Witness Name: Mr Martin Wilson
Statement No: 1
Dated: 12.06.2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF MR MARTIN WILSON

I, Mr Martin Wilson, Chief Operating Officer of Newcastle upon Tyne Hospitals NHS Foundation Trust ("The Trust") Trust Headquarters, Freeman Road, Newcastle upon Tyne, NE77DN will say as follows: -

1. I make this statement to assist the UK Covid-19 Inquiry and further to the Rule 9 letter which was received by the Trust on the 8th October 2024. I can confirm that I have held the post of Chief Operating Officer since October 2018 and therefore was part of the Trust throughout its response to the Covid-19 pandemic. I can also confirm that in order to prepare this statement, I have spoken to my colleagues within the Trust in order to ensure that the information could be provided to deal with each request for information.

2. I am a Registered Nurse and a professional manager. I trained as a Graduate Management Trainee within the NHS and have worked for 25 years in local, regional and national roles within a number of organisations. Previous roles I have held include senior and director level roles in the North East Strategic Health Authority, St George's University Hospitals NHS Foundation Trust, University College London NHS Foundation Trust, NHS England and the Department of Health and Social Care. I also worked for three years as a senior management consultant within McKinsey and Company. In addition to my role as Chief Operating Officer at Newcastle Hospitals, I took on additional responsibilities during the Covid-19 pandemic; as Managing Director of the Nightingale Hospital North East; as Managing Director of the Integrated Covid Hub North East (ICHNE); and as Executive SRO for the North East and North Cumbria

Covid-19 Vaccination programme. Each of these functions was regionally hosted by Newcastle Hospitals on behalf of the wider NHS and healthcare system. It is primarily in my role as Managing Director of the Integrated Covid Hub North East that I make this statement on behalf of Newcastle Hospitals.

Pre Covid

3.Prior to the emergence of the Covid-19 pandemic the Trust's Microbiology and Virology Services (Hospital Laboratory) provided laboratory based diagnostic and clinical services to Newcastle upon Tyne and reference Microbiology and Virology services to the North East and Cumbria. The laboratory was also the regional Public Health laboratory, under commission from Public Health England.

4.The laboratory was (and continues to be) based on the Freeman Hospital site and part of a wider Integrated Laboratory Medicine Directorate. The Trust was the only hospital within the region providing a full diagnostic service for virology, with a large range of molecular assays and experience in the development and use of laboratory developed molecular assays and the only hospital in the region at the time employing Clinical Consultant Virologists.

5.Prior to the Covid-19 pandemic the Trust had both analyser and staffing capacity to manage typical winter demand, regularly processing up to 60 respiratory samples per day (Monday - Saturday) for Influenza and other winter viruses.

6.The Trust analysers ranged from high throughput automated systems, collectively capable of processing up to 300 samples per day (for a wide range of sample types), to manual single sample rapid analysers. The Trust was able to provide results on the same day of testing for both high throughput (8hrs) and rapid (<2hrs) depending on clinical need, offered Influenza A, B and Respiratory Syncytial Virus (RSV) tests in what was called a short screening panel as well as a full respiratory screen (Influenza A, B, RSV, Adenovirus, human Metapneumovirus , Parinfluenza 1-4, and human Rhinovirus) depending on patient cohorts. Pre-pandemic the Trust had 8 Health and Care Professional Council (HCPC) trained and competent staff running the molecular analysers 6 days per week.

7.Prior to the emergence of Covid-19 Test, Trace and Isolate infrastructure, laboratory testing and capacity was based on known pathogens, however, the existing technology, platforms and staff could be and were adapted to low volume SARS-CoV-2 testing once test methods became available.

Covid-19 response – In Trust Testing

8. Newcastle was not initially included in the testing plans; however, we expressed an interest to Public Health England via the PHE Network and were included within the first wave of test roll out plans. Working closely with Public Health England (PHE), the Hospital Laboratory (Pillar 1) became one of the first diagnostic laboratories in the UK capable of testing up to 10s of samples per day (Go-live 17th February approximately 10 days.).

9. In order to test in this way, the laboratory explored, verified and validated several molecular assays, associated platforms, processes and sample types. A dedicated area of Containment Level 3 (CL3) laboratory was utilised. The CL3 laboratory is nominally used for investigating tuberculosis samples. However, this was reprofiled and a further two class 1 safety cabinets were added which were dedicated to Covid-19 sample processing. Some remedial work was undertaken to reconfigure existing laboratory space. A small molecular office was converted into laboratory space with support from Newcastle Estates Department, this included the addition of fixed benching to accommodate a high throughput testing platform (Genetics Signatures), benching was also removed in the existing molecular lab space to create space to install floor standing equipment (Amplidiag x2). All remedial work was minor therefore no business cases or planning permission was required. All work was completed in less than 24 hours.

10. The 8 existing HCPC biomedical scientists delivered training to new and seconded staff from other areas within the Trust, local university and Public Health England using the first iteration of the Covid-19 Competency Framework. A 24/7 shift service was devised and launched (commenced 1st April 2020). This was only possible due to the commitment and tenacity of the staff.

11. The number of staff able to work in the molecular section of the laboratory tripled with focused and bespoke training. The Trust was able to move staff to the point of need as Business as Usual (BAU) activity in other areas of the laboratory reduced.

12. Between February 2020 to August 2020 15+ iterations of SARS-COV-2 tests were validated and verified both on existing and analysers, workstations and extraction platforms provided by central government. Discussions and decisions regarding onboarding centrally procured equipment took place at daily Covid-19 meetings with David Wells, NHS England Head of Pathology and regionally with the North 1 Incident Commander and nominated Trust Leads. Some of the staff energy and resources were misdirected as advice from the Central Government team was to onboard analysers, which eventually were considered not fit for purpose and were deemed not sensitive enough to be used for patient samples. At peak activity the Trust was processing and reporting 1200 samples per day.

Covid-19 response – the concept of the Integrated Covid Hub North East

13. In response to the Covid-19 Pandemic the Newcastle upon Tyne Hospitals NHS Foundation Trust (The Trust) supported the Test,Trace and Isolate system (Test, Trace and Isolate) by proposing, establishing and running the 'Integrated Covid Hub North East' (ICHNE) under contract to the Department of Health and Social Care (DHSC). The concept and model for the Integrated Covid Hub North East was developed in July 2020 following initial discussions between the local Director of Public Health and the Trust noting that existing national test and trace arrangements required improvement and additional capacity was needed, ideally with NHS support. The proposal was made to the DHSC Test and Trace Team on 23rd July 2023. (Exhibit INQ000618467)

14. The specific improvements that the proposal sought to deliver were:

- Significant increase in Covid antigen testing capacity of up to 80,000 tests per day, delivered through an additional new lab and tightly integrated with the existing network of NHS lab capacity across the region thus removing the distinction between pillars 1 and 2.
- Rapid turnaround of testing, with an aim of delivering regional test-registration to returned result time of 12 hours maximum, minimising case-identification to contact-isolation times, and optimising viral-shedding exclusion in screening.

