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focus towards the health literacy of the US population. During the COVID-19 pandemic, a well equipped public health system would have ensured greater availability of testing facilities and universal implementation of preventive measures. By acting as the front-line barrier, it would have buffered the clinical health-care delivery system by substantially decreasing the burden placed on it. Failure to do so has cost the USA in terms of deaths and illness related to COVID-19 and the cost of the stimulus package and the vaccines.

The country's leadership in the development of the COVID-19 vaccines is yet another testament to the USA as a powerhouse for medical research and innovative technology. It is not enough. The Biden administration provides an opportune time for improvement in planning and deployment.

We declare no competing interests.

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For Get Us PPE see <https://getusppe.org/>

## UK guidelines for managing long-term effects of COVID-19

Robin Gorna and colleagues<sup>1</sup> state that people with lived experience should have been involved in developing the National Institute for Health and Care Excellence (NICE), the Scottish Intercollegiate Guidelines Network (SIGN), and the Royal College of General Practitioners (RCGP) guideline on managing the

long-term effects of COVID-19. The expert advisory panel for developing the NICE–SIGN–RCGP guideline had 23 members who contributed substantial clinician and patient experience to discussions.<sup>2</sup> Two stakeholder consultations were held and the guideline was adapted in response to feedback from patient-led, health, and care organisations. This adaptation included the addition of a table of commonly reported symptoms.

The panel heard evidence from clinicians and patients who felt that symptoms were not taken seriously. A need for detailed assessment of all symptoms and their overall effect on a patient was emphasised. We stressed the need for timely referral and investigation and for the development of individualised treatment plans. We reject Gorna and colleagues<sup>1</sup> suggestion that we overly focus on self-management.

The panel's rationale for the term post-COVID-19 syndrome is to reflect that the acute phase of the illness has ended, and that the ongoing illness includes a wide range of symptoms that might not have been evident during the initial infection. Patient feedback raised the concern that the term long COVID implied ongoing infectivity, for which there is no evidence. The panel did not consider that there was adequate existing evidence to propose underlying mechanisms for post-COVID-19 syndrome at this time.

Research recommendations were made relating to the urgent need for mechanistic studies and clinical research into best investigative and treatment approaches. The guideline will be continually updated as such evidence becomes available.

WS is chair of the Independent Advisory Expert panel of the NICE–SIGN–RCGP rapid guideline Managing the Long-term Effects of COVID-19, and is a general practitioner. MH and SO are expert panel members for the NICE–SIGN–RCGP guidelines. SO is also the lay representative for the NICE–SIGN–RCGP guidelines.

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## Effective supply chain surveillance for PPE

Control of the COVID-19 pandemic has been hampered by reported shortages of personal protective equipment (PPE) and other crucial supplies for health-care providers across the USA.<sup>1</sup> A key impediment to increasing the supply to meet this demand is reliable data on nationwide needs.<sup>2</sup> Reliable forecasting models could help provide information to more accurately scale PPE production, set expectations for health-care facilities on bidding and pricing, and enable appropriate deployment of resources, such as funds from the Coronavirus Aid, Relief, and Economic Security Act (2021).<sup>3</sup> However, predictive modelling of needs for key necessities during public health disasters are largely non-existent. To the best of our knowledge, the most comprehensive publicly available data has been the Get Us PPE shortage index, but it is an incomplete and non-representative picture of national PPE needs within the USA.<sup>4</sup> We recommend the following framework to better inform crisis response for inevitable future public health disasters.

First, there is a need to aggregate demand data. Similar to a strategy to estimate incidence of injuries in emergency departments, data should be collected from a representative sample of health-care institutions (eg, acute and non-acute care facilities and clinics) where PPE is necessary.<sup>5</sup> Key data elements and a comprehensive humanitarian data dictionary should