All-Party Group on Coronavirus - Oral Evidence Session 9

Transcript by Communique Communications Ltd.

6 October 2020

Layla Moran MP

Well thank you all for being with us at again a very opportune time given recent events in the news and the purpose of today's session of the All-Party Group on Coronavirus is to explore some of the issues around test, trace, isolate or indeed find, test, trace, isolate and support as we prefer to try and call it in the APPG. And we have two panels this morning, the first panel is with us already and we'll go until quarter past 12 and then the next one will also be 45 minutes starting at 12:15, but in this first panel we really wanted to focus in a bit on the impact on frontline staff, you know what is happening right now on the ground and also to reprise some of the conversations that we'd had previously, so it's a real delight and a massive thank you to Mark Adams, CEO of Community Integrated Care, Judy Downey, Chair of the Relatives and Residents Association and Professor Andrew Goddard, President of the Royal College of Physicians, thank you all for coming to us again and giving us evidence, giving us a bit of an update of where things are now and I'll crack on, so to begin with and I'll come to Mark first and then Judy and then Andrew; how well is it going now compared to how the system was operating perhaps as a comparison in July and August, how is it comparing to how it was before? Mark.

Mark Adams

OK well good morning and it's very nice to be with you again. I think that if I look back to sort of August and September we were sort of relieved that finally we had testing being done proactively, we weren't having to wait for people to be symptomatic, we did have this intention of weekly testing for care staff on the frontline and obviously monthly testing for residents. Now I was checking the figures and in August we were having about 40% of the tests for our teams hitting the two day target, by September that had dropped to about 10% hitting the two day target with the worst cases being ten days that we were waiting for test results to come back. As of this week we're looking at around about 30-40% of tests hitting the two day target, the average is three and a half days and the worst case is six days. But you can imagine that, you know, well over six months into this the staff are very weary, they are very anxious that there's an increasing amount of pressure to allow home visits to be starting again with families, we know there's high incidences of community carrying infection where something like half of our services are in local lockdown. So, we're in a situation where people are really at the moment just hoping that the system can get on top of this because frankly waiting for longer than two days is too much.

Layla Moran MP

Thank you so much Mark, Judy Downey.

Judy Downey

Hi, I kind of echo a bit of what Mark said, sorry I ought to say thank you for inviting us and delighted to be giving evidence again. Certainly in the summer things seemed to be improving, they weren't brilliant but they seemed to be improving for care homes, now we seem to have gone backwards, the

explanation seems to be the impact of schools, universities and those pressures and also the fact that various members of the care home staff who were not as it were delivering personal care but had supervisory jobs, for example you know if you were running say you know 20 homes you have people who visit the homes and make sure that practice is as it should be, that staff are coping, that relatives … the normal supervisory managerial roles and those people have now been refused tests on the grounds that they don't have a hands-on function and that if they exhibit symptoms of course they may have a test, because if they exhibit symptoms they have to isolate for two weeks, so it seems a very topsy-turvy sense of priorities in that sense. And the delay that Mark referred to seems to have been pretty ghastly in some places, there are some places where they haven't had the test from last week back before the next one is due and even longer than a week. The idea that residents are tested it seems to be somewhat mythical in a lot of places and even where relatives are offering to have tests and pay for them that's a very hit and miss business and also some homes are not accepting tests not done by the people who do it for them, so it's a very mixed and pretty upsetting picture frankly.

Layla Moran MP

Thank you very much, very concerning, Professor Andrew Goddard.

Andrew Goddard

So, good morning everybody, I think our situation sort of is slightly different from that because I'm talking about sort of NHS physicians generally working in hospitals and secondary care. So, back in July 88% were able to get a test within 24 hours, that's fallen to 80% last week and back then 36% were then getting their results within 24 hours and that's fallen to 26%. However, there is a caveat to that because of course things have changed radically. The number of people being tested back in July was about four times fewer than it is now and the return of school has meant that lots of particularly doctors with young families have ended up having to self-isolate because they've got children or household members who have been sent home with symptoms and whilst, so the demand for testing in those household members is much, much greater than it was in July. So, I think we are comparing apples with pears slightly, but clearly there is significant delays.

Layla Moran MP

Thank you very much. Lord Russell.

Lord Russell

Yes, just sort of following on from what each of you have just said and if I could ask you to respond in the same order, can you just dig a bit deeper and tell us some practical instances of the knock-on effects of this very sort of sporadic performance in terms of a) getting the tests and b) how quickly they're coming back, what are the actual practical consequences of that, can you sort of bring it to life a bit? Mark.

Mark Adams

Thank you Lord Russell. I mean I think first and foremost it's the anxiety of the teams and the families because the only thing that gives you certainty is accurate and timely testing. We've had instances where we've had results back after ten days and they have confirmed that a member of the team has

had Covid and they know that for the last six or seven days they've been providing close contact care and then you're just playing the waiting game hoping that you haven't passed that infection on and that's just completely unrealistic pressure on people that are very tired at the end of this period. You obviously have families who are desperate to now start coming in and visiting and you know I think everyone will have seen the Amnesty report and commentary on this, the only way to do that is to start testing families as key workers as well as the staff and given that the staff ratio is normally about one member of staff to something like five residents you'd potentially be looking at a five or six times increase in testing and when the testing isn't working on the current demand, you know this is a kind of Herculean task that you're then reaching for. In addition to this we've now got the extra pressure of team members being told that their children are being sent home to self-isolate because the schools have got an issue and therefore you're losing staff, not necessarily due to the environment they're working in but the outside environment. And then if you're trying to move new staff in to cover for the staff that are ill and you can't get the testing back again you're worried that you're transferring someone into a home and you're going back to the March/April/May scenario where we saw so many losses, so you know … and just to give a comparison I mean for my sins I used to run a lab group in the Middle East with 16 labs, that lab group now is handling most of the Covid criteria for large parts of the Middle East and they're working on a four hour turnaround, so literally you can get a test before you fly. So, for us to be in a situation where we're looking at ten days, I mean it really is dark ages in comparison.

Lord Russell

Judy, could I ask you the same question please?

Judy Downey

Yes, I think that Mark's put it very well, I think that you know words like 'severe anxiety' could also be replaced by 'anguish', 'depression', 'bereavement' and 'despair'. The effects of not having tests are not simply mechanistic, they are having real effects on real people at the end of their lives, people are actually losing hope, the effect of the drag as it were between testing and results not only does it mean that staff are anxious and that places are under-staffed but it also means that there's greater reliance on agency workers and on ad-hoc replacements and the people who are ringing our helpline in utter despair and who we used to think we could help, we now can offer very little because the guidance is so rigid and unhelpful, there's no scrutiny, particularly of those places where there are serious concerns about standards frankly, so it's not just people aren't being tested what a pity, it's the impact on day-to-day life, on relationships, on staffing and also as Mark said we don't live in a bubble here, we're hearing about 15-minute testing in Italy, in New York, in Germany, in France and I don't know if any of you saw the Mail, but they did quite an interesting exposé of how those tests were offered here and refused, or just not responded to and you know people have a certain tolerance but six months plus on people have died, people are now being allowed end of life visits and the person they're visiting through a glass pane or in a freezing garden no longer know who they are.

Lord Russell

Thank you, Andrew please.

Andrew Goddard

Hard to follow that, so we've come to talk about hospitals again, so it's very different from care homes so probably less than sort of one in ten healthcare workers are regularly being tested if they are asymptomatic, so we're only talking about people who had symptoms and/or who have household contacts who have symptoms and the impact of that is that probably we know at the moment about one in 15 doctors are off sick, of which about half are due to either having a household contact or having symptoms and are waiting tests for Covid. So, that sort of equates from the point of view of household members and are waiting tests are about one in 35 doctors. So, that's actually quite a big thing because if you've got a department of ten people you end up having one or sometimes two if you're unlucky people off, you then have to get people covering shifts and doing ward rounds that they weren't expecting to do and all of us have jobs that are generally pretty busy and then to cover other work it becomes difficult. Now we've managed that so far and I think most people have stood up to that, it means that we're a bit more rushed about doing stuff. What I'm worried about is what's going to happen as things accelerate and the last time I was talking to this committee I was asked the question did I expect a second wave and I said yes, and I think Mark said yes, I think we were in the minority at that point, sadly we were right and we're now in the case where we're having to think about how do we deal when the numbers really crank up and the likelihood is that those sickness rates and waiting for testing is becoming more and more of a problem and that's going to add pressure to the workforce and that's as true in hospital setting as it is in the care sector.