- Dedicated innovation unit to support national level moves towards mass rapid testing through end point PCR and point of care testing, delivered through the Biosphere, a specialist lab tailored for the commercialisation of innovation.
- Capability to move beyond basic Test and Trace, through extensions of targeted screening to embrace Test and Trace enhancements, source, and case-finding and, potentially, mass-testing.
- Flexibility to incorporate multiplex testing in controlling winter pressures; future serology testing; surge capacity for additional challenges.
- Integration of results into NHS systems via the Great North Care Record.
- Optionally, a base for consolidating Test and Trace Levels 1-3 into an integrated regional system, working with local and national partners to enhance tracing linkage and use of innovative approaches to real-time disease surveillance.
- Coordination of region-level elements of response (e.g. mobile scanning unit deployment and response planning, future mass-vaccination programme).

A focus for regional JBC / CONTAIN collaboration and working, integrating data capabilities of our broader partnership.

15. The Integrated Covid Hub North East model was designed in partnership between the Trust, Newcastle City Council and Newcastle University, bringing together respective strengths in large scale laboratory provision, public health and health epidemiology and analytics.

16. The key areas of expertise and resources each of these partners brought were as follows:
    - Newcastle Hospitals - regional virology, laboratory and infection prevention and control expertise; experience of building and running large scale Covid-19 functions and projects at scale and pace such as having recently created a 500 bed Nightingale Hospital in 4 weeks, recruitment and training large numbers of staff; innovation and commercial partnerships.
    - Newcastle City Council - public health thought leadership and operational delivery; public and partner engagement; infrastructure and planning.
    - Newcastle University - Covid-19 health analytics; epidemiology; health inequalities – initiated as part of the development of the Nightingale Hospital North East which had recently been created.

17. The Integrated Covid Hub North East was comprised of three elements, newly created specifically to respond to the Covid-Pandemic:
    - a very large Lighthouse Laboratory, a high throughput facility that is dedicated to Covid-19 testing for NHS Test and Trace.
    - an Innovation Laboratory created at the Helix in Newcastle upon Tyne to support the development of diagnostic tests for Covid.
    - a Coordination and Response Centre (Coordination and Response Centre) which mainly supported local authority partners in coordinating Test, Trace and Isolate activities including data analytics. The Coordination and Response Centre brought together regional data gathered first-hand through the Track and Trace effort alongside national data provided by the government, organisations and stakeholders to produce management strategies to control the spread of the virus.

18. In developing the proposal for the Integrated Covid Hub North East the Trust were very keen to utilise local infrastructure, resources and expertise both to maximise speed, impact and effectiveness in dealing with Covid-19 and also looking to the future in term legacy opportunities for the North East if The Trust were able to demonstrate the assets of the region and how successful the Trust and partners had collaborated on the Covid-19 response.

19. The Integrated Covid Hub North East was one of the first of its kind in England and sought to place the region at the forefront of managing the Covid-19 pandemic.

20. In terms of overall timelines, the proposal for the creation of the Integrated Covid Hub North East was submitted to the Department of Health and Social Care in July 2020. The Integrated Covid Hub North East became operational in a phased way from January 2021, with the Lighthouse Lab beginning testing on 4 March 2021. The Integrated Covid Hub North East began to close down its operations in February 2022, with the Lighthouse Lab ceasing testing at the end of March 2022 at the request of the UK Health Security Agency (United Kingdom Health Security Agency) as part of its national strategy. The Coordination and Response Centre closed later that summer. The Innovation Lab was subsequently repurposed and continued within the Trust

supporting NHS and life sciences work funded by commercial and NHS innovation funds. All matters related to the Integrated Covid Hub North East were finally closed in February 2024 following the settlement of all leases and financial matters between the Trust and United Kingdom Health Security Agency.

Covid-19 response – Integrated Covid Hub North East leadership and governance

21. The Integrated Covid Hub North East was hosted by Newcastle upon Tyne Hospitals NHS Foundation Trust (NuTH) on behalf of a partnership involving North-East Local Authorities (LAs), NHS organisations, public health teams, local universities, and industry.

22. The Trust held the legal responsibility for the Integrated Covid Hub North East and all the services it delivered. This included renting the premises, equipping them, recruiting, employing and training staff, processing polymerase chain reaction samples delivered to the laboratory, testing and assuring new diagnostic tests in the Innovation Laboratory, and supporting local authorities with their Covid-19 response public health activities. The Integrated Covid Hub North East was run as a separate business unit within the Trust.

23. The Trust Board of Directors was led at the time by the Chairman of the Trust Sir John Burn, and the Chief Executive Officer Dame Jackie Daniel.

24. Mr. Steven Morgan was appointed as the Integrated Covid Hub North East Non-Executive Director representative on behalf of the Trust Board of Directors.

25. I extended my responsibilities as Chief Operating Officer of the Trust to also become Managing Director of the Integrated Covid Hub North East. As part of this role, I led a senior team for the Integrated Covid Hub North East which included the following key leaders:

- Prof Eugene Milne - Director of Public Health Newcastle City Council and Deputy chair of the Integrated Covid Hub North East Senior Team

- Dr Vicky McFarlane Reid - Executive Director of Business and Development and Director of the Integrated Covid Hub North East Innovation Laboratory
- Dr Akhtar Husain - Integrated Covid Hub North East Medical Director and Clinical Director of Integrated Laboratory Medicine,
- Prof Stephen Singleton - Director of Integrated Covid Hub North East Coordination and Response Centre (former regional CEO, Medical Director and Director of Public Health)
- Prof Fiona Matthews - Integrated Covid Hub North East Director of Health Analytics - Dean of Research and Innovation, Professor of Epidemiology, Population Health Sciences Institute - Newcastle University
- Dr Chris Shaw- Integrated Covid Hub North East Lighthouse Laboratory Director of Operations,
- Dr Sheila Waugh - Consultant Virologist
- Dr Julie Samuel - Infection Prevention and Control lead
- Jennifer Collins – Laboratory Manager of Microbiology and Virology
- Daryl Perry - Director of Integrated Covid Hub North East PMO & Coordination and Response Centre Operations

