Witness Name: Joanne Beer
Statement No.:
Exhibits: 4
Dated: 14/04/2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF JOANNE BEER

Reference Request - M7/UHP-NHST/01

I, Joanne Beer, will say as follows: -

1. This statement pursuant to Rule 9 of the Inquiry Rules 2006, is provided in support of Module 7 of the UK Covid-19 Public Inquiry. The information provided reflects the University Hospitals Plymouth NHS Trust's (the Trust) response, focusing on Test, Trace and Isolation arrangements and learning.

2. From the outset, a command structure was established within the Trust, to oversee the pandemic response arrangements, with demand for testing capacity increased through Derriford Hospital's Microbiology laboratory.

3. The Trust Gold received regular up-dates and advice from the Trust Covid Clinical Advisory Group (CCAG), that considered national guidance including 'Test, Trace and Isolate' (TTI) implications for staff, patients and visitors. CCAG was chaired jointly by me as the Chief Operating Officer and an Infectious Disease Consultant, supported by:
    a. Director of Infection Prevention Control / Accountable Emergency Officer
    b. Infection Prevention and Control Team
    c. Emergency Medicine Consultant (Military)
    d. Respiratory Consultants

e. Immunology Consultant
f. Intensive Care Consultant
g. Occupational health
h. Vaccination lead
i. Emergency Planning lead

4. The CCAG met daily, moving to every 1-2 weeks, dependent on the situation at the time. These meetings both briefed and directed actions when needed, with a short agenda focused around:
   a) latest Covid modelling (Exhibit JB/01 **INQ000587364**
   b) operating context and current position
   c) surge escalation plans (Exhibit JB/02 **INQ000587361**
   d) any other issues that required mitigating or managing at that time.

5. Short minutes from these meetings were made for reference (Exhibit JB/03 **INQ000587362**

6. The 'Test, Trace and Isolate' system was integral to hospital procedures in respect of patient assessment, patient placement and staff absence. Patients were often notified by the NHS Tracing system that they were positive, when they were already inpatients, with action taken to isolate and contain any potential spread of the infection. Patients who tested positive to Covid-19 were transferred to single rooms under droplet transmission-based precautions for 14 days. The volume of cases rapidly exceeded single room occupancy and patients were cohorted in bays or wards dedicated to Covid-19. Patients with co-infections or other transmissible infections were prioiritised for placement in single rooms. The period of isolation changed from 14 days to 5, which was reflected in the Trust's guidelines.

7. Patients notified by TTI were assessed in relation to the date of test and the current national isolation guidelines. On discharge, Inpatients were advised on their individual period of isolation.

8. Collaborative working with other organisations was limited to assisting Care Homes to process swabs when they had difficulty in accessing swabs/tests and

providing infection control advice and guidance. As a result, the Trust was able to provide quicker result turn-around times to these organisations and enable rapid support in outbreaks.

9. The patient admission process was also revised to include asking patients if they had symptoms and/or known exposure to a confirmed case of Covid-19.

10. In support of TTI, the Trust established a Staff Hub for reporting absence and to provide support to staff affected by Covid-19. Arrangements put in place included establishing a 24/7 telephone line staff by senior nurses, for staff to report their sickness and receive advice on current isolation requirements. The Staff Hub also booked staff to attend for a PCR test and for those too unwell, the test kit was delivered to them at home via a courier. Staff were contacted once the test result was reported and advised of what action to take, relevant to their specific circumstances. Wellbeing calls were also made with staff off sick for longer that the infectious period and to the high risk immunocompromised, unable to attend the workplace. The Staff Hub also undertook risk assessments with staff, to determine whether they were fit to work and offered alternatives, where able. Processes were also revised, as and when national guidance was issued including the implementation of temporary changes to the NHS Agenda for Change staff terms and conditions. This included the relaxation of sick pay rules and triggers for absence recording.

11. The Lighthouse Laboratory (LHL) Plymouth commenced testing in March 2021 until the end of March 2022, when it was stood down to a pandemic preparedness facility.

