Witness Name: Professor Sir Stephen Powis

Statement No.: 5

Exhibits: nil

Dated: 29 November 2024

UK COVID-19 INQUIRY

FIFTH WITNESS STATEMENT OF PROFESSOR SIR STEPHEN POWIS

Module 3 post-hearing evidence

Introduction

1. During the course of my Module 3 evidence to Inquiry I offered on a number of occasions to enquire further within NHS England for information requested that I did not immediately have to hand, if it would assist the Inquiry. NHS England Chief Executive Amanda Pritchard made similar offers during the course of her evidence.

2. Following the hearing the Inquiry has confirmed which of those offers of further evidence it would like to take up. The further information in response to those matters, from the questions put to both Ms Pritchard and to me, is set out below.

3. As with previous statements, the information in this statement includes some matters outside my personal knowledge. As such, some of the information in the statement is the product of drafting after communications between external solicitors and relevant NHS Employees. Given the process here described, I can confirm that all the facts set out in the statement are true to the best of my knowledge and belief. Through the rest of my statement I have referred to myself in third person.

Triggers for NHS England correspondence regarding DNACPRs

4. Professor Powis was asked whether there were particular triggers for notices to the NHS system, on 11 May 2020 and 4 March 2021, reiterating the importance of appropriate use of DNACPRs.[1]

5. It is important to note that communications on 11 May 2020 and 4 March 2021 were only two of many instances of NHS England providing guidance, or links to guidance, on the proper use of DNACPRs. As noted in Professor Powis' Third Witness Statement, from paragraph 193 to 204, communications were sent to parts of the NHS system on the proper use of DNACPRs on 3 April 2020, 7 April 2020, 8 April 2020, 11 May 2020, 4 September 2020, and 4 March 2021.

---

1 Transcript for 7 November 2024, column 103, line 8.

6. Professor Powis also made public statements on the proper use of DNACPRs in parliamentary committees on 22 July 2020, 27 August 2020, and 1 December 2020.

7. The 11 May 2020 guidance came at the end of a period in which issues relating to DNACPR use had been the subject of concerns reported in the media, and by charities such as Mencap. On hearing of these concerns, NHS England made a number of public comments to ensure guidance on the proper use of DNACPRs was well publicised. The 11 May 2020 bulletin followed a number of communications from NHS England in April 2020.

8. The 4 March 2021 correspondence followed communications from Mencap, which NHS England's National Director for Learning Disability and Autism had asked to keep her updated on any issues that it became aware of relating to DNACPRs. In mid-February 2021 Mencap had noted that it continued to receive some reports of improper use of DNACPRs, although Mencap also noted it was unclear whether these reports were contemporary or dated back to early 2020, and in many cases there was very little information on the situation as reported. At the time, NHS England had already been in internal discussions about issuing further communications about DNACPRs, reiterating the message in the early 2020 correspondence.

Data about healthcare workers in NHS England's Long Covid registry

9. Professor Powis offered to provide any further available evidence on whether NHS England's Long Covid registry included data about healthcare workers affected by Long Covid.[2]

10. The Long Covid registry data includes information on the number and proportion of adults accessing Long Covid services for the first time who are employed by the NHS. The registry also holds other data for those accessing Long Covid services – such as relating to deprivation – but is not able to apply both filters at the same time (ie, it does not contain information on deprivation for NHS staff accessing Long Covid services).

---

2 Transcript for 7 November 2024, column 196, line 21.

11. As discussed in Professor Powis' evidence, NHS England is currently undertaking a stocktake of Long Covid services. That stocktake includes consideration of whether current data being collected around Long Covid services is sufficient.

Visitors' guidance

12. Professor Powis offered to provide any further available evidence in response to questions about consultation and equality impact assessments undertaken in relation to restrictions on visitor guidance.[3]

13. NHS England did not conduct consultation with disabilities advocacy groups between issuing its 8 April 2020 guidance on visiting restrictions **[INQ000000132]** and issuing an updated version on 5 June 2020 **[INQ000330865]**. The change to the restrictions in the 5 June 2020 guidance, which [broadened the exception to the restriction on people], was prompted in part by correspondence sent to NHS England on behalf of people with disabilities, setting out why they considered the 8 April 2020 restrictions to be overly restrictive and would have had significant implications had either of those individuals been hospitalised. The correspondence set out the individuals' health conditions in detail, the reasons why they would need a support person, and the reasons that the 8 April 2020 restrictions were overly restrictive. Following receipt of that correspondence, on 30 April and 1 May 2020, NHS England did not undertake further consultation and instead, having considered those concerns, prioritised making the changes to the guidance, which was published on 5 June 2020. Equality impact assessments carried out from July 2020 as part of considering further changes to visitor guidance noted the need for personal assistances for some disabilities, and that personal assistants and carers should be treated as a visiting staff member rather than a visitor.