26. Governance arrangements were put in place, this included a Strategic Oversight Group (exhibit INQ000618469,INQ000618470, INQ000618471, INQ000618472, INQ000618473, INQ000618474, INQ000618475,INQ000618476,INQ000618477, INQ000618478, INQ000618479, INQ000618480, INQ00061848, INQ000618482, INQ000618483, INQ000618484, INQ000618485, INQ000618486, INQ000618487, INQ000618488, INQ000618489, INQ000618490, INQ000618491, INQ000618492, INQ000618493, INQ000618494, INQ000618495, INQ000618496, INQ000618497, INQ000618498, INQ000618499, INQ000618500, INQ000618501, INQ000618502, INQ000618503, INQ000618504, INQ000618505, INQ000618506) which met as frequently as required, over the 18 month period the group met 15 times. The group comprised of senior representatives of the Trust, Newcastle City Council and Newcastle University. Newcastle City Council sought to represent all North East and North Cumbria local authority public health directors on the Strategic Oversight Group. Mr. Steven Morgan, Non-Executive Director at the Trust, was appointed as Chair of the Strategic Oversight Group.

27. The role of the Strategic Oversight Group was to provide strategic oversight of the establishment and operations of the Integrated Covid Hub North East (ICHNE). The SOG did not have formal decision-making authority regarding the operation of the ICHNE, as such authority has been delegated jointly to two executive directors of the Trust and who were Executive Leads for the SOG. The SOG had objectives to provide advice and support regarding:

- Engaging with key stakeholders
- Influencing strategic direction
- Operational progress
- Finalisation of the service agreement with the Department of Health and Social Care (DHSC) and subsequent oversight of agreed key performance indicators (KPIs)
- Financial strategy
- Providing assurance to the Trust Finance Committee and Board of Directors; and Communicating key messages.

The SOG impacted the work of the Integrated Covid Hub North East in a number of positive ways, including in providing perspectives on effective programme management from the other industries such as logistics and the military in which non-executive members had direct experience.

28. The Integrated Covid Hub North East Senior Management Team included senior representatives from Newcastle Hospitals, Newcastle City Council and Newcastle University. These meetings were typically twice weekly but had the flexibility to be stood up as and when required and could sometimes be as frequent as daily (exhibit INQ000618471).

29. As the Integrated Covid Hub North East utilised NHS staff and expertise in the development of the laboratory, close working relationships and collaboration between the Integrated Covid Hub North East and the Trust hospital sites and partners were maintained. A key example of this was the creation of the Integrated Covid Hub North East Clinical Advisory Group, this was chaired by a Clinical Virology Lead who also worked as a Clinical Lead for virology within the Trust. The groups initial functionality was to support the set up phase of the Integrated Covid Hub North East and then transitioned into a specialist clinical and scientific expertise and oversight group to

ensure processes and outcomes met the standards required for laboratory accreditation ISO15189:2012.

Covid-19 response – partnership working

30. It was very much from recognition of the shared expertise that partners brought that the proposal for the Integrated Covid Hub North East was developed. The very positive working relationships that already existed between the Hospital Trust, the City Council and the University, and respective deep expertise included at scale laboratory testing, clinical virology, microbiology, large scale construction and operational programme management, public health, analytics, partnership working and governance in the necessary elements of the Integrated Covid Hub North East were crucial to successful delivery.

31. To capitalise on these strengths the Integrated Covid Hub North East was very much developed as a partnership, with a joint proposal to Ministers in the first place and a governance and operational delivery structure that had all three organisations represented by very credible senior individuals working closely together.

32. The Integrated Covid Hub North East worked in partnership with a number of organisations in delivery of its work, these included the Department of Health and Social Care, NHS Test and Trace, ThermoFisher who provided the technology, equipment and reagents used in the Lighthouse Laboratory and the 12 local authorities in the North East and North Cumbria.

33. Once operational the main roles of the founding partners were as follows:

- Newcastle Hospitals - management of the Integrated Covid Hub North East including employment of staff, running of Lighthouse Lab, Innovation Lab and Coordination and Response Centre. Liaison with DHSC contacts such as Baroness Dido Harding, Dame Jenny Harries, Professor Dame Anna Dominiczak, United Kingdom Health Security Agency, finance, quality and safety etc.

- Newcastle City Council - senior public health oversight of the work of the Coordination and Response Centre and supporting links with other public health teams across the region.
- Newcastle University - in providing the Covid-19 Health Analytics function within the Coordination and Response Centre. This included forecasts of covid disease, testing, hospital admissions, mortality and vaccination activity, with a particular focus on health inequalities data. There was a specific focus on inequality data because as the initial proposal for the Integrated Covid Hub set out 'The health of the north east is amongst the very worst in the UK, and local partners are determined to do everything to ensure that Covid does not make the position worse. There is a strong desire for a significant increase in rapid Covid testing and tracing, as part of an integrated whole system local support and containment response. This is key to preserving life and preventing the NHS being overrun, ahead of a vaccine being available'. Newcastle University focused on this data because it was an area of real strength for the University and the ICHNE leadership team had collectively identified that taking an inequalities approach was key to an integrated whole system local support and containment response

Covid-19 response – recruitment.

34. The Integrated Covid Hub North East project generated around 750 new jobs in the public sector and required the rapid creation of a brand-new workforce that was 'fit for purpose' to deliver the requirements of the national and local response to the coronavirus pandemic.

35. The Integrated Covid Hub North East recruitment strategy outlined specific goals from the outset. These included to:
    - Deliver services where equality, diversity and inclusion were embraced and evident in the everyday work of our staff.
    - Create a 'representative workforce' with equality of opportunity.
    - Ensure a workplace in which people felt valued because our success would be built on the commitment, skills and attitudes of all staff.

- Nurture a skilled, diverse and committed workforce where every individual regardless of background could share our purpose and reach their potential.
- Foster a culture of inclusion and belonging to support staff retention.

36. It was identified that there was a need to offer greater support to people at different 'job ready' stages and key measures included:
    - An inclusive recruitment campaign, using materials developed through engagement with community groups/third sector partners.
    - Specialist support to help vulnerable people into employment.
    - Championing equality and promoting voluntary and community sectors, including our internal internship for those with learning disabilities.
    - Diverse recruitment panels.

37. The North East has one of the lowest black and minoritised ethnic populations in the country and this is reflected in our workforce. The region's black and minoritised ethnic population has doubled in the last 15 years, but this increase is not reflected in our workforce. In view of this, the Integrated Covid Hub North East recruitment campaign for the Hub was simple – recruit for diversity. Recruitment campaigns actively targeted direct engagement with local communities and under-represented groups openly demonstrating commitment to supporting a diverse workforce and focused on being an inclusive, compassionate place to work.

