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UK COVID-19 INQUIRY

SECOND WITNESS STATEMENT OF PROFESSOR SIR STEPHEN POWIS

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I, Professor Sir Stephen Powis, of NHS England, Wellington House, 133-135 Waterloo Road, London, SE1 8UG will say as follows:

Introduction

1. When SARS-COV2 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; whether, how quickly, or in what ways it could be transmitted; and to what extent it would impact on individuals and countries around the world. Globally, healthcare providers and the systems supporting them had to adapt and expand their care offering to look after people with COVID-19 and continue to care for people with other conditions.

2. As the pandemic continued, emerging evidence and patient testimony began to show a growing number of people who had contracted COVID-19 but could not fully recover from the effects of the virus months after initially falling ill. Symptoms were often wide-ranging and fluctuating, but included breathlessness, chronic fatigue, "brain fog", anxiety and stress.

3. These long-term effects of COVID-19 are often referred to interchangeably as Long COVID or post COVID syndrome. For the purposes of this statement, I will use the term "**Long COVID**" to refer to both.

4. Long COVID is a condition which is highly likely to be a direct consequence of SARS-CoV-2. The existence of a significant cohort of patients with symptoms which did not resolve only became apparent after large numbers of individuals had been exposed to the virus and developed COVID-19, towards the end of the 'first wave' of the pandemic.

5. I have been asked to describe the extent to which NHS England was involved in an assessment of how emergency response measures, including non-pharmaceutical interventions ("**NPIs**") would impact upon those likely to suffer from Long COVID.

6. NPIs were introduced by Government during the pandemic to reduce the rates of transmission of the COVID-19 virus. In doing so, the aim was to reduce deaths and serious illness, and to lessen the impact on the NHS so that demand did not exceed capacity. If Long COVID is a direct result of the virus, it follows that the implementation of NPIs aimed at reducing transmission would be expected to

reduce the incidence of Long COVID (as with other interventions designed to reduce transmission, such as vaccines).

7. Consideration of specific Long COVID related issues would not have been part of early NPI decision making given that the existence of the condition was not known at that time. However, many viruses do result in post viral syndromes, and it is therefore conceivable that a reduction in the overall transmission of the virus and resulting infections would also have reduced the number of patients with post viral syndromes. It would not have been possible to foresee the specific constellation of features of Long COVID, nor could its incidence have been predicted at the start of the pandemic.

8. The National Institute for Clinical Excellence ("**NICE**") / Scottish Intercollegiate Guidelines Network / Royal College of General Practitioners guidance on managing the long-term effects of COVID-19 (published on 18 December 2020, updated on 11 November 2021 and 3 November 2022) gives the following clinical definitions for Long COVID: **[SP2/01 – INQ000205655]**

   a. Ongoing symptomatic COVID-19: signs and symptoms of COVID-19 from four to 12 weeks

   b. Post COVID-19 syndrome: signs and symptoms that develop during or after COVID-19 and continue for more than 12 weeks and are not explained by an alternative diagnosis

9. Because symptoms being reported were so wide ranging (multi-system) and there was (and is still) no known single definable pathogenic mechanism responsible for Post COVID ill-health, NHS England, as the commissioner for health services in England, formed a multi-professional response based on rehabilitation and treatable traits. In October 2020 a National Taskforce for Long COVID, chaired by NHS England's Medical Director for Primary Care, was established to bring together people with lived experience, clinicians, academics, voluntary community and social enterprise ("**VCSE**") sector and policy makers to address this growing healthcare challenge.

10. Alongside this, the Government hosted monthly Long COVID Roundtable meetings for a similar group of stakeholders, including representatives from NHS

England. This engagement has helped shape Long COVID policy in the absence of definitive evidence about this new condition and how to treat it.

11. While we have learned a great deal about COVID-19 since the start of the pandemic – and new treatments are available – the long-term effects of the illness can be debilitating, even for young, fit people, or those who did not go to hospital when they had COVID-19 symptoms initially. In March 2022, the Office for National Statistics ("**ONS**") Survey found 1.7 million people living in private households (2.7% of the UK population) were experiencing self-reported Long COVID. Fatigue was reported as the most common symptom. As a proportion of the UK population, prevalence of self-reported Long COVID was greatest in people aged 35 to 49 years, females, people living in more deprived areas, those working in social care, teaching and education or health care, and those with another activity-limiting health condition or disability. **[INQ000218367]**

12. Retrospectively, there has been wide ranging academic and scientific discussion about, and analysis of, the use of NPIs during the pandemic, which included a combination of containment and mitigation activities with the intention of delaying major surges of patients and levelling demand for hospital beds, whilst protecting the most vulnerable from infection, including elderly people and those with co-morbidities. That retrospective analysis has also included discussion of the unintended consequences of those NPIs, which are reported to include, amongst others, economic effects, social isolation, family relationships, health related behaviours, disruption to essential services, disrupted education, psychological effects and impact on health.

13. In this statement, I discuss the extent to which NHS England was involved in the assessment of impact of core central government decisions in respect of NPIs, on those suffering long term sequelae, including Long COVID. However, it is worth observing that scientific understanding of the long-term sequelae of COVID-19 is a developing area. It is still unclear whether there is one underlying mechanism of Long COVID, or whether it is a collection of different conditions, and it may be more appropriately addressed in a broader sense by expert evidence.

Executive Summary

14. Long COVID is a condition which is highly likely to be a direct consequence of infection with SARS-CoV-2 and therefore, it was only recognised towards the end of the 'first wave' of the pandemic.

15. The introduction of NPIs may have detrimental effects on the general population and during the COVID-19 pandemic, many of the disbenefits of NPIs were in broader social, societal, educational or economic terms that were often harder to measure. The task of weighing the benefits and disbenefits in the balance and making the important decisions around the imposition of NPIs, was the Government's along with wider technical advice beyond the remit of the Scientific Advisory Group for Emergencies ("**SAGE**") or the Chief Medical Officers ("**CMOs**").

