Witness Name: Anthony Marsh
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Module 3 UK COVID-19 Public Inquiry

WITNESS STATEMENT OF ANTHONY MARSH

In my capacity as;

National Strategic Adviser for Ambulance Services at NHS England Urgent & Emergency Care (UEC) Directorate (2018 – Current)

Chair Association of Ambulance Chief Executives (2014 – July 2020)

I, Anthony Marsh, Chief Executive of the West Midlands Ambulance Service University NHS Foundation Trust (WMAS) based at Millennium Point, Waterfront Business Park, Waterfront Way, Brierley Hill, DY5 1LX, will say as follows: -

I am making this statement in my capacity as National Strategic Adviser for Ambulance Services at NHS England Urgent & Emergency Care (UEC) Directorate, a position which I have held since 2018, and also in my capacity as Chair of the Association of Ambulance Chief Executives (AACE) from 2014 until July 2020. My role as Chair of AACE ended during the Inquiry's relevant period, and whilst I have therefore focussed my responses to be confined to the period between March 2020 to July 2020, given my wider roles as both National Strategic Adviser and Chief Executive of the West Midlands Ambulance Service it is possible that I am also able to comment on some issues outside of that period where they happen to fall within my general understanding and knowledge acquired as a result of those wider roles. My role as National Strategic Adviser for Ambulance Services at NHS England is in the Urgent and Emergency Care Directorate, therefore I am not requested to provide advice on every ambulance service matter from other Directorates within NHS England as I am not always involved in all ambulance related matters at NHS England.

Association of Ambulance Chief Executives Chair (AACE)

1. As Chief Executive Officer (CEO) of WMAS, I held full membership within AACE. I was elected to the role of AACE Chair, with my first tenure beginning in 2014 and ending on 23 July 2020 at which point the Chair rotated to Darren Mochrie of North West Ambulance Service NHS Trust (NWAS). As AACE Chair, I was responsible and accountable for the following area detailed in AACE's document from May 2020, role of the Chair Exhibit AM/01 [INQ000409762]:

- Promoting the highest standards of integrity, probity and governance throughout the association
- Demonstrating visible and ethical personal leadership by modelling the highest standards of personal behaviour and ensuring that the ACEG follows this example
- Leading a well led association with strong positive values and culture
- Leading both the AACE Board and the ACEG in establishing effective decision-making and assurance processes and acting as the guardian of due process
- Ensuring that constructive relationships based on candour, trust and mutual respect exist between AACE members – both full and associate, the AACE Board and the AACE Council (CEOs and Chairs) and within each of the aforementioned groups

- Developing productive working relationships with all AACE members
- Providing oversight of the core AACE team

2. AACE was chaired by myself as Chief Executive from an English ambulance service. The appointment is determined by other full members of the AACE through an election process facilitated by the AACE managing director or deputy managing director and overseen by the AACE Board.

3. Under the AACE Arrangements and Operating Principles 2018 Exhibit AM/02 [INQ000409761], the Chair is elected for a term of three years and can stand for one subsequent term if formally re-elected to do so by AACE members.

The History and Role of the Association of Ambulance Chief Executives (AACE)

4. The Inquiry has requested that I provide a brief description of AACE, including its history, purpose, membership and its functions and in order to answer this I have referred to the AACE Strategic Approach 2023-2026 Exhibit AM/03 [INQ000410577] and 'Strategic Priorities 2018-2019 and 2019-2020' Exhibit AM/04 [INQ000410578].

5. AACE was established in 2011 to provide ambulance services with an over-arching body that could support and facilitate its members as they deliver NHS strategy and policy, and to represent the sector on national issues, as agreed by its members.

6. AACE is a members' organisation constructed as a company limited by guarantee and regulated by the Companies Act 2006. As a membership organisation, AACE has no jurisdiction over, or accountability for, member organisations which are all individual legal entities, governed by their own Board of Directors.

7. The Chief Executive Officers (CEOs) of all ten English NHS Ambulance Trusts and, since April 2021, the Welsh Ambulance Service NHS Trust are full members of AACE. CEOs of ambulance services operating in Scotland, Northern Ireland and the Republic of Ireland are associate members. The Isle of Wight, the Isle of Man, Guernsey and Jersey along with the British Overseas Territory of Gibraltar, are also associate members. English and Welsh ambulance service Chief Executives have all the rights expressed in the AACE Articles of Association whilst Associate Members have the right to be present and to speak at general meetings but not the right to vote at any such meetings or to count in the quorum Exhibit AM/04a [INQ000470135].