Lord Russell

Thank you very much.

Layla Moran MP

Barbara Keeley.

Barbara Keeley MP

Thanks Chair, well I'll split the questions across the panel in a particular way because it is a slightly different perspective that you're representing with us. So, I'll start with you Andrew if I may and if we can just amplify what you've just said really on the impact of the slow return of results, or the lack of testing. What impact is that having now in terms of, I mean what's the knock-on if you like in terms of treatment and where could that go once we've got the, not just the second wave but winter, winter flu, you know impacting on that too. Where do you predict this is going?

Andrew Goddard

OK, so what we're seeing at the moment is we're seeing sporadic cancellation of elective activity, so we'll always prioritise the emergency work, so if there is you know I'm due to be in clinic today but one of my colleagues is away I will go and cover their on call because that is, you know that's clearly the urgent stuff, but that then means that people won't be coming to clinic or people are cancelling lists for procedures and things, so clearly that will have a knock-on effect on the patients who are expecting to see somebody or have a procedure. So, that will happen more and more as sickness rates go up. At the peak in April we were seeing you know large numbers of people off sick at any one time, so one in five doctors were off sick in the middle of the first peak. Now we clearly hope we never get anywhere near that again, but even if we get near-ish that that has a big impact on the ability to deliver

care. Now because we had cancelled everything in the first wave and we'd cancelled elective activity and everybody was [inaudible 0:20:41.8], there was more cross cover. Our aim now is very different, we need and we must continue to keep the normal NHS services going for as long as possible and so therefore the impact of sickness is probably going to be greater because there's going to be less flexibility from the workforce in order to cover each other and also this time around we haven't got this … so last time we had three and a half thousands medical students acting up as FIY1s, they were fantastic, brilliant, lovely resource, great to have them. We don't have them this year because the medical students are too early in their training and plus they sort of didn't have much clinical training over the first wave. So, I think the workforce is going to be really stretched as we go through winter and winter again, we're in a different time, in April we were in spring and the diseases and things that would normally come our way in spring are far less than what happens in winter, so that's why everybody is worried about winter. So, we've got the potential triple whammy that we all go on about, about the normal winter pressures, plus flu, plus Covid.

Barbara Keeley MP

OK thank you, and for Mark and Judy, Judy you've touched on this in terms of visits but what would be needed in terms of testing for visits to care homes, both you know resuming those because in some parts of the country they're not happening and/or carrying them on. You've talked about speed of tests but do you have a feel for either of you what regime of testing would we need in place for care home visits to either continue where they are going ahead, or to resume in all the parts of the country where they're not going ahead.

Judy Downey

Well, I think one of the problems is that most visitors who are visiting care homes are either spouses or children or people very close to the residents. They're not likely on the whole to be mixing widely in the community, we're talking about people in care homes now in their 80s, 90s and 100s largely, often 80% with dementia, many with hearing and sight problems for whom visits, you know using technology or panels of glass or you know sort of places in gardens are really not suitable and you know gardens at this time of year and going on are going to be really problematic, particularly for people who are bed-ridden. I think that what we really want to see is a system that treats relatives or close people as care givers in the same way as the Ontario Act which has just gone through their Parliament does, and ensure that the relatives can also help in a situation of shortage, there are people who help to bathe, help to feed, give reassurance and we'd really like to know more and perhaps your Committee will help to establish this, about the facts of relatives bringing infection into homes because all the research that's been done has shown that it's largely the care workers who are obviously [inaudible 0:23:51.3] children, families, partners who work in the public sector and elsewhere and it's a much more worrying cohort of people than relatives on the whole. We don't know if the guidance is based on hunch or good practice or research or what someone had for breakfast, because the idea that all visits in the guidance should be supervised is something else I'd like to get onto actually, but you know the fact that …

Barbara Keeley MP

Can we just do testing for now.

Judy Downey

Yes, but relatives who have offered to pay for tests in some cases have still not been allowed to go into homes and there have been some really serious implications of that which are about residents' health when they've got MRI appointments for cancers or serious medical conditions and they've been told that if they go for those conditions for an outside appointment they will be isolated in their rooms for two weeks and the relatives are saying no, we are not putting our relatives through that, we're taking the risk that they'll live with whatever it is. It's a serious business.

Barbara Keeley MP

OK thank you Judy, it is yeah. And Mark anything to add, you said about earlier a five to six times increase in testing would be needed for family visits, do you have anything to add to that? It's the quantity and the turnaround isn't it?

Mark Adams

It is and I mean first of all, you know I totally and utterly sympathise with what Judy is saying, I mean it is difficult for families but it's also emotionally difficult for staff to be dealing with that separation of loved ones and nobody would wish that on their worst enemy. The reality is that you know if we're gonna get an increase now of winter colds, winter flus, if the testing isn't coming back then you're gonna have to send everybody home who is symptomatic of a cold unless you're absolutely clear that there's something that they've got that isn't consistent with a Covid diagnosis, so you're going to have to err on the side of caution on the staffing side which is going to create shortages. It would be lovely to have the families coming in and supporting but there's a two risk factor, there is that increased foot flow of about six times more people coming into the building and whether or not it is more prevalent from staff or for families the reality is the risk increases, but then the risk also increases because as Judy said most of the visitors are probably in the 60, 70, 80, 90 year age category so there's also a risk to the people visiting if there's an outbreak in a care home or a potential outbreak where you've got asymptomatic staff members. The advice is confusing because we're being asked to say if the family member does visit they should be chaperoned and supported and we don't have the model where the staff capacity is there to allow for that. So, I think if we could crack the testing on … I mean there was a project in Southampton for 90 minute testing and I think Matt Hancock talked at one stage about it being available almost immediately and then he kind of corrected himself and said actually he didn't mean to say that, it would only be used in labs to start with. But if there was a 90 minute test I think some families would be very happy to drive to a care home, sit in the car park after having a test and once the test result is through to then visit their family and at least that element of risk would be taken out, but having had that announcement from the Secretary of State we haven't heard anything since.

Barbara Keeley MP

Thank you.

Layla Moran MP

Thank you very much. Before I go to Caroline Lucas just a quick friendly reminder we've got just over 20 minutes left so if everyone could keep questions and answers as short as possible, bearing in mind of course how important these questions and answers are, that would be wonderful. Caroline Lucas.

Caroline Lucas MP

Thanks Layla, I wanted to ask a question about the story that's been dominating the headlines for the last few days about these 16,000 positive tests that went missing, I mean there's understandably and rightly been a real outcry about that but I wanted to ask you more about what the impact of that will be in terms of frontline and in terms of care settings, just in practical terms. I don't know if Andrew Goddard you might start on that.

Andrew Goddard

We don't know, so we know that those 16,000 were all notified, so they would have gone into self-isolation and we know that's probably the main key sort of factor when it comes to tracking and tracing. The contacts, and I think the Secretary of State is updating the House as we speak about where they are at with that and understanding how many of those people are at risk of passing it on beyond. We don't know. And I think there really isn't any good data, you need mathematical models like Professor John Edmond and I'm not one of those to try and really have a reasonable idea of what the actual impact from the number of possible admissions say is from a set number of people not being contacted through a contact trace system. It's hard to believe there isn't going to be any impact, it's hard to believe there won't be any hospital admissions as a result but saying how many I think is very, very difficult.

Caroline Lucas MP

OK, thank you. Mark.

Mark Adams

Thank you, I mean like Andrew says you know without mathematical analysis it's very hard to speculate on the impact but I think for me for a test and trace system to work it's got to have public confidence. You've got many people who are very aware and very scared of the kind of Orwellian Big Brother personal tracing on your mobile phone and we need to reassure and to give everybody confidence that this is something that everyone has a moral obligation to support and when this State system can't get an Excel spreadsheet capacity right it doesn't give confidence to people and again it then feeds into you know half of our 490 services are in areas of local lockdown and if our people have been out in the community, you know we don't have that extra form of protection if they have been in contact with someone. So, you know we keep scoring these own goals and it isn't helpful.