38. The recruitment campaign was highly successful and showed impressive results for black and minoritised ethnic, lesbian, gay, bisexual, and transgender people and those with disabilities. The key results of recruitment for people from certain protected characteristic groups were:
    - Black and minoritised ethnic people. Trust 9.8%; census for central Newcastle 14.8%; Hub:
        - Lighthouse lab 17%
        - Coordination and Response Centre 37%
        - Innovation lab 18%
    - Lesbian, gay, bisexual and transgender people - Trust 5%; census for central Newcastle 5%; Hub:
        - Lighthouse lab 14%

- Coordination and Response Centre 17%
- Innovation lab 9%

- People with disabilities. Trust 2%; census for central Newcastle 15%; Hub:
  - Lighthouse lab 7%
  - Coordination and Response Centre 15%
  - Innovation lab 0%

39. The Integrated Covid Hub North East recruitment strategy in 'Recruiting for Diversity' was shared with regional and national NHSE/I teams and policy advisors and participated in an NHSE/I recruitment pilot and where learning was shared throughout the NHS and regional groups. Through links and engagement with local community organisations the team were able to facilitate conversations with community groups around working for the NHS and continue to profile the public sector as an employer of choice, focusing on ethnic minorities and people living with disabilities.

40. The Integrated Covid Hub North East recruitment strategy was recognised nationally in December 2021 when the Trust was awarded Winner of the 'Best Recruitment Strategy 2021' by HR Magazine.

Covid-19 response - Lighthouse Lab infrastructure

41. From an infrastructure perspective it was already known that there was not sufficient laboratory capacity in either the NHS, universities or industry within the region to be repurposed to create a Lighthouse Laboratory.

42. Instead, facilities were quickly identified at a newly built warehouse in Gateshead and the commercial building partners to convert it into a new Category 2 Lighthouse laboratory with appropriate containment facilities. This determined that the Laboratory would be in Gateshead and influenced the work in recruiting c1000 staff (after including for turnover) from areas with appropriate public transport links to this location (see section on staffing).

43. The purpose-built facility in Gateshead was designed for a very high throughput capacity of 80,000 samples per day specifically for Covid-19. Newcastle Hospitals led the design with architects and engineers of what would be required to convert an empty warehouse into a containment level 2 high throughput testing laboratory including air handling, waste disposal, sample receipt and processing, logistics and goods in, teaching/training space, IT requirements for instrumentation, office space, staff welfare and Test, Trace and Isolate reporting to Department of Health and Social Care.

44. This facility comprised of two warehouse buildings, one furnished as a Pillar 2 testing facility capable of testing up to 80,000 samples per day running a 24/7 service with around 650-1000 staff. The second building was designed as a staff welfare facility and the testing facility was designed and fitted as Containment Level 2 laboratory housing office space, logistics/stores, sample receipt area, sample processing areas and 13 testing bays each housing a ThermoFisher Amplitude system.

45. The laboratory was initially designed to house Perkin Elmer testing platforms, consumables and reagents, however, a change in test provider following a successful tender meant that minor alterations to design were required. Whilst designed for 80,000 samples per day the volumes to be required of the laboratory were reduced by Test and Trace to 32,000 tests per day prior to go live due to updated national modelling of demand. Volumes were later increased as described in section 71.

46. Changes in laboratory space were required as the pandemic developed to allow the introduction of new equipment which was needed to implement variants of concern genotyping. When Pillar 2 VOC Reflex Testing was initiated at request of DHSC, further equipment was required to complete this testing. This was sourced and supplied by DHSC and included:

- I&S

To accommodate the additional equipment and undertake new testing two office spaces were converted to provide additional space. We already had lab space already designed for this type of work, and this was also utilised to train staff on instrument operation, test procedure, results analysis and reporting.

Covid-19 response - Lighthouse Lab staffing

47. Existing staff were utilised to support the Integrated Covid Hub North East and whilst utilising existing NHS staff and expertise was a clear advantage for the Integrated Covid Hub North East, the use of key Hospital staff added significant pressure to existing hospital testing capacity, including staffing, at a time when the system was already overwhelmed.

48. Many key staff within the hospital laboratory directorate were formally seconded to the Integrated Covid Hub North East for all or part of their time. A significant number of State Registered Biomedical Scientists applied for secondment. The large number of posts at the Integrated Covid Hub North East (and other labs across the country) caused significant issues to the microbiology laboratories in the region, in finding suitably qualified staff for vacant positions or to increase pillar 1 testing capacity.

49. Through partnership and collaboration strong links were maintained with the regional hospital laboratory network, the Integrated Covid Hub North East and Public Health England (the Trust laboratory being the regionally commissioned Public Health Laboratory). Practical collaboration included all variant testing for the NHS in the region (pillar 1) being performed at the Lighthouse Laboratory, as well as some primary polymerase chain reaction testing for Newcastle Hospitals.

Covid-19 response - Lighthouse Lab operations and network

50. Following the establishment of the Integrated Covid Hub North East Lighthouse Laboratory in late 2020, the Trust became part of the Lighthouse Laboratory Network. As the Lighthouse Laboratory Network was already fully established by the time it became part of the Network support to the Trust was primarily operational rather than

strategic. For example, the Trust had strong links with sister Lighthouse Laboratories Leamington Spa, Milton Keynes, Plymouth, Newport, Alderley Park, Randox, Glasgow and Brants Bridge which provided mechanisms for securing biological samples, which were then supplied to industry developers or used in the innovation lab to verify and validate diagnostics for clients.

Covid-19 response – working with national partners

51. Newcastle Hospitals proposed the creation of the Integrated Covid Hub North East to the Department of Health and Social Care on behalf of partners. Civil servants and Ministers reviewed the proposal from Newcastle Hospitals to create the Integrated Covid Hub North East, supported by a number of online meetings and one or two site visits from civil servants (exhibit MW05).

52. Once we had received a commission from the Department of Health and Social Care to create the entity based on the proposal outlined in section 14 of this statement, we worked closely with Department of Health and Social Care, NHS Test and Trace, Public Health England, and eventually United Kingdom Health Security Agency to become operational and to work as part of the growing Network of Covid-19 Lighthouse Laboratories.

53. In relation to the Innovation Laboratory and Coordination and Response Centre there was some initial engagement with Department of Health and Social Care civil servants, but this stopped once the facilities were operational. The Integrated Covid Hub North East was not involved with other Government Departments.