8. The Association is funded by a subscription from each member organisation. These funds are used carefully and economically to get the best value for money on behalf of the ambulance sector. There is a core team led by a Managing Director, currently made up of 8 employees and 6 contracted Subject Matter Experts (SMEs). There are currently 4 additional posts funded by NHS England to coordinate key, time-limited national projects - violence prevention and reduction (2 posts), volunteering and improving sexual safety. AACE also provide bespoke, commissioned services for individual organisations, both UK and international, providing subject matter advice and expertise, independent reviews, and leadership coaching and mentoring. It has a team of SMEs who provide these services on a contracted basis and any profit is put into the AACE's national work undertaken on behalf of members.

9. As well as working closely with CEOs across the UK NHS ambulance services AACE collaborates with partner organisations, such as NHS Providers and NHS Confederation. AACE is a corporate member of NHS Confederation on behalf of ambulance services. AACE also liaise on behalf of the sector with Government departments and national bodies such as NHS England (NHSE), UK Health Security Agency (UKHSA – formerly Public Health England PHE), the National Police Chiefs Council (NPCC) and the National Fire Chiefs Council (NFCC).

10. AACE has a structure of national director level groups and sub-groups Exhibit AM/05 [INQ000409764], which the AACE core team facilitate to co-ordinate sharing of learning and experience and to assist in the development of guidance and resources. To support members, such activities focus on common priorities and policies that are fundamental to the ongoing development of UK ambulance services and the improvement of patient care.

11. A key aim of the Association is to ensure that ambulance services share their knowledge and skills and learning to better meet the emerging challenges and opportunities facing all ambulance services.

My Involvement and Working Relationship with Key Stakeholders

12. It may assist the Inquiry if I describe my involvement and working relationship as AACE Chair with key stakeholders and in addition to this describe any pertinent relationship that the stakeholder and the AACE core group had.

National Ambulance Resilience Unit (NARU)

13. AACE liaised closely with colleagues in NARU, which is an NHS England commissioned team, hosted during the relevant period by WMAS. AACE were engaged with NARU in relation to establishing and co-ordinating 999 call handling and other forms of operational mutual support between all UK ambulance services.

14. The AACE National Director of Operations Group (NDOG) had regular representation from the NARU team at their meetings and regular communication, particularly in relation to the maintenance of NARUs specialist capabilities such as Hazardous Area Response Teams (HART). As AACE chair, I had no direct involvement with NARU, however during the relevant period I was involved with NARU as the CEO of the host organisation and as the National Strategic Adviser for Ambulance Services to NHS England.

National Incident Response Board (NIRB)

15. As AACE chair, I was not involved with NIRB. However, I understand NIRB was formally established as a 'committee in common' of the NHS England and NHS Improvement boards on 01 April 2020, but many of its members had been meeting collectively since 18 February 2020. It became collectively known as the COVID-19 NIRB (referred to only as "NIRB" generally throughout the arrangements and in this statement). NIRB supported the discharge of each organisation's respective duties and powers and their combined responsibilities by setting the strategic direction and providing oversight of the response to the COVID-19 pandemic. In addition, NIRB's role was to challenge and steer the Strategic Incident Director, the Incident Director, the NHS England Emergency Preparedness, Resilience and Response (EPRR) team and national Directors in relation to the pandemic response. AACE had no involvement in NIRB.

National Ambulance Coordination Centre (NACC)

16. As AACE chair I was not involved nor did I have oversight of the NACC, although AACE staff would liaise directly with those staff on duty within the NACC in relation to general coordination and provision of 999 call handling mutual aid between ambulance services in England for example.

National Ambulance Service Medical Directors (NASMeD)

17. NASMeD is one of the national director groups. As AACE chair I was not involved with NASMeD but did attend a small number of their meetings to provide an update and receive feedback on their work. NASMeD had frequent meetings to discuss how each service was managing the pandemic, promoting collaboration and support and undertaking peer reviews of measures being taken. AACE also facilitated sharing ideas on focused topics including but not limited to clinical response and Infection Prevention and Control (IPC).

18. The clinical lead within AACE's core team supported the NASMeD Chair and other ambulance service Medical Directors and facilitated work which required a national stance, such as the translation of, and input into, national clinical guidance as it was developed, and clinical aspects of Personal Protective Equipment (PPE), or development of ambulance specific clinical guidance.