Test, Trace and Isolate Infrastructure and Capacity

12. Prior to the onset of Covid-19 the Microbiology laboratory within Derriford Hospital undertook diagnostic tests including previous Covid strains. As Covid-19 impacted, capacity moved from 100-200 per day. By December 2021 as more technology was onboarded, capacity rose to 1,400 per day.

13. Testing equipment utilised prior to the Covid-19 pandemic included Abbot M2000, ABI Prism, Biomerieux EasyMag, Cepheid GeneXpert and Abbott Alinity M.

14. Initially samples were sent to Bristol Public Health England, then inhouse testing moved to online using Biomerieux EasyMag.

15. Later Abbott developed an assay on M2000. Cepheid also developed an assay on GeneXpert, then Abbott Alinity M was used to increase capacity to test.

16. Microbiology produced results that were sent electronically via Public Health England's Second Generation Surveillance System (PHE SGSS), where patient names and other demographics were recorded. Microbiology also produced results for inpatients and these were recorded on ICNET, the electronic platform for clinical surveillance, outbreak management and patient clinical record, used by the Trust's Infection Prevention and Control team.

17. As a result of Covid-19, Microbiology acquired new technology (Abbott Alinity M, Biomerieux E-Mag, Thermofisher ABI Prism), in support of increased resilience and capacity.

Lighthouse Laboratory Network

18. Representatives from the Department of Health & Social Care (DHSC) visited a number of locations in the South West of England in September 2020 to identify the most suitable site for a Covid testing lab for that region. The Estover site in Plymouth, operated by the Trust was the location of choice. No reason was given by the DHSC selecting Plymouth but at the time the Trust emphasised that the Trust had a facility available on a long lease, that the Trust planned to use longer term for pathology testing. The Trust explained to DHSC representatives that the opportunity to develop a Covid testing laboratory fitted with our vision to develop a centre of excellence in "high tech" clinical support services. The Trust had staff available and with support from neighbouring Trusts, had the necessary skills to deliver the facility within the challenging timescale.

19. The Trust further felt that the opportunity to deliver and manage the service would promote Plymouth as an exciting location to create a centre of excellence. This would serve to enhance and promote the Trust's reputation as a first-class employer and generate positive publicity and pride within the local population. The Trust also believed that delivering and managing the facility would help create a lasting post Covid legacy and attract highly qualified personnel to consider coming to work in Plymouth.

20. The LHL Plymouth was designed by Perkin Elmer, although the Trust chose to oversee the building of the facility and then to manage the laboratory internally. This decision was made by the Trust Executives and was affirmed following discussions with Dame Anna Dominiczac, the Government's UK Director of LHL's.

21. The Deputy Chief Executive was designated lead for the delivery of the LHL Plymouth with a Relationship Manager appointed by UKHSA, as a conduit between the Lab and UKHSA.

22. Building and infrastructure took place during the winter of 2020, by Kier construction and completed in February 2021. The Trust was proud to be a part of the National response to the global pandemic and supported the program by recruiting key personnel. Expertise was identified within the Trust and key staff were seconded to into appropriate roles. The Trust also agreed secondments from other NHS Trusts where necessary, including the original Laboratory Manager and Clinical Director.

23. An experienced Project Manager was recruited to oversee the construction of the facility.

24. The Trust also allocated key personnel from the Pathology laboratories, Procurement, Finance, HR, IT and Estates to provide support and expertise, and those personnel became part of the Project Board. In addition, the Trust authorized the establishment of specific teams to ensure the smooth running of the LHL as a standalone facility, but with input and guidance from the internal subject matter experts. This included establishing teams for:

a. Quality
b. Procurement
c. IT
d. Warehousing and logistics
e. Engineering / technical support
f. Security
g. Internal cleaning
h. Health and Safety

25. Where staff were seconded into key roles internally, the Trust approved the backfilling of their posts, as an opportunity to support career development of individuals.

26. The Trust formed links with a recruiting agency (Medacs) to identify staff nationally and internationally, with the necessary skills to enable the laboratory to function with over 350 staff being onboarded between January - March 2021. All recruitment was managed by Medacs. No international candidates who were based abroad were recruited, however, if candidates had the right to work in the UK and were living in the UK at the time, they were considered for employment.

