Witness Name: Tracy Nicholls OBE
(Officer of the British Empire)
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**UK COVID-19 INQUIRY**

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**WITNESS STATEMENT OF TRACY NICHOLLS OBE**

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I, Tracy Nicholls OBE, will say as follows: -

1. I am Tracy Nicholls OBE, Chief Executive of The College of Paramedics ("CoP" or the "College"). In terms of my professional background, I have been a qualified paramedic since 1998. I progressed to become Director of Clinical Quality and Improvement at East of England Ambulance Service NHS Trust from 2018 to 2019. In January 2020, I was appointed Chief Executive of The College of Paramedics and I remain in that role. In the New Year's Honours List 2023, I was awarded an OBE for services to the paramedic profession. I make this statement on behalf of the College, in response to the Inquiry's Rule 9 request for evidence made to our organisation in respect of Module 3.

Introduction to the College

2. By way of background, the College is the recognised professional body for all paramedics in the UK. Our role is to promote, represent and develop the paramedic profession across England, Northern Ireland, Scotland and Wales. We are not the statutory regulator of the paramedic profession; that is the Health and Care Professions Council ("HCPC"). Under The Health Professions Order 2001, the HCPC is the body with legal responsibility for setting standards for paramedics' education, training, and practice; approving programmes which paramedics must complete to register with the HCPC; keeping a register of professionals and acting if professionals on the HCPC register do not meet required standards.

3. The College was established in 2001 and is a membership organisation with over 21,900 members. The College is also a charity, having been registered with the Charities Commission since 2015.

4. College membership is open to all UK paramedics registered with the HCPC, student paramedics who are studying towards qualification and registration with the HCPC and those who have an interest in the paramedic profession and healthcare delivery. The College provides advice to members and student members alike and is a source of information and guidance for those who are considering becoming a paramedic.

5. All members have access to a wide variety of learning resources that provide high quality continuing professional development (CPD) across a range of platforms and at many events held around the UK.

6. The College supports the paramedic profession through publication of a wide range of documents that underpin the profession, including undergraduate and post graduate curricula, practice education guidance and a postgraduate career framework. The College supports its members in all aspects of paramedic practice spanning the four pillars of education, leadership, research and development as well as clinical practice in order help our members achieve the highest possible standards of patient care. To do this, the College organises a variety of national stakeholder working groups, advisory committees and ongoing research projects.

7. The Research and Development Advisory Committee, a sub-group within the College Research Centre, has a strategic role in shaping research policy and activity on behalf of the College.

8. The College also has its own peer-reviewed journal, the British Paramedic Journal, available online to its members.

9. The College provides professional support services to paramedics including legal representation and peer support for those under investigation by the HCPC. The College also represents the interests of paramedics and ambulance clinicians by providing a contact point for the media, publishing social media guidance, and by

responding to consultation documents and requests for advice from Government, and other professional bodies.

The impact of the COVID-19 pandemic on ambulance-related healthcare services and workers and the lack of guidance to support the sector.

10. At the beginning of the pandemic, like many other organisations, the College found that the guidance being disseminated by government bodies, such as Public Health England (PHE) and the Department of Health and Social Care (DHSC), in respect of COVID-19, was often confusing and contradictory to evidence being provided by other professional organisations[1]. The lack of clear guidance had a profound impact on our members and their ability to perform their jobs. Healthcare workers felt unsure which infection prevention and control guidelines to follow, when those available were unclear, impractical, or constantly changing and where local guidance differed from national and international guidance.[2] In particular, in March 2020, Infection Prevention and Control (IPC) Cell guidance limited the requirement for healthcare workers use of higher levels of Respiratory Protective Equipment (RPE) such as FFP3 masks, which are necessary to protect the wearer from airborne viruses and diseases, to only some medical procedures known as 'Aerosol-Generating Procedures' (AGPs) and for all other medical care only recommended the use of lower-level protection, such as Fluid Resistant Surgical Masks (FRSMs). The rationale for this IPC Cell guidance was based on an assumed primary pathway for the transmission of the COVID-19 virus through droplets and did not take into consideration the significant airborne route of transmission of the virus.

11. I do not intend to go into detail about the scientific evidence base for the airborne route of transmission of the COVID-19 virus in this statement, and instead refer the Inquiry to the detailed submissions on this subject given in the Module 3 Rule 9 response of the COVID-19 Airborne Transmission Alliance (CATA), of which the College is a member and contributor. However, I wish to highlight that this tension between the IPC Cell guidance on RPE and the scientific evidence otherwise available was a source of

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[1] For further analysis and examples of this, see John P Thomas, Anand Srinivasan, Chandu S Wickramarachchi, Parveen K Dhesi, Yat MA Hung and Ajay V Kamath, 'Evaluating the national PPE guidance for NHS healthcare workers during the COVID-19 pandemic', Clinical Medicine 2020 Vol 20, No 3: 242-7, DOI: 10.7861/clinmed.2020-0143. [TN/01 - INQ000257930]

[2] For further analysis and examples of this, see Houghton C, Meskell P, Delaney H, Smalle M, Glenton C, Booth A, Chan XHS, Devane D, Biesty LM, 'Barriers and facilitators to healthcare workers' adherence with infection prevention and control (IPC) guidelines for respiratory infectious diseases: a rapid qualitative evidence synthesis.' Cochrane Database of Systematic Reviews 2020, Issue 4. Art. No.: CD013582. DOI: 10.1002/14651858.CD013582. [TN/02 - INQ000257931]

concern, confusion and severe anxiety for our members from the very start of the pandemic. This anxiety heightened as the pandemic progressed and it became increasingly apparent that the IPC guidance being widely relied on was not providing our members with appropriate protection.

12. In addition, as much of the public information regarding transmission coming out was to wear masks, distance, protect yourselves, and ventilate where possible, our members were concerned because this advice did not seem to have been applied to ambulance-related services – despite the fact that they were working in confined spaces in the back of ambulances, often for prolonged periods of time due to delays of patient handover at hospitals. The nature of an ambulance does not permit the crew to be more than two metres apart, a requirement for general members of the population throughout much of the pandemic. Instead, the IPC cell guidance provided that crew members should wear FRSM's only whilst in the cab. This did not address the lack of ventilation in the cab and did not include opening the windows during the driving to and from emergency calls.