National Director of Operations Group (NDOG)

19. As AACE chair I was not involved with NDOG but did attend a small number of their meetings to provide an update and receive feedback on their work. NDOG is one of the national director groups, who meet regularly, however during the pandemic meeting frequency increased significantly. The National Director of Operations Group (NDOG) is a forum administered by AACE and chaired by an Operations Director of a UK ambulance service. It provides a forum for peer support enabling communication between ambulance operations Directors on a wide range of issues. Typical topics would include sharing emerging operational challenges and discussing strategies to address those challenges. The group shares examples of good practice and – on occasion where practicable and appropriate – agrees common approaches to improve consistency. In addition, NDOG provides a forum through which those proposing new initiatives that may impact on operational delivery can consult with senior operational leaders in order to secure their support and/or gain feedback on areas that would require further consideration. NDOG was consulted by members of NHS England's central ambulance team in relation to a range of policies including routine consideration of escalation and de-escalation of pandemic protocols related to 999 call handling.

20. The AACE core team provided a named lead acting as additional support to the NDOG Chair and helped to progress the work of the group outside of their meetings. During

the pandemic the AACE core team extended this support providing two leads with relevant operational and ambulance Emergency Operations Centre (EOC) experience to NDOG. In addition to this, the AACE core team also provided administrative support to NDOG including minute taking and the recording of key recommendations and decisions. AACE subject matter experts (SMEs) were routinely the first point of contact for materials that NDOG were required to consider during the pandemic. SMEs would summarise the issues and offer NDOG their view on possible options and recommendations. AACE SMEs would typically be the main link between NDOG and NHS England on emerging policies and procedures. The most significant piece of work that AACE SMEs facilitated on behalf of NDOG was to design and facilitate improved 999 call handling mutual aid arrangements between Trusts. Pre-existing mutual aid arrangements were principally built to manage the rare occasions where an ambulance service had a complete technical failure resulting in the total loss of their call handling capability, or very small numbers of calls where the responding Trust had a delay of more than 5 minutes in answering an incoming 999 call. The events of the pandemic saw some ambulance services experiencing significant increase in staff sickness absence – up to 30% of call 999 handlers.

21. AACE SMEs facilitated twice daily calls between ambulance Trusts and British Telecom to anticipate and plan for staffing shortages in affected ambulance Trusts. Additional, pre-planned 999 call handling support from other ambulance services was arranged based on a forecast of the affected Trusts anticipated demand level and anticipated staffing shortfall. This ensured that – as far as possible – there was less delay in 999 calls being answered and triaged in other parts of the Country. AACE SMEs also worked with ambulance services to rapidly develop and implement a technical solution enabling the service who had answered a 999 call on behalf of an affected Trust to transfer the case details following triage directly into the affected Trust's Computer Aided Dispatch (CAD) system using an interface called the Inter-operability Tool Kit (ITK). Prior to this work services would pass back cases manually by placing a phone call to the responding Trust and relaying the details of the incident by voice. This would have been impracticable during the pandemic given the volume of calls involved.

22. The net effect of this support was that 999 calls – including Category 1 (immediately life-threatening) calls – continued to be answered, triaged and transferred to dispatch in an unprecedented mutual aid effort between all ambulance services in the UK. These arrangements have now been improved, automated and embedded as business-as-usual through the 999 Intelligent Routing Platform, an NHS England led project in which the same AACE SMEs were engaged to help design and implement the system.

National Ambulance Service Infection Prevention and Control Group (NASIPCG)

23. As AACE chair I was not involved with NASIPCG. NASIPCG is a sub-group of the Quality Improvement, Governance and Risk Directors (QIGARD) group, the latter being made up of executive Directors with responsibility for patient safety and quality improvement within their respective Trust, many of whom are IPC nurses. The AACE core team provided a coordinating and facilitating link for QIGARD, which met at least weekly and received recommendations and drafts for guidance from NASIPCG and either amended or approved these before they went to Ambulance Policy Assurance Advisory Group (APAAG).

24. NASIPCG met weekly, and more frequently in the early stages of the pandemic. NASIPCG played a crucial part in supporting their services during the pandemic with IPC advice, the AACE IPC specialist adviser provided a link between NHS England and other partners such as UKHSA and the Department of Health and Social Care. A nominated NASIPCG chair (from members IPC Leads) led the group during the pandemic however the chairs' role became increasingly demanding and time-consuming. In response to these issues, members provided additional funding to support a dedicated additional post within AACE. This post holder allowed the NASIPCG chair to relinquish their responsibilities within their own ambulance service to support all Trusts and enabled AACE to provide full-time coordination and representation for the sector on national bodies i.e. PHE (UKHSA) and NHS England and a direct link between them and ambulance services.

