Witness Name: Dr Bernie Croal
Statement No.: tbc
Exhibits: None
Dated: 08 May 2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DR BERNIE CROAL

I, Dr Bernie Croal, President of the Royal College of Pathologists, will say as follows: -

A. Role, function and responsibilities

1. The Royal College of Pathologists ("RCPath") is a professional membership organisation with charitable status, concerned with all matters relating to the science and practice of pathology. It oversees pathologists and scientists working in 17 different specialties, which include cellular pathology, haematology, clinical biochemistry and medical microbiology.

2. Pathology is the study of disease and is the bridge between science and medicine. It underpins every aspect of patient care, from diagnostic testing and treatment advice to using cutting-edge genetic technologies and preventing disease. Pathologists play a critical role in research, advancing medicine and devising new treatments to fight viruses, infections and diseases like cancer.

3. 95% of clinical pathways rely on patients having access to efficient, timely and cost-effective pathology services. Pathologists play an important role in disease prevention, diagnosis, treatment and monitoring. If you have ever had a blood test, cervical smear or tissue biopsy, a pathologist will have been involved in your care.

4. RCPath develops standards for pathology education, training and research, and guidelines for pathology practice, to improve patient care and safety.

B. COVID-19 testing: a national strategy (Reference the Royal College of Pathologists National Testing Strategy published June 2020)

5. The lack of any direct relationship with the pathology community following the loss of NHS clinical advice in this area was an issue, and so the College was asked to help.

6. Public Health England (PHE) communicated directly with the clinical virology community, but information flow was often indirect to the laboratories. There were challenges with information sharing from PHE in relation to literature and data from other countries as they stated they'd need to get 'permission' to share data

7. The initial testing was developed and performed by PHE very rapidly, but the roll out and scaling up was slower. Some quality control issues with the initial assays needed resolving. Commercial assays came on stream relatively quickly but required validation and verification. A steering group was set up with the National Institute for Biological Standards and Control (NIBSC) to help provide control material as rapidly as possible, together with individuals from PHE (virus controls) and NHS Blood and Transport (NHSBT) (serology). NIBSC and this relationship worked effectively and efficiently in this context.

8. Supply chain issues very quickly became problematic, and these were actively managed across the NHS labs through weekly or more frequent pathology network meetings. The diversion of consumables and equipment to lighthouse labs created additional pressures on some laboratories, most of which rolled out one form of testing modality then having to switch to another. The infrastructure for HPV genome testing was switched to COVID-19 testing, providing additional capacity. The links with the laboratories was key in trying to balance test and consumable availability.

9. The advice to link IT for lighthouse labs with the NHS at the beginning of the proposals to establish these labs was not taken, and so information transfer was not optimal, and had to be 'retrofitted', with data sharing agreements having to be

implemented mid pandemic. This resulted in outbreaks being picked up by infection colleagues from news sources rather than public health information.

10. The College played a major role in active and live education, regarding testing and the pathogen more widely, with the virology community running a really important series of webinars, in addition to the webinars run by PHE.

11. The strategy document was born out of frustration with the approach to testing that was being taken. This was an attempt to put a simple logical and coordinated framework in place that had wide professional consensus. It was developed in coordination with all the organisations named, all of whom commented or approved.

12. The four pillars of the strategy were:

    a. Testing matched to purpose and pathways.
    b. Innovation to adoption at pace.
    c. Infrastructure and workforce for a stable future.
    d. SARS-CoV-2 is not the only virus

C. Pandemic preparedness and system readiness

13. The UK's pandemic preparedness at the time the COVID-19 pandemic struck appears to have been governed by the UK Influenza Preparedness Strategy 2011. This strategy has a very narrow focus and was informed by limited expert engagement. As a result, it doesn't provide the necessary safeguards for the UK. Furthermore, the last large-scale exercise undertaken to test this strategy prior to the COVID-19 pandemic appears to be 'Exercise Cygnus', held over three days in 2016.