16. As Long COVID was not recognised until the end of wave one, it is difficult to see how government could have considered it when contemplating the first national lockdown. However, once it had been identified, the impact of NPIs on all individuals with health sequelae arising from the pandemic, including Long COVID would have been relevant considerations in government decision-making.

17. However, decisions around imposing lockdowns or NPIs was not the remit of NHS England. NHS England is not a government decision-making body (and that remained the case through the pandemic), and it did not take decisions on the government response to the COVID-19 pandemic. Consideration of what NPIs to impose, in what combination, and when, was not NHS England's role; it was the Government's.

18. On a practical level, NHS England was available to central government and other bodies such as Public Health England ("**PHE**") (now UKHSA) to provide advice and information that central government could use in making decisions. In particular, this included advising Government on the existing and potential capacity of the NHS, the operational challenges, and the steps that could and were being taken to respond to the pandemic and the likely impact on the NHS of developing Reasonable Worst-Case Scenarios ("**RWCS**") and other potential scenarios.

19. NHE England's responsibility was to commission health care services throughout the pandemic including the development of appropriate services to meet the clinical

needs of those who developed Long COVID, bearing in mind that both COVID-19 and Long COVID were new conditions which were not fully understood.

20. Whilst NHS England officials were often involved in meetings where the use of NPIs (and their impacts on e.g. social, economic, mental health, educational factors) were considered or discussed, NHS England's role was to operationalise the decisions taken by Government in response to the pandemic, particularly in respect of treatment of those affected by COVID-19 (and latterly by Long COVID).

21. As it was not our role to do so, we did not advise, inform or seek to influence the Government on the potential impact of NPIs on the population; either in relation to COVID-19 or Long COVID. Accordingly, NHS England was not involved in any assessment of how emergency response measures, including NPIs would impact upon those likely to suffer from long term sequelae, including Long COVID, arising from COVID-19 infections.

22. I have been the National Medical Director of NHS England since early 2018. I was also Interim Chief Executive Officer of NHS Improvement between 1 August 2021 and 31 July 2022 (when NHS Improvement was abolished and legally became part of NHS England). I was in post throughout the COVID-19 pandemic, an NHS England Board Member and member of the National Incident Response Board ("**NIRB**"). I attended SAGE meetings regularly from 25 February 2020. From time to time, I attended other key government meetings in the management of COVID-19 such as COVID-O.

23. 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 10 May 2023 pursuant to Rule 9 of the Inquiry Rules, specifically relates to Module 2 of the Inquiry, and raises supplementary questions (the "**Supplemental Module 2 Rule 9 Request**") to NHS England about NPIs and Long COVID.

24. The Supplemental Module 2 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.

25. 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.

26. 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).

27. 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.

28. Within this witness statement, we refer to documents which are exhibited to support a particular point being made. These documents are exhibited as [SP2/x], 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 Professor Sir Stephen Powis. These are referred to as [SP/xxx] 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.

Approach to the Module 2 Supplemental Rule 9 Request

29. We understand that the purpose of this document is to provide a corporate statement on behalf of NHS England to assist the Chair of the Inquiry in understanding the matters set out in a Supplemental Module 2 Rule 9 Request received on 10 May 2023 pursuant to Rule 9 of the Inquiry Rules; specifically relating to NHS England's engagement with UK government decision-making on emergency response measures, including NPIs, in respect of long term sequelae of COVID-19 or Long COVID.

30. The scope of Module 2 itself is focussed on the UK's core political and administrative decision-making in relation to the pandemic between early January 2020 and February 2022, with particular attention paid to the period between January and late March 2020.

Outline of this corporate witness statement

31. This statement contains responses to questions set out in the Supplemental Module 2 Rule 9 Request, received by email on 10 May 2023.

32. Some of the issues touched on in this statement have been addressed in greater detail in the First Witness Statement of Professor Sir Stephen Powis (the **"First Witness Statement**"), but this statement is limited to only addressing the Supplemental Module 2 Rule 9 Request.

33. The statement is structured as follows:

34. **Section 1** covers a summary of the evolution of our understanding of Long COVID, including when and how knowledge of the condition first developed. In this section we also touch on NHS England's Long COVID Plan, the National Taskforce for Long COVID and our attendance at the Government's Long COVID Roundtables during the early part of the pandemic.

35. **Section 2** provides a high-level discussion of NPIs.

36. **Section 3** covers NHS England's role in assessment of initial government strategies around emergency response measures to COVID-19; specifically, NPIs. This includes the lead up to the first national lockdown and also the subsequent national and local lockdowns. In this section we also discuss the factors influencing decision making around NPIs (and to what extent NHS England was involved).

37. **Section 4** provides a discussion of those areas which worked well and areas where there were obstacles or missed opportunities in relation to Long COVID.

38. **Annex 1** sets out the search parameters undertaken when identifying relevant documentation in support of this witness statement

39. In this statement I have referred to NHS England, Department for Health and Social Care ("**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: Long COVID – a summary of the evolution of our understanding of the condition

40. We have been asked to set out the extent to which NHS England was involved in the assessment of how emergency response measures, such as NPIs, would impact those likely to suffer from long term sequelae, including Long COVID. We have also been asked to set out the extent to which we sought to influence or inform UK Government decision making in this arena. Before doing so, it is worth setting out a brief summary of how and when Long COVID was first recognised as a long term sequelae of COVID-19.

41. In discussing the evolution of our understanding of Long COVID, we also touch on the work that NHS England, as commissioner for health services in England, undertook in response to commissioning cohesive services and care pathways for those suffering with the condition, as understanding of it developed. This includes, for example, the Long COVID Programme and the Long COVID Five Point Plan. However, as the Supplemental M2 Rule 9 Request relates to NHS England's engagement at the most senior level on the development of key policies and decisions made by Government around Long COVID, we do not discuss the Long COVID Programme in any great detail but refer to it only for context and background information.