Ambulance Policy Assurance Advisory Group (APAAG)

25. In March 2020, NHS England requested AACE provide additional support to me in my role as National Strategic Adviser to Ambulance Services, through the formation of an Ambulance Policy Advisory and Assurance Group (APAAG), the terms of reference for APAAG has been provided Exhibit AM/06 [INQ000409767].

26. APAAG was initially focussed on addressing operational and clinical issues however the scope of APAAG was expanded to include other matters surrounding national guidance including IPC. Membership comprised operational and clinical subject matter experts (SME) and chairs of several of AACE's national director groups e.g. NASMeD and QGARD, to assist in the development, co-ordination and communication of policy particularly when it was considered important to have a nationally consistent approach.

27. APAAG functioned in an advisory capacity and NHS England retained responsibility for the issuing of national guidance and for assuring implementation of policy that they decided to mandate. I cannot recall any occasions where APAAG advice was not followed by NHS England.

28. Ambulance CEOs agreed that the business as usual resources of AACE should be redirected to support the sector in responding to the ongoing COVID-19 pandemic. Providing this support to NHS England was in the best interests of both the sector, the general public and patients.

29. As AACE chair I was not directly involved with APAAG, this group was chaired by the AACE managing director, who provided me with regular updates on programmes of work.

Emergency Call Prioritisation Advisory Group (ECPAG)

30. As the AACE Chair I had no involvement with ECPAG, however I did Chair this group in my capacity as NHS England National Ambulance Adviser. AACE has representation within ECPAG and a routine working relationship with this NHS England led group. A brief description of the aims and role of ECPAG is included at paragraph 93.

31. During the pandemic ECPAG communicated all changes to triage protocols (Advanced Medical Priority Dispatch System (AMPDS) or NHS Pathways) and triage escalation levels to all ambulance services, once they were approved by NHS England. A key member of ECPAG was a representative from the 'Ambulance Heads of Control Group' as well as a representative from NASMED, who, amongst other members of ECPAG were able to raise any issues specifically affecting ambulance services as a result of changes to protocols and Pandemic levels during the relevant period. The only issue I can recall arising at ECPAG is discussed in more detail at paragraph 192. NHS England hold minutes of all of the ECPAG meetings during the relevant period.

NHS England National Ambulance COVID Cell

32. This cell was an NHS England group. The AACE Managing Director attended these meetings during the early stages of the pandemic. Although I did attend these meetings as National Strategic Adviser, it was not in my capacity as AACE chair.

College of Paramedics (CoP)

33. The AACE core team maintained regular communications with the CoP and worked together with them and other partners including unions and staff representative organisations to produce resources to support the ambulance workforce. As AACE chair I was not directly involved with CoP.

AACE's Working Relationships with Stakeholders

34. The Inquiry has asked me to provide a summary of the nature of the relationship between AACE and key stakeholders which I have defined:

NHS England and its equivalent bodies in Wales, Scotland and Northern Ireland

35. AACE worked with NHS England teams and relevant 'cells' that were set up to specifically address pandemic issues during this period. These working relationships between AACE and NHS England helped to ensure that members were receiving the latest guidance and meant that AACE could assist NHS England in testing and developing new initiatives and approaches to managing the pandemic response. AACE acted as a conduit for information and queries between NHS England and national ambulance service groups, seeking clarity between both parties when required. Although AACE is not answerable to NHS England or any other national body they did provide subject matter expertise to NHS England during this period.

36. AACE provided ambulance subject matter expert representation on the NHS England IPC Cell to provide the ambulance service perspective. AACE were able to provide specific information and context in the development of national guidance. AACE also provided subject matter expertise to support the NHS England Central Ambulance Team and the National Strategic Ambulance Adviser when needed, to help develop national policy and guidance applicable to ambulance operations in England. Advice would have been in relation to application of guidance within the ambulance working environment / context and included:

- In collaboration with NHS England, AACE supported the development of ambulance IPC guidance
- In collaboration with NHS England, AACE supported the development of COVID Secure: Working Safely During the Winter Exhibit AM/06a [INQ000409786]

- Support to NHS England IPC Cell in the development of the guide for Supply Failure of Single Use PPE Exhibit AM/06b [INQ000470139]
- Support NHS England in the development of Patient Transport Service (PTS) COVID-19 Guidance Exhibit AM/06c [INQ000470140]
- Support to the NHS England PPE Cell
- Development of the 'IPC Hierarchy of Controls – Ambulance Sector', in line with the NHS England addendum of the National IPC Manual Exhibit AM/06d [INQ000470141] & Exhibit AM/06e [INQ000470142]

37. Keith Willett, in his role as NHS England Strategic Incident Director for the COVID-19 Response held regular webinars (weekly in the height of the pandemic) for all NHS Medical Directors and others to provide regular briefings and updates.