13. Indeed, throughout the pandemic, the College found a lack of clear guidance on issues specifically relating to the provision of ambulance-related services. This lack of guidance can in part be explained by the focus on healthcare other than ambulancerelated services. Before the onset of the pandemic, there had long been a paucity of good quality pre-hospital research, including into ambulance-related services, and prehospital research tended to be undertaken by other professions, not by paramedics. As a result, the majority of IPC guidance for the protection of healthcare workers focused on the evidence available in respect of doctors and nurses in hospital settings and there was limited evidence to support ambulance-related services specifically. It therefore seemed incongruous to the College that an undifferentiated, "one size fits all" approach was taken to guidance, when the environment of an ambulance is very different to that of other medical professions – as described above, it being a confined space in which staff and patients could be contained for extended periods of time. For example, there is limited research into issues such as ventilation in ambulances and the risk to ambulance workers when caring for patients in that clinical setting, such as when caring for a coughing patient.[3]

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[3] For further analysis of this issue, see Gedge DA, Chilcott RP, Williams J. 'Quantifying the Risk to Health Care Workers of Cough as an Aerosol Generating Event in an Ambulance Setting: A Research Report.' Prehosp Disaster Med. 2022 Aug;37(4):515-519 [TN/03 - INQ000257932].

14. The College suspects that the underlying assumptions in the IPC Cell guidance discussed above, that adequate ventilation was afforded to those in ambulance settings, was influenced by the widely cited paper by Khai Tran and others 'Aerosol generating procedures and risk of transmission of acute respiratory infections to healthcare workers: a systematic review'. This paper has been directly referred to in publications by public health bodies as providing part of the rationale for not classifying common ambulance procedures as AGPs (for example see [TN/04 - INQ000257933] and [TN/05 - INQ000257934]). However, importantly, this study did not focus on ambulance settings, but instead on hospital settings, and in its own conclusions highlights the 'lack of high quality studies' available on which to base its findings [TN/06 - INQ000257935].[4]

15. A specific example of contradictory guidance, failing to cater to the specific needs of the ambulance sector, is the Government guidance on 'Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022' [TN/07 - INQ000257936], which was withdrawn in May 2022. This guidance recommended the universal use of face masks for staff, patients and visitors. However, in reality, there was often limited stock of masks of any type, making it difficult to comply with this guidance. This advice also did not consider the specific situation faced by ambulance staff in which it could be detrimental to a patient's health to ask them to wear a mask for their entire ambulance journey and hospital delay if they were experiencing respiratory problems. In addition, the guidance recommended physical distancing of at least one metre, and where possible two metres, in particular where patients were suspected or confirmed to have a respiratory infection, which, as discussed above, could not be accommodated in the cab of an ambulance or in the saloon where treatment is administered.

16. From the beginning of the pandemic, we also heard from our members that, appropriate RPE was difficult to obtain, and there remained confusion about the levels that were required for attending and treating patients, depending on their COVID-19 status. Our members reported that there were often limited supplies of appropriate

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[4] For further analysis of the low quality of the evidence and studies available in respect of defining AGPs and AGP settings, see Wilson NM, Norton A, Young FP, Collins DW. 'Airborne transmission of severe acute respiratory syndrome coronavirus-2 to healthcare workers: a narrative review'. Anaesthesia. 2020 Aug;75(8):1086-1095. doi: 10.1111/anae.15093 [TN/08 - INQ000257937] and Wilson NM, Marks GB, Eckhardt A, Clarke AM, Young FP, Garden FL, Stewart W, Cook TM, Tovey ER. 'The effect of respiratory activity, non-invasive respiratory support and facemasks on aerosol generation and its relevance to COVID-19'. Anaesthesia. 2021 Nov;76(11):1465-1474. doi: 10.1111/anae.15475 [TN/09 - INQ000257938].

RPE[5] and, pursuant to the IPC cell guidance discussed above, higher level respiratory protection was mostly reserved to AGPs. We were informed by many of our members that higher levels of RPE, such as FFP3 masks, were often locked away from staff and that if a paramedic chose to use an FFP3 mask to protect themselves in a setting other than one recognised as an AGP, they were often chastised. Members reported being forced to explain why they had chosen to use a higher level of protection and having to justify this to their managers before receiving any replacements. We also heard from members that they were provided with disposable aprons (likened to those worn at Greggs, the bakers) as a form of 'Personal Protective Equipment' (PPE). These aprons were completely impractical and once you went outside, any spillages or pathogens that may be on them were blown into the paramedics' faces by gusts of wind. We also heard that some of the FRSMs provided to and used by paramedics were out of date by some degree. These out-of-date masks had often been in the storage for some time and our members contacted us very anxious about the level of protection they were afforded. There was confusion regarding the guidance on which type of PPE would protect healthcare workers best, the best way to put on and remove PPE, and how best to train healthcare workers in respect of the same[6]. Our members often also reported that they did not feel supported in obtaining access to adequate PPE and identifying the correct guidance[7].

17. The availability of appropriate RPE was variable across the UK and the experiences of our members often depended upon the policies and resources of the Trust for whom they worked. For example, the devolved administrations had inconsistencies in their supplies of RPE, with Northern Ireland being particularly problematic. We heard from many of our members in Northern Ireland that they had to justify and get management authorisation to replace high-level RPE if they had used this in the course of their work, after deciding that it was necessary to protect themselves, and that it was kept under lock and key in some areas of the service.

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[5] For further information regarding limited supplies and the potential reasons for the same, see the 'National Audit Office Report: The Supply Of PPE During The COVID-19 Pandemic', 3 November 2020 [TN/10 - INQ000257939].

[6] For further analysis of the evidence available in 2020 regarding which types of PPE and practices for using PPE best protected healthcare workers, see Verbeek JH, Rajamaki B, Ijaz S, Sauni R, Toomey E, Blackwood B, Tikka C, Ruotsalainen JH, Kilinc Balci FS, 'Personal protective equipment for preventing highly infectious diseases due to exposure to contaminated body fluids in healthcare staff', Cochrane Database of Systematic Reviews 2020, Issue 4. Art. No.: CD011621. DOI: 10.1002/14651858.CD011621.pub4 [TN/11 - INQ000257940].