54. As part of its work in managing international markets for access to covid diagnostic supplies, the Department of Health and Social Care played a major role in identifying the two potential providers of the technology and reagents to be chosen from by the Trust to be used by the Integrated Covid Hub North East Lighthouse Laboratory. The two potential providers of technology and reagents were PerkinElmer and Thermo Fisher Scientific.

55. The final decision on which equipment supplier to use was made by the Trust in collaboration with the Department of Health and Social Care. Department of Health and Social Care officials participated in a small number of site visits during the commissioning process, including working through an operational implementation check list.

Covid-19 response – Lighthouse Laboratory equipment and quality

All relevant documentation pertaining to the Department of Health and Social Care Operational Readiness Checklist was submitted. This assessed readiness based on the testing operations, authority to proceed, site preparation, laboratory preparation, laboratory process, quality assurance, leadership and governance, people, IT, management of information, logistics (samples and consumables), waste management, staff facilities, security, preparation for go live and preparation for post go live. (Exhibits INQ000618507, INQ000618508, INQ000618509, INQ000618510, INQ000618511, INQ000618511)

56. Installation and verification of equipment was undertaken by ThermoFisher, and assay verification was undertaken comparing data with that generated on a comparator assay used at hospital Lab and third-party quality control material.

57. In relation to quality control, all reagents and consumables were batch acceptance tested prior to use. Stock control measures were in place and reagents, consumables and control material were held in quarantine until suitably verified for use. This allowed for the eventual identification of an instance of contamination relating to a specific batch of pipetting tips.

58. All thermal systems e.g. incubators/ovens, fridges, freezers and cold rooms were temperature mapped prior to use and together with any ambient storage space, constantly monitored using the Kelsius system of probes and control units.

59. External quality control programmes were completed (Quality Control for Molecular Diagnostic and INSTAND), and regular comparability testing took place to compare instruments with those in use at hospital and Innovation laboratory.

60. The Trust hospital laboratory was accredited by UKAS to ISO15189 standards. Accreditation for the Lighthouse Laboratory was also sought as it was extremely important to demonstrate that high quality standards in our hospital laboratory were also present in the Integrated Covid Hub North East. Accreditation (to ISO15189) was successfully extended to cover the Lighthouse and Innovation laboratories in March 2021.

61. Performance was monitored daily by Department of Health and Social Care. Performance in relation to the Lighthouse Laboratory Network was monitored via the bi-weekly Operational Directors call. All data was reported centrally in real time, which highlighted any inconsistencies and variation internally and across the network.

62. The Lighthouse Laboratory performed a small amount of pillar 1 polymerase chain reaction testing in early 2022 to help support the hospital laboratory, this could have been expanded had the pandemic continued. In addition, the Lighthouse Laboratory performed variant testing for pillar 2 samples (as required by the network) and all pillar 1 samples from hospital laboratories in the North East region.

63. As the hospital laboratory was a Public Health England commissioned laboratory, the Trust was required to provide variant testing for Trust patient samples and those from other hospitals within the region. The Trust chose not to duplicate effort at a time when the hospital laboratory was under significant pressure by performing all variant testing within the Lighthouse Laboratory.

Covid-19 response – Lighthouse Laboratory capacity and testing volumes

64. The Trust were involved directly with Pillars 1, 2 and 3, however, the Lighthouse Laboratory was set up for the purpose of Pillar 2 testing (polymerase chain reaction testing for members of the public as part of Test, Trace and Isolate).

65. More than 8 million pillar 2 polymerase chain reaction tests were performed over the operating period of the Lighthouse Laboratory with results feeding directly into Test, Trace and Isolate; these samples originated from the local region and country wide. Pillar 1 (polymerase chain reaction testing for NHS patients) and Pillar 3 (antibody testing) were primarily performed within the hospital laboratory, which in addition tested NHS Trust staff samples. The Hospital laboratory also supported research projects, including the SIREN study. The SIREN study was a national core study established in response to Covid-19 and in response to a National Institute for Health and Research (NIHR) urgent priority study providing vital research into immunity and vaccine effectiveness and a unique, large-scale partnership with NHS healthcare workers providing an agile response to an evolving pandemic.

66. When setting up the Lighthouse Laboratory the Trust had hoped it might be possible to provide support to pillar 1 testing, given the considerable capacity and staffing challenges in the hospital laboratories. This integration of Pillar 1 and 2 testing within the Lighthouse Laboratory required solutions for significant IT and logistical challenges as well as confirmation from the network that spare capacity could be used in this way.

67. The Lighthouse Laboratory accommodated large fluctuations in capacity and demand.

68. It is important to note that the Trust did not have any involvement in setting the national 100,000 a day target. In the nine months between the Trust submitting its proposal to establish the Integrated Covid Hub North East to the Lighthouse Lab becoming operational, there were significant increases in requests from the Department of Health and Social Care regarding the volume of tests the Integrated Covid Hub North East lab would be asked to undertake. It is my understanding that this was driven by updated modelling of demand, and by increased confidence from Department of Health and Social Care of being able to source sufficient polymerase chain reaction testing equipment and reagents for Newcastle to do an increased volume of tests. We were not provided directly with updated modelling, but representatives participated in national clinical leads meetings where the findings of this modelling were briefed out to Laboratory Lighthouse leadership teams. We did not input into the updating of models.

69. Initially the bespoke facility was constructed to be capable of processing 80,000 Covid-19 polymerase chain reaction tests per day on 13 ThermoFisher Amplitude systems. However, just prior to the proposed go-live date in January 2021 the Department of Health and Social Care undertook a national re-assessment of capacity and go-live was halted until the beginning of March 2021. The reassessment of capacity and any national request to delay go-live dates was a matter for DHSC/ Test and Trace based on the progression of the pandemic. I am unaware of the specific reasons behind national requests impacting on the Integrated Covid Hub North East.

70. Following this initial delay Department of Health and Social Care instructions were to commence testing with a revised operating capacity of 32,000 tests per day, in addition to 1000 Variant of Concern (VoC) tests.

71. During October 2021, the capacity was once again increased to 52,000 primary covid screens per day plus 1000 VoC. The increase in capacity was primarily achieved by adopting continuous improvement methodology throughout the course of the initiative, which included detailed process mapping, continuous evaluation of workload and changes to staffing profiles day and night to accommodate large daily fluctuations in demand. Practical examples of this include:

- Extending recruitment beyond direct replacement of leavers due to staff attrition to support the request for ramp-up to 52,000 from 30,000 in October 2021.
- Development of an IT Lead/data analyst to allow for precise analysis of workflow and hot and cold spots to support the development of staffing/workflow models in conjunction with efficiency modelling.
- Flexing of staff meant that samples flowed through process efficiently as staff "followed" samples as they moved through each laboratory process from receipt to pre-analytics, testing and reporting. As staff finished one process and nothing was pending, they were able to bolster the staffing at the next stage of the process. This allowed for increased staff availability to open and run a greater number of instruments.
- Prior to ramp-up lower numbers of samples per run had to be performed in order to make KPIs, as samples numbers increased runs could be filled to capacity in a quicker timeframe therefore more samples processed without affecting KPIs.