14. The report of 'Exercise Cygnus' makes little reference to diagnostics, and limited references to the improvements required for the 'management of excess deaths'. 'Exercise Cygnus' focused on the clinical issues relating to an influenza pandemic, failing to consider the diagnostic or system requirements. This meant key

organisations such as RCPath and the Institute of Biomedical Science (IBMS) were not involved or consulted, nor was the UK Clinical Virology Network (key in this because most pandemics are viral). The exercise therefore missed the opportunity to gain valuable insights into the potential gaps in, and risks posed by, the existing strategy, and so how these gaps might be bridged, and risks might be avoided or mitigated. If the exercise had involved the right people and had the report recommended the appropriate corrective action, thousands of lives could have been saved in the COVID-19 pandemic.

15. The right people would have been clinical virologists. Clinical virologists are responsible for diagnosing viral infections and also investigating the pharmacological response of viruses to antiviral drugs and the evolution of drug resistance. They give expert advice to colleagues on hospital wards and to veterinarians, as well as to the government. Virologists also work in public health and health protection medicine giving advice on immunisation and vaccine use. When there is a viral outbreak on a ward, virologists work together with the hospital's infection control team, advising staff on the ward on the extent of transmission and how to limit further infection.

16. By not seeking the expertise of clinical virologists in sufficient depth by authorities managing the pandemic, there were significant deficiencies in the roll out and understanding of tests, notably lateral flow and use cases. Furthermore, asymptomatic infection and pre-symptomatic infectivity were not adequately factored early on.

17. One of the gaps that wasn't identified early enough was lack of standardisation of virus testing terminologies at laboratory, public health and SNOWMED (structured clinical vocabulary for use in an electronic health record) level. This would have enabled a consistent and accurate capture of data resulting in more efficient and effective decision-making.

Existing expertise and infrastructural capacity

18. The 2009 H1N1 pandemic had a reduced global impact compared to the SARs-CoV2 pandemic. However, even then it was demonstrated that infrastructural capacity with regards to diagnostics, quarantine facilities and tracing was not adequate. There was expertise in virology amongst virologists, microbiologists, infection prevention and control teams and infection specialists within PHE and the NHS. However, the increasing remit of these specialists against a background of workforce shortages and retirements has meant that responding to pandemics largely depends on goodwill and was a challenge in 2009 and an even greater challenge in 2020. There were government groups which did have NHS clinicians providing expertise to inform decision making, but as discussed RCPath feels that overall, there was a lack of consultation with non-government affiliated NHS experts. Moreover, the RCPath medical microbiology and medical virology specialty advisory committee was not consulted and a working group not formed until the middle of the pandemic. Older hospitals meant poor infrastructure with regards to isolation facilities.

19. At the time of January 2020, pandemic preparedness was mainly the remit of central government bodies which limited the understanding of how prepared NHS hospitals and Trusts could be given any local challenges/restrictions they may have had.

20. To our knowledge there was very little utilisation of pathology and diagnostic expertise within secondary care, or lessons learnt from secondary care experiences during the 2009 pandemic.

21. It is difficult to comment on whether TTI featured as a priority issue for key policy and decision makers such as those within Cabinet Office, The Department for Health and Social Care and other relevant institutions given that SARS-Cov2 was a novel pathogen during this time period and thus the focus at the time had to be on developing a robust test to detect it. Because the national pandemic plan had been based on the assumption that the next pandemic would be due to influenza, as discussed there was a very narrow focus and contact tracing would not have

been a priority consideration until more was known about the nature of SARS-CoV2 with regards to transmissibility and pathogenicity.

22. Over the preceding 20 years two novel coronaviruses had emerged (SARS and MERS). Although there were travel related cases with MERS, overall, these viruses mainly affected and were contained within countries in the Middle East, China and Hong Kong. However, they could have been used more in modelling exercises to help predict the nature of SARS-CoV2 which may have informed earlier and more robust TTT strategies.

23. Involvement of NHS expertise at this point would have been advantageous as an understanding of the challenges faced by primary, secondary and social care and their expertise in managing outbreaks could have helped inform the narrative given to the public by the Cabinet Office.