[7] For further analysis of the psychological impact on healthcare workers see, Steve Kisely, Nicola Warren, Laura McMahon, Christine Dalais, Irene Henry, Dan Siskind, "Occurrence, prevention, and management of the psychological effects of emerging virus outbreaks on healthcare workers: rapid review and meta-analysis', *BMJ* 2020; 369 :m1642 doi:10.1136/bmj.m1642 [TN/12 - INQ000257941].

18. In addition, throughout the pandemic FIT testing of RPE across the ambulance sector was inconsistent. FIT testing refers to the practice of testing RPE on individuals to ensure that it fits them properly, matches their facial features and that it provides a proper seal, which is essential to ensuring its effectiveness. There are several methods available and the Health and Safety Executive's (HSE) information document INDG 479 provides information on how the HSE expect FIT testing to be conducted [TN/13 - INQ000257942]. The performance of tight-fitting respirators relies on achieving a good seal between the facepiece of the respirator and the wearer's face. If the seal is inadequate, contaminated air will take the path of least resistance and will travel through leaks in the face seal. Consequently, a poor seal to the face will reduce the level of protection provided to the wearer. As people come in all sorts of shapes and sizes, it is unlikely that one particular type or size of RPE facepiece will fit everyone [TN/14 - INQ000257943]. For example, facial hair – stubble and beards – often make it difficult to get a good seal of the mask to the face. Likewise, many women are often unable to manage a good seal due to their smaller facial anatomy. Alternatives should be sourced where individuals are unable to pass a FIT test.

19. Whilst many NHS trusts had kept up to date with their FIT testing processes, there was often no resolution for those who could not get a good seal during testing. Again, the level of FIT testing available differed across the UK depending on the Trust for whom each paramedic worked. The College is not aware of the individual compliance figures for each Trust and therefore cannot provide the names of specific Trusts who did or didn't provide appropriate levels of FIT testing. The College is however aware, as a result of reports from its members, that the discrepancies in FIT testing could often be due to whether a Trust had the ability to release staff to conduct a thorough FIT test in a simulated environment, as stipulated by the HSE.

20. The College is also anecdotally aware from its members that, in the East of England Ambulance Service, as the demand for higher level respiratory protection increased during the pandemic, it brought in a number of FIT testers, who performed training so that staff could perform FIT testing internally within the Trust, some of whom were innovatively sourced from furloughed members of the construction industry wanting to help. Similarly, the College was made aware that the West Midlands Ambulance Trust, who were later followed by the South East Coast ambulance service, purchased Versa Flo hoods for their staff as an alternative to FIT testing. Likewise, the College was informed that some Trusts supported their staff to utilise RPE that was at an increased

level to that being recommended by IPC guidance, as they recognised anxiety around RPE and FIT testing among staff – but we are unable to corroborate this statement with any further evidence.

21. The College suggests that each ambulance service will have auditable data on its FIT testing compliance, but that data is not readily available outside of the ambulance sector.

22. The College was informed by members that often, when staff challenged their line managers about their levels of protection, they were told that the ambulance sector had aligned themselves with the national guidance issued by NHSE, which emanated from the IPC Cell, and that no higher protection was required. As the IPC cell guidance was focused on transmission of COVID-19 through droplets, it emphasized elements of the Hierarchy of Controls (HoC), such as making hand washing and surface wiping the main means of infection prevention and control.

23. It was a failure of pandemic management that our members faced such difficulty in obtaining PPE/RPE that could effectively protect them and that they faced potential repercussions at work for challenging the inadequate IPC Cell guidance. This failure is epitomised by stories we have been told by members during the pandemic that some ambulance sector workers were buying their own high-grade PPE/RPE and hiding it from their managers in order to feel safe.

24. We recognise too that Exercise Cygnus (2016) should have given the UK the opportunity to enact the recommendations made within it, including making better use of cross-agency working with supply and demand of critical items such as RPE, but this did not materialise. Every ambulance trust had a pandemic flu policy, but there did not seem to be a preparedness arising from these historic exercises or policies at the time that the COVID-19 pandemic took hold.

25. At the point when COVID-19 became more prevalent and many members of the public were still unvaccinated, it became clear that FRSMs alone were not adequate protection, despite most ambulance staff being vaccinated from around January 2021. This was evidenced by the high sickness absence rate following exposure to COVID19 positive patients who members were conveying in the back of their ambulances. This was particularly apparent once vaccine efficacy began to wane, around six months

after the initial rollout. The exposure risk to ambulance staff was exacerbated by the lengthening handover delays at the emergency departments where paramedics and ambulance clinicians had to sit in close proximity with patients for hours on end with very little opportunity for ventilation.

26. In our view, another reason for the lack of clear guidance to our members was a lack of understanding on the part of those issuing guidance about the unique challenges faced by those providing ambulance-related services. Throughout the pandemic, the working environment of a paramedic in the ambulance sector meant that the COVID19 status of patients they were going to see and/or treat was often unknown. This was particularly acute in the early stage of the pandemic. Our members routinely, and often multiple times a day, had to enter situations with unknown risks of exposure to a deadly virus. The difficulty became more problematic as the Emergency Call Prioritisation Advisory Group (ECPAG) – an NHS England (NHSE) led group whose primary purpose is to advise on issues of ambulance call prioritisation [TN/15 - INQ000257944] – were unable to agree to a requirement for an additional Pre-Arrival Instruction (PAI) at the end of 999 calls asking those who had called to open their windows to ventilate their homes. The College was informed by senior paramedic members at several ambulance trusts who had felt the need to raise this issue that this suggested PAI had been declined by the ECPAG. It was suggested by the senior clinicians who contacted us that this was due to a perceived infringement of patients' rights within their own homes. The College is not however able to verify this information as there are no published minutes for the ECPAG meeting where this was discussed. Nevertheless, we do know that the PAI was not added to the script for ambulance calls and the College was frequently contacted by members about their anxiety in relation to entering patients' homes where the virus was present and there was no ability to ventilate to protect themselves. Without knowing the risk of exposure to COVID-19 on a given call out, our members were often placed at potentially higher risk as they were unsure what level of RPE to wear prior to entering the call location.