- VOC KPI was to process up to 1000 samples per day but not at the detriment of screening KPIs. Due to the points described above, this target was continually met without hinderance to Covid screening performance.

72. During the transition phase from 32,000 – 50,000 the Laboratory reached out to external Local Authority contacts and secured additional temporary staffing from the Tyne and Wear Fire Service to support pre-analytical tasks. As the facility was created to accommodate 80,000 tests per day analytical capacity on the Amplitude systems was never an issue, nor was reagent supply from ThermoFisher.

Covid-19 response – Lighthouse and other laboratories

73. In May 2021, a variant testing service was established at the Integrated Covid Hub North East, at the request and with support of United Kingdom Health Security Agency and the network. The VoC testing service for Pillar 2 was developed at the Lighthouse Laboratory and this was also provided to hospitals in the North East region as part of pillar 1 testing.

74. The Lighthouse Laboratory provided surge capacity for other labs in the Lighthouse Laboratory Network where redirection of samples was required. A process was developed for daily transfer of positive samples to Sanger Institute and Northumbria University as part of a national sequencing program looking at variants and checking test performance against new variants. The Innovation Lab also supplied clinical samples to industry who were developing tests for variants or checking their test performance against new variants.

75. Following the development of asymptomatic testing in line with Public Health England guidance within the Pillar 1 (hospital based) diagnostic laboratory, it is recognised that SARS-COV-2 RNA could be detected for significant periods after infection and did not therefore necessarily correlate with infectivity.

76. Clinical Virologists in the Trust were involved in the algorithms set up for interpretation of results within the hospital. In the hospital setting (pillar 1) they were able to review

results with clinical information and request repeat samples in real time for those samples which were positive at the Limit of detection (PLODS).

77. For pillar 2 testing in the Lighthouse Laboratory no patient identifiers were provided or information on whether the swab was from a symptomatic or asymptomatic individual. The Test, Trace and Isolate system only allowed for reporting as negative, positive or indeterminate.

78. There was no consensus among laboratories on which results should be called indeterminate, partly due to the differences among the network in assays and platforms in use.

79. The Trust was an active operational member of the Lighthouse Laboratory network and was involved in a number of operational meetings. These included daily meetings with Department of Health and Social Care / United Kingdom Health Security Agency (initially Deloitte) Relations Manager, weekly Site Directors meetings, weekly Pillar 2 Quality Meetings, weekly ThermoFisher meetings, Department of Health and Social Care/United Kingdom Health Security Agency Sequencing and Sanger Institute operational meetings.

80. The Trust Consultant Clinical Virology lead attended a weekly Lighthouse Laboratory Clinical Advisors Meeting during the period when the laboratory was operational. These meetings were chaired by the Central Test and Trace Quality Team Scientific Advisor and included the Clinical Virology Advisors from each of the Lighthouse Laboratories. These meetings largely focused on sharing experience and learning relating to specific issues encountered. Example minutes can be found in Exhibit MW/06.

Innovation Lab

81. A key decision supported by the Lighthouse Laboratory Network was the establishment of the Innovation Lab. Dr Victoria Mcfarlane-Reid (Executive Director for Business, Development and Enterprise) extended her responsibilities and acted as Director of

Innovation for the Innovation Lab, employing a team of scientists and business managers (10 in total) to work in the laboratory. The lab was run by a specialist team of scientists working with industry and academia to accelerate the development, evaluation and adoption of new diagnostics. The lab provides access to cutting-edge equipment, biological samples and expertise to evaluate and validate new diagnostic technologies.

82. The role of the Innovation Lab was to accelerate development of next generation diagnostics, initially for Covid-19. The lab did not input into national strategies for testing, but did communicate frequently with United Kingdom Health Security Agency about the role it could play for future pandemic preparedness. The vision of the Innovation lab was clearly aligned with the UK's life sciences vision, to future proof the diagnostic landscape and testing capabilities of the country.

83. The Innovation Lab who worked specifically with academia and industry on the development of new Covid-19 tests. This 10-person team supported the CONDOR, FALCON and Department of Health and Social Care studies of Covid-19 diagnostics and in part the Coronavirus Test Device Approval process. CONDOR (COVID-19 National DiagnOstic Research and Evaluation) was a NIHR funded research platform study which examined the efficacy and use of COVID tests. It was established as a single, national route to rapidly evaluate new diagnostic tests for COVID-19 in various healthcare settings and FALCON (Facilitating AcceLerated Clinical validation Of Novel diagnostics for COVID-19) was a sub study of CONDOR examining the efficacy of COVID tests in hospital settings.

84. The Lighthouse Laboratory and hospital laboratory also worked with ThermoFisher (the main supplier among the suppliers used at the Integrated Covid Hub North East for equipment and reagents) (exhibit MW07) to obtain validation evidence for Coronavirus Test Device Approval (CTDA) of the TaqPath assay.

85. The Innovation Lab also worked directly with industry and academics who were developing new diagnostic tests. Support induced access to samples directly from the Lighthouse lab and hospital patients as well as expert support in the validation of new test devices.

In total, the lab worked on 44 projects during the time that the Lighthouse Lab was commissioned. These came from 20 different diagnostics companies (Exhibit INQ000618468) The work entailed provision of samples, performance evaluations and test validation. The types of devices that the lab was working with were Point of Care Tests, Covid-19 lateral flow tests and Covid-19 polymerase chain reaction tests.

Coordination and Response Centre

86. The Coordination and Response Centre (CRC) was established to support local authority partners in coordinating Test, Trace and Isolate activities including data analytics. The Coordination and Response Centre brought together regional data gathered first-hand through the Track and Trace effort alongside national data provided by the government, organisations and stakeholders to produce management strategies to control the spread of the virus.

87. The Coordination and Response Centre was developed through collaborative discussions with partners across the North East. Through these discussions, a collective ambition emerged which was to localise and improve existing national test and trace functions, bringing them into the Integrated Covid Hub North East model under the direct leadership of the Coordination and Response Centre.