24. Involvement with pathology at this time would have helped develop capacity within pathology networks; during the 2009 H1N1 pandemic PHE laboratories quickly became overwhelmed and there had to be more local testing. This should have been understood and formed part of pandemic preparedness at a government level.

Engagement with the pathology community

25. RCPath considers that there should have been stronger engagement with the pathology community during the pandemic. We believe this would have saved lives, saved money, established a stronger foundation for future pandemics and reduced the scale of backlogs NHS staff are now facing.

26. As discussed, pandemic preparedness should have involved engagement with the pathology community to understand capability for diagnostic preparedness, and also to understand the capabilities of implementing adequate infection prevention and control measures in secondary and social care. Development of local pandemic pathology networks would have kept expertise within pathology

laboratories with the possibility of expanding testing at speed without the need for lighthouse laboratories.

D. Co-working and collaboration with government departments and other advisory bodies

27. Given the lack of involvement or engagement from government departments, agencies and advisory bodies with RCPath or relevant expertise in the pathology community during the pandemic, particularly at the early stages, we considered it was necessary to draw these resources together to support our members and safeguard patients.

28. In terms of the manner in which the RCPath engaged with, consulted and/or collaborated with international partners and healthcare organisations in respect of matters relating to TTI, and whether this engagement was effective, Turkmenistan, whose government at the time claimed they did not have any incidents of COVID-19, requested that we run a webinar about COVID-19. They reported that they found the webinar helpful.

29. As indicated throughout our response, we don't consider that the Government effectively engaged the pathology community.

E. NHS Test & Trace

30. RCPath was not engaged by policy or decision makers as to RCPath's views on the efficacy and usefulness of NHST&T in terms of its organizational performance.

F. Policies and strategies for test, trace and isolate

31. In terms of the work the RCPath undertook in relation to the development of policies and strategies for TTI in England, Scotland, Wales and Northern Ireland between 1 January 2020 and 28 June 2022, one of our college fellows College (Sudhanva Malur) was in charge of the Lighthouse Labs. Working with him and via the Medical Microbiology & Medical Virology Specialty Training Committee we

advertised tours for members/trainees to go and see them in August 2021. The learning outcomes were to understand:

a. The scale of incoming samples (to test 100,000 samples per day – 4166 samples have to be opened per hour).
b. Manual versus automated CAS processing
c. Extraction – the huge numbers required
d. PCR machines – the huge number of machines
e. Machine learning software to analyse
f. Quality control systems
g. The sheer scale of all the logistics

Devolved nations

32. We are unable to comment on whether efforts were made by the UK government to encourage consistency and complementary approaches, appropriate coordination and communication in respect of TTI policy and strategy across the devolved nations.

G. Policy context

Testing technologies and strategies

33. RCPath was not engaged by policy or decision makers in the decisions around the development of testing technologies, including the use of PCR tests, lateral flow tests, the development of antibody and/or genomic testing and other forms of testing which may have been relevant.

34. Regarding the RCPath views on the efficacy of PCR testing, Lateral Flow, serology and LAMP testing, and the advantages/disadvantages of each:

Test	**Description/how the test works**	**Advantages**	**Disadvantages**
PCR testing	Detect the virus' RNA. These tests are normally	They are extremely	Cannot differentiate

	carried out in a laboratory using a swab of the nose and/or throat.	sensitive and the best/most accurate test for current infection	between live and dead virus, so there is the possibility of over diagnosing active infection. Detects a target so where there is a novel pathogen, there may be a delay in developing a sensitive and specific PCR test.
Lateral flow	They detect proteins from the virus, not RNA. They use a swab of the nose and/or throat and are carried out on a small flat plastic device like a pregnancy test.	They are convenient because they can give a result within 30 minutes and do not need a laboratory	These tests are not as sensitive/accurate as PCR.[1]
Serology	Serology tests determine antibody levels in the blood and help determine whether or not an individual has been infected by a virus/infectious agent.	Use for retrospective testing for epidemiological purposes.	These tests are not suitable for diagnosing acute infection in individual patients who suspect they may be infected because they have symptoms

[1] Accuracy of Lateral Flow Antigen Tests for COVID-19

LAMP testing	Lamp testing uses reverse transcription loop-mediated isothermal amplification to detect the viral RNA, with a pH-based colorimetric readout.	Because the test does not require lengthy RNA extraction c.f PCR, it is faster than PCR.	These tests are not as sensitive/accurate as PCR.[2]

35. As discussed, RCPath was not consulted and so were not involved in the development of testing strategies. RCPath was part of a working group with British Infection Association and Hospital Infection Society which aimed to utilise NICE methodology for review of available literature on modes of transmission[3].