27. Another tension between the IPC cell guidance and working practice for our members was that it did not consider the ambulance environment in a similar way to other similar environments, such as on an Intensive Therapy Unit (ITU). ITU's were recognised as environments dealing with very sick patients and ITU workers were recommended higher levels of RPE. However, this was not recognised in the IPC cell guidance for ambulance-related services, despite the fact that many of the very sick patients in ITU

would first be transported and wait in an ambulance for many hours. Our members' frustration at the apparent contradiction in guidance was exacerbated by the fact that the hospital staff who came out to see the patients in the rear of ambulances as part of their triage were in much greater RPE protection than was afforded to the ambulance paramedics and clinicians.

28. We were grateful that the Royal College of Nursing (RCN) had devised its own risk assessment framework and toolkit which we highlighted in conversation with the Association of Ambulance Chief Executives ("AACE") IPC Lead for the ambulance sector [TN/16 - INQ000257945]. Access to this type of resource helped our members in making their own decisions about the level of RPE that they would choose, based on an evidence-based framework of risk.

29. It is the College's view that the IPC cell guidance failed to apply the precautionary principle and that, in the absence of concrete evidence that high level RPE was not necessary, the guidance should have been promoting provision of the highest levels of protection available for our members, especially as the pandemic progressed and new, unknown variants of the virus appeared.

30. Another particular concern during the pandemic, and one that was confused and complicated by unclear guidance, was the complex and challenging problem posed by dealing with patients who suffered a cardiac arrest. The level of protection from the COVID-19 virus required to perform cardiopulmonary resuscitation (CPR), such as chest compressions and defibrillations, potential intubation and advanced airway management was untested with little, or no evidence published. In particular, there was considerable contradictory evidence regarding whether CPR procedures should be classified as an AGP and the subsequent level of PPE required for conducting the same.[8] This was despite the fact that prior to the pandemic these procedures had been classified as AGPs by the UK Government and health authorities [TN/17 - INQ000257946]. The College, along with Resuscitation Council UK (RCUK) felt that it was highly likely that procedures such as CPR and intubations were AGPs and in March 2020, the College issued a statement to our members outlining the rationale for this [TN/18 - INQ000257947].

[8] For further analysis of this issue see, Evelyn Brown and Lai Man Chan, 'Should chest compressions be considered an aerosolgenerating procedure? A literature review in response to recent guidelines on personal protective equipment for patients with suspected COVID-19', Clinical Medicine 2020 Vol 20, No 5: e154–9, DOI: 10.7861/clinmed.2020-0258 [TN/22 - INQ000257951]

31. Nevertheless, during the pandemic CPR and intubations were removed from the UK AGP list, despite the same continuing to be classified as an AGP in other countries, with the only explanation given by the IPC Cell being that "they do not currently have a strong evidence base" for its inclusion on the list [TN/19 - INQ000257948]. The College does not know exactly when and by which body this decision was made, as the minutes of meetings and decision-making records in relation to the AGP list are not publicly available. However, the College notes that the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) published an evidence review in April 2020 which concluded that CPR and intubation procedures did not result in a significantly increased risk of transmission [TN/04 - INQ000257933] and PHE subsequently released a statement confirming chest compressions would not be included on the UK list of AGPs [TN/20 - INQ000257949]. The Independent High Risk AGP panel also reviewed the issue in July 2021 and concluded that there was not sufficient evidence to support inclusion of CPR and intubations on the AGP list [TN/21 - INQ000257950].

32. The College found out about this decision through speaking to stakeholder partner organisations and scouring the NHSE website for any amendments. We had to rely on our members and partners, and our own investigations and intelligence sourcing, as there was no formal route to having this information shared with us by AACE or NHSE.

33. We note that the evidence supporting the removal of intubation from the list of AGP's was based on studies performed in a hospital controlled environment, in which patients were anaesthetised and paralysed. However, as paramedics do not routinely have the ability to anaesthetise or paralyse their patients, which is the remit of those trained in critical care procedures, such evidence was not sufficient to support the removal of intubation from the AGP list in ambulance and paramedic settings [TN/23 - INQ000257952].

34. There was a paucity of evidence in respect of the levels of RPE/PPE required to carry out CPR – however, what was known was that the quickest response to a cardiac arrest has the most optimal chance of saving a patient's life. In order to reduce the risk to the CPR provider, without negatively impacting the patient's chances of survival, it was recommended that patients have their mouths covered by a cloth or towel [TN/24 - INQ000257953] (if you were a member of the public doing CPR), or an FRSM. For

an ambulance crew, the first crew member donned Level 3 RPE, whilst the second crew member approached the scene to determine whether any life saving techniques could be immediately applied. Our members informed us that this caused greater anxiety for paramedics and ambulance clinicians as they were put in positions where they often felt that they were risking their own safety by attending to a cardiac arrest patient without donning the correct level of RPE out of a professional drive and responsibility to save a patient's life. The College recognised that this dichotomy caused moral injury to paramedics and ambulance clinicians.

35. Indeed, the College was contacted by many members to communicate their distress and anxieties surrounding CPR and intubation procedures. Many were concerned that the RPE/PPE being recommended would not provide them with sufficient protection. There was also an overwhelming feeling of guilt communicated by our members – as they worried that they might need to protect themselves, by donning the appropriate levels of PPE/RPE before helping their patients, which made them feel deeply uncomfortable. We were told by many members that they had felt so guilty that they were going into unknown cardiac arrest situations without appropriate PPE so as to act as quickly as possible and not to provide any patient with suboptimal care. Other members were also concerned about how their performance at cardiac arrest calls may be perceived by their regulator (the HCPC) if they were delayed in putting on their PPE/RPE.