42. Long COVID describes a longer, more complex course of illness than that which emerged from initial, formal reports from Wuhan. The February 2020 World Health Organisation ("**WHO**") China Report stated, '*the median time from onset to clinical recovery for mild cases is approximately 2 weeks and is 3–6 weeks for patients with severe or critical disease.*' **[INQ000218368]**

43. The UK's CMO, Professor Sir Chris Whitty stated, in May 2020, *'the great majority, probably 80%, will have a mild or moderate disease, might be bad enough for them to go to bed for a few days, not bad enough for them to have to go to the doctor.'* **[INQ000064510]** However, patients were sharing experiences on social media, which drew attention to possible longer term COVID-related sequelae and on 5 May 2020, the *British Medical Journal* ("**BMJ**") published an account by Professor of Epidemiology at Liverpool School of Tropical Medicine, Paul Garner, of suffering seven weeks of a *'roller coaster of ill health, extreme emotions and utter exhaustion.'*

He termed this the COVID 'long tail' **[INQ000218364].** However, no peer-reviewed articles had yet documented long-lasting symptoms following COVID-19 infection.

44. In May 2020, NHS England's Long Term Plan Programme team for Respiratory Care, within the Clinical Policy Unit, was approached by University Hospitals Leicester NHS Foundation Trust ("**UHL**"), to work in partnership on a new online portal to support people recovering from COVID-19, called '*Your COVID Recovery'*. This was designed to provide online support to people recovering from COVID-19. Following assessment of the proposal by clinical and policy leads, together with growing feedback from Respiratory Clinical Networks of the increase in patients with long term symptoms asking for support from respiratory services, NHS England's team worked quickly to commission the service from UHL.

45. NHS England launched the first phase of the online portal "*Your COVID Recovery*" in July 2020. This was a website containing information to support people suffering from the longer-term effects of COVID-19. The second phase of '*Your COVID Recovery*', launched a few months later, was an interactive tool, where people who were suffering long term effects of COVID-19 (not just patients who were admitted to hospital) could communicate with nurses, physiotherapists, and mental health specialists. The service was designed to give people access to a local clinical team who could respond to enquiries and to an online peer support community, exercise tutorials, and mental health support.

46. NHS England's announcement about the online portal said [**SP2/02 – INQ000205651**]; "*The new 'Your COVID Recovery' service forms part of NHS plans to expand access to COVID-19 rehabilitation treatments for those who have survived the virus but still have problems with breathing, mental health problems or other complications… Patients who have been in hospital or suffered at home with the virus will have access to a face-to-face consultation with their local rehabilitation team, usually comprising of physiotherapists, nurses and mental health specialists. Following this initial assessment, those who need it will be offered a personalised package of online-based aftercare lasting up to 12 weeks, available later this Summer. Accessible, on-demand, from the comfort of their own home, this will include:*

    a. *Access to a local clinical team including nurses and physiotherapists who can respond either online or over the phone to any enquiries from patients;*

b. *An online peer-support community for survivors – particularly helpful for those who may be recovering at home alone;*

c. *Exercise tutorials that people can do from home to help them regain muscle strength and lung function in particular, and;*

d. *Mental health support, which may include a psychologist within the online hub or referral into NHS mental health services along with information on what to expect post-COVID"*

47. During this period, more information was appearing in the mainstream media and medical publications about what was being called '*Long COVID'.* For example, on 14 July 2020, the BMJ published an article entitled *"COVID-19: What do we know about "long COVID"?* This reported on the growing number of people, including doctors, who had been infected with COVID-19 and were still reporting lasting effects of the infection or had had the usual symptoms for far longer than would be expected, but acknowledged that *"aside from anecdotal evidence, there is as yet little research on this issue…however it is being actively discussed within the research community."* **[INQ000051231]**

48. By mid-August 2020, Long COVID had stabilised into a recognisable "scientific object" although its precise contours remained subject to debate. On 21 August 2020, the Director General of the World Health Organisation ("**WHO**") met advocates from across the world about COVID-19 (NHS England did not attend). It was discussed that in July 2020, the WHO COVID-19 Technical Lead, Maria Van Kerkhove, had contacted a group called Long COVID SOS, which represented patients with long term effects from COVID-19. Those patients had highlighted the need for recognition of their disease, appropriate rehabilitation services and more research to be done into the long-term effects of the illness and WHO confirmed their commitment to work with countries to ensure this occurred. 'Long COVID' and 'Long-haul COVID' were used in communications within and around the event.

49. There was growing testimony from groups representing people with lived experience and clinicians, particularly respiratory physicians, about an increase in people suffering long term symptoms following an episode of COVID-19, and so, the Long COVID Programme was established to develop and implement the NHS England commissioned response to this new healthcare challenge. As symptoms being

reported were multi-system and wide ranging; and because the pathogenetic mechanism(s) responsible for post covid ill health were not well understood, NHS England formed a multi-professional response based on rehabilitation and treatable traits.

50. On 28 August 2020, NHS England's Director of Clinical Policy, Quality and Operations at NHS England prepared a briefing paper on '*Manging the Long-Term Effects of COVID-19'*. **[SP2/03 - INQ000205637] [SP2/04 - INQ000205638]** The briefing included, amongst other issues, information about current understanding of Long COVID, numbers of patients known to be impacted, monitoring and rehabilitation needs and proposed actions to strengthen NHS services and meet new demand. It was noted that whilst much work was underway, a series of interconnected actions were recommended, including review and maintenance of guidance, definition of care pathways linking physical/mental and/or commissioning approach, rolling out community monitoring, community rehabilitation, and clinical capacity. It also noted that individuals with Long COVID may have related mental health issues, such as anxiety and depression, and would need access to local health services, with specific post-COVID psychological therapies, to support them.