[3] Transcript for 11 November 2024, column 28, line 1.

Disability data collection and dissemination

14. Professor Powis also agreed to provide further information about steps that have been taken to improve data collection and dissemination across the NHS in relation to disability.[4]

15. This area remains a work in progress for NHS England, where it is continuing to work to make improvements (working alongside central government bodies, particularly DHSC). Set out below is a summary of key workstreams by reference to their current status and how they will continue to develop:

16. **Accessible Information Standard ("the AIS")**: The AIS is discussed in Professor Powis' Fourth Witness Statement (from 268 onwards). A refresh of the AIS is currently underway and an updated version will be published in due course alongside a self-assessment framework and e-learning resources for those who are required to comply with the AIS. The refresh has considered-the effectiveness of the AIS, how it is implemented and enforced in practice. The AIS relates to capturing information about disability-related communication needs. The refresh, led by NHS England, creates opportunities to promote greater awareness of the AIS at ICB and local level, improving how such needs are recorded and met .

17. **Reasonable Adjustment Digital Flag ("the RDAF"):** the RADF is a national record that captures information about the reasonable adjustments that patients may need as a result of their disability or impairment. It enables enable health and care professionals to record, share and view details of those adjustments across the NHS and social care, wherever the person is seen and or treated. The flag indicates that reasonable adjustments are required for an individual and may include details of their significant impairments, underlying conditions and the key reasonable adjustments that should be provided to ensure their care is equitable and meets their needs as required by the Equality Act 2010. The RADF was built and launched by NHS England in September 2023 and is being implemented in phases. NHS organisations will be required to fully comply with the requirements of the RADF by 31 December 2025.

---

[4] Transcript for 11 November 2024, column 28, line 19.

18. **Unified Information Standard for Protected Characteristics ("the UISPC"):** DHSC recommissioned the UISPC scoping project in late 2021/22, the UISPC will apply to the NHS as a whole. This UISPC Publication Steering Group, led by NHS England, has representation from cross-government agencies and NHS system partners.

19. The purpose of the project was, and is, to provide recommendations on the collection of improved equality monitoring data on protected characteristics data relating to patients and the NHS workforce. The aim is to enable DHSC and the wider NHS to identify viable options for improving the consistency, detail and quantity of equality data in major NHS information systems. Once published, it is intended that the UISPC will lead to the development of a unified Information Standard or a number of separate but coherent information standards (i.e. the UISPC).

20. Once implemented, the UISPC will enable NHS organisations to better respond to their equalities duties by reference to protected characteristics under the Equality Act 2010 and better meet the needs of patients and the NHS workforce.

21. Progress against the commission is still underway and will continue into 2024/25.

Long Covid symptoms

22. Counsel for Long Covid Groups stated that, until April 2022, NHS England's website continued to state that Covid-19 was short, mild, and flu-like with only three cardinal symptoms of fever, cough, and shortness of breath, despite a significant number of people suffering from other symptoms. She added that the CDC in the United Stated updated its website regularly including on the understanding of new symptoms, and asked why NHS England did not update its website information with updated understanding of Covid-19 symptoms. Professor Powis noted that in principle NHS England updated its website to ensure there was up to date and contemporaneous evidence, but would need to write to the Inquiry to provide specific information.[5]

---

5 Transcript for 11 November 2024, column 45, line 21.

23. Professor Powis' Fourth Witness Statement notes that NHS England had a limited role in advising the public on managing Covid-19 at home, in line with communications strategies agreed between the key health agencies. NHS England did provide some guidance directly to the public, often on issues particularly relevant to the NHS, such as what to look out for before seeking NHS care.[6]

24. Throughout the pandemic, the various iterations of Government Covid-19 public health advice were incorporated into NHS England communications, such as its owned corporate social media channels and the NHS England website.[7]

25. NHS England's website made clear it was designed for clinicians, and directed members of the public to the nhs.uk website, managed by NHS Digital (as it then was).[8] The nhs.uk website is funded by DHSC. NHS Digital does not develop guidance on the nhs.uk site, and instead its content is typically based on content created by a number of other organisations, such as Cabinet Office, DHSC, NICE, PHE/UKHSA, and NHSE England.