36. It was highly disappointing that the advice of organisations such as the RCUK, who had already identified that caution should be used to minimise the time to the side of a patient and keep those attempting CPR safe, was not followed, despite them being eminent in the field of cardiac arrest medical care and having undertaken years of research with experts dedicated to saving patients' lives. Indeed, in April 2020 RCUK issued a statement further highlighting their concern regarding the AGP list decision [TN/24a - INQ000257954]. However, the AACE in fact countered RCUK's advice by issuing a statement in May 2020 that failed to consider the precautionary principle and gave no new evidence to draw on [TN/25 - INQ000257955].

37. A further impact on the ambulance-related sector that should be highlighted was that on the control rooms (Ambulance Operations Centres), responsible for taking 999 calls, identifying available ambulance services and being the first point of contact for the public. The control rooms were put under immense pressure when COVID-19 was

most prevalent and there were high numbers of people needing emergency medical care. This was often exacerbated by control rooms suffering staff shortages, as COVID-19 could spread rapidly if one member of staff in the room contracted the virus. All of this had a knock-on impact on ambulance call pick-up times. In addition, those in the control room bore a heavy emotional burden as they were often working long shifts, of around 12 hours, taking continuous calls, while other waiting calls stacked up behind them, often listening to someone deteriorate very quickly over the phone, or pass away, and trying to support the callers' friends and families.

38. The College also heard from our student members who were experiencing vastly different practices across the UK. These inconsistencies ranged from students not being able to have the vaccine as they were not part of the core workforce, to them not being able to use the PPE/RPE due to the stocks being so low, all of which often prevented student members from being given time on work placements, due to the high risk. Often students were used in the ambulance operations centres rather than to support a dwindling workforce that had suffered a great deal of short-to-medium term sickness. This meant that the ambulance sector missed out on an opportunity to bolster the workforce and students in turn missed out on a lot of important experience before they qualified.

39. The College also wishes to highlight that, as the pandemic progressed, there was a failure to react and change government guidance in response to the clear negative impact that was being had on the ambulance-sector services and workers. The dogma that continued to be espoused from PHE and the DHSC, which focused on more rigorous hand washing, and surface wiping as the key, as opposed to respiratory protection, did not correlate with the high levels of sickness and the spread of COVID19 in a vaccinated workforce that we were seeing. Ambulance trusts recorded the highest rates of sickness absence rates across the NHS [TN/26 - INQ000257956, TN/27 - INQ000257957]. Furthermore, over 30 of our members lost their lives to COVID-19, some of whom had taken it upon themselves to come out of retirement to support their fellow colleagues during the pandemic, the highest out of all the allied health professions (AHP) [see table 9 of TN/28 - INQ000257958]. This death rate is reflective of the nature of the ambulance work our members undertook bravely and commendably, but also of a failure to protect our sector.

40. The challenges posed by the pandemic tested the personal resolve of our members and is still having an impact today. Throughout the pandemic the ambulance-related sector faced severe levels of burnout among staff members and difficulties retaining the workforce. A study in December 2021 found that more than 50% of ambulance staff were experiencing varying levels of burnout, with 87% displaying moderate or high levels of depersonalisation towards their work, with contributing factors including lack of management support, involuntary overtime and a poor work-life balance [TN/29 - INQ000257959]. In addition, in the 12 months before June 2022, 1 in 10 paramedics left their jobs and 1 in 4 said when surveyed that they would leave their role as soon as they could find another job [TN/30 - INQ000257960]. It is clear that the experiences of the pandemic had and will continue to have a profound impact on staff retention in our industry.

41. We are also aware of large numbers of our members continuing to suffer with Long Covid following an infection they contracted while at work.

42. The College did not specifically identify any major inequality related issues in respect of the delivery of ambulance services during the pandemic. As a profession, we are grossly under-representative of our communities within our workforce, with only between approximately 4 and 7.5% of our workforce being from an ethnic minority background. Those staff who identified as having clinical vulnerabilities were able to shield and, as front-line emergency workers, the vaccination program was rolled out early to those who were working in the ambulances and control rooms.

43. All of the above inevitably put a huge strain on the ambulance-related sector and on the College itself. Prior to the pandemic, the College had never received such a volume of concerns and queries from our members. The failure of the IPC cell, PHE, NHSE and the UK Government during the pandemic to recognise the specific and unique challenges faced by ambulance-related services, and the failure to manage the supply and availability of appropriate PPE/RPE, caused the College and our members continual challenges. As the working environments of ambulance clinicians and paramedics became more and more extreme, too many issues of high importance to paramedics proved to be consistently unresolved causing immense frustration. From very early on in the pandemic we became a source of support for members who were grappling with anxiety over how to protect themselves and their families, as well as continue with their work providing lifesaving services to the community. This put the

College in a very difficult position, as felt compelled to try to ensure the safety of members, with limited resources and expertise to manage such widespread issues. At the same time, the College was also struggling to coalesce the national guidance being disseminated by government with the scientific evidence and information that we were receiving from other professional bodies in respect of the airborne transmission of COVID-19 and the protection that should have been being provided to ambulancesector workers. We were in essence required to fill the void where the specific guidance for our sector and our members was otherwise lacking.

The College's response to the COVID-19 pandemic and the issues facing our members.

44. The College provided guidance to its members and sought to lobby and seek clarity on issues during the pandemic because they were of fundamental importance to our members' safety. Notwithstanding our outspoken stance, we did fully appreciate the unprecedented scale and complexity of the challenge presented by COVID-19. It was fundamentally important to us that our members were able to look after themselves and their colleagues during this time and to use any support mechanisms that were made available to them.

45. Due to that lack of clear guidance for our members, at the early stages of the COVID19 pandemic, the College tried to reach out to stakeholders to find the latest evidence on how to protect our members and those within the profession. We recognised that many of our members work within the ambulance sector and were therefore placed at significant personal risk.

46. On 13 March 2020, in the absence of other guidance, we put out a generic statement to our members, signposting them to the ambulance IPC guidance available [TN/31 - INQ000257961]. However, upon reviewing the IPC guidance, we recognised that the information contained within it was insufficiently clear and helpful, so on 20 March 2020 we wrote to the then Secretary of State for Health and Social Care ("SoSHSC"), Rt Hon Matt Hancock MP, asking for urgent attention to be paid to the lack of RPE being made available to frontline healthcare workers and for a review of the unique environment that our members were working in, with so many unknown factors [TN/32 - INQ000257962] – highlighting our view, as discussed above, that the precautionary principle should be applied.