51. On 8 September 2020, the Secretary of State for Health and Social Care ("**SSHSC**"), Matt Hancock, referred to "Long COVID" when speaking to a parliamentary committee. **[INQ000218365]**

52. NHS England, as the commissioner for health services in England briefed the SSHSC on what a cohesive service offering to Long COVID patients should look like, including that it would be better led by primary and community care as it was likely these services would need to be predominantly locally commissioned, with a link into specialised commissioning for highly specialised services if needed.

53. On 7 October 2020, NHS England announced that the NHS was to offer a five-part package of measures to boost NHS support for Long COVID sufferers **[SP2/05 - INQ000205652].** The Long COVID Five Point Plan was the NHS' initial response to Long COVID, including £10 million for designated Post COVID assessment services in every ICS area of England. The Five Point Plan comprised:

    i. New guidance commissioned by NHS England from NICE by the end of October on the medical 'case definition' of Long COVID.

ii. Refresh of the 'Your COVID Recovery' online rehabilitation service, to include development of rehabilitation plans which were tailored for individuals

iii. Designated Long COVID Clinics

iv. National Institute for Health Research ("HIHR") funded research on Long COVID

v. NHS oversight by the newly established NHS England Long COVID Taskforce

54. On 19 October 2020, NHS England's National Medical Director presented a paper to NIRB about "Implementing the Long Covid Plan" **[SP2/06 - INQ000205642]** and requested the Board to *"note the five-point plan to support people suffering long term health effects from COVID-19 and agree the approach to rapidly establishing post COVID specialist assessment clinics.*" In keeping with NHS England's role as commissioner, the paper was focussed on delivering care to those affected by Long COVID, including the appropriateness of establishing specialist centres to support them, location of those clinics and how they would be funded, but additionally covered issues around improving understanding of the condition.

55. NIRB approved the approach to implementing post-COVID assessment clinics and recommended that the funding should be allocated to regional teams to allocate to their systems to establish the proposed clinics, based on the specification and reporting arrangements being developed by the medical directorate. Additionally, further work was requested to clarify the potential impact of Long COVID on NHS staff and the actions that could be taken to manage this, working with occupational health.

56. NHS England established the Long COVID National Taskforce, chaired by the Medical Director for Primary Care, to bring together people with lived experience, clinicians, academics, voluntary community and social enterprise (**VCSE**) sector and policy makers to address this growing healthcare challenge. The first meeting of the Long COVID National Taskforce took place on 29 October 2020. **[SP2/07 - INQ000205643]**

57. On 15 November 2020, NHS England announced the launch of a network of 40 Long COVID specialist clinics to help thousands of patients suffering debilitating effects of

the virus months after being infected. The clinics, due to start opening at the end of November, would bring together doctors, nurses, therapists and other NHS staff to help with the physical and psychological assessments of those experiencing enduring symptoms. **[INQ000218366]**

58. On 11 December 2020, a Long COVID Plan update paper was presented to NIRB. **[SP2/08 - INQ000205653]** This noted that rapid progress being made against the NHS Long COVID Plan but specifically commented that *"Our work will evolve the more we learn about the condition, patient demand, referral patterns and best treatment. Research and data we are beginning to collect will inform the next phase of long COVID work."* NIRB approved the proposals outlined in the paper.

59. Work continued and in June 2021 NHS England published its 2021/22 Long COVID plan **[SP2/09 - INQ000205656].** This confirmed that the NHS would be committing a further £100 million funding to support Long COVID services. The plan detailed a very broad range of measures being introduced to support this patient group including clinics, GP services and rehabilitation.

60. Whilst the Long COVID Plan subsequently evolved, and continues to evolve, as knowledge and understanding of Long COVID develops, within 10 months of the COVID-19 virus arriving in the UK, NHS England had a nationally commissioned service in place for those suffering from Long COVID, which was one of the quickest responses in the world.

Long COVID Roundtables

61. Alongside the National Taskforce for Long COVID, the Government hosted monthly Long COVID Roundtable meetings for a similar group of stakeholders. This engagement helped shape Long COVID policy in the absence of definitive evidence about this new condition and how to treat it.

62. In broad terms, the Government's Long COVID Roundtables were directed at clinical understanding of the condition and engagement with key stakeholders, so that those suffering Long COVID could get access to the care that they required. The Long COVID roundtable meetings brought together views and information from a range of representatives, for example, those leading National Institute for Health and Care Research ("**NIHR**") funded research studies, data collected by ONS, guidance from

both NICE and the Royal College of General Practitioners ("**RCGP**"), progress on NHS England's Five Point Plan and feedback from those representing people with lived experience. For NHS England, the feedback gathered in those meetings was used to inform, alongside other research, evidence and feedback, the development of the Long COVID plan for 2021/22 in June 2021 and the Long COVID Improvement Plan in July 2022. Whilst part of that included a discussion of why certain categories of people were more affected by COVID-19, Long COVID, and related issues such as impact on mental health, the Roundtables were not directed at considering or assessing how Government policy for managing the pandemic was impacting those likely to suffer Long COVID and other long-term sequelae.

63. The first Long COVID Roundtable took place on 28 September 2020, **[SP2/10 - INQ000205639]** and was attended by representatives from DHSC and NHS England. NHS England's National Medical Director attended at the invitation of Lord James Bethell, Parliamentary Under Secretary of State for Innovation, who chaired the meetings.

64. Various early examples of the Long COVID Roundtable meeting readouts and briefing notes are exhibited to this statement and discussed below.

65. On 13 October 2020, **[SP2/11 - INQ000205640] [SP2/12 - INQ000205641]** there was a discussion about the learning from around the country and how insights on Long COVID suggested that those from ethnically diverse backgrounds were more seriously impacted.