26. The team at nhs.uk collated a spreadsheet providing links to 179 unique URLs, showing there were a total of 3,927 versions of these pages (this figure includes updates to pages that are substantive and those that might be made to correct a spelling error).[9]

27. As noted in Professor Powis' Fourth Witness Statement, at paragraph 1028, information on long term symptoms from Covid-19 began to be published from July 2020, on the Your Covid Recovery website. That website was further updated in October 2020 with more specific information about Long Covid, as part of the wider Long Covid plan which also saw the opening of Long Covid Clinics.

28. NHS England sought to refer to and disseminate Government guidance in order to ensure consistency of messaging and advice through the pandemic.[10] NHS England messaging should be viewed in the context of communication from other

---

6 Professor Powis' Fourth Witness Statement, at paragraph 837.
7 Professor Powis' Fourth Witness Statement, at paragraph 855.
8 Professor Powis' Fourth Witness Statement, at paragraph 856.
9 Professor Powis' Fourth Witness Statement, at paragraph 877.
10 Professor Powis' Fourth Witness Statement, at paragraph 882.

government agencies which were also involved in messaging. Counsel referred to the Centers for Disease Control and Prevention (**CDC**), which is the national public health agency in the United States. The equivalent in the UK is PHE/UKHSA, not NHS England.

29. NHS England published information on long term symptoms of Covid-19 from July 2020 and certainly well before April 2022. Symptoms beyond those three identified by counsel were also noted in patient-facing materials prepared by NHS England, for example:

    a. **INQ000470464**, a 10 June 2020 patient discharge leaflet, which also referred to a loss or change of sense of smell or taste as one of the most important symptoms of Covid-19;[11] and

    b. **INQ000470513**, a December 2020 patient-facing leaflet published on the NHS England website and the nhs.uk website, and also cascaded to GP services, for those with suspected covid-19. As well as cough and high temperature, this leaflet noted other symptoms included muscle ache or tiredness, mild chest pain, dizziness or headache, loss of taste or sense of smell, diarrhoea and vomiting, and rashes.[12]

Recording data on deaths of healthcare workers

30. Ms Pritchard gave evidence on work done to prepare for recording deaths of healthcare workers in the event of future pandemics or emergencies, and offered to provide further information on whether this new system would include ethnicity data for healthcare workers.[13]

31. Staff ethnicity was captured from the outset of the collection of NHS staff Covid-19 deaths data, beginning in early March 2020, as noted in my Third Witness Statement from paragraphs 875 to 892. NHS England would draw on the evaluations of its data collection mechanisms during the Covid-19 pandemic in the event it had to establish a mechanism for capturing data on NHS staff deaths

---

11 Professor Powis' Fourth Witness Statement, at, paragraph 867.
12 Professor Powis' Fourth Witness Statement, at paragraph 878.
13 Transcript for 11 November 2024, column 146, line 22.

in a future death or emergency. In such a situation, ethnicity data for NHS staff deaths would be able to captured as it was during the Covid-19 pandemic.

Guidance on the use of HEPA filters and UV devices

32. Ms Pritchard offered to provide further information on:

    a. whether advice on HEPA filters and UV devices should be treated as mandatory guidance under the relevant NHS Health Technical Memoranda; and

    b. work being done on increasing access to HEPA filters in the NHS Estate.[14]

NHS England's Lessons Learned Report

33. In its Lessons Learned report [**INQ000226890**], NHS England recognised the importance of ventilation:

3.20 Effective ventilation and air quality in NHS buildings

121. Ventilation was, and still is, vital in the management of Covid-19, particularly where the risk of airborne transmission is higher such as when aerosol generating procedures are being undertaken. NHSE worked with industry experts and DHSC to develop comprehensive advice and guidance on the legal requirements, design implications, maintenance and operation of specialised ventilation in healthcare premises. This guidance was updated during the pandemic to ensure adequate procedures such as lamina flow and air changes are in place for certain environments.

122. Since then, lessons learnt during the pandemic experience have led to additional guidance being published relating to ultraviolet (UVC) devices for air cleaning and high efficiency particulate air (HEPA filters). Going forward, further work will be undertaken to ensure effective ventilation of new and existing healthcare premises over the longer-term, and increased use of technology such as CO2 monitors.

Technical Guidance Programme Overview

34. In 2017 DHSC transferred responsibility for the update of the technical guidance programme over to (then) NHS Improvement. This responsibility transferred as

[14] Transcript for 11 November 2024, column 152, line 23.

part of the merger to (now) NHS England. NHS England is responsible for maintaining technical guidance for the NHS Estate.