47. Despite further letters to the Secretary of State for Health and Social Care [TN/32 - INQ000257962 and TN/33 - INQ000257963], the College was not granted an explanation nor an opportunity to meet with government for many months. Eventually, a meeting with PHE in early 2021 gave us the opportunity to explain our members' anxieties. We outlined that the ventilation rate within the ambulance saloon was not sufficient to move the air around the ambulance and the FRSMs were not the correct level of respiratory protection if patients were COVID-19 positive. Our initial discussions were met with empathy, and we were told that PHE would approach the IPC cell for further clarification. PHE seemed to appreciate this was particularly important given that there were at this time two new variants identified which had a much higher rate of transmission, that extended handover times were leading to more ambulance staff being infected and more ambulance staff were taking sickness absence leave.

48. However, the response back from PHE was bitterly disappointing [TN/34 - INQ000257964]. PHE stated that whilst they had great sympathy for the ambulance sector, our members should increase the IPC cell's application of the Hierarchy of Controls, wash surfaces more often, and open a window and open a door, if possible, but there would be no precautionary principle afforded to us at this time. In January 2021, we saw handover delays at hospitals reach between 10 and 12 hours, sometimes more. Coupled with temperatures of minus 2 degrees, this was not an environment where you could open a door for ventilation without compromising the environment for the patient. Despite the attempts of AACE to ask crew members to rotate every 15 minutes to ensure that they did not have a high exposure rate, this was obviously not good enough given that airborne transmission was the way the virus was spreading predominantly.

49. AACE published further guidance in January 2021 [TN/35 - INQ000257965] and the College was also party to information received by AACE and the IPC Cell from NHSE [TN/36 - INQ000257966] which outlined that there was, in their view, no need to increase the levels of RPE to protect ambulance staff, but that they should instead practice more diligence in applying the existing IPC precautions.

50. In light of all these concerns, the College joined with CATA (then known as the Airborne Generating Procedures Alliance – AGPA) in February 2021 to write to the then Prime Minister, Rt Hon Boris Johnson MP, [TN/37 - INQ000257967] asking jointly with others

for better ventilation, PPE awareness and more emphasis on research to investigate our concerns.

51. In April 2021, the College received a response to one of its letters to the Secretary of State for Health and Social Care from the Parliamentary Under Secretary of State at the Department of Health and Social Care, Jo Churchill MP [TN/38 - INQ000257968]. This letter failed to answer any of the concerns we had raised about paramedic and ambulance clinician safety and simply reiterated current IPC guidance.

52. Further documents were issued by AACE and national groups [TN/39 - INQ000257969, TN/40 - INQ000257970 and TN/41 - INQ000257971] that simply failed to recognise the strength of feeling of the staff who were on the front lines, where COVID-19 was rampant and sweeping through communities with extremely high hospital admissions and death rates. The College was sent the Hierarchy of Controls poster [TN/42 - INQ000257972], but the focus continued to be on controls that were not suitable for the risks being faced by the ambulance-related sector, rather than the RPE that was really needed by our members.

53. In respect of the specific issue of guidance for ambulance-sector workers caring for patients suffering cardiac arrest, further to the guidance on CPR and intubations already published by the College and RCUK in March 2020 [TN/18 - INQ000257947], the College also made submissions in to the Secretary of State, Matt Hancock, in a letter in January 2021 on the need for an urgent review of the respiratory protections being recommended in IPC guidance and for there to be specific consideration of the environments in which paramedics and ambulance clinicians work [TN/33 - INQ000257963]. In addition, the College attempted to engage the IPC Lead for the Association of Ambulance Chief Executives on these issues. However, as discussed, our efforts were largely ignored, and the CPR and intubations remained absent from the list of AGPs.

54. While the government guidance to the ambulance-sector remained stagnant, the College recognised that the first and second-line managers within the ambulance sector would be facing some unprecedented challenges with their staff, both in terms of keeping them safe and allaying their fears, but also keeping the staffing levels up to meet the demands placed on the sector by the pandemic. The College therefore issued guidance for managers on the mental wellbeing of and psychosocial support for

ambulance personnel in a pandemic crisis to endeavour to support those managers who may have found themselves in unchartered territory or may be junior managers themselves [TN/43 - INQ000257973].

55. In addition, to inform our guidance to members during and since the pandemic, the College conducted three main studies in direct response to the pandemic – the COVID19 Ambulance Response Assessment (CARA) study [TN/44 - INQ000257974, TN/45 - INQ000257975, TN/46 - INQ000257976]; the Bio-Aerosol Distribution and Generation in Enclosed Spaces study (BADGERS); and the Study Of elements of cardio-Pulmonary resuscitation thought to Generate Aerosols during these Procedures (STOPGAP), as well as developing an E-learning module for paramedics [TN/47 - INQ000257977].

    a. The College undertook some primary research on how staff were feeling about their preparedness and wellbeing during the pandemic in the form of the CARA study [TN/47a - INQ000257978]. The CARA study was a national survey, led by the College's Research and Development Advisory Committee, of ambulance service healthcare professionals' preparedness and response to the COVID-19 pandemic, aligned with the COVID-19 Emergency Responsive Assessment (CERA) study for emergency medicine. The CARA study, using three questionnaires in April 2020, May 2020 and September to October 2020, aimed to enable the experiences of UK frontline ambulance staff working during the first wave of the pandemic to be heard, specifically in relation to their feelings of preparedness, suggestions for leadership, the impact on ambulance sector-workers psychological stress and perceived ability to deliver care, and experiences on infection prevention and control practices. The CARA study resulted in three publications [TN/44 - INQ000257974, TN/45 - INQ000257975 and TN/46 - INQ000257976] - the findings of which I have discussed in more detail below in paragraphs 56 – 58.