27. The LHL Plymouth went live and commenced testing on the 09/03/2021. Initially the demand was for 20k tests per day, although the lab had been planned and was equipped to have a capability for processing 40k samples each day.

28. Following Executive level discussions between the Deputy CEO for the Trust and Dame Anna Dominiczac of UKHSA, the internal infrastructure was put in place and key personnel were appointed / seconded.

29. A senior Trust manager was seconded to work on site and to liaise directly with the Deputy Chief Executive, who was the Senior Officer responsible for delivery of the project.

30. The onsite manager facilitated fast tracking of recruitment and chaired a project team to include muti disciplinary staff including Executive Leads, IT, Procurement, Estates and Scientific personnel.

31. An internal Project Board was established with Executive representation in order to initially monitor progress with the construction and fit out, agree and approve resources, and once operational, to monitor performance against KPI's, consider and agree strategies and ensure effective ongoing links with UKHSA.

32. The LHL Plymouth then became part of the Network and as such attended bi-weekly technical forum with all the other LHL's as well as weekly LHL Site Directors meetings. These were chaired by Dame Anna Dominiczac, Director of Light House Laboratories (UK) who reported directly to the Cabinet Office. Dame Anna was supported by technical and operational leads who were available for individual labs within the network to access for specialist advice.

33. Key performance indicators detailing operational and quality targets were agreed, and these became the standards against which the LHL's performance was measured.

34. The Trust shared processes, innovations and initiatives within the Network through the weekly meetings.

35. The Network provided a valuable resource that not only updated the LHL's on trends and potential demands, but also as a means to share expertise and issues with other laboratories.

36. Although minutes were not produced for the meetings, UKHSA did provide action logs which were displayed visually during meetings. The actions were managed by a Relationship Manager who acted as a communication conduit between each laboratory and the Network management.

37. Each laboratory reported activity electronically at 6 hourly intervals. This was done automatically and included data detailing samples received, processing times, numbers of void samples etc.

38. Much of the information provided enabled laboratory performance to be measured, and from this, systems of "best practice" were identified and shared. For example, LHL Plymouth suggested that the practice of using time expired collection devices, which was in place in some laboratories was not best practice and therefore should be rejected. This was supported by another laboratory and the change was adopted across the whole network.

39. Specific information relating to service provision and attainment of KPI's were discussed and issued through the Relationship Manager for action / discussion utilising DHSC software. In Plymouth this was used to report back to Trust Executives on matters relating to laboratory performance. This was done at a fortnightly local LHL board meeting with executive representation in attendance.

40. The meetings further served to update laboratories of rates of positivity and trends across the UK and further afield. This enabled some forecasting of impacts including likely fluctuations in demand. Similarly, laboratories had the opportunity at network meetings to update on any challenges encountered. This allowed for samples to be re-directed to labs with spare capacity. One example was when a particular laboratory had some issues with contamination.

41. Table 1 details a timeline of events and key decisions in relation to LHL Plymouth:

Date	**Event**
Oct 2020	Estover site chosen by DHSC/UKHSA to deliver a Covid-19 testing service for the South West, managed by Perkin Elmer
Oct 2020	UHP proposed that the management of the testing facility would be the responsibility of the Trust.
Nov 2020	Key roles were employed directly by the NHS
Nov 2020	The Trust established an internal board to ensure resources and expertise were available to facilitate an effective facility
Nov/Dec 2020	Letter of intent signed by the Trust and DHSC Exhibit JB/04 **INQ000587363**