35. There are over 100 technical guidance and standards documents which set out the safe design and operation of the NHS Estate. They are categorised as follows:

    a. **Health building notes (HBN)** give best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities.

    b. **Health Technical Memoranda (HTM)** give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare.

    c. **NHS Estates Technical Bulletins (NETB)** enable updates to guidance to be passed to local systems at pace and outside of the usual schedule of HTM or HBN updates. This is useful in the case of legislation change, safety learnings and innovation adoption.

    d. **Other technical guidance** is developed in response to critical areas of innovation and safety.

36. Guidance is updated on a rolling basis, using subject matter experts and consulting with professional bodies, institutions and medical Royal Colleges.

HTM 03-01: Specialised ventilation for healthcare premises

37. This is the core ventilation guidance document for the NHS **[INQ000130579]**. It sets out the design, specification, installation and acceptable testing for all healthcare ventilation systems, alongside the operational management, maintenance and performance testing of systems. It was updated in 2021 and was checked against learning from Covid-19 prior to issue via a Short Life Working Group. The working group was requested by the MHCLG Chief Scientific Officer and involved the Devolved Nations and Professor Catherine Noakes, Professor of Environmental Engineering for Buildings, University of Leeds, from whom the Inquiry has heard evidence.

38. Work had commenced on updating this document prior to the pandemic (in 2019).

39. There were 56 acknowledgements for specialist contributions to the document, including Professor Noakes and Professor Clive Beggs (from whom the Inquiry has also heard).

40. The HTM provides specific advice for clinical areas – spaces within the building where surgical or medical treatment is administered to patients (this includes patient bedrooms). Specific air change rates are also provided for these areas. In non-clinical areas (spaces where patients may be present but are not under direct treatment as well as staff and healthcare services areas) relevant building regulations are referenced.

41. The HTM requires fresh air is used to provide the recommended air changes and provide dilution. This will not require a HEPA filter as the air is not being recirculated. EPA or HEPA filters will only normally be required in ultra-clean systems and designated "clean rooms". For example, they are used in the canopy section of ultra-clean operating theatre ventilation systems. The recirculated air is EPA filtered to ensure that biological contaminants released by the surgical team are not discharged back into the clean zone.

42. All business cases for new builds and refurbishments which come to NHS England for approval are required to comply with the HTM standards. This currently applies to any capital work of more than £25m, and includes the New Hospital Programme.

Further Ventilation Advice related to HTM 03-01 [NETB 2023/01A and NETB 2023/01B]

43. In 2023 NHS England published two technical guidance notes specifically in response to learnings from the pandemic. These relate to the application of ultraviolet (UVC) devices for air cleaning in healthcare spaces and the application of HEPA filter devices for air cleaning in healthcare spaces. These were new guidance notes and are written to be read in conjunction with the main HTM 03-01 guidance document (as explained in HTM 03-01). Professor Noakes was an author of these documents along with other specialists.

44. Within the healthcare setting there are several factors which need to be considered when using standalone units such as HEPA filter devices, some of the key considerations are:

    a. A local risk assessment is required.

    b. Units should comply with all building regulations and electrical guidance, in other estate use of units may be problematic due to overloading systems (as more than one unit would be needed in a larger ward area).

    c. Units should be positioned so that they do not interfere with the provision of care or provide an obstruction – such devices are designed for rooms not wards, and therefore mitigation is required against trip hazards and specific consideration must be given to people who have visual impairments or restrictions on their mobility.

    d. Units may pose a ligature risk, which must be risk assessed.

45. The use of mobile and semi fixed HEPA devices is for use in existing healthcare and patient-related settings where there is poorly performing and inadequate ventilation. Provision of these would be down to local Trust assessment of the current performance of the ventilation system.

HBN 04-01 Supplement 1: Special ventilated isolation facilities for patients in acute settings

46. This is a supplement to the adult inpatient facilities document which set outs the NHS' guidance for the design of special ventilated isolation facilities in which the movement of air within the isolation facility will control the ingress and/or egress of airborne harmful pathogens and contaminants in acute settings. It was updated in July 2024. There were 20 acknowledgements for specialist contributions to the document, including Professor Noakes who signed off the document.

Current Status

47. There is work happening across the Devolved Nations to align guidance on ventilation (NHS England has the most up-to-date guidance) and NHS England

plan to make minor amendments to their guidance to reflect best practice updates from the devolved nations. This is part of the usual update programme.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Professor Sir Stephen Powis, National Medical Director

PD

Dated: 29 November 2024