66. On 16 November 2020, **[SP2/13 - INQ000205644] [SP2/14 - INQ000205645]** there was a discussion about the mental health impacts of Long COVID, including that *"COVID patients may be up to twice as likely to develop a mental health condition in comparison to patients suffering from other illnesses such as flu"* and *"the major mental health conditions that are associated with Long COVID are depression and anxiety."* The social and economic impact of Long COVID was also noted, and the effect this can have on mental health. It was agreed that an integrated pathway was needed that had a single commissioning process, with mental health as part of it. Commissioning that integrated pathway was the remit of NHS England, which is why we were invited to the Long COVID Roundtable meetings.

67. On 16 December 2020, **[SP2/15 - INQ000205646] [SP2/16 - INQ000205647] [SP2/17 - INQ000205648]** Mark Davies of DHSC spoke about the work he had been

carrying out in respect of COVID (but not specifically Long COVID) health inequalities. He confirmed that the biggest risk factor for COVID was age, but ethnicity was also a risk factor, with ethnically diverse people more likely to be affected by the social factors which led to worse COVID-19 outcomes. Ian Dodge, NHS England's National Director of Primary Care, Community Services and Strategy and Senior Responsible Officer ("**SRO**") for the Long COVID programme, from November 2020 to June 2022 confirmed that equality and diversity issues would be at the centre of the NHS Five Point Plan and that NHS England would commission analysis of the characteristics of people with Long COVID to aid understanding. Subsequently, equality and diversity issues were embedded into both Long COVID plans and age, sex, ethnicity and deprivation data is now published in the monthly Post COVID assessment service activity data.

68. On 28 January 2021, SAGE published its Independent Report on Long COVID. **[SP2/18 - INQ000205649]** This document focused on the clinical understanding of the condition and recommendations to further broaden this. However, the report was not directed at considering or assessing how Government policy for managing the pandemic was impacting those likely to suffer Long COVID and other long-term sequelae.

SECTION 2: NPIs

69. On 1 December 2022, the *'Technical Report on the COVID-19 pandemic in the UK'* was published **[SP2/19 - INQ000205650].** This was produced to assist future UK Chief Medical Officers, Government Scientific Advisors, National Medical Directors and public health leaders in a pandemic. The CMOs of the four UK Nations authored the report, along with a range of contributors, including Patrick Vallance, (UK Government Chief Medical Advisor), Jenny Harries (Deputy Chief Medical Officer of England and then Chief Executive of UKHSA) and Jonathan Van Tam (Deputy, Chief Medical Officer of England) and NHS England's National Medical Director.

70. The report discusses NPIs, also known as 'public health and social measures', used during the COVID-19 pandemic and so it is helpful to set some of that information out here, for context.

71. 'NPIs' referred to the measures to reduce transmission of COVID-19 that did not depend on drugs, vaccines or other specific medical countermeasures. The aim

throughout the COVID-19 pandemic, as with previous pandemics and major epidemics, was to get to the point of having available medical countermeasures as soon as possible, through scientific development and understanding of the disease. Inevitably there was a period at the start of the pandemic when medical countermeasures were not available and almost all of the actions to blunt the effect of the pandemic had to be, out of necessity, NPIs. As medical countermeasures came on stream, the relative contribution of NPIs decreased, but this was a gradual process.

72. At all times in the pandemic, medical and scientific advice, as well as political decision-making, had to recognise the balance between the harms of not undertaking measures and the potential harms caused by these measures. In contrast to medical countermeasures, where there are long-standing structures and processes to measure the benefits (protection from or treatment of disease) and risks (side effects) using clinical trials, many of the disbenefits of NPIs were in broader social, societal, educational or economic terms that were often harder to measure and required wider technical advice beyond the remit of SAGE or the CMOs.

73. Whilst NHS England officials were often involved in meetings where the use of NPIs (and their impacts on e.g., social, economic, mental health, educational factors) were considered or discussed, NHS England's role was to operationalise the decisions taken by Government in response to the pandemic, particularly in respect of treatment of those affected by COVID-19. As understanding of Long COVID developed, that also included commissioning health services and integrated care pathways for those affected by that condition. It was not NHS England's role to make an assessment of how these measures would impact the general population and also those suffering from Long COVID.

74. One area where it was NHS England's role, however, was in the work around ensuring those patients who did not have COVID-19 came forward to access the health services they needed. A number of paediatric units, children's A&E departments, some stroke and heart attack services and cancer care services noted a downturn in patients and there were concerns that people were delaying coming forward for care when they needed it. A range of potential factors were thought to be the cause of this, but contemporaneous research confirmed that 4 in 10 were too concerned about being a burden on the NHS when it was dealing with the pandemic,

whilst others were unsure about how the NPIs in place impacted their ability to access health services. **[SP2/21 - INQ000226901]**

75. In response to this, on 25 April 2020, NHS England announced that they were launching a large-scale public communications and social media campaign to remind people that the health service was there for them, and people should continue to access care when they needed it. The campaign, called "*Help Us Help You",* also confirmed that seeking medical help was one of the four reasons that people could safely leave home in line with Government advice. **[SP2/20 - INQ000205654]**

SECTION 3: NHS England's role in assessment of initial government strategies around emergency response measures to COVID-19; specifically, NPIs

76. NHS England's focus and role in the first phase of the pandemic response was on (1) understanding the pharmaceutical and clinical interventions we should be developing to ensure the NHS had as much capacity to handle patients in hospitals as possible, and (2) expanding wherever possible that capacity.

77. NHS England was focussing on how the NHS could care for patients that fell ill with COVID-19. Others with public health responsibilities had the wider responsibility of considering what other steps could be taken to slow down transmission in the national population. Also, others with public health responsibilities had the wider responsibility of considering how any of the measures to slow transmission would affect the national population more widely, including social, economic, access to education, mental health and access to healthcare services for non-COVID conditions.