Caroline Lucas MP

Thanks, and Judy did you want to add anything on that?

Judy Downey

Well, I don't really know, I'm not qualified to comment on the lost cases but what I would like to mention is the fact that you know when we don't have confidence in a system as Mark said, it really makes it [inaudible 0:30:41.9] some of its impact. But the system we've got really discriminates

against older people in the sense that you have to have a phone that's relatively new and if we really want to protect older people how many people have got a phone, I've got an iPhone 6E, I think I'm really trendy but actually most people I know of my age, I'm 82, don't. My husband who inherited my old phone can't … and who has had to be sheltered at some point, can't join the system so really I mean one despairs, sorry.

Caroline Lucas MP

Yeah, very good point, I think we're gonna come back to in a second but thank you very much.

Layla Moran MP

We'll come back to the app in a moment, but first Lord Mendelsohn.

Lord Mendelsohn

Thank you, I just want to ask everyone a general question, in August at the previous session there was some concern, a need to improve the data flow that came from the commercial labs through the system, just in review from where we were then to now, has this improved or is it all good or are there other issues that have been thrown up as well if that one has indeed been solved? Andrew.

Andrew Goddard

I think we can't answer that, I certainly can't answer that question but you have three people in your next session who should be able to.

Layla Moran MP

Thank you, Mark or Judy is there anything you'd like to add to that?

Mark Adams

No, I agree with Andrew, I think that's a technical question really that needs to go to the next group.

Layla Moran MP

OK, thank you very much and coming back to the app, Baroness Masham.

Baroness Masham

I was wondering with our excellent panellists if they know anything about how the new app is working, because are there enough staff to do the testing and the tracing and how is this seen by the people who have the apps, are they suspicious?

Layla Moran MP

Yeah, well I think Judy you started some of that, I don't know if you want to start and then we'll go round the houses, but what's your experience of the app?

Judy Downey

Well, I haven't any, I mean you know I don't know anyone who's using it, who is able to access it frankly and it seems a bit bizarre to start a system that depends on you being, you know up with the technology. That's all I can say really about that.

Layla Moran MP

Thank you, Mark.

Mark Adams

Thank you, I mean I probably actually agree with Judy that we have got 6,000 care worker team members and I reckon that probably a good 10-20% of them are still using a kind of equivalent of an old Nokia phone so when your own team can't actually download an app or be contacted there's a risk. I think at the moment you know in the care environment you've obviously got a situation where you know you don't fall under that kind of I've been in close proximity to Covid if you're caring for somebody with Covid, but then if you get on the bus going home and somebody on the bus has got Covid you could suddenly be told that you need to actually take precautions because you could have been exposed. So, you know the guidance to care workers is a little bit confused and at the moment I think everybody is just looking at the actual roll-out of the app as embryonic and far from proven.

Layla Moran MP

Thank you very much and Andrew, do you want to add anything there?

Andrew Goddard

So, my take on the app is that this is another weapon that we've got in the fight against coronavirus, clearly it is not there to replace our sort of contact tracing system that we have set up for outbreaks and you know I have the app on my phone, I turn it off when I go into the hospital because that's the right thing to do and then I turn it off, but if there's an outbreak in the hospital that will be investigated as per normal and if I've been in contact with somebody there then I will be contacted, so I am reassured that there are sort of ways to cover the whole of the system. But it does then cover me for when I'm on the bus as Mark said, or when I'm on the train or in contact with people I don't know about, it's to catch those people that you don't know that you're with and I think it's far from perfect, we all accept that, but it is yet another if you like weapon that we've got and adding them all together … and it comes back, people are focusing on testing and tracing and this session is focused on that but social distancing and all the non-pharmacological interventions are really what is going to help keep Covid under control this winter and if the app encourages people to think about that a bit more that in itself would be a good thing.

Baroness Masham

Layla, could I ask you how many politicians are using it?

Layla Moran MP

The app? Oh, I don't know, I'm not sure we can know through GDPR. We'll ask our colleagues in the tea room shall we? Lord Strasburger. Oh, you're on mute I'm afraid.

Lord Strasburger

Thank you for that. Yes, I am using the app myself having declined to use the previous version. Thank you Chair and thank you very much to the three panellists for giving us your time. Looking at the bigger picture on testing and tracing, how have we moved over the last couple of months, are we in a better position now or a worse position over the whole test and trace service? Perhaps I'll start with you Mark.

Mark Adams

Thank you Lord Strasburger. I mean I think it would be wrong to say that there hasn't been some improvement, I think that you know keeping the economy going and supporting our children's education has undoubtedly put pressure on laboratory capacity and you know that notwithstanding testing is better than it was, but it is a long way from where it needs to be. I would just remind though the Committee that when we talk about these things we're talking about the care home sector which is something like 450,000 beds. In the supported living sector where many people have exactly the same sort of vulnerability, many people at the same sort of age, there are 850,000 people that aren't yet eligible for testing, so you know what we are desperately waiting for is our Charity has two thirds are vulnerable people on the supported living side and we haven't heard yet that there's any moves to start extending the testing to them and that could be a major crisis if we have a big problem this winter.

Lord Strasburger

Thank you. Judy could we go to you please?

Judy Downey

I think that what Mark said about other client groups and other age groups is really important and they're also the older people in the community often living with complex health conditions who aren't eligible for testing and who are suffering enormously from the lack of medical services. We know that for example there's a great dearth in care homes now of visits by chiropodists, by physios, what worries me also about when we're talking about testing is that a majority of care homes have not had Covid, we're hearing very little from them about what works and why they have been successful. When I've talked to the managers of some of those care homes they are very frightened of putting their heads above the parapet because they're not necessarily obeying the guidance to the letter, which means that they are very frightened of insurance claims, we think that the DHSC ought to indemnify them, but also they're worried about you know being sanctioned or criticised or in other ways being affected by CQC if they are not abiding strictly by guidance. So, it's a sort of perverse

incentive. At the same time, we're hearing about hospitals now and local authorities paying extra to certain homes to make them take people from hospital back into care homes, paying much larger than normal sums per week, which seems a peculiarly perverse development when relatives can't come in and people from hospitals are being admitted, so it's a terribly confusing … I mean Alice in Wonderland sounds more like a textbook to us at the moment rather than a fantasy.

Lord Strasburger

That's an interesting point you've raised there, if there is a little bit of rule-bending which is actually improving outcomes it might be interesting to know what those are. Can you give us any examples?

Judy Downey

Well yes, I mean I can't obviously name the care home managers or those groups.

Lord Strasburger

No, no.

Judy Downey

But they have been meticulous in the way that they've trained their staff, kept in touch with relatives, protected visitors, but it has a cost, it has a cost and particularly some of the, you know not for profits that we're in touch with … and some private companies too, have invested hugely in the protection of their residents and relatives and not all care homes either can or do that. You know at a time of crisis when bed occupancy is dropping, when research shows that people are more frightened of going into a care home than getting cancer, the care home sector has had a very bad press and it's seen as a place of death and also a place of isolation increasingly which is why we started our End Isolation in Care campaign because you know care homes are there for people to end their lives in a good way, not in isolation.

Lord Strasburger

Thank you, Andrew would you care to give a view on how test and trace has improved or not over the last few months?

Andrew Goddard

I would agree with Mark, I think we are in a better place, clearly we've got an app now which we didn't have, the number of tests we're doing far exceeds where we were a couple of months, but the demand is much greater and that's the trouble, because we are now trying to test regularly asymptomatic people, it's great that that's all happening in the care homes, that's not really happening yet within hospitals and if we need to keep people coming to hospital and being reassured that they can come to hospital and be safe we do need to get testing for you know, keeping those Covid secure bits of the NHS working. So, I think at the moment we're always going to struggle, the demand is going to be

greater than the ability to deliver for testing and hopefully, you know, in three months' time or whatever we will have enough tests but there is the resource is stretched and there are still problems with getting hold of reagents. But the other thing to remember, and it was a great quote from somebody that I heard this morning saying we can't test our way out of this crisis, testing is a useful way for us to help control and mitigate the effect of Covid, but it is not the solution and therefore waiting to see what the vaccines bring us and what that means long term for the crisis is probably the most important thing.