88. A local Test and Trace Working Group was established, and this provided the platform for the Coordination and Response Centre (CRC) Tracing teams to work in partnership with the local authorities and Public Health England Health Protection Teams. The working group was a CRC support group drawn from the regular meetings of the twelve local Directors of Public Health (DsPH) and representatives of the Health Protection Unit (HPU) for the region (part of PHE). The larger group met twice a week and resolved local questions about the interpretation and implementation of the national guidance. Members of CRC attended some meetings (all were virtual) and there was a weekly meeting of the CRC with DsPH to discuss the CRC developments. The CRC operated to a strategic plan agreed with the DsPH and HPU. The advice was general and iterative based on the experiences developed by the DsPH in their

respective local authorities and the HPU. The Coordination and Response Centre, as a regional provider, sought to be guided by the expertise of existing local teams. This meant adapting to policies and procedures created by each local authority.

89. Once local Trace teams were created, close relationships evolved between the Coordination and Response Centre and local authorities with regular day-to-day working taking place. Standard Operating Procedures (SOPs) were created that suited the requirements for each local area, which the Coordination and Response Centre would work flexibly to support. This ensured a truly local approach was adopted for individuals across the North-East despite interaction from a regional body.

90. Throughout the Coordination and Response Centre's trace involvement, an offer to 12 local authorities was available to seek the support of the Coordination and Response Centre as an additional resource to complement respective local trace services. The 12 local authorities in the North East of England are Darlington, Durham, Gateshead, Hartlepool, Middlesbrough, Newcastle-upon-Tyne, Northumberland, North Tyneside, Redcar and Cleveland, South Tyneside, Stockton, and Sunderland.

91. This offer was developed and adapted as necessary to suit the local requirements as the pandemic evolved. Consistent to the offer was the option for the Coordination and Response Centre to manage all positive cases within local authorities. However, only 7 of the 12 local authorities opted to accept the Coordination and Response Centre's offer over the 12-month period of live Tracing. The local authorities that the Coordination and Response Centre supported were:

- Newcastle – from February 2021
- Darlington – from March 2021
- Hartlepool – Ad Hoc support from April 2021
- Stockton – from April 2021
- South Tyneside – from April 2021
- Gateshead – from June 2021

92. Similarly, an offer for regular communication between operational teams within the Coordination and Response Centre and individual local authorities was available. Weekly meetings were instated between those receiving support from the Coordination

and Response Centre where issues and opportunities could be highlighted. In addition to this, bi-weekly regional Local Trace Partnership (LTP) meetings were held for all 12 local authorities with tracing representatives in attendance.

93. Regular engagement with the 6 of the local authorities that the Coordination and Response Centre routinely supported allowed for improvements in the operational delivery of tracing. As the benefits of a localised trace approach were key to the objectives of the Coordination and Response Centre, its tracing team adapted their processes to ensure the best outcomes were delivered for individuals. This included producing local authority specific standard operating protocol (SOPs) in partnership with trace leads in each area. In addition, the Coordination and Response Centre produced a Regional SOP that outlined the generic processes its teams would follow when providing trace support.

94. The Coordination and Response Centre's Trace team supported the North-East region from 18th February 2021 to 23rd February 2022. Over this year, the Coordination and Response Centre staff made 34628 calls, successfully completed 9238 index case Contact Tracing and Advisory Service questionnaires (CTAS) and collected 16127 associated contacts. This had a significant impact on the region's efforts to control the spread of the pandemic and potentially saved countless lives, particularly in the 7 local authorities that the Coordination and Response Centre supported.

95. Following establishment there was some initial community hesitancy to engage with the Coordination and Response Centre and NHS groups. The Coordination and Response Centre set up key links with community and charity groups to improve community engagement and charities to ensure that minority groups were reached to help dispel key health inequalities in regard to health information, disabilities and health conditions (such as deaf and blind communities), marginalised communities (women's refuge), homeless community, those impacted by poverty, ethnic minorities and those who do not have English as their first language etc. The CRC initially depended upon the DsPH for both guidance and requests for engagement or support from their respective communities. Each local authority was rightly regarded as the local experts on their community characteristics and needs. This hesitancy was reported to us under a variety of 'reasons', including they were doing fine before the

CRC was established so why engage; they were sufficiently large and resourceful to manage their own coordination work; and/or they were getting sufficient other support from the HPU (PHE). In general, the smaller local authorities representing smaller communities, were eager for engagement and support.

96. Various cross- local authority communities were much more enthusiastic about support of any kind. Examples include the Tyne and Wear Fire and Rescue Service, the police constabularies (all of which wanted testing training support) and housing associations and various homeless people charities. They welcomed support in testing training, testing capacity and other (telephone based) support. This enabled access to regular testing for small but elevated risk and excluded communities.

97. It is likely that the formal movement of DsPH into local authorities because of the 2013 NHS reorganisation, led to some of the hesitancy and lack of preparedness for regional coordination and direct regional support to needy communities. After 2013 the loss of Strategic Health Authority (SHA) emergency planning coordination between the NHS and local authorities and the loss of the SHA based role meant that the necessary (and well-practiced) links between local authorities, the NHS and the public health specialists had to be built from a relatively standing start. As the CRC developed its capacity for analysis and delivery the coordination became much easier but especially from the smaller and less well-resourced local authorities.

98. The Coordination and Response Centre initially recognised multiple health inequalities within the vicinity from December 2020 and started to liaise with vulnerable groups such as the homeless and those seeking refuge. The approach included engaging with third sector organisations to understand the identified needs for specific groups, then the development of appropriate accessible information, training and/or testing arrangements as appropriate, jointly implementing these local initiatives and then evaluating their impact. (exhibit INQ000618512, INQ000618513).

99. Different approaches for support were considered and the idea for self-test support became apparent through an obvious gap in how testing facilities catered to the vulnerable communities of the public. An example of this is the registration for lateral flow/polymerase chain reaction tests, to register for a lateral flow or polymerase chain reaction test the requirement was to provide details such as your name, phone

number, email address and home address which seemed reasonably customary, however for communities such as homelessness, these simple details presented a difficult barrier to testing. The Coordination and Response Centre aimed to provide access to testing services for hard-to-reach communities via their trusted networks.

100.The Coordination and Response Centre worked with Newcastle University to undertake significant analysis into health inequalities. This included a product called the 'static vulnerability index', which was published in the Lancet online journal (https://www.thelancet.com/pdfs/journals/lanepe/PIIS2666-7762(21)00282-9.pdf). (Exhibit INQ000618518)

101.In addition, there was twice weekly analysis published (Exhibit INQ000618519) to all twelve of the Local Authorities in the North East. The intention was to get ahead of the curve and identify outbreaks, trends and learnings.