    b. The BADGERS study was a collaboration between the College and the University of Hertfordshire Toxicology Research Group in February 2021. It was a small-scale experiment undertaken in a laboratory facility in Andover to estimate the risk of COVID-19 infection to paramedics working within the confined space of an ambulance cabin. In summary, an infectious dose was achieved within minutes in laboratory conditions. The results from this study,

using risk modelling, highlighted concerns about the efficacy of masks and how they are measured internationally. This stimulated the development of the next phase of research, STOPGAP. There are not yet any publications available as a result of this study.

c. STOPGAP was a study jointly funded by the College and the University of Hertfordshire Toxicology Research Group to investigate the elements of cardiopulmonary resuscitation procedures thought to generate aerosols. The study was stimulated by the uncertainty of aerosols and particle distribution during COVID-19 and the subsequent risks to ambulance staff and the public – however it is hoped its findings will be of relevance to other situations, as well as preparing for any future pandemic. The study is currently in its final year of three and is in the clinical phase, measuring aerosol spread and particle intensity in live cardiac arrest in an ambulance service and Emergency Department. Other phases of this study have included testing a variety of FFP3 marks being worn by paramedics during cardiac arrest, the level of protection afforded by these masks as a patient coughs, and further qualitative exploration with paramedics around the wearing of PPE. There are not yet any publications available as a result of this study.

56. In respect of feelings of preparedness, the CARA study's first paper ("See us as humans. Speak to us with respect. Listen to us". A qualitative study on UK ambulance staff requirements of leadership while working during the COVID- 19 pandemic) found that a large number of participants expressed low confidence and anxiety resulting from disagreement, inconsistency and an absence of transparency related to policy implementation [TN/44 - INQ000257974 and TN/48 - INQ000257979]. To further support their well-being, staff wanted leadership to understand and empathise with their working conditions, to work to reduce the risks and if required, and to facilitate access to appropriate mental health support.

57. In a second paper in respect of wellbeing, ("The COVID-19 Ambulance Response Assessment (CARA) study: A national survey of ambulance service healthcare professionals' preparedness and response to the COVID-19 pandemic: What are the predictors of psychological distress?" – which is awaiting publication), participants in the CARA study completed the General Health Questionnaire-12 (GHQ-12) to measure their anxiety, mood and general health through three phases of the study,

which covered the acceleration phase of the first wave of the pandemic and two further phases during the peak and deceleration phases of the pandemic. A score of greater than 12 indicates the participant may be experiencing psychological distress. The overall mean scores during phase one were 16.5, reducing to 15.2 by phase three, indicating significant numbers of ambulance-sector workers suffering psychological distress. Common factors leading to higher mean GHQ-12 scores included feeling unprepared for the pandemic, a lack of confidence in both using personal protective equipment and managing out of hospital cardiac arrests in patients with confirmed or suspected COVID-19 [TN/49 - INQ000257980 and TN/45 - INQ000257975].

58. In a third paper, ("Family members screaming for help makes it very difficult to don PPE." A qualitative study on UK ambulance staff experiences of infection prevention and control practices during the COVID-19 pandemic – which is awaiting publication) the CARA study also found that many members lacked confidence in using PPE because of low familiarity with it, a perceived inadequate evidence base, confusing communication and changing policies, as well as experiencing insufficient supply, items of poor quality and suboptimal FIT testing [TN/46 - INQ000257976 and TN/50 - INQ000257981]. Compliance with policy and confidence in PPE use was further influenced by discomfort, urgency, and perceptions of risk.

59. The College also notes that in studies conducted by other researchers, ambulance staff described a stretched system, with resources to respond to patient demand being stretched thinner by staff sickness and isolation, longer job cycle times and increased handover delays at hospitals, as well as the emotional load of responding to the pandemic, particularly for call centre staff [TN/51 - INQ000257982].

60. In addition to carrying out research to support its members, the College offered specific e-learning to its members during the COVID-19 pandemic, including co-creating an Elearning module, alongside Health Education England (HEE), through *e-Learning for Health,* which was offered to paramedics [TN/47 - INQ000257977]. We also offered a number of wellbeing initiatives as we recognised the continued psychological impact of having to work under such conditions.

61. The College also produced some non-technical guidance with the support of our critical care advanced practitioners, which emphasised the stressors of using RPE and the

importance of keeping one another safe [TN/52 - INQ000257983]. The guidance also highlighted the impact on our members' mental health and wellbeing.

62. In order to assist members suffering with Long Covid, while the College as a professional body is not able to provide direct support services, we refer our members to The Ambulance Staff Charity (TASC) who have the ability and expertise to support those who, amongst other issues, have had their working and personal lives impacted by the condition. The College has signposted resources on its website for those who are impacted by Long Covid and has also undertaken fundraising activities to support TASC to continue its vital work. We understand from TASC that they have subsequently provided support to ambulance staff suffering with Long Covid in order to make their lives easier – for example, by fitting stair lifts in their homes [TN/53 - INQ000257984].

63. Additionally, although the College is not able to function as a trade union, we understand that all ambulance services across the NHS ceased to provide sickness leave payments to employees with Long Covid in 2022, and we have raised concerns in respect of the same in our regular dialogue with AACE.

64. The College also has a signposted members to an E-learning for health module on Long Covid [TN/54 - INQ000257985].

65. The College also put out some guidance to our student members in March 2020 [TN/55 - INQ000257986 and TN/56 - INQ000257987]. The College tried wherever possible to provide additional support for students as their placements and experiences were suboptimal due to the constraints of vaccines and the desire to protect existing staff.

66. As set out above, the College spent a lot of time providing communication to our members. We were aware this could, at times, conflict with the information that was coming to them from their trust and from AACE, but we always sought to provide our members with the best and most up-to-date evidence. We recognise and acknowledge that the College was not in a position to make a difference to the levels of RPE that were being offered by each trust.

Conclusion

67. Overall, it is our view that the College, despite being the only professional body for paramedics in the UK, was largely ignored. We recognised that the ambulance sector would have little choice but to abide by national guidance, but the College remained disappointed that its members did not feel like their concerns were being addressed. The fact remains that we were only asking for the precautionary principle to be applied until more evidence emerged regarding the dangers of COVID-19, in order to protect all those providing emergency, undifferentiated care to the hearts of communities at one of the most challenging times in our lives. Instead, our members described feeling like `cannon fodder' and `canaries in the coal mine', completely unprotected and that the risks they took and the service they provided were not valued.