78. It is important to reiterate that NHS England is not a government decision-making body (and that remained the case through the pandemic), and it did not take decisions on the government response, such as decisions to impose lockdowns or NPIs. However, NHS England was available to central government and other bodies such as PHE (now UKHSA) to provide advice and information that central government could use in making decisions.

79. Initially, NHS England did not have a presence on SAGE, although by 25 February 2020, the National Medical Director began attending SAGE meetings, and thereafter attended regularly. Central government modelling was undertaken by the Scientific

Pandemic Influenza Group on Modelling ("**SPI-M-O**"), with relevant input from NHS England, including key operational data as the pandemic progressed.

80. In the weeks before the first lockdown announcement, NHS England was carrying out its own internal modelling and data collection to inform its operational response and was also sharing data on NHS capacity with central government through SAGE and the CMO. As the pandemic progressed and to support decision making for the second wave in Autumn 2020, NHS England collaborated with SAGE's modelling organisation SPI-M-O. From 2021, NHS England expanded its data infrastructure to encompass reporting on vaccine deployment.

81. Therefore, while NHS England was involved in SAGE and other discussions where NPIs were discussed, our priority and area of expertise was always at the patient level and operational focus.

(a) *First National Lockdown - March 2020*

82. The first national lockdown was announced on Monday 23 March 2020, although a number of measures to reduce transmission had already been introduced prior to this date.

83. NHS England's involvement in respect of the decisions around this first national lockdown was limited. Minutes of SAGE meetings held before NHS England began attending, record that a range of NPIs were already under consideration to potentially delay the spread of a UK outbreak. **[INQ000051883, INQ000051925, INQ000061515 INQ000052171, INQ000052429].**

84. Internally, we began taking steps to prepare for increased demand for NHS services and increase capacity from early February, with the collation and consideration of data (sitreps), and early modelling. This modelling informed early decision making on the need to increase critical care capacity to cope with anticipated demand, which sits squarely within NHS England's remit. However, RWCS clearly and consistently indicated that the NHS would not have sufficient bed capacity to treat the possible numbers of patients requiring hospitalisation and the focus during SAGE (and of SAGE modelling outputs) during this time, was around the two possible responses to the pandemic in order to limit the impact of COVID-19 on the NHS, specifically;

increasing capacity and resource available within the NHS and introducing a set of NPIs that would reduce transmission and infection (and demand upon the NHS).

85. Others acknowledged the wider implications of NPIs during this time. On 16 March 2020, Imperial College published its report entitled "*Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and healthcare demand*" **[SP/0184 – INQ000087315]**. This acknowledged that "*the impact of many of the NPIs detailed [in this report] depends critically on how people respond to their introduction, which is highly likely to vary between countries and even communities*". The report also confirmed that "*We do not consider the ethical or economic implications of either strategy [suppression or mitigation], except to note that there is no easy policy decision to be made. Suppression, while successful to date in China and South Korea, carries with it enormous social and economic costs which may themselves have significant impact on health and well-being in the short and longer-term. Mitigation will never be able to completely protect those at risk from severe disease or death and the resulting mortality may therefore still be high.*"

86. SAGE advised that there was clear evidence to support additional social distancing measures to be introduced as soon as possible and should be accompanied by a significant increase in testing. SAGE also confirmed it would further review whether school closures should be required to prevent NHS capacity being exceeded. At this point, NHS England was asked to look at the potential impact of school closures, but only in respect of how it would impact on NHS staffing. **[INQ000052569]**

87. On 20 March 2020, the following were announced on a national basis **[INQ000065323]:**

    a. Further social distancing measures to close entertainment, hospitality and indoor leisure premises;

    b. Schools, colleges and nurseries in England ordered to close 'until further notice'; and

    c. Government to publish the scientific evidence provided to SAGE supporting the UK government response

88. On 22 March 2020, the following additional measures were announced **[INQ000119670]:**

a. Shielding measures - up to 1.5 million people identified as being at higher risk of severe illness if they contract Covid-19 should stay at home;

b. Guidance published on shielding and protecting people defined on medical grounds as extremely vulnerable; and

c. Further social distancing measures come into effect requiring people to stay at home, stop social gatherings and the closure of certain businesses.

89. On 23 March 2020, a meeting took place between the Prime Minister, the Chancellor of the Exchequer, the Minister for the Cabinet Office, the Prime Minister's special advisor, the cabinet secretary, along with a number of NHS England officials including the Chief Executive Officer, Chief Operating Officer, London Regional Director, and the Medical Director for London to discuss slides prepared by NHS England which showed demand for ITU beds doubling every three days and that additional premises would be needed to cope with potential demand. During this meeting, it was suggested that the ExCeL Centre should be converted into a 4,000 bedded field hospital, and eventually, this became the first Nightingale Hospital set up in response to the COVID-19 pandemic.

90. As discussed earlier in this statement, during this particular period (pre- and up to the first national lockdown), very little was known about Long COVID. It was an emerging condition and knowledge, and understanding was new and developing. Therefore, to our knowledge, there was no specific discussion around this condition and the impact NPIs would have on this, and access to treatment for it, during the early part of the pandemic and the early part of the first national lockdown.