Nov/Dec 2020	The Trust defined its own workforce requirements, embedding quality and this enabled application for UKAS accreditation ISO:15189: 2012
Dec 2020	The Trust employed its own quality team, on-site engineers and IT staff
Dec 2020	Capacity for the LHL Plymouth was originally planned to be 40k samples each day. However, it was agreed that the service would commence with a demand of 20k per day to allow for ongoing recruitment of technical staff and allow for the completion of validation and verification of instruments.
Jan 2021	Decision to utilize artificial intelligence due to national skill shortages in the analysis of PCR. Plymouth was the last lab to open and the Trust forecast challenges in recruiting staff with appropriate qualifications and skills. FastFinder by Ugentec was used to read results, to determine whether a result was void, negative or positive. This reduced the requirement for manual reading of every result but still required qualified Biomedical Scientists to assess the quality controls of each run to validate the results. No result was authorized or released until the quality controls were validated and each result assessed as correctly reported.
Feb/Mar 2021	Service commenced using Perkin Elmer equipment, which was not the most efficient and not our equipment of choice. The Trust subsequently introduced more effective alternatives.
Mar 2021	Final section for the Validation of the Perkin Elmer assay and state of readiness submitted to UKHSA with approval granted.
June 2021	Capacity increased to 30k per day
Sept 2021	The Trust and LHL Network supported the LHL's ambition to change technology, to improve turnaround times and workflow.
Sept 2021	The Trust provided a commitment to UKHSA for continued support to provide resilience and pandemic preparedness support
Dec 2021	UKHSA requested LHL to increase capacity to 50k tests per day, to support national demand for Covid-19 tests. The Trust supported the recruitment of additional staff, shortly after which demand was

	reduced significantly due to the implementation of lateral flow testing in January 2022.
Feb 2022	Notified of closure of the Lighthouse Laboratory network due to stopping community PCR testing, with the RFL Laboratory to deliver the 'vulnerable and care home' testing
March 2022	LHL Plymouth closed
March 2022	Approached by UHKSA to provide a resilience service in the financial year 2022/23. The Trust took the decision to retain a residual workforce to meet the needs for any potential resilience contract.
May 2022	LHL Plymouth awarded a resilience contact
June 2022	Resilience contract commenced and ran until 31/03/2024
March 2023	LHL Plymouth awarded 1-year Pandemic Preparedness contract
March 2024	Initial 3-month contact awarded to LHL Plymouth
June 2024	LHL Plymouth was awarded an extension to the contract, becoming the sole Lighthouse Laboratory in the UK

Table 1

42. The equipment from Perkin Elmer (now Revvity) were liquid handlers - Janus G3 and the extraction platform the Chemagic360. The main restrictions with the Janus equipment is that it only has an 8-probe capacity. Transferring a plate of 94 samples and all the reagents required for nucleic acid extraction was approximately 1 hour. The setup of the reaction plate (four 96-well plates effectively merged into one 384-plate) was approximately 45 minutes. The barcode reader could not read reprinted labels and manual checks were required when scanning in primary samples. The pumps on the liquid handler required degassed water, as any air in the water affected the pumps and reduced efficiency and accuracy.

43. The Chemagic360 performs the nucleic extraction. The only issue with this item of equipment was the computer supplied had insufficient memory (RAM) when the mandatory Trust anti-viral software was added in the background, making these instruments very slow (up to 5 min) to start a run.

44. The changes implemented at the end of 2021 were adding alternative liquid handlers into the workflow acquired through asset repurposing, including 4 Mantis, 4 Apricots, and 2 Bravos. In extraction they were used to dispense the re-agents and the Janus remained just to dispense the primary samples into a plate format. The Mantis is capable of dispensing low volumes (<10uL) into the 96 well plate in approximately 2 minutes. The Apricots have a 96-well head and can dispense reagents into a 96-well plate in approximately 30 seconds. The Trust added two Mantis and four Apricots in extraction. The new turn around time for the sample transfer was then approximately 20minutes.

45. In PCR set-up, the Janus was removed totally for the PCR set up process. The Bravo is also a 96-well head liquid handler and can merge four 96-well plates into one 384-plate, ready for PCR amplification in approximately 5 minutes. The Trust added 2 Mantis to dispense the low volume of CPR master-mix, and 2 Bravos to add extracted sample to the amplification plate for the PCR set-up part of the process.

46. With regard to the resilience contract, initially the Rosalind Franklin (RF) laboratory was awarded a contract for post pandemic Covid 19 testing. In the event of a significant increase in testing demands, or in the event of service difficulties at RF, a Resilience contract was awarded to two laboratories. These were the Laboratories at Brants Bridge in Reading and the LHL Plymouth.