102.The Integrated Covid Hub North East analytics hub grew from the regional analytics that started at the beginning of the pandemic. This was due to the lack of regional specific data for planning services across the hospitals. National predictions and estimates did not reflect the region as these grouped the North-East with Yorkshire and Humber. These two areas (and even sub areas within them) were at very different stages of the epidemic and local observed patient numbers did not align with these estimates. Due to the imbalance in inequalities, the workforce mix and the underlying health conditions that caused different baseline risks to the wider population. The Integrated Covid Hub North East analytic hub continued to make regionally specific estimates across issues including the take up of vaccinations as well as the Covid-19 burden.

103.To further engage communities, it was evident that public health messaging and communication with communities was required. One of the first communication innovations that the Coordination and Response Centre created was an animated video (exhibit INQ000618520) which showed patients receiving a message to say they were positive and the process of how to report and log it.

104.The Coordination and Response Centre communication team continued in its aspiration to support the change and encourage our communities to engage and change behaviours to tackle the pandemic. The Change of Heart regional campaign was specifically commissioned to increase vaccination rates, following analysis highlighted low vaccination rates in 16–29-year-olds - a group deemed to be at high risk of contracting and spreading Covid-19. In February 2022, around 25% of north easterners in the age group were unvaccinated, equivalent to around 106,000 people, making this the age range with the highest proportion of unvaccinated adults.

105.The content and approach for the campaign was based on detailed insight gained from qualitative research with young people across the region. The creative was based on the premise that it is never too late to change your mind and get vaccinated, whether it was your first, second or booster jab. From March 2022, the campaign ran for two months across a range of advertising media and included a comprehensive communications toolkit to support wider amplification across NHS, local authority and higher education settings.

106.The approach was highly effective, with:

- 65% of the target audience recalling at least one element
- 40% of people recognising the TV adverts
- digital advertising recognised by over a third.
- Importantly, 84% of the audience took at least one of the campaign's desired actions and 24% stated that they had a vaccination after seeing the campaign.

Lessons for the Future

107.In situations of national crises that require rapid response, there is tremendous value in harnessing complementary skills from adjacent communities and infrastructure. Specifically, collaborative and close working between industry, academia and NHS Trusts can deliver results that are bigger than the sum of the individual parts.

108.Fully integrating pillar 1 and pillar 2 testing from offset would have allowed more pragmatic use and deployment of staff and resources.

109. Utilising the skills and knowledge from healthcare scientists in NHS diagnostic laboratories to support strategic decision making was essential in managing the pandemic; hence must continue to be harnessed in future central diagnostic service planning. It is important to note however that by introducing mass testing facilities that were separate from NHS diagnostic laboratories, 100's of years of cumulative experience were temporarily lost from the diagnostic labs in a matter of days. Many NHS diagnostic laboratories remained understaffed and underskilled as a result of this, some including Newcastle are still feeling the repercussions of this.

110. Timely decisions and consistency around suppliers, design, equipment and alterations. Initial Department of Health and Social Care discussions focused on the use of a specific supplier of instrumentation and associated reagents and consumables. However, sometimes at very short notice, when the building was fully underway, a second supplier would be identified and tender processes altered. Instrumentation was sometimes vastly different in size, complexity, utility, service needs, environmental and IT requirements. This then required remodeling of design and would then impact on cost and timing of build project. It was also noted that some alterations to fabric of the building were too expensive or impractical due to time constraints.

111. Solving the difficulties the Test, Trace and Isolate response found in trying to use the additional Pillar 2 capacity to deal with Pillar 1 testing. Had the pandemic continued for longer this would have taken a huge amount of pressure off the overstretched hospital pathology teams. The challenge was that the process diagram for the pandemic NPEX (national pathology exchange) system did not actually exist. The process was mapped out by the Integrated Covid Hub North East, which was then shared with the National Pathology Exchange (NPEx).

112. There will always be interoperability problems and snags between systems (particularly IT systems) so the pandemic question is always “how quickly can this be solved?” Given speed is lifesaving in these circumstances, single systems of accountability are essential. Consideration should be given to ensure this operates at a

regional level for two complementary reasons: (i) at the 'England' level the scale is too large for operational control and needs to be focused on strategy, not tactics; and (ii) local networks already exist at a regional level (between public health teams, between pathology services, between NHS operational leaders, etc.) and these can therefore be co-opted into a single command structure for the delivery operational solutions very quickly.

113. The principal lesson learned in trying to support the national and local Test, Trace and Isolate response was that consensus management in a crisis is an inevitable driver of delays and frustrations in logistics and operational delivery. We would strongly recommend that a single command structure is designed and exercised prior to the next pandemic and implemented immediately in situations where there is cause for concern about a possible or actual pandemic. This command structure should be regionally based and include both public health and NHS organisations (in this context, Scotland, Wales and Northern Ireland can be seen as 'regions' in any UK wide structure and response). A regional director should have leads in healthcare operational capacity, testing capacity, and public health capacity. An effective combination of local authority expertise about communities with NHS operational capacity can only be fully realised in a single accountability framework. This would benefit all aspects of pandemic response from prevention of spread to caring for very sick patients but it would be particularly important in Test, Trace and Isolate with respect to (i) enabling local authorities of very variable size and capacity to respond equitably to their population needs; (ii) enabling resources to be deployed according to need rather than accidents of LA boundary; (iii) enabling agreed innovation (applying learning quickly as the pandemic progresses) to be piloted, evaluated and rolled out within a single decision making structure; (iv) enabling economies of scale (in testing, data analysis, operational response -ICT solutions, for example- and efficiency for "the duration")

114. Health inequalities must be identified early in a pandemic response and appropriate actions taken to address these.

115. Finance and contractual processes were overly complicated. This was due to the rapid turnover of staff at United Kingdom Health Security Agency. Work had to be repeated, and the same conversations had multiple times. Agreements were often

made and then renegotiated due to staff turnover. This did not support a rapid response to the pandemic and created further resource pressures (time, money and people). The United Kingdom Health Security Agency were often slow at signing agreed documents. The Trust could not move ahead in good faith without the promised contract lengths and activity levels as this could have created multiple risks to the Trust.

116. Considering the effort and expense put into development of the Integrated Covid Hub North East, it is unfortunate that no consideration or funding was given to help us retain some of these laboratories (in some form), both to support the significant pressures, age and space constraints of the existing laboratory establishment and to allow more rapid scale up of testing when faced with a future pandemic.

117. 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

Martin Wilson, Chief Operating Officer

Dated: 12.06.2025

END