Centralisation

36. RCPath was not engaged by policy or decision makers in relation to the development of TTI infrastructure and TTI technologies and the decision to adopt a centralised approach to TTI in the intitial stages of the pandemic.

37. Regarding this approach, at the outset, government efforts to increase testing capacity did not give due regard to the importance of effective testing pathways and appropriate prioritisation of testing. The focus was on performing huge numbers of tests against numerical targets, with constantly changing guidance regarding who should be tested, and little apparent thought of how to use the available capacity to best effect by prioritising tests which would make the most clinical difference. Consequently, the testing capacity which did exist during the ramp-up was used inefficiently. Lessons could have been learned from the H1N1 (swine flu) pandemic in 2009 where a similar situation occurred.

[2] Accuracy of Lateral Flow Antigen Tests for COVID-19 **BC/01 INQ000587616**

[3] Presymptomatic, asymptomatic and post-symptomatic transmission of SARS-CoV-2: joint British Infection Association (BIA), Healthcare Infection Society (HIS), Infection Prevention Society (IPS) and Royal College of Pathologists (RCPath) guidance **BC/02 INQ000587615**

38. Later in the pandemic, once reagent and equipment supply had been established and stabilised, many NHS clinical diagnostic laboratories (and also universities) could have had capacity to carry out more testing than they did, but testing was outsourced to private laboratories which were not all subject to the same high standards of quality assurance routine in NHS laboratories. Use of existing clinical labs (and of university labs and skilled staff) would have been much more financially efficient. There was a missed opportunity to invest this resource in equipment and infrastructure for existing NHS labs, with huge resources going to temporary, often lower-quality facilities in the private sector instead.

39. Lack of front-line clinical virologists and clinical microbiologists (specialists in pathology) in government advisory groups, decision making and operational bodies during the initial phase of the pandemic led to technical problems and delays in setting out practical plans for testing.

40. In addition, staffing resources were depleted in NHS facilities due to Lighthouse laboratories offering much higher wages resulting in an exodus of highly qualified, experienced and trained staff to private facilities. This left NHS laboratories with the challenge of implementing rapid testing with inexperienced staff, adversely impacting NHS facilities as well as potentially impacting patient care and flow within NHS organisations. There are still ongoing impacts from this.

Testing capacity

41. RCPath was not engaged by policy or decision makers in relation to decisions relating to testing capacity and in particular the UK government's engagement with the private sector and non-governmental bodies including universities, hospital laboratories and other research organisations.

42. Although reliable high-quality PCR diagnostic tests were rapidly established, there was not the diagnostic laboratory capacity to carry testing out at the scale required. A lack of suitable equipment and reagents meant testing could not be scaled up rapidly enough. Chronic underinvestment meant clinical labs did not have the equipment and facilities needed to ramp up.

43. At the outset, government efforts to increase testing capacity did not give due regard to the importance of effective testing pathways and appropriate prioritisation of testing. The focus was on performing huge numbers of tests against numerical targets, with constantly changing guidance regarding who should be tested, and little apparent thought of how to use the available capacity to best effect by prioritising tests which would make the most clinical difference. Consequently, the testing capacity which did exist during the ramp-up was used inefficiently. Lessons could have been learned from the H1 Ni (swine flu) pandemic in 2009 where a similar situation occurred. Later in the pandemic, once reagent and equipment supply had been established and stabilised, many NHS clinical diagnostic laboratories (and also universities) could have had capacity to carry out more testing than they did, but testing was outsourced to private laboratories which were not all subject to the same high standards of quality assurance routine in NHS laboratories. Use of existing clinical labs (and of university labs and skilled staff), would have been much more financially efficient. There was a missed opportunity to invest this resource in equipment and infrastructure for existing NHS labs, with huge resources going to temporary, often lower-quality facilities in the private sector instead.