38. AACE had representation from NASMeD on the NHS England Frontline Clinical Cell, which met weekly and provided advice to NHS England.

39. AACE does not normally, and did not during the pandemic, work directly with the equivalent bodies in Wales, Scotland and Northern Ireland, although ambulance service representatives from the devolved administrations were involved in various national meetings with NHS England. Members from the devolved administrations are also included in the AACE national director groups, for example, NASMeD and NDOG.

Public Health England (PHE) (now UKHSA) and the equivalent bodies in Wales, Scotland and Northern Ireland

40. AACE's involvement with PHE occurred through the NHS England IPC Cell. The AACE IPC specialist adviser would also liaise with colleagues in PHE on occasions to double-check advice, rationale, and timings for publication of guidance. AACE does not normally, and did not during the pandemic, work directly with the NHS England or PHE equivalent bodies in Wales, Scotland, and Northern Ireland, although their representatives were involved in the various national meetings convened by NHS England.

The Secretary of State for Health and Social Care and the equivalent Ministers in Wales, Scotland and Northern Ireland and their officials

41. AACE did not have any direct dealings or communications with the Secretary of State or equivalent Ministers in the devolved administrations.

Chief Medical Officers in England, Wales, Scotland and Northern Ireland

42. AACE did not have any direct dealings or communications with the Chief Medical Officers (CMOs) in England or those in the devolved administrations.

Ambulance Trusts in England and the equivalent in the devolved nations

43. All ambulance services in UK are members of AACE, which includes full and associate members.

44. Throughout the pandemic, the AACE core team was available to provide coordination and support to members. The structure of national groups enabled collaboration and rapid knowledge sharing across ambulance services. Support included facilitating frequent virtual meetings for the Ambulance Chief Executive Group (ACEG) and national director group meetings.

45. Prior to the pandemic such groups met on a monthly, bi-monthly or even quarterly basis in person. During the pandemic however frequency increased to every week (as a minimum) via on-line meeting platforms such as Microsoft Teams and were often set-up at short notice to discuss a specific issue or an update that needed urgent input or dissemination. This helped to support consistency in approach, as far as practicably possible and where beneficial, in the adoption of guidance or policies, collective problem solving, and establishment of mutual aid when necessary. These groups and their meetings also played a vital role in providing essential peer support during a very challenging period. Most group meetings have now returned to meeting on a monthly basis.

46. As a membership organisation the role during the pandemic, as always, was to facilitate coordination, consultation, and collaboration across member services. AACE was not however accountable for individual ambulance service operations, performance or compliance.

AACE's Role in Supporting Ambulance Trusts During the Pandemic

47. The Inquiry has requested that I provide a description of AACE's role in providing support, coordination and implementation of national policy in response to the COVID-19 pandemic and to detail any concerns relating to the interpretation, translation and timing of national guidance to the healthcare sector.

48. Members of the AACE core team and AACE's national groups, played a key role in interpreting and translating national guidance and assisting in the development of specific ambulance sector guidance. There is no specific date when AACE took on the role of interpreting and translating national guidance. It is something that would be undertaken routinely, not just in the pandemic, with our national groups reviewing guidance and making sure it is applicable to the ambulance context. In relation to the pandemic, NHS England requested that AACE provide additional support through the formation of APAAG in March 2020, to provide a clear conduit for information and ratification of any ambulance specific guidance of position statements. As guidance emerged it was discussed and feedback was provided as appropriate. AACE had representation from expert colleagues on the NHS England IPC Cell from very early on, but AACE do not hold the minutes for these meetings so cannot be specific about the date that involvement began.

49. AACE members (ambulance services) were responsible for the adoption and implementation of national guidance. AACE as a body does not, and did not during the pandemic, have any jurisdiction to mandate members on how they implemented guidance, nor gained assurance in this respect. Working together however, as a sector, AACE endeavoured to be as consistent as reasonably practicable in agreeing what the guidance meant and on occasions, how to explain to staff the rationale behind the guidance. An example where a query from an ambulance service came to AACE for clarification can be seen in the email conversation relating to publication of a World Health Organisation (WHO) document which appeared to take a conflicting position to the UK / NHS England position regarding whether nebulisation was classed as an aerosol generating procedure or not Exhibit AM/06f [INQ000470145]. AACE were able to check this with NHS England and confirm that the WHO stance did not affect the UK guidance.