(b) Ongoing lockdowns – May 2020 onwards

91. The initial lockdown was eased during May and June 2020 but unfortunately, numbers of COVID-19 cases began to rise in different areas of England. As a consequence, the SSHSC announced, on 29 June 2020, that the first local lockdown in Leicester would begin on 4 July 2020. There then followed a period (between 4

July 2020 and 14 October 2020) when various regional / local lockdowns were introduced and revoked. **[INQ000088025]**

92. Prior to the announcement about the Leicester lockdown, a Joint Biosecurity Committee GOLD call which NHS England's Strategic Incident Director and Chief Nursing Officer joined, confirmed that No. 10 had asked DHSC to develop a playbook on responding to small local COVID-19 outbreaks through to regional and national lockdowns, including roles and responsibilities for triggering the use of NPIs and local enforcements. The playbook was being produced for the following week as there was a recognition that there was a potential for local outbreaks to lead to another national outbreak and a sense that there was some pressure from Government to be thinking one step ahead. A substantial data dashboard to support the management and monitoring of outbreaks was also being developed which would seek to capture the totality of the response, including NPIs, testing, community infection rate, COVID admissions, workforce infection profile etc with NHS England asked to contribute on health sector KPIs. **[SP/0205 - INQ000087441] [SP/0206 - INQ000087442]**.

93. As with the earlier decision about the first national lockdown, NHS England supplied information to the Government about operational pressures on the NHS nationally and within areas and regions. Government used the information we gave them when reaching decisions about imposing or easing lockdowns, together with a range of voices and sources of information which they considered when determining policy.

94. This continued over the summer and early Autumn of 2020 via a range of meetings or commissions from various Government departments including DHSC, the Civil Contingencies Secretariat and Cabinet Office. Data produced during this period included regional information about admissions and bed capacity, to help inform decisions around NPIs adjusted by location, but did not consider the impact of NPIs on those with Long COVID. See for example, the COVID-19 Situational Awareness Meetings and the SILVER and GOLD calls and briefings, which NHS England were involved in.

(c) The tier system (October 2020) and further lockdowns

95. NHS England played the same role in relation to implementation of the Tier System and further lockdowns in the UK.

96. On 12 October 2020 the Prime Minister announced that the Government was simplifying local restrictions by introducing a tiered system **[SP/207 – INQ000087548]**. On 14 October 2020 the new tiered system; medium, high and very high, was implemented. This remained in place until the start of the second lockdown, announced on 31 October 2020 and imposed on 5 November 2020.

97. Before the tiered system was announced, NHS England's National Medical Director attended a SAGE meeting on 8 October 2020 **[SP/208 – INQ000087466]**, where the adoption of NPIs to limit rises in cases was discussed because of the increasing numbers of infections. SAGE reviewed the SPI-M-O medium term projections and the NHS data showing increases in hospital admissions, particularly in the North West, North East and Yorkshire. It was noted that if there were no decisive interventions, continued growth would have the potential to overwhelm the NHS, including the continued delivery of non-COVID treatments.

98. SAGE noted that the interventions previously recommended for consideration were those which would have significant population-level impact on reducing transmission. Case control studies indicated that restaurants and bars were associated with increased transmission risk. SAGE also noted that the epidemiological impact of NPIs would depend on context and how they interacted, and public behaviours in response to the measures. Substitution behaviours were considered important (e.g. the impact of closing pubs would be reduced if people instead socialised in restaurants or private homes). Further studies (e.g. case control studies, cohort studies) were needed to understand where transmission was taking place and where people were at most risk.

99. SAGE determined at this meeting that a package of NPIs needed to be adopted to reverse the exponential rise in cases. SAGE noted that policymakers would also need to consider potential economic impacts and other associated harms, including non-COVID health harm, alongside the epidemiological impacts of NPIs on R and growth rates. I understand that SAGE may have made relevant recommendations but believe that Government would have made any resulting decisions.

100. A second national lockdown was announced on 31 October 2020 and imposed from 5 November 2020 until 2 December 2020. Subsequently, the country reverted to the tiered system, but with London moving to Tier 3 on 16 December 2020.

101. On 19 December 2020, Tier 4 was announced and came into force at 7am on 20 December 2020 across London and large parts of the South East of England. The tier 4 rules were broadly the same as those applied during the national lockdown imposed in November 2020. In tier 4 people were required to stay at home unless they had a reasonable excuse to leave. All non-essential retail and hospitality businesses were closed (apart from click and collect, delivery and takeaway services) and people could only meet with one other person in certain public outdoor places.

102. On 4 January 2021 the Prime Minister announced a third national lockdown for England. The Government made Amendment Regulations on 5 January 2021 to the existing tier system. The changes came into force at midnight on 6 January 2021, although people were urged to stay at home from 4 January 2021. On 22 February 2021 a four-step plan was published for easing the third lockdown which is outlined below. On 8 March 2021 people were permitted to leave home for recreation with their household and/or support bubble or with one person from outside their household. **[INQ000086664]**

103. The first COVID-19 vaccination outside of a clinical trial took place on 8 December 2021. This signalled the start of a new phase of the pandemic, which lasted until 23 February 2022, as was the point at which the approach to managing the pandemic began to move from being predominantly reliant on NPIs to the use of COVID-19 therapeutics; the rapid take up of vaccines has allowed the withdrawal over time of a range of NPIs, and drug treatments have become increasingly available.

Factors influencing decision making around NPIs

104. A number of factors may have influenced Governmental decisions as to choice of NPIs during the COVID-19 pandemic, including the predominant respiratory route of transmission, the mortality rate, and the distribution of mortality and morbidity across the population with the greatest risks in the elderly but much lower in children. Government decision making around use of NPIs, in what combination and for what duration, was informed by scientific advice, including from SAGE and the CMO.

105. NHS England worked closely with DHSC, PHE, and others to respond to the pandemic, as well as being present at some meetings with the Prime Minister, No.10, and other Government ministers, and through its attendance at SAGE,

COBR, Covid-O etc. meetings, where relevant to do so. This included existing meetings (such as QUAD meetings) as well as other meetings or groups set up specifically in response to the pandemic, and formal and informal contact where relevant.