44. In addition, staffing resources were depleted in NHS facilities due to Lighthouse laboratories offering much higher wages resulting in an exodus of highly qualified, experienced and trained staff to private facilities and leaving NHS facilities vulnerable with respect to provision of 24-hour on-site testing for SARS-CoV2 and other pathogens. There are still ongoing impacts from this.

45. Innovation in the testing system did occur, as evidenced by the introduction of testing technologies that were new to many diagnostic labs. This happened due to a need to have rapid results for patients as well as for patient flow and was facilitated by a rapid increase in the availability of diagnostic tests. However, some of those technologies were of inadequate quality, and the constant switching of instructions to diagnostic labs to switch testing from one technology to another was counter-productive in using otherwise precious resources to constantly

troubleshoot and validate new testing kits. The loss of experienced and trained staff to private testing facilities was a barrier to innovation in some NHS facilities.

46. The target of 100,000 covid tests a day did not appear to be related to clinical need and was not to the knowledge of RCPath undertaken following consultation with NHS or specialist organisations. It added to the workload of an already stretched and depleted workforce. If there had been expert engagement at the start of and during the pandemic it is likely that testing could have been increased at scale in a more appropriate way.

47. RCPath in partnership with the DHSC, the UK Bioindustry Association and British In Vitro Diagnostics Association set up a sourcing platform to seek new and novel solutions to help deliver this number of tests by the end of April 2020. This was a crowd sourcing initiative looking at new technologies and existing solutions. It was open to the NHS, scientists and industry. With regard to impact, in particular it informed the use of dry swabs rather than the viral transport medium that was in very short supply at the time. This was very helpful. RCPath supported it, and we were not aware of other approaches that might have been more helpful.

48. Hospital capacity, staffing levels and diagnostic reserves were major barriers to the UK Government's ability to effectively manage the COVID-19 pandemic and protect the public. These issues were mitigated to some extent by the goodwill and reserves of NHS staff and volunteers.

49. We needed to establish the reserves to provide a continued, resilient, high quality pathology testing service for routine fluids, biopsy samples, etc. in any future pandemics. Many laboratories had unnecessarily shut down or vastly reduced their routine services, leading to backlogs, breach of agreed turnaround times, and as a result, delayed treatments. Decisions were made by middle-management in hospitals or pathology departments, without clinical expertise. The lack of sufficient workforce has really been showcased by the struggle that pathology is facing at the moment. The government needs to focus on provisioning for a properly funded and staffed NHS which will help ensure that it is better equipped and prepared for such medical emergencies in the future. Prevention is better than cure.

50. The increased system capacity that was enabled by the creation of lighthouse/mega labs has been eroded as these are dismantled post-pandemic. Whilst there may be some organisational memory available for future pandemics, the labs themselves would need to be built from scratch, costing time and resources. Any organisational memory should be captured so it is not lost over time, and learning taken into account when formulating guidance on any future development. In particular, the training, and use, of individuals who came forward to support these labs. We know many of our trainees were asked to pause their clinical work and be redeployed to these labs for training, never to be called upon to provide valuable services.

51. Clinical virologist and microbiologist training programmes in the UK need improvement. The number of consultant Virologists and Microbiologists are on the decline; the most recent RCPath workforce survey showed 20.3% of all funded FTE consultant-level medical microbiology posts, and 14.6% of all funded FTE consultant-level medical virology posts are vacant. Many medical virologists are in the twilight of their career with no sustained and robust succession plan in place. In many NHS facilities, medical virology is managed by medical microbiologists with appropriate qualifications and expertise. Their remit continues to increase with no increase in workforce. An area of real concern for pandemic preparedness in the future and one which needs to be addressed immediately as it takes many years to complete specialty pathology training.

H. Tracing

52. RCPath was not engaged by policy or decision makers in key decision-making around tracing in England, Scotland, Wales and Northern Ireland between 1 January 2020 and 28 June 2022.