Lord Strasburger

I hear what you say but is the converse true that without a very effective test and trace system it's going to be very difficult to extricate ourselves from this?

Andrew Goddard

Oh, don't get me wrong, yeah it is a really important part of the strategy and it will mitigate and reduce that big peak that we've seen previously and will keep it low but it will keep it long as well and yeah … and as Judy said earlier you know the public have to have confidence in it for it to work, you know you need people to use the app, you need people to be happy to be contacted and happy to self-isolate, so public confidence is everything.

Lord Strasburger

Thank you very much.

Layla Moran MP

Necessary but not sufficient. Baroness Finlay.

Baroness Finlay

Thank you very much and I apologise for coming into this a little late, my question is really for Mark Adams and that is in terms of how much do you think at a local level leadership in planning what is done has the care home sector and the domiciliary care sector around the table, because I've been hearing concern from quite a lot of the care home sector that they just don't feel that they are at that central table planning locally as to how to manage so that test and trace and so on are all things that are done to them, but they're not being consulted and don't feel they have a say in organisation and different areas are very, very different. They've got different populations and different geography as well.

Mark Adams

Thank you Baroness Finlay. I mean this is a very, very sensitive and complex area because certainly regionally public health has been decimated with cutbacks over the years so they weren't prepared

or geared up to handle a crisis like this. The way in which the system works is you know peculiar and complicated, I mean I sit as a NED on an acute trust board and watching both sides of the sector with kind of equal frustration and confusion because the system doesn't work in a fully joined up way. As one of the largest social care charities we haven't been requested locally to sit down in any part of the UK and give our contribution or experience. I sit on the Board of the National Care Forum, they are more involved nationally but again I think that the future of health and social care really does need to be delivered locally with much greater forms of joined up cooperation because we're just missing so many tricks, you know we could have done this an awful lot better, including I think just using University laboratories, private laboratories and setting the local authorities with the task of making sure they had the capacity to meet their needs and trying to run a model like that nationally is always going to be difficult.

Layla Moran MP

Thank you.

Baroness Finlay

Thank you.

Layla Moran MP

We're going to be picking up on in the next session I'm sure. So, we've done incredibly well and I've one final question left to ask you all and you've got a maximum of a minute so in just a minute, but if I was a coronavirus fairy godmother and could grant you just one wish, one thing for Government to do as soon as possible from your perspective what would it be? And I'll go to Andrew, then Judy, then Mark.

Andrew Goddard

For testing it would be to have testing within 24 hours for all health and social care and care workers.

Layla Moran MP

Thank you very much. Judy.

Judy Downey

Certainly, to include relatives as care givers and secondly to give CQC Inspectors the right to be tested so that not everyone has a relative and we need scrutiny.

Layla Moran MP

Thank you. Mark.

Mark Adams

If I could be really greedy and sort of squeeze two in.

Layla Moran MP

Of course, you can.

Mark Adams

I think that 90 minute testing if that could be proven and scaled that would solve an awful lot of issues with regards to families and loneliness and all the issues we've been talking about and then I would just flag up that the £546 million increase in the infection fund won't get us through this winter and is going to cause some severe problems fairly quickly so if the fairy godmother can look at that as well.

Layla Moran MP

How much money would you like the fairy godmother to give you?

Mark Adams

Well, I mean obviously at the start of the crisis we had a total of something like £3.8 billion passed through local authorities in various guises and that was for a shorter period to less people. I don't think it necessarily needs to be to that magnitude but I would be thinking that you'd be looking at at least two or three times the initial commitment.

Layla Moran MP

Which is significant. Well thank you all three of you, a very sobering 45 minutes I think for us all, but wonderful to have you back, really appreciate it. Thank you for your thoughts and your suggested recommendations, as ever we will take those on board, include it in our reports, write to various departments and continue to press on your behalf. Thank you for your continued engagement, we really, really appreciate your time. So, Mark Adams, Judy Downey and Andrew Goddard, thank you so much for being with us this morning and I see already that Allan Wilson and indeed Rachael Liebmann is on the call, so we can segue neatly to the next session and of course all three of you, you are very welcome to stay but I know you're incredibly busy people and we shan't be offended if you go off and do something else, so by all means stay.

So, thank you so much all of you for joining now the second half of this session, we are focusing as I said at the beginning on test, trace and isolate, a very apt time to do so given the news, but what we are going to now move to is the organisation of test and trace and hopefully be able to dig down a

little bit into this issue with some real experts in this. So, I welcome Dr Rachael Liebmann who is the Vice President of Communications and International at the Royal College of Pathologists and also is Group Medical Director of the Doctors Laboratory and Health Services Laboratories, so wonderful title there but clearly full of experience and I'm sure lots of knowledge that we will draw on. And also welcome to Allan Wilson who is the President of the Institute of Biomedical Sciences, so it sounds very much like you are very much in the thick of it. So, I'll start by asking a very general question, perhaps to Allan first and then to Rachel if I may, what are the key issues in regards to testing at the moment and has the situation from your eyes improved as the pandemic has progressed. Allan Wilson.

Allan Wilson

Thank you and thank you for inviting me to present evidence to this hearing. I think the main emotion at the moment felt within laboratories is probably frustration. I think I'll answer your second question first and I think generally speaking it has improved. The pillar one labs have worked very hard in the background to build capacity across all the NHS labs and private partnership labs and that capacity is slowly grown over the last six months, but as we've heard in the previous session on occasion that's been really stretched by an increase in demand. I think what the frustration comes down to, we think within the pillar one labs that we could make this work better and we have a variety of suggestions where we could make this work better and I think one of our main limitations is that we have this separation of the two testing streams between pillar one and pillar two that we view as unnatural, foreign to lab testing, diagnostic testing within the UK and also the secrecy which pillar two operates under makes it very difficult for us to find out what the issues are. So we are asked questions about capacity, about turnaround times and we can answer that for the pillar one laboratories but struggle to get information about pillar two, and pillar two labs are still the labs that are doing the majority of the testing for the test and trace strategies, so the issues that we … it's clear there are issues as already demonstrated round about turnaround time but we're not quite sure what that means and we're not quite sure what the capacity issues are.

The other thing I think that's still key, we're still holding capacity issues due to intermittent problems in the supply chain and that rises every now and again. We have certainly as I said worked very hard within pillar one labs to maximise our capacity and we've done that largely through innovation, through ingenuity by taking on different testing platforms, by spreading the load across different testing platforms to make us more resilient and at this stage I would like to pay tribute to the people in pillar one labs particularly who've done this work over the six, seven months since the pandemic started and I sit regularly on the Scottish Network meetings but I know meetings regularly take place within the English Pathology Networks and we work very collaboratively together, we share expertise, we share reagents, we share chemicals, we share capacity for testing to try and ensure that that testing is delivered where it's needed most and I think we are now facing significant challenges with that though because we had the capacity at the beginning of this pandemic, due to a decline in workload from GPs and from outpatient clinics that capacity has now been slowly eroded simply because we're now returning to business as usual, so the swabs and the bloods and the urines that come in from GP practices are now returning to their usual numbers so we're now having to do Covid testing which obviously did not exist pre-Covid, plus business as usual and also now being asked to take on some samples that were previously destined for Lighthouse Labs due to capacity issues within the Lighthouse Labs.

So, I think the overall feeling I think is one of frustration, we think this could be run better and I'm sure we'll get onto that later but at the moment we see real issues and a frustration that we can't, we're not being asked to help.

Layla Moran MP

Yeah, thank you very much for that precis and if we don't come back to the specific points that you want to raise in terms of how we can do this better please do crowbar those in because I think that's vitally important. But, Dr Rachael Liebmann do you want to give your overview right now, how are we doing? I'm afraid you're on mute.

Allan Wilson

You're on mute Rachel.

Dr. Rachael Liebmann

The classic problem. So, I don't want to repeat what Allan has said but I would echo what he has said so far and point out one area where we definitely have improved and just for your information. Allan mentioned supply chain issues and we now have central procurement for a great deal of the equipment and the reagents, that was a … it was a blunt instrument but a very necessary instrument during the first wave and that system is now working much better than it was. We've got a series of networks which are closely aligned to help distribute those pieces of equipment and that reagent supply to maintain our ability to keep up the testing in pillar one and also there is national procurement which keeps pillar two supplies as well. So, I thought it was important that you know that that's working well and also I think we need to pay tribute to two people who have been keeping that going with almost interminable calls and no rest and that is David Wills and Angela Douglas whose contribution to that national supply chain has been phenomenal, so I just wanted to pay tribute to them.