106. The *'Technical Report on the COVID-19 pandemic in the UK'* **[SP2/19 - INQ000205650]** helpfully explains that in the early part of the pandemic, the force of transmission was such that extensive use of multiple NPIs used together was needed to bring the reproduction number (R) below 1. In reviewing different combinations of NPIs to achieve this, the Government were informed by scientific analysis from a range of sources which fed into SAGE, and it was SAGE which then advised the Government. NHS England did not seek to influence the Government's decision making around what, if any package of NPIs was appropriate at any given time.

107. As part of that, Government had to weigh in the balance the ratio of harms and benefits for individual NPIs. Different types of harms were considered from early in the pandemic by scientific advisers and CMOs and they were discussed publicly early in the pandemic, such as at the UK COVID-19 press conference on 16 March 2020. **[INQ000052566]**

108. The balance of the benefits and disbenefits of NPIs, and how that balance changed over time, was for the Government. This was also true in relation to Long COVID, because, as it is a condition which is highly likely to be a direct consequence of infection with SARS-CoV-2, measures aimed at reducing transmission of that infection would be expected to also reduce the incidence of Long COVID.

109. Again though, NHS England's role during the pandemic was not in relation to consideration and assessment of socio-economic factors relating to NPIs, nor indeed did NHS England have a role in making decisions or influencing decision makers about the use of NPIs and in what combination. The extent of NHS England's involvement in these issues was around advising Government on the existing and potential capacity of the NHS to ensure that appropriate services could be provided, the operational challenges, and the steps that could and were being taken to respond to the pandemic and their likely impact on the NHS.

SECTION 4: Long COVID – areas which worked well and areas where there were obstacles or missed opportunities

110. Since 2020, there have been a large number of reflective documents and articles produced by a range of scientific, academic, operational and policy making sources on the pandemic as a whole and also in relation to Long COVID. In this statement we have been asked to reflect on key areas that worked well or where there were obstacles or missed opportunities in relation to NHS England's engagement with UK Government decision-making on emergency response measures, in respect of long-term sequelae or Long COVID. For the purposes of this Inquiry, what worked well and what opportunities were missed may be more appropriately addressed in a broader sense by expert evidence.

111. The *'Technical Report on the COVID-19 pandemic in the UK'* , **[SP2/19 - INQ000205650]** (which the National Medical Director for NHS England contributed to), sets out that "*improvements in care reflect the extraordinary efforts of medical, nursing and allied staff"* and notes that "*their repeated determination to go well beyond their normal practice over prolonged periods, learn and disseminate best clinical practice and redesign operational systems for the benefit of patients was remarkable*". Additionally, the rapid flow of international experience was "absolutely essential" whether that was through formal routes or informal networks.

112. The introduction of a novel disease with rapid transmission and severe sequelae will always be a significant challenge for the health and care sector to adapt to, but the efforts of health and care staff, together with rapid innovation by clinicians and spreading of new best practice steadily improved outcomes.

113. Innovation occurred and spread through the NHS, public health and the wider health and social care sector by several routes. For clinical management, initially the sharing of contemporary best practice by clinicians and scientists from countries hit early in the pandemic, including from China, Singapore and Italy, allowed the early management of people with COVID-19 in the UK to be based on some prior knowledge. Clinical trials and formal observational studies were launched in the UK at almost the same time the first cases were imported. While these provided the most robust testing of drugs and other interventions, clinicians adapted rapidly as they observed patients' progress and learned.

114. Effective collaboration also played a large part in the interactions with Government, via a range of official meeting spaces, information channels and the energy to get teams together to jointly problem solve.

115. The response to Long COVID evolved in a similar manner, although research into the causes, pathophysiology and management of this disorder is ongoing, with recognition and understanding improving over time.

116. Quite early in our understanding of the condition, NHS England, with input and advice from key stakeholders, developed and implemented a commissioned response to this new healthcare challenge, focussed on delivering care to those affected. This included a series of interconnected actions, including review and maintenance of guidance, definition of care pathways linking physical/mental and/or commissioning approach, rolling out community monitoring, community rehabilitation, and clinical capacity.

117. It was quickly recognised that individuals with Long COVID may have related mental health issues, such as anxiety and depression, and so access to local health services, with integrated specific post-COVID psychological therapies to support them were also commissioned by NHS England.

118. Collaboration with Government again took place, with the Government's Long COVID Roundtables being one such example. These meetings brought together views and information from a range of representatives, including those leading NIHR funded research studies, data collected by ONS, guidance from both NICE and RCGP and feedback from those representing people with lived experience. For NHS England, the feedback gathered in those meetings was used to inform, alongside other research, evidence and feedback, the development of the Long COVID plan and the Long COVID Improvement Plan.

119. As with the response to the pandemic itself, the complexity and novelty of Long COVID meant that actions had to be taken at speed and with limited knowledge. During the initial stages of our understanding of Long COVID and the early phases of establishing new structures or care pathways to care for those with it, there was inevitably a period of learning, whilst we identified the most effective methods of responding. Practical lessons had to be learned in real time by the people working to

support the response and based on that learning, the response was adjusted accordingly.

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 Medical Director
Print Full Name	Professor Sir Stephen Powis	**Date**	1 August 2023

ANNEX 1 - 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). There was no one system for saving emails as records, with nhs.net email accounts being hosted externally by NHS Digital.

4. 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).

5. 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.

6. 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.

7. 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.

8. 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.

9. 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

10. 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.

11. 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.

Searches conducted

12. For this Supplemental Rule 9 Request, records deemed in scope have been located from key word searches conducted on CERMS and by also directing searches towards the key personnel and teams involved in Long COVID and the Long COVID

programme. Searching has therefore been targeted to the records locations, individuals and repositories where we consider the relevant records are most likely to be held.

13. 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 Long COVID due to the data volumes held corporately. There are considerable practical limitations to our abilities to do this in any event, because of the volume of records that we hold as an organisation. 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.

14. 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.