Digital

RCPath was not engaged by policy or decision makers in the development of any digital tracing technology, including with the NHSX app.

I. Isolation

53. RCPath was not engaged by policy or decision makers in relation to the development of the TTI approach to isolation in England, Scotland, Wales and Northern Ireland between 1 January 2020 and 28 June 2022.

J. Data and modelling

54. RCPath was not involved in the role of data and modelling in the development of an effective and scalable TTI system, so we're unable to comment.

55. RCpath was not involved in the role of modelling to inform the development of responses to the pandemic in relation to TTI, so we're unable to comment.

K. RCPath's response to the COVID-19 pandemic: research and publications

56. Given the lack of involvement or engagement from government departments, agencies and advisory bodies with RCPath or relevant expertise in the pathology community during the pandemic, particularly at the early stages, we considered it was necessary to draw resources together to support our members and safeguard patients. We have set out these resources below. We are not aware that these materials fed into any policy or decision making, we believe this is unlikely.

Document title	Focus of document
COVID-19 resources hub **BC/03 INQ000587614**	Providing information available on COVID-19 relevant to the practice of pathology https://www.rcpath.org/profession/coronavirus-resource-hub.html
RCPath Bulletin April 2020 **BC/04 INQ000587518**	Providing updates on the guidance and resources we had developed in relation to COVID-19
RCPath 'COVID-19 testing a national strategy' June 2020 **BC/05 INQ000587517**	A simple logical and coordinated framework to support COVID-19 testing

RCPath Bulletin July 2020 **BC/06 INQ000587513**	A Bulletin edition dedicated to COVID-19 – discussing key events and milestones, service provision, pathology training, seminars, remote working, remembering those lost,
RCPath Bulletin October 2020 **BC/07 INQ000587515**	Discussion on RCPath's public affairs work in relation to COVID-19, our international response to the pandemic, and point-of-care testing
RCPath Bulletin January 2021 **BC/08 INQ000587511**	Highlighting what we could have learned from the animals, a reflection on our COVID-19 focused International Pathology Day, a personal account from a pathology trainee redeployed to a mortuary, an article covering West Hertfordshire Hospitals Microbiology Laboratory Service's robust response to the COVID-19 pandemic
RCPath Bulletin April 2021 **BC/09 INQ000587519**	Improving understanding of the vital role vaccines have in preventing disease and improving public health.
RCPath Bulletin July 2021 **BC/10 INQ000587514**	Addressing COVID-19 vaccine misconceptions and sharing reflections on teaching undergraduate pathology during COVID-19
RCPath Bulletin October 2021 **BC/11 INQ000587516**	Discussing a return to normality post-pandemic, reflecting on the contributions pathology made, and considering testing strategies
RCPath Bulletin January 2022 **BC/12 INQ000587512**	General COVID-19 content/reference throughout
RCPath Bulletin April 2022 **BC/13 INQ000587510**	A review of the impact of COVID-19 on pathology training to support future provision

57. The key barriers to sharing this information was a lack of engagement from the UK Government with the pathology community and the experts within it.

L. Borders

58. RCPath was not engaged by policy or decision makers in the development of border policy and quarantine in relation to test, trace and isolate to contain the spread of COVID-19 between 1 January 2020 and 28 June 2022, and any barriers identified.

M. Public messaging

59. RCPath was not involved in public messaging relating to TTI, so we're unable to comment.

N. Inequalities

60. RCPath did not undertake a detailed assessment of inequalities.

61. We are not able to comment as to how the disproportionate impact of TTI measures on vulnerable groups and the issue of inequalities during COVID-19 might be mitigated in the event of a future pandemic.

62. In reality, the outcomes reported during the COVID-19 pandemic suggest the inequalities and vulnerabilities were incompletely assumed. Had they been foreseen accurately, specific groups may have been treated differently (like did occur for immune supressed populations, for instance). Similarly, investment in contingencies around diagnostics, track and trace, healthcare capacity in the community and hospitals may have followed.