Layla Moran MP

Well thank you for that and I think we can all echo the tributes to everyone who has been managing this crisis and thank you Allan for raising those. Allan I just want to ask a quick follow-up, it's also based on the evidence that we've seen prior to the session beginning about the idea of competition between pillar one and pillar two labs, I was wondering if you could expand a little bit on where that competition is coming from and how you see us being able to solve that because it strikes me as being bizarre that we've got labs competing in this way in a system that's meant to be working altogether to keep us all safe, I was wondering if you could expand on that?

Allan Wilson

There's two potential issues here, I think one of them has largely been solved and certainly at the beginning of the pandemic we were all searching for when there was a real scramble around for trying

to source the equipment and consumables to do the testing and we were certainly in competition there, particularly for those reagents and chemicals that are core to any test that we do, for example some of the transport mediums and some of the swabs that we were all struggling to get and I think setting this high number of tests, I think forced labs to stockpile some of these chemicals and consumables that we need that were critical to the testing pathway and therefore we ended up with stock in some places sitting on shelves and other places in the country where there was desperate shortage of chemicals and some of the reagents. I think that's largely been solved now simply because the supply chains are slightly more secure and there's more in the market so those pockets of problems have been largely ironed out, although they still surface intermittently as supply … as we have intermittent interruptions to the supply chain.

I think the other issue that we're facing at the moment though is slightly more interesting is that where I think we're now in competition for staff and I think that's something that's now emerging and is going to become more of an issue. As the more of these Lighthouse Labs emerge and it's interesting to note that two have passed their forecast opening dates without any operational activity as far as we can see, I think now and certainly within the NHS and other pillar one labs we've all been asked to give plans for future delivery of Covid testing, so we're all recruiting, we're all looking for staff to deliver this testing over the next year to two years and also now the Lighthouse Labs and pillar two are doing the same, so we're now actually competing for a relatively small group of expert staff by medical scientists, clinical scientists and other expert staff and I think that's going to be a real issue and I do think this is a potential factor in the fact that these Lighthouse Labs have now not opened on their due date, it's simply because I think they're struggling to find staff because we're competing for that. We're all fishing in the same relatively small pool of expert individuals.

Layla Moran MP

Thank you very much, very interesting. Rachael do you want to add anything there?

Dr. Rachael Liebmann

No, except to say that I think that a much closer working relationship between pillar one and pillar two would benefit everyone. There is a great deal that pillar one could learn from pillar two and vice versa and there is to my mind no good reason why we don't have mutually beneficial relationships. So, the College would like to see a relationship between every new lab that's being set up and an existing diagnostic laboratory, public or private, but those existing diagnostic laboratories have already solved all the problems that the new labs are just encountering for the first time. We've been doing this for years and doing it well and with all of the IT and logistical support that you need, we know what the answers are, so I think that's really key to making sure that we have the kind of capacity that we need.

Allan Wilson

I can really echo that, I think it's a frustration right from the beginning of this pandemic that we view ourselves as the experts in this area and that's what we have, the scientists working in pillar one labs have been doing this for decades, running diagnostic labs, connecting the whole specimen pathway from when the sample was taken to the final report goes out, so we have decades of experience within

our memberships of connecting, of IT connecting systems because that's what we do, it's bread and butter to medical scientists and other working in the pillar one labs and largely we were bypassed at the beginning of this and it's interesting to look at how we set up the Nightingale Hospitals as an extension of the existing NHS, with using NHS staff whereas when we started, we looked at testing we set up a parallel but unconnected model testing stream from NHS laboratories and that expertise that exists in pillar one labs was largely bypassed and I think that's a real frustration and I think there's an element of that frustration word coming out again that we think we could have done this better and a different model would have existed if we'd been involved in this decision making process at the beginning and I fully agree with Rachael, I think pillar one should be controlling pillar two, we should be looking at that, we should be working together to produce one flexible testing pathway where we could move work around where there are pockets of problems and we can work together to solve those issues that we're currently seeing coming out.

Layla Moran MP

Thank you so much. Barbara Keeley.

Barbara Keeley MP

Thank you and we reminded ourselves this morning that pillar one for those who've joined us is swab testing in Public Health England labs for those with clinical need and health and care workers. I should say that I think that does include the new saliva testing because I'm an MP in Salford where we're starting to work on that. And pillar two obviously swab testing for the wider population processed in the Lighthouse Labs. Obviously there is a need to test widely and we're very interested in getting into this organisation question with you, so I guess my question is can the current system of pillar one and pillar two be used to achieve that goal of testing much more widely because the demand is driving up and up and up and I guess there's a secondary question really, will our current test and trace systems cope with the pressure of winter and if they're not I mean do you want to enlarge on what needs to change that you've already started on really in terms of talking about cooperation or the pillars working together in ways that they're not at the moment. So, can they just be … the system used as it is at the moment to test more widely and can it cope with winter, if not what needs to change?

Dr. Rachael Liebmann

Shall I start with that? So I think I would firstly gently challenge the assumption that we need more wider testing, I think that we need testing that is for a purpose, testing has to be of specific individuals, so they either need to be individuals who have symptoms or who are the contacts of those who have proven to have Covid-19, or they are people who are being tested in order for a function to be carried out and that might be healthcare workers, health and social care workers, key workers. But what it isn't is just any member of the public who wants a test being able to access a test. If you've got no reason to access a test and we have capacity issues then I would argue that we're not really using it properly. So that's the first thing to say as I just think an assumption that it needs to be everybody is not in my view correct, it needs to be in the right context and I'm not sure we've got that at the moment.

But certainly, we do need as much capacity as we can get for those focused activities. So, there's certain activities where we already provide testing and they should remain and for symptomatic patients who have been referred to a sampling centre by their GP to be turned away because all of that capacity has been used up by people who may not have any symptoms at all is completely inappropriate and it doesn't fit with healthcare, if we're here to provide for people's health that's not appropriate, someone with symptoms referred by their GP should take priority and that's something we're used to in the NHS, we do prioritisation all the time and I think we should be prioritising testing. I don't think we need to go back to the Draconian situation that we had during the first wave when testing was very much more limited where you could only get a test if you had severe symptoms and were being admitted to hospital with severe symptoms. Our capacity issues are not back there again, but we do need to have a strategy that tests for a purpose and currently we don't appear to have one of those.

So, we've already touched on the improved collaboration, I think quite clearly you need a combined management structure between a pillar two laboratory and a pillar one laboratory or a network of laboratories in order to make sure that several things happen. Firstly, you break down those competitive barriers which Allan has so eloquently talked about before, you also make sure that you've got best use of resources and that's intellectual resource as well as physical resources, reagents, consumables and equipment. Obviously your staff rotas then become easier to provide on a 24/7 basis if you know what you've got across a wider field of people, but one of the important things is [inaudible 1:05:00.5] secrecy and that secrecy and mistrust I know we're going to probably touch on that later but it's a major problem, it is a major problem and it really doesn't help for those of us who represent experts in the field, like Allan and myself, to have to say to the people in our organisations well I don't know, and one of the things that we've noticed is that we recognise the outcome of decisions and then we, as the College and the Institute of Biomedical Science, have to retrofit what we think the decisions were that led to those outcomes. That shouldn't be the case. So, in all of the Committees that are set up to run test and trace, testing systems and each of the pillars, in all of those Committees given that test is one half of test and trace you should be able to see pathologists and people who work in pathology laboratories represented almost 50% on each of those Committees, it's absolutely not the case. It's a real struggle to find anybody with testing experience and knowledge involved in the decision making, but that collaboration, and I mean really quite close collaboration, I don't mean the occasional trip down the road to see each other's laboratories, pleasant though that is that's not good enough. What we need is real working together and combined management and leadership structures to make sure that we make the very best use of what capacity we've got. So sorry that was a little long-winded but I think it was important.

Layla Moran MP

I let you continue because it was clearly very, very important. Allan Wilson.