47. The resilience laboratories were required if needed, to provide a testing capacity of 10k samples per day ideally within 24 to 48 hours of being activated. From receipt of notice, the Trust was contractually required to guarantee daily capacity of 5,000 tests per day within 5 days and 10,000 tests per day within 14 days.

48. When operating as a resilience laboratory, the LHL Plymouth transitioned from Cold to Hot 4 times, with the last time in conjunction with LHL Brants Bridge taking over the testing programme in January 2023 until March 2023 when all testing ceased. Transition from cold to hot was achieved with less than 48 hours' notice on each of the following dates:

    a) 12/07/2022 - 22/07/2022
    b) 24/08/2022 - 25/08/2022

c) 03/09/2-22 – 15/11/2022

d) 17/01/2-23 – 28/03/2023

49. The Trust planned a post Covid Legacy to identify talent from agency staff who would be interested in developing a science-based career within the NHS, and who would help the Trust in addressing a shortfall of staff with the skills required in the future. On reflection, more notice of contact extensions would have been helpful, not least to avoid losing valued staff through uncertainty of continued employment, which in turn could have jeopardized the Trust's aspirations to service additional contracts.

50. The Trust has continued to provide support by agreeing placement of key staff within the organisation who can be called upon to return to the LHL, to provide resilience or pandemic preparedness support, when needed.

Interaction with UK Government

51. The Trust's interaction with UK Government was through participation in the LHL Network meetings, through Dame Anna Dominiczac's role as Director of Lighthouse Laboratories (UK) working with the UK Government. Our methodology and processes were transparent and were seen as being exemplary, innovative and economically viable, with the outcome being that the Trust worked closely with UKHSA in developing ongoing resilience and pandemic preparedness methodology and processes.

52. Across the 5 Pillars of National Testing Strategy, the Trust supported Pillar 2 – Mass Testing of the Community.

53. To help inform UK Government strategies, the Trust provided live up-dates on:

a. turn-around times

b. quality

c. void samples

d. samples processed

e. positivity rate

54. Oversight and scrutiny in developing the Network was provided through various channels. A Validation document to assess the lab's state of readiness before going live was issued by the DHSC, scrutinized and signed off by Dame Anna Dominiczac, Director of Light House Laboratories (UK). This included key performance standards, quality management, technical assay and site metrics, all of which had to be approved by UKHSA before the site could go live.

55. Performance was routinely scrutinized and monitored by DHSC/UKHSA via Relationship Managers who monitored turn-around times, voided samples, service failures and capacity targets daily through bespoke software systems. This enabled speedy identification of any matters of concern which in turn, facilitated rapid corrective actions. The software system at the LHL Plymouth was Spotfire from Perkin Elmer, which was a display of metrics for the lab only (turn around times, positive, negative and void numbers and rates). The software used by UKHSA/DHSC was Splunk which again had performance metrics for each site. Each used the hourly result / report files sent directly from LHL Plymouth to DHSC/UKHSA to inform the data.

56. There was a contractual obligation to satisfy key performance indicators based on 80% capacity. Results and outcomes were uploaded hourly and entered on UKHSA business intelligence monitoring systems and dashboard for scrutiny by UKHSA.

57. Information relating to performance was given to individual laboratories by the Relationship Manager through daily calls, and, if necessary, through individual lab calls and meetings with members of the Lighthouse Laboratories technical and commercial teams.

58. Weekly performance of the whole network was discussed and shared by Dame Anna Dominiczac and her team with all Lighthouse Laboratories, through a weekly Network meeting with Lab Managers and Directors. This followed detailed scrutiny of labs' performance. The bi- weekly meetings also allowed for trends and forecasting to be shared to plan and meet predicted trends and likely short- and medium-term demands

59. The LHL Plymouth Performance was shared with the internal Project Board, whose membership included the Deputy Chief Executive (who was the Executive Director lead responsible for the LHL), and our Relationship Manager, together with senior LHL managers and Trust Finance representatives.

Testing Regime

60. Microbiology was not directly involved in the development of national policies and strategies around testing at the time. However, Microbiology increased testing capacity by acquiring new analysers in support of demand.