63. Aside from the impacts during the pandemic, the very significant backlog issues currently facing NHS services are exacerbating health inequalities for all areas of the population with many people struggling to reach the appointments they need or facing unacceptable delays.

O. Existing evidence on the RCPath's work during the pandemic

64. The College's views and findings include that:

a. 'ordinary' health and care pathways, such as cancer screening programmes, needed to be opened up to patients as soon as possible
b. There were serious concerns over the lack of preparations made to deal with the backlog of patient need and the expected surge in demand.
c. 97% of histopathology departments (critical to deliver cancer pathways), didn't have enough staff to meet clinical demand. There were, and continue to be, shortfalls of career and training grade staff in pathology.
d. significant risks were posed by the poor digital infrastructure available to support the delivery of pathology services, and this presented limitations to the delivery of diagnostic services (this continues to be the case).
e. The UK was unwilling to listen to international experience – building in capacity for horizon scanning would help mitigate this in the future.
f. The expertise and experience of NHS Virologists, Microbiologists was not harnessed in any meaningful way. They should have been involved more and at a much earlier stage than occurred.
g. The National Laboratory Oversight Board in Scotland's agreement around a Distributed Service Model for laboratory diagnostics was a helpful in making effective use of available resources nationally (for Scotland) whilst ensuing local equitable availability and resilience.

65. Through these activities/documents, RCPath recommended:

a. Urgent digital pathology transformation
b. A national digital pathology system
c. Investment to research and innovate for safe and effective use of AI
d. Local services, coordinated nationally to provide a model of safe, sustainable and resilient NHS services with equitable access.
e. Investment in education and training are vital
f. Enabling clinical trials and research and quality improvement projects remain a central component of high-quality healthcare and should be promoted and supported as core activities.

g. The value of and need for a focused professional health programme has never been more clearly made

P. Lessons learned and legacy of COVID-19

a. i. The ability to introduce new accurate diagnostic tests at speed was a welcome innovation and demonstrates how well industry can work with the NHS when barriers are removed.

ii. NHS expertise was not sought during the pandemic with regards to testing and diagnostics. This should be one of the priorities both pre-pandemic and during any period of increased concern of communicable pathogens, not just pandemic. National pandemic plans should be made in consultation with infection organisations such as RCPath to ensure a safe, sensible and manageable plan is developed to prevent services becoming rapidly overwhelmed. Consideration should be given to developing testing capacity of existing laboratories and pandemic pathology networks to ensure parity of testing capabilities regardless of postcode. This would be more sustainable and responsive than building private testing facilities. Removal of barriers with regards to procurement of analysers and tests will help ensure that testing can be ramped up at speed and scale.

'Comms clearance' from PHE during the pandemic was a major inhibitor of sharing information and meant that organisations such as RCPath had to provide workarounds through swift delivery of guidance.

b. i. Scientific journals permitted free for all access to journal articles pertaining to SARS-Cov2. This was of great benefit to the scientific community. However, because of the need to publish at speed due to the rapidly evolving nature of the pandemic, peer review was often not undertaken, and the scientific arena was flooded with numerous articles, many of which would not have stood up to the rigour of the peer review process. It would be difficult to do this differently but for future pandemics an online sharing portal may be suitable. The British Infection Association (BIA) already has an online forum which was used a lot during the

pandemic for information sharing and demonstrates the willingness of the infection community to work together.

ii. Data sharing is a challenge but having data sharing capabilities within local health economies would greatly benefit patients as well as hospitals when patients move between them. Access to data regarding test results and antimicrobials administered would greatly benefit patient outcomes as well as patient flow within hospitals.

iii. Understandably, patient communication and health messages were a challenge during the pandemic due to the evolving nature of the organism. However, it is felt that the Cabinet Office gave mixed messages from the beginning of the pandemic, underestimating the size of the problem. This reduced public confidence and may have contributed to the lack of adherence to isolation and social distancing measures introduced. The impact of social media cannot be underestimated. Government should work with infection societies to ensure a coherent message is given to the public.

Statement of Truth

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

Signed: **Personal Data**

Dated: 08 May 2025