Allan Wilson

I've not much to add to that, I think that was a very eloquent description of where we need to be as I've said I think it's summed up that I think pillar one needs to direct pillar two, I think we have that expertise and that's what should have happened from the outset of this and that's now what we should try and do and it's slightly frustrating to see the new Lighthouse Labs emerging still not listening to that professional advice about how these laboratories should run, meaning absolutely no disrespect

to those who run the pillar two labs, these people working in the pillar two labs and the Lighthouse Labs do not have decades of experience and breadth of experience that we have within the membership of the College and Institute to help with that, we have academics basically who run research labs, that is not the same as running a busy diagnostic lab and I think that's been more clearly highlighted in the IT issues that we've seen recently and over the last six months, we've got that experience of connecting systems because that's what we do.

Layla Moran MP

Thank you very much.

Barbara Keeley MP

Thank you both, can I just ask a quick question to Rachael because it was a very good answer on organisational changes needed. On testing more widely we did hear that to allow care home visits safely it would take five to six times increase in the amount of testing in care homes, would you include that in your schedule of who needs to be tested?

Dr. Rachael Liebmann

So, definitely in terms of key workers and key carers, yes they would certainly be included. There is, to my mind there was in the first wave too much of a focus on primary care and too little of a focus on secondary care and again in diagnostic pathology we provide services across both of those sectors, as well as to the general public in terms of screening programmes and we do that very well and at a very large scale, so we're used to doing that, but that's not quite the same as just anybody who wants a test getting access to a test.

Barbara Keeley MP

No, it isn't, thank you.

Layla Moran MP

Thank you so much. Lord Strasburger.

Lord Strasburger

Thank you Chair and thank you to both our panellists. I want to ask a question about something that has fallen out of public discussion recently which is the accuracy of these tests. Could you give us the up to date position on how accurate these tests are, if I get a positive or a negative test how likely is it to be correct? And are you also able to cover antibody tests while you answer the question? Rachael, would you like to go first?

Dr. Rachael Liebmann

OK, so I'm happy to go first. I wish Lord Strasburger, that I could say that there was a perfect pathology test anywhere, unfortunately that does not exist. What we have are pathology tests which are extremely accurate but there are always going to be exceptions to the rule because pathology works in a biological circumstance. The staff aren't robots, the equipment is not the same in every single laboratory, nor the structure, nor even some things that we test for can be affected by temperature changes and you know how much that changes during our annual cycle in the UK. So, all of these tests have got some false positives and some false negatives but the most accurate is the throat and nasal swab PCR test, that is the gold standard for deciding whether or not someone has Covid-19. Even that has limitations if you take the swab too early the patient may already have the infection but not have enough virus onboard that it shows up on the PCR test and the restrictions or the limitations of that test at the end of an infection are that sometimes it's so sensitive that it will pick up residual viral particles after the person is well and can get back to work. So, as we've learnt more about Covid-19 we've learnt how to deal with those issues and there is a sweet spot as to when it's appropriate to get a test and that was shown to be quite a problem when we had difficulties with people being able to book tests in that the sweet spot was passed before they were able to access that, and that's a problem. So, definitely when you are symptomatic or if you've been told you're a contact or there are other good reasons because of your work that you need to access a test it needs to be relatively quickly but within that sweet spot of when is the right time to test.

Lord Strasburger

Can you put any approximate percentages on that?

Dr. Rachael Liebmann

I wouldn't like to because each individual assay varies and the assays vary in each laboratory, so I mentioned earlier that there's been a move to centralised procurement, there's also been a move towards centralised if you like verification of tests and I would caution against an idea that there's only one group of experts in the country who can decide whether or not a test is useful, for the reasons I've mentioned, firstly there's not just one group of experts in the country, that's the first thing to say and the second thing is that …

Lord Strasburger

We seem to have lost you.

Layla Moran MP

You've left us on tenterhooks with the second thing, I hope …

Lord Strasburger

Shall I move over to Allan for the time being?

Layla Moran MP

Let's go back to … yes indeed, so Allan do you want to answer that question and then we'll come back to Rachael when her line improves hopefully.

Allan Wilson

Well I think, is that her back on now, is that …

Layla Moran MP

Are you back Rachael?

Allan Wilson

Are you back Rachael? We lost you there Rachael.

Dr. Rachael Liebmann

Sorry, I do apologise, I haven't done anything to affect it. So, the thing was around expertise in deciding which tests could work and which ones can't work and what the accuracy of the tests are, so I think it's a mistake to say that there's only one group of experts in the country who can decide that, that is not how pathology tests are ruled out. Each individual laboratory has to, as an accreditation requirement, assess and individual test for its own use and they will get a slightly different set of percentages Lord Strasburger, than the previous central testing laboratory. So it makes sense for the country to invest in things which have been proven centrally, I mean it does not make sense to invest millions of pounds in untried and unproven technology, but then as those technologies are rolled out the percentages of sensitivity and specificity are not static, they will slightly change depending on which laboratory they are used, because that's one of the things that expertise does, it tweaks, so if I were to give everyone on this panel a recipe and say now I want you to be an APPG Bake Off, you'd all come up with a different result and that's because despite the fact that the recipe is written down it turns out differently in different kitchens in different ovens and so you have to actually take that into account with laboratory practice as well.

Lord Strasburger

Yeah I think we've got that message, thank you. Allan.

Allan Wilson

Yes, I agree, I think the choice of test is vital, the PCR is undoubtedly the gold standard and that is what we're using across the country. I think the other thing worth mentioning is the performance of this test will also be depending on the prevalence of the disease and I think that's not clearly

understood in some areas as well, especially we had interesting issues when we had a very low prevalence, that seems like a distant memory now unfortunately but when we had a low prevalence of this disease the tests sometimes was producing effectively false positive results, were often because as Rachael has described it's not a perfect test but it's the best we have at the moment and within the constraints that we have it's the one we should be continuing to use. I would caution against some of the headline grabbing headlines that we see about new tests and what they're able to do and how quickly you're able to do them, they're very easy to write, very difficult to evidence and I think some of these have absolutely no place within the NHS or within the UK, others are certainly worth a further investigation and we will certainly do that and we will try and verify these and see where they fit, but I think it's very frustrating sometimes, we said when we're somehow seen to be resistant to tests that take half an hour and can be the answer to everyone's prayers, they're often not, if a story is too good to be true it's often because it's not true. And I think we have to be careful about looking at these and running with these stories and putting political pressure on laboratories to do that, that we have seen and we have to be cautious and listen carefully and observe carefully the evidence base for this and not run in the wrong direction as sometimes we are having pressure to do.

As for the antibodies tests, sorry … as to antibody tests I think we've been doing antibody tests for some time now, they are probably of very little routine use in the fight against this virus at the moment simply because we don't know what the answers tell us, people who have antibodies that may very well have antibodies to this virus but that does not infer immunity and I think that's the issue here and I think the challenge sometimes is that if people prove positive for the antibodies they somehow think they have donned a bulletproof vest and can go out and have challenging behaviours simply because they have immunity, whereas at the moment we do not know what that antibody test gives us and actually [inaudible 1:16:46.0] suggests that immunity only lasts a matter of months.

Lord Strasburger

OK, thank you very much.

Layla Moran MP

Philippa Whitford.

Philippa Whitford MP

Thanks, if I could start with a short follow-up with Rachael and then Allan. Obviously the original advice was to try and get tested as quickly as possible after developing symptoms, preferably within three days and an absolute within five days, but on Friday the Government has extended that just saying get tested within eight days and I can't find any real change in evidence and I've seen public health people criticising that, it is still the old advice in Scotland so Rachael are you aware, has that been changed because of a genuine reason or to manage demand and is it not just going to delay when people get a result and get contact traced?

Dr. Rachael Liebmann

So, I'm not aware like yourself of any change to the evidence on which the guidelines for testing timescales has been based. I suspect that this is a pragmatic decision based on demand and supply.

Philippa Whitford MP

And yourself Allan?

Allan Wilson

Yes, I would agree, I've not seen any evidence and it's interesting in Scotland where I work we've maintained that three days guidance and I suspect it is, as Rachael suggested, pragmatism round about turnaround times and supply and demand.

Philippa Whitford MP

I mean the problem is as people become infectious about two days before they become symptomatic if they're only tested on day eight and only get the result day ten or 11, their contacts being out and about for two weeks, I mean I can't see the sense in it. Thanks very much to you both.