61. For the testing of new variants, specimens were sent to other laboratories, outside of the Trust.

Partnership and Co-operation

62. The Infection Prevention and Control Team supported local Care Homes by PCR testing in the early outbreaks and worked with SWPHE and, Plymouth City Council, Devon County Council and Cornwall County Council.

63. At the outset, Microbiology sent samples for testing to PHE, until Microbiology developed in-house testing.

Expertise, Advice and Previous Learning

64. Microbiology did not advise or provide expertise in the development of the Network or testing regime, as its role was to produce and report diagnostic results. In addition to informing the clinician involved in the care of the patient, results were sent via PHE SCSS electronically, to help inform their response requirements.

65. From the outset, consideration was given to implementing and revising existing plans for a flu pandemic and arrangements to isolate and support VHF patients. This was led by the Covid Clinical Advisory Group, with expertise input from military consultants with experience in managing infections overseas.

66. Following Exercise Cygnus in 2016, the Pandemic Influenza plan was revised

incorporating revised planning assumptions and reflected changes in organisational infrastructure at the time.

Robustness and Efficacy

67. Both the Microbiology Lab and Plymouth Lighthouse Laboratory are UKAS accredited to ISO15189, with quality control tests also UKAS accredited.

68. As the Microbiology Laboratory was already established and supporting the work of hospitals and local community, this facility was utilised to increase testing demand through extended hours of operation and additional equipment.

69. With regard to quality and accuracy of PCR testing, Microbiology matched the sensitivity and specificity of the Manufacturers' claims. Microbiology also interfaced the tests to reduce/eliminate misreporting.

70. To help manage demand and patient flow, Microbiology had processes in place to managed urgent (< 1 hour), with routine testing and screening (within 24 hours). Microbiology was able, where required, send to other local Microbiology labs, to help manage peaks in demand for testing.

71. The vast majority of testing was undertaken where Covid-19 was clinically indicated. However, occasionally, Microbiology did undertake PCR testing for vulnerable people, when requested.

72. All staff that undertook PCR testing were competent with training records maintained.

73. Natural retirements and staff turnover did occur in Microbiology but these were not due to Covid-19 demands.

74. The Trust's Business Intelligence Team were actively involved in the Covid Clinical Advisory Group, providing data and modelling, to help inform decision making.

Vulnerability and Inequalities Considerations

75. The Trust participated the City-wide Tactical Co-ordination Group, chaired by the Director of Public Health for Plymouth City Council, where vulnerable groups were actively considered and action taken to help reduce the impact of Covid-19 eg homeless, hard to reach groups and residents in care homes.

76. Decisions were made in the context of best evidence available at the time.

77. Pre-national guidance, the Trust implemented swabbing of patients, pre-discharge from hospital, to protect vulnerable groups in care homes/community placements.

78. Vulnerable staff were supported to work from home and additional risk assessments were introduced, as evidence of risks increased around vulnerable groups.

79. The Trust also supported high risk staff, enabling them to work from home or attend work in a different environment. Where possible, this improved as the pandemic progressed and options such as Teams became common place.

80. Consideration of vulnerable people and staff are also included in local Infection Prevention and Control guidelines/standard operating procedures for both inpatient and outpatient settings.

Public Compliance

81. No significant issues were reported through the command structure in place at the time, in relation to compliance with TTI processes and the impact of public behavior or public health messaging.

Lessons for the Future

82. The Trust was able to recruit staff during the pandemic when over 300 staff were on boarded within a period of circa 3 months. It was also of note that there was an abundance of skills that were available within the existing staff base. This, coupled with the Trust's willingness to permit staff to undertake secondments into key roles this was of value in providing guidance and instilling Trust and NHS values. Particularly as many staff were joining the Trust (mainly on short term agency

contracts) for the first time.

83. A good relationship was built with an employment agency who, after detailed discussion with the Trust relating to required skills, experience, attitude etc trawled for appropriate candidates. Much of the bureaucracy associated with recruitment was removed or done by others, and while the Trust undertook final interviews, the staff shortlisted already satisfied many of the qualities and desirable attributes that the Trust was seeking.