68. Ambulance services are essential to the NHS and to providing medical care to those in need, including emergency treatment, demonstrated by the huge volume of calls out for ambulances during the pandemic. However, the failure to protect ambulance-sector workers created a vicious cycle and had a negative knock-on impact on the provision of services to the wider public. Had ambulance-sector workers been properly protected, there would have been lower infection rates and sickness absence among them, and there would have been greater resources to meet the high demand for ambulance services. Instead, the delays in ambulance arrivals and hospital handovers were exacerbated by shortages of ambulance-sector workers – a trend which may continue as the workforce dwindles and the number of workers facing burnout and psychological trauma increases.

69. The College wishes to emphasize that all the issues facing the ambulance-related sector and its workers that have been discussed throughout this statement, have also had an inevitable and severe impact on patient care and the provision of ambulancerelated services to those in our communities that needed them.

Lessons for the future

70. During the course of Module 3, the College asks that the Inquiry investigates the following issues in respect of paramedics, ambulance road crews and clinical/nonclinical staff in control rooms:

- The impact of the speed at which Governmental/ NHS/ IPC advice changed on the ability to appreciate those changes in real time in a live environment. Specifically,

whether staff had the time needed at points of high demand to read and understand what was required.

- The impact of dealing with back-to-back complex patient cases, both on the treatment received by patient and the on our members' own health and wellbeing.
- What training was available to support rapid clinical remote triage.
- The impact of dealing with delays, feelings of helplessness and lack of control.
- The impact on staff availability during the pandemic when transmission rates where high due to the confined work environment, the need for self-isolation, the high staff sickness rates and the subsequent high risk of onward transmission to other staff members.
- Whether staff had confidence about having access to sufficient RPE to support their working environments and how this has impacted their confidence about access to protective equipment in future crises.
- The extent to which ambulance staff experienced communication issues with vulnerable patients whilst wearing RPE.
- The extent to which there existed and staff were able to access psychological support to deal with the impact of distressing work.
- The extent to which there existed advice and guidance available for staff about how their families may have been affected by their work during the pandemic.
- Whether the healthcare system had adequate guidance, protocols and procedures to deal with long term sickness due to contracting Covid, including the impact on sickness pay and job retention.

71. In respect of the issues identified above and lessons that can be learned for the future, the College makes the following recommendations:

- Clinical teams should be kept away from call handlers and dispatchers. This should reduce the infection rate of the non-clinical staff.
- Training for remote triage should be provided to a wider group of clinicians to ensure resilience.
- Within the hierarchy of the profession and in NHS trusts, there should be a better understanding of the impact of pandemics/ public health emergencies on staff health and wellbeing, both physical and mental. This applies not just in the moment, but also to the legacy and intelligent use of learning.
- The NHS IT systems should be upgraded to provide the ability to access control room systems from other sites, for example, at home. This should reduce the impact of control room staff having to self-isolate.

- The links between NHS111 and the ambulance sector require urgent review and then improvement.
- The use of other emergency call handlers (police/fire) should be considered in emergency situations to support the healthcare system. The other emergency responder professions should be trained in NHS control room guidance and triaging.
- A presumption should exist that staff can apply scientific guidance in the safest way they deem possible, without sanction from their employers.
- A mechanism should be created for the NHS leadership to provide advice to the wider healthcare workforce which filters, explains and applies rapidly changing scientific and workplace safety guidance to ensure minimal disruption for staff working in the ambulance sector.
- The healthcare system and Government should have a robust supply chain for appropriate RPE with regular FIT testing by all ambulance trusts and alternatives for when FIT testing is non-compliant due to facial anatomy or hair growth. The healthcare system and Government should have back-up plans for supplies which can be stood-up and stood-down when appropriate.
- Training should be developed and then provided to staff which covers communication with patients when they are unable to see you as a whole person. This will take into account those with hearing loss and those with learning difficulties or psychological illnesses.
- Support training should also be developed and provided to those staff dealing with patients who need additional support at times of great distress, i.e. death of a loved one.
- A support system should be established and developed within the wider healthcare system to ensure that mental health support can be provided to staff in times of great distress, when moral injury and psychiatric injury can occur. This service should form part of the healthcare system's occupational health division and staff should not have to rely on the assistance of charities.
- Guidance relating to Coronaviruses should be drafted now to provide clarity to staff about decontamination after work, so that they feel safe when going home to their families, should another pandemic occur.
- A framework should be drawn up by Government to address the impact of work related physical (including Long Covid) or mental injury during the pandemic to ensure that people are entitled to appropriate compensation and job protection.

72. In respect of the long-term effects that the COVID-19 pandemic has had on ambulance services, our key reflection is that it has led to a considerable strain on the resources available and thus continues to have an impact on the efficiency of services and patient care provided. At the time of writing, we reflect that more people have left our profession than ever before. In our profession, we have a mental health and wellbeing crisis that will take years to recover from. During the pandemic, paramedics witnessed patients at their most vulnerable and were exposed to more death and critical illness than is imaginable. They also carried their own personal burdens, for example with fears of taking home a virus that could harm their own families and friends. There was no respite for those working in the ambulance sector, as you cannot turn off emergency services, especially during a pandemic, and it is essential that the public can access an ambulance when they need one. The effects of conditions such as Long Covid have also left a mark on many of our members who can no longer work in the profession. In turn, patients have suffered from shortages in the numbers of ambulance staff available to attend to and care for them, as well as long ambulance and hospital handover wait times. The College believes that the ambulance sector has been forever changed by the impact of the pandemic and the NHS will take many years to recover from it. It is crucial that ambulance trusts, GPs, and urgent treatment centres and the emergency departments all need support during the recovery phase of the pandemic.

73. The future of our profession lies in the provision of more collaborative care for those in need, along with better protection for the individuals providing that care to prevent immense pressure on the ambulance-related sector and members of the public having to wait for extraordinarily long times for help when they dial 999.

**Statement of Truth**

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

**Signed**: Personal Data

**Dated**: 19/09/2023