Layla Moran MP

Excellent. Caroline Lucas.

Caroline Lucas MP

Thank you Chair. I wanted to ask a question really a little bit about the resilience of the laboratory capacity and in particular this question that you've touched on a couple of times between centralisation and decentralisation. I think during the course of having listened to you maybe my question about whether or not we needed more decentralised labs has been overtaken by what you've said but I just remember very early in the pandemic there was a lot of discussion about universities having capacity for testing but they were being bypassed because there was a real push to have centralised tests, so I guess my question is is there unused testing capacity that would be useful to bring back online and if that's not necessarily just in terms of increasing the total number of tests being done, would it actually strengthen the resilience of the whole system so it's less likely to topple over when things go wrong?

Allan Wilson

Yes, I think it probably … I think we would like to see testing moved more locally in general, I think the centralised testing model delivered through the pillar two and Lighthouse Labs I think has well demonstrated flaws and I think moving the testing into a more local environment would improve turnaround time, it would improve response rate as well and I think it would improve, it would

potentially reduce transmissions of this virus, so I think we should look to use testing as locally as we can within those areas and link it as Rachael has suggested to NHS laboratories or pillar one laboratories and I think that would help markedly.

Caroline Lucas MP

Without putting too much pressure on those pillar one labs though would we need more lab capacity locally to make that work?

Allan Wilson

Yes, I think we would and we are building that, at the moment somewhere within the pillar one labs we have a capacity somewhere around the region of about 60,000 tests per day, we see that rising quite steadily until close to 100,000 by the end of October and that would build the capacity to deliver most of that testing locally, but again if we split, if we had this control over, this collaboration between pillar one and pillar two we would be able to move work between the two sectors very readily so that if one was overwhelmed we can send to the other and vice versa and I think that's what we're looking for, both Rachael and I have highlighted is that we need this collaboration, open relationship, and effectively I think the first step of this is simply to have a round the table meeting between representatives on both pillar one and pillar two and look at our problems and see how we can help each other. We're not suggesting that pillar one has all the knowledge, what pillar two have done should not be overlooked, they have made a huge capacity in a very short space of time and they need to be congratulated for doing that and it's been an incredible effort and we can learn from that as well, they have industrialised the test to a scale that's probably foreign to most NHS and pillar one labs, so we're keen to learn how they did that as I'm sure we're keen to offer them our expertise to the pillar two labs. But keeping it local if we control it locally then we can flex between pillar one and pillar two.

Dr. Rachael Liebmann

So, if I can follow up on that, the first wave saw research activity come to a real screeching halt in the UK and elsewhere because of the pandemic, so researchers who would normally be working in academic laboratories in Universities were sent home, so of course there was capacity but as we all know with very interesting results, Universities are back in business so they're back in business both teaching and doing research, non-Covid related research, and so that level of capacity is no longer there.

Layla Moran MP

Thank you very much, there was a quick follow up question I'd like to ask now about do we have any evidence of quality control issues being a problem in pillar two labs, Allan I wondered if you wished to comment on that, is there any reason to suspect that the quality of testing in those labs is not as high as in pillar one or is it more organisational issues that you're referring to that need to be learned from?

Allan Wilson

My issue is secrecy, it's very difficult to find out what is happening in those labs to make actually an informed opinion on what quality issues there are so that has been my first point, second I think there were some quality issues at the beginning of this and that's maybe not surprising given what they were trying to do at such a pace, but more recently I think that the results coming out give some confidence that there is that what they are doing and the test kits that they are using that they are less, I think they've reduced those quality issues but as I say there's very little evidence to actually be sure about that. I think what we would push for is that what the laboratories lack is HCPC registered by medical scientific staff to run those laboratories and there seems to be precious few of them within those laboratories and we need to see them moving to accreditation as well, but then NHS labs are still moving to accreditation so they're not unique in that as well, but I would say there's no overwhelming evidence at the moment to say that there's a quality issue with what's coming out … there's been some well publicised problems round about one particular lab but again I think my perception of this is those issues are being addressed.

Layla Moran MP

Thank you very much. Lord Russell.

Lord Russell

Yes, Allan I'll start off directing this to you because you did touch on it earlier, the much publicised correct or the incorrect accounting for tests which has recently caused a degree of embarrassment for the Government. I think you alluded earlier to the fact that you felt this was in a sense an accident waiting to happen and if this had been set up properly in the first place it would never have happened, could you just expand on that and say what you think needs to be done to make sure it doesn't recur.

Allan Wilson

I think we need to lean on the experience of the labs who have experience of doing this, so building IT connectivity between systems. Certainly, it is pretty foreign to find within NHS labs at the moment using spreadsheets to transfer data, that's not something that we would do. If we had integrating systems we integrate them by direct interfaces between the testing platforms and the laboratory information system and that interface is designed over time and tested to make sure that the appropriate data items are going to not only into the information system but then being passed on to those that need to act on them. So, I think that's what we need to do, we need to use systems like that rather than using spreadsheets to transfer information. That's something that I wouldn't say it's foreign that you use spreadsheets but certainly not in this way, we don't use that to transfer information between IT systems in the NHS generally speaking and I think that I would have hoped if we'd been involved in this from the beginning and we'd looked for the pathology community expertise we would have not developed a system along those lines. Something that we maybe use at the very beginning of a system, very quickly we would move to a fully integrated what we call an interface where the results pass seamlessly from one system to the other and then they're available almost instantaneously to the commissions that requested them.

Lord Russell

Rachael, do you have any further comment?

Dr. Rachael Liebmann

No, I totally agree with Allan and I know that the College position is that we want electronic communication as much as possible and that does not involve Excel.

Lord Russell

And would it be fair to say if what you strongly suggested was the much tighter coordination between tier one and tier two, if that actually happened this would be an issue which would be sorted as part of that cooperation?

Dr. Rachael Liebmann

Yes.

Allan Wilson

We would hope so, yes.

Layla Moran MP

Thank you very much. Lord Mendelsohn. Who is on mute I'm afraid.

Lord Mendelsohn

My apologies, I just wanted to cover a couple of questions, one is a more general one and one is very specific to the recent times. One is just if you could give some observations on the correlation between the number of tests and the number of people tested and how that has changed over time and also what are the issues that we have about defining capacity versus the number of tests, versus the number of people because we have a capacity figure of 2.6 million and it doesn't seem to be clear how we arrived at that and what that relation is to the testing one, so just some observations about how those numbers stack up and how we should see them and interpret them.

And then something more specific about these positive tests, the 15,893 tests that were found to be positive and not in the Excel spreadsheet, what impact do you think that has on public confidence in the testing regime and what's the easiest and best way to be able to get that back and to be able to encourage people to have full confidence that the testing regime will satisfy their requirements and the country's requirements?

Allan Wilson

I can pick up the capacity issue, I think it's a very difficult one. You can measure capacity within laboratories in many different ways, it depends how you ask the question and you need to have the knowledge to then go on the follow up as to what you mean by that, capacity can be measured by if you buy a piece of a testing platform it will quote you a capacity of X thousand tests per day. That's obviously dependent on you having the staff to run it, having the consumables to put on that to do that and having the connectivity around it to generate those results. So I think we've been asking sometimes the wrong question or maybe just listening to the answer and we like the answer, that was fine without drilling down and actually asking the difficult questions about what you mean by that and is that real time capacity, is that something that's theoretical and dependent on other steps being in place before you can realise that capacity and I just am cautious that the capacity figures we've been quoting have been flawed, simply not because we've not been asking the right questions or we've liked the answer we've got and we've said yes, that sounds a nice big number so we'll run with that, without actually asking what that means and can we deliver that capacity on the day. Because the first time that capacity was tested we failed and we did not meet that, so there's an issue here round about definition of capacity and I think we have to be very tight especially we're now talking of bringing on new Lighthouse Labs and what that capacity brings, we need to be very clear exactly what that means and that they are fully operational, staffed, have the supply chain to deliver the numbers that we talk about.