84. The Trust also developed new relationships within the University of Plymouth and other academic institutions, to help recruit suitably knowledgeable and qualified staff. As well as setting up a Covid testing lab in a challenging timescale, the Trust recognised that the pandemic gave us an opportunity to attract scientific staff to the NHS, identifying that there was a skills shortage that would need to be filled for ongoing service provision.

85. With this in mind, staff were informed that this was an opportunity for those who displayed the correct attributes, to shine and have an opportunity to be considered for permanent employment with the Trust post pandemic.

86. The need to backfill seconded staff also gave valuable opportunities for other staff to "act up" into more senior positions and thus aid future career development.

87. Collaboration with other Trusts enabled some key positions to be filled by experienced personnel, which highlighted the advantages of inter-Trust working and sharing of ideas and expertise.

88. Nevertheless, there were some issues where the Trust encountered skills shortages. This was primarily associated with Analysts who had to be specifically qualified, and being the last of the LHL's to open, there was only a small pool of available persons that could be recruited.

89. To support this position, the Trust agreed to the use of artificial intelligence to help filter test results, where there was a clear negative (ie no covid) outcome. This reduced the burden on Analysts with just those results that were positive, or "borderline" being referred to an Analyst for detailed scrutiny.

90. The need to acquire goods and equipment quickly saw a faster procurement process, and decisions relating to "different ways of doing things" were made transparently through weekly internal project board meetings which included Executive Director oversight.

91. Close links and regular communication with the LHL Network enabled some (including high cost) equipment and stock to be transferred between labs, a process that has potential to be expanded across the NHS.

92. Recruitment and procurement were 2 areas where time and associated costs could be better utilised by adopting alternative approaches. Similarly sharing of resources across the NHS, perhaps regionally initially may have benefits and be a more effective use of limited resources.

93. When unable to recruit a clinical lead from our Consultant Microbiologists due to pressures within Microbiology Laboratory, the Trust contracted this post to a person from the Public Health Laboratory at Bristol – who provided valuable support and insight.

94. With regard to the Government's decision to use private suppliers, it was felt that there was a good mix of NHS and private suppliers. There were undoubtedly, many excellent staff in both sectors who had the expertise necessary to work collectively in response to the global pandemic, and it is questionable whether the NHS had the resources and infrastructure to act solely without additional providers involvement.

95. The Trust is proud of the role that LHL Plymouth played in the pandemic and feel that our work has been acknowledged by UKHSA, given that the Trust is the sole remaining LHL offering pandemic preparedness support until 31/03/2025.

96. The length of time it took to confirm extensions to service contracts, impacted on staff employed on fixed term contracts and delays in making awards resulted in us losing competent staff, who left to secure ongoing employment elsewhere.

97. Key to our contract extension was the Trust's ability to:

a) ramp up from a "cold" or inactive status to being active.
b) increase our capacity in steps.
c) call staff to key posts and plans to recruit further staff to maximum capacity within challenging timescales.

98. The Trust employed its own technical staff to support the instruments and equipment and enable repairs etc to be conducted speedily, to avoid the need for visiting support personnel to schedule a visit to our geographically distant location.

99. When the LHL Plymouth was quiet, the Trust moved staff into the Derriford Pathology laboratories, which allows for:

a) Retention of a small number of key staff
b) Increased staffing levels provided to the Derriford Laboratories
c) Enable a fast recall of key staff to activate the LHL if / when called upon
d) Maintenance of Quality Systems
e) Ongoing running and testing of instruments
f) Assist with training of fresh staff if the lab is called upon to go live

100. The Trust has also identified how automation of our processes would enable faster testing, with a need to recruit fewer personnel. This would enable rapid maximum capacity to be met more quickly.

101. There are plans to establish a new Pathology Laboratory on the Estover site, moving existing services away from the hospital to release precious floorspace for other services. Incorporating the LHL into the new Pathology Laboratory will create a legacy capacity from the pandemic.

102. Given the Trust's experience and continuing contract provision, LHL Plymouth is well placed to support the UK in any future pandemic. This is mainly due to the ability to rapidly switch services back on services and speedily ramp up to maximum capacity.

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: 17th April 2025