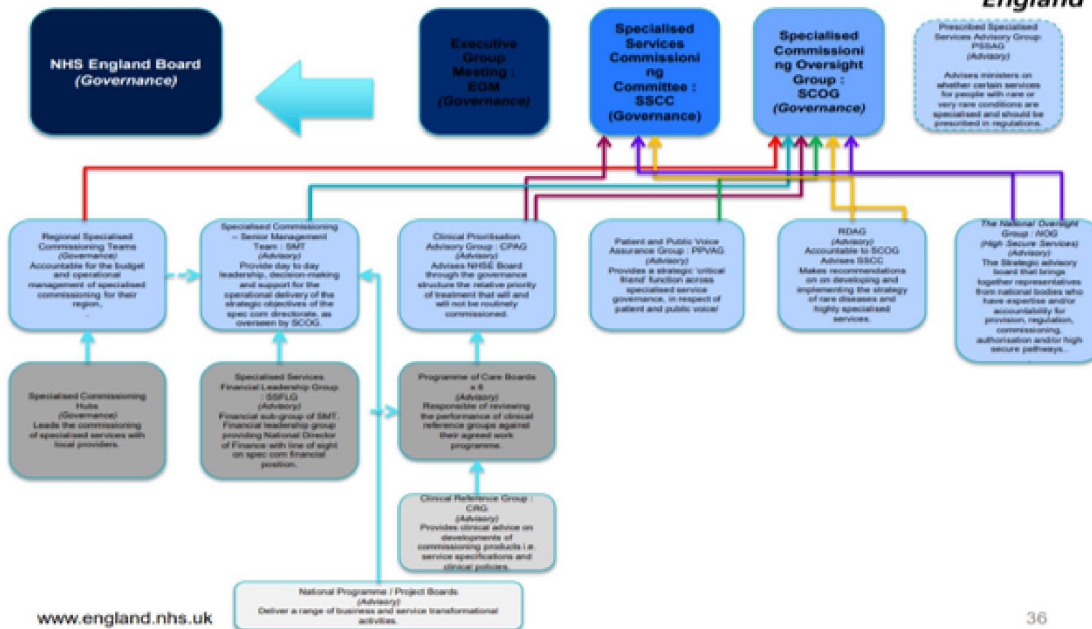
	EPRR National Pandemic Flu Lead (since April 2013)
	London Region Pandemic Influenza Coordinator (2008 until 2016)
Tim Young	Head of NHS Operations (since approx. April 2014 until 2017/18)
HCID	
Mike Jacobs	HCID Programme Director (until ?2018)
Dr Jake Dunning	HCID Programme – Deputy Lead with Mike Jacobs (January 2016 until April 2018)
Fiona Marley	Head of Highly Specialised Commissioning
John Stewart	National Director, Specialised Commissioning
Cathy Edwards	Clinical Programmes Director, National Specialised Commissioning

ANNEX 2 – View of NHS England’s Specialised Commissioning governance during the period of the HCID programme (2017/18)

Governance and Scope of the Plan



Specialised Commissioning Governance Structure



ANNEX 3 – Records management – background, structure, volume and searchability

1. NHS England is obliged to comply with the legal and professional obligations set out for records. In accordance with these obligations, records are created by NHS England to provide information about what happened, what was decided, and how to do things. Therefore, as part of their daily work, NHS England staff must keep a record; by updating a register or database, writing a note of a meeting or telephone call, audio recordings of customer interaction or filing a letter or email in order to ensure that they and their successors have something to refer to in the future.
2. Since inception in October 2012, NHS England (NHS Commissioning Board) has not had one single electronic records management system as part of its IT platform(s). Prior to the pandemic, teams and individuals worked off a variety of servers and systems transferred from legacy organisations. This included TDA, Monitor, DHSC, and the NHS Commissioning Board servers.
3. No standard process was in place, with documents saved on personal, corporate shared-drives and SharePoint sites, as well as external “data lakes” – across multiple platforms (MS Teams, Office 365, Microsoft Outlook etc).
4. There was no one system for saving emails as records, with nhs.net email accounts being hosted externally by NHS Digital.
5. In order to provide some consistency of record management across disparate teams and IT systems, NHS England has, for some time, had a Corporate Records Team. The Corporate Records Team produces and owns the Corporate Document and Records Management Policy (the “**policy**”), which sets out advice and guidance to all NHS England staff regarding creation, management, storing and disposal of records. The current version of the policy is 4.0 which was updated in June 2022 (from October 2021).
6. All NHS England directorates fall within the scope of this document. This includes staff who are employed on a permanent or fixed term basis, contractors, temporary staff and secondees. Where organisations have merged with NHS England alignment to our policies is expected going forward.
7. The policy is mandatory and relates to all documents and records held by NHS

England, regardless of format, including, but not limited to, email, paper, digital, instant messages, social media, videos and telephone messages. The policy covers all stages within the information lifecycle, including create/receive, maintain/use, document appraisal, declare as a record, record appraisal, retention and disposition.

8. Staff members must not alter, deface, block, erase, destroy or conceal records with the intention of preventing disclosure under a request relating to the Freedom of Information Act 2000 or the Data Protection Act 2018.
9. NHS England's approach to records is that they are a valuable resource because of the information they contain. High-quality information underpins the delivery of high-quality evidence-based healthcare. Information has most value when it is accurate, up-to-date and accessible when it is needed. An effective records management function ensures that information is properly managed and is available whenever and wherever there is a justified need for that information, and in whatever media it is required.
10. Records management is about controlling records within a framework made up of policies, standard operating procedures, systems, processes and behaviours. Together they ensure that reliable evidence of actions and decisions is kept and remains available for reference and use when needed, and that the organisation benefits from effective management of one of its key assets, its records.

Searchability

11. The records and documents generated during the COVID-19 pandemic have, in large part, been copied over to NHS England's COVID Electronic Records Management System (CERMS). This is a document repository developed in Office 365.
12. NHS England now has a vast amount of information that it generated during the COVID-19 pandemic. This presents NHS England with a challenge in terms of searching and extracting information in order to supply it to the Inquiry.
13. A particular challenge in relation to responding to this Supplemental Rule 9 Request is that, records in relation to the request largely pre-date the COVID-19 pandemic and also pre-date the introduction of CERMS. NHS England's records from this time period are held in a number of different ways on a number of different servers and

legacy IT systems.

Searches conducted

14. For this Supplemental Rule 9 Request, records deemed in scope are outside of the collation of COVID-19 specific records. Records have been identified within teams and individual record repositories across the organisation. As a consequence, our Supplemental Rule 9 Request specific searches have been limited to the specific teams and cells within NHS England whom we know had responsibility for HCID highly specialised commissioning.
15. We have not conducted an exhaustive search of all of the records across the whole organisation during the date range prescribed, looking for anything in relation to HCID due to the data volumes held corporately. There are considerable practical limitations to our abilities to do this in any event, because of the records being held in a number of different ways on a number of different servers and legacy IT systems, as described above. The time afforded to us to respond to this request and the cost/resource required to undertake such wide reaching searches has also been prohibitive. Searching has therefore been targeted to the records locations, individuals and repositories where we consider the relevant records are most likely to be held.
16. The disclosure process in relation to this response has been largely directed by the statement signatory and the subject matter experts involved in the production of this statement, and as set out above, searching has been targeted to the record locations, individuals and repositories where we consider the relevant records are most likely to be held. Where we have been unable to locate full sets of a series of documents, we have provided the examples we do have. Documents are specifically exhibited to support a point made in the statement and otherwise, are disclosed to provide background and colour to the narrative.