Dr. Rachael Liebmann

So, I would agree with that, I would add as well it needs to be additional capacity because of additional [inaudible 1:29:42.2], if you take a centralised procurement and you just spread it more thinly you haven't increased your national capacity at all and I'm afraid I can't answer the question as to what exactly is our capacity compared to the number of tests and that's partly down to that secrecy element that Allan was talking about. The transparency isn't there for us to be able to make those judgements. I wish it were, and it should be, we should know what our national capacity is, especially since we have national procurement for some aspects of it. But capacity comes down to equipment, reagents and I'm sad to say that some of the equipment manufacturers sold the UK large volume pieces of equipment and then didn't follow up with enough reagents to be able to work those, and so our potential capacity was very constrained by that. It's also things like consumables, so at the moment some of the assays have got a problem with pipette tips, which are the little plastic bits that go on the end of the pipette to allow you to move samples from one test tube if you like to another. And if you don't get exactly the right ones of those your capacity is impacted and they are specific to the assay.

It's obviously greatly around people and how you use your people, those rotas, so are they voluntary staff who will go back to the day job, are they permanent staff, are they part-time, full-time, is it possible to move to a 24/7 rota with those people or will that simply stretch them too thinly, so again we need actually to understand all of that. And it's also around space, so a lot of these samples are coming in in postal sacks and if you can just imagine how many postal sacks we're talking about when we're talking about for example 7,000 that my laboratory does on a daily basis, just imagine how many postal sacks that is and the people needed to unpack them and to log those onto a computer system, it's a huge logistical issue but it impacts on capacity. So, we also have to see capacity in terms of what I mentioned earlier on which is managed demand, we simply do not have and never will have the capacity for everybody who wants a test to simply get a test, we need to manage that and we need to

manage with very clear messaging who should be attending for a test, how often and where and how do they book it.

Layla Moran MP

Thank you so much.

Lord Mandelsohn

Layla could I just very quickly …

Layla Moran MP

Very quickly.

Lord Mandelsohn

Very quickly, just it's a very quick answer so we can't have confidence in the capacity number, should we have confidence in the test number, the people number or only the number that we know of people who were not put on the system?

Allan Wilson

I think we can have reasonable confidence in the test number, certainly from pillar one and even I think largely from pillar two and test numbers generally speaking I think are now accurate in what we're doing with that utilisation, but certainly the capacity I think is still a little bit dubious.

Layla Moran MP

Right, thank you. Baroness Masham.

Baroness Masham

What do Rachael and Allan think of the new app on telephones, is there enough people to trace and is there enough capacity in the labs and how do you think it's going to work out?

Layla Moran MP

Allan first.

Allan Wilson

I think it's certainly a step forward the new app, certainly there's some frustrations round about it about the technology required and the fact that they don't work between Scotland and England which is slightly odd, but certainly I think it should detect outbreaks, it should allow us to control those outbreaks and more people that download the app then we certainly we would hope we would have that capacity locally to deal with those outbreaks, so yes I see the app as a positive step for providing this but it does need adoption, we do need that widespread adoption of that app to then hopefully we can then do the contact tracing and the isolating.

Layla Moran MP

Thank you. Rachael.

Dr. Rachael Liebmann

So, I would agree, I would say that the use of technology and in particular mobile phone apps makes a great deal of sense because it's something that quite a few of us never leave the house without now. And I know that there have been some really successful passporting systems using mobile phones that directly connect back to the laboratory that's done the testing and an example of that is in Premier League testing where there is a passport that says you're safe to come into this sporting arena because you've had a negative test within the last X number of hours and that is electronically linked immediately to a mobile phone app. So, there's some really good examples out there of how this can work. I have one slight reservation on a population wide basis, this is in addition to Allan's reservation around the devolved administrations having different apps and different jurisdictions. My reservation is I wonder does it increase that inequality of access because we already have an inequality of access in that those who can drive to a swabbing centre are more likely to be able to access a test and we know that 40% of care home workers do not have a car. And if you then say that only the technologically able and adept and those with smartphones have access to the app and therefore have access to this, I have concerns about that as a doctor about what that means for our communities because I don't feel that in inappropriately skewed access to testing helps us in any way with an infection that we know specifically seems to be targeting those who are in at risk groups and who are in at risk occupations.

Layla Moran MP

Thank you very much. We are in borrowed time but very interesting final question, Philippa Whitford.

Philippa Whitford MP

Yeah, thanks very much Layla, if I could start with you Allan, the Lighthouse Lab in Glasgow recognised quite early that postgraduate students would go back to Uni and put in things like automation and standardisation quite early on. Is that going forward in the other Lighthouse Labs and are they standardising the packaging, because what Rachael described about the sacks of post, I read that literally all the packages and swabs and tubes can be totally different which obviously wastes a lot of time.

Allan Wilson

I think it's largely standardised now and certainly I think, again I'll go back to the secrecy issue around the Lighthouse Labs, we don't know what platforms they're using. My understanding is that they are what we call tooling up with more automated platforms that are less staff dependent, but actually we don't know and we don't know what new platforms are going into the new Lighthouse Labs that have been signed in Loughborough and Newport, we have some rumours but that's all, we don't actually know what they going … but the packaging and everything I think has largely been addressed now and we can move work around between pillar one and pillar two simply because we are using largely the same swabs.

Philippa Whitford MP

When you talked about pillar one leading, would you like to have seen that samples would have come in through the NHS which would have meant we would have had one IT system, we would have had GP access to results and then back up could have been used from university or Lighthouse based on the patients NHS number, so totally confidential, do you think something like that would be achievable now?

Allan Wilson

Absolutely, it might be difficult and challenging to retro-fit that but that would certainly be how we would like to see things and that's how if we started doing that from the beginning we wouldn't have the majority of the IT systems that we're having now, yes.

Philippa Whitford MP

OK thanks Allan, Rachael.

Dr. Rachael Liebmann

So, just to say I know that it must seem really … it's counter-intuitive to imagine that we would want to have multiple different types of swabs and tubes but this is a pandemic, it's not just affecting the UK and so our sources of swabs and the tubes that they go in is extremely limited. We have had as laboratory professionals, we've had to be hugely innovative including in my own laboratory Dr Lisa Levert came up with an extraction free solution to be able to carry out Covid-19 testing without extraction of the agent which we could not get hold of during the first wave. That innovation has been crucial as has a diverse supply chain. If we only said we're going to buy one set of swabs and then the company had a hiccup then the entire country would not be able to test for Covid-19. So, actually for business continuity and resilience reasons we need that diversity and also because we've got a lot of innovation happening, so people are doing things in different ways but that's bolstering our capacity.

Philippa Whitford MP

And is it being shared, the new learning, the new techniques with all this commercial hiding is there a forum within which you can all share your good ideas?

Dr. Rachael Liebmann

Absolutely, there is an innovations website and people can upload their data, their findings without having to wait to go through the full peer review publishing process and also Covid-19 has increased the number of papers that are being pre-printed, which means they're being made available on an international scale before going through formal peer review. Now you can imagine that has pros and cons but most of us are able to judge wood from trees and you can download those methods, try them in your own laboratory and if they work you're away and you've improved capacity and resilience.

Layla Moran MP

Well, that positive note seems like a very good place to stop and thank you so much both of you for giving us your time today and for staying six minutes longer than we'd advertised but it was so interesting and I don't know about my colleagues but I certainly felt by the end of that I felt I was getting somewhere in my own understanding of this but also very heartened to know that you are there and leading from the front and I thank you so much both of you for giving us your time today, but also everything that you are doing. Please stay in touch, please let us know how it's going, let us know how we can press. We will be taking your recommendations which I think were coming across loud and clear to us during this session and pressing those upon Government and getting answers. But if there are others that you feel you weren't able to get across please do send those in and we'll include them. So, thank you Allan Wilson, thank you Rachael Liebmann, thank you all Parliamentarians, thank you for those who are watching at home and those in the gallery as it were, who have been watching the session live.

It's worth saying just as we end we had a huge amount of interest in this session, we received nearly 1,700 individual pieces of evidence from members of the public in the week prior as we advertised that this was coming forward, it's clearly of great public interest and so thank you all for your participation today, I hope we've given those people at home who submitted evidence some of the, a glimpse into some of the answers that they're seeking. So, thanks very much everybody and we will have another session again in two weeks' time on a subject that we have yet to decide, we'll have to see what life throws up. Thank you very much everybody.