50. APAAG was established early on to help with finalising national guidance relevant to the ambulance sector, including IPC, clinical and operational guidance and gained sign off by NHS England. This approach helped to ensure that any potential queries or challenges in understanding or implementation were addressed before guidance was disseminated to staff and volunteers.

51. Ambulance services needed to provide guidance to frontline clinicians from day one as they were sometimes the first NHS staff to be assessing and treating COVID-19 patients. AACE supported NASMeD in clinical discussions involving NHS England clinical leads about assessment and management of patients, incorporating discussions and advice for IPC measures. As part of these discussions AACE peer reviewed guidance that individual ambulance services were issuing to their clinical staff, in order to agree best practice. AACE supported these discussions and once developed and agreed in NASMeD, clinical guidance was shared through APAAG and across ambulance services via the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) app which was accessible to frontline ambulance staff via an electronic guidelines' application accessible through Trust or personal mobile device.

52. In relation to IPC, PHE published IPC guidance on Gov.uk website, the first ambulance IPC guidance hosted on Gov.uk was published on 21 February 2020. PHE were members of the NHS England IPC Cell alongside AACE and other sector representatives. All aspects of guidance were discussed and clarified and final documents signed off at the NHS England IPC Cell; drafts were circulated between the group for comments and amends. AACE was consulted by PHE (and vice versa) and by NHS England on the cell.

53. AACE would share links to guidance on the relevant Gov.uk website and documents with ACEG and national director groups where appropriate. Ambulance services would then use their own channels for internal dissemination and communication.

54. Due to the emerging nature and understanding of COVID-19, guidance was evolving rapidly. Perhaps inevitably, in the early stages of the pandemic, national guidance, particularly in respect of IPC, was sometimes released at short notice, with urgent timelines for implementation.

55. National guidance was (and is) invariably based on hospital settings and this frequently meant it required checking for suitability within the ambulance setting. Clarification for the ambulance perspective often resulted in multiple revisions, or the development of separate ambulance guidance, all of which took time to turn round.

56. Obtaining NHS England approval for pandemic triage code set changes or changes to escalation levels often proved to be challenging due to the time this could take. NHS England decision-making invariably involved an approval process and scheduling of the NIRB meeting which meant that decisions were not always implemented quickly enough for

operational purposes. I am not able to advise on what impacts – if any – Trusts may have experienced due to a delay in decision-making about escalation or de-escalation through the Pandemic Protocol. Similarly, I'm not aware of any instances of ambulance services in England choosing to adopt an escalation level other than that which had been approved by NHS England. At the start of the Pandemic all ambulance services agreed to maintain consistent application of the Pandemic level Protocol. My recollection is that there was a brief period where the London Ambulance Service (LAS) – with the agreement from NHS England – escalated to a higher level than the rest of the Country due to the speed at which the first wave of the pandemic progressed in the Capital. Those discussions would have been directly between LAS and NHS England and AACE were not party to them. Ambulance services in the devolved administrations were not bound by NHS England directives and my recollection is that there may have been occasions where the Welsh Ambulance Service (WAS) adopted a different level of escalation from services in England.

57. There were occasions when guidance received was not consistent between national organisations, for example, NHS England, PHE and Resuscitation Council UK (RCUK); a specific example was in consideration of ventilation using bag, value, mask, chest compressions and Aerosol Generating Procedures (AGP) procedures. A meeting of NASMeD on 23 April 2020 Exhibit AM/07 [INQ000410581] which considered guidance that RCUK had issued which advised against performing chest compressions without level 3 PPE and the impact that this could have on patient outcomes.

58. AACE issued a position statement which assessed both the evidence presented alongside drawbacks and benefits to patients and agreed with PHE's position which was that chest compressions should not be considered an AGP Exhibit AM/08 [INQ000257955]. This AGP issue was discussed in APAAG on 24 April 2020 and the confusion that this caused escalated to NHS England, Exhibit AM/09 [INQ000409766]. The AACE Chief Executive Group approved the position statement following PHE guidance, but importantly all CEOs agreed to include a new paragraph within the draft position statement which supported crews undertaking a dynamic risk assessment to determine if higher level of PPE needs to be worn on a case-by-case basis Exhibit AM/10 [INQ000410584].

59. Staff and their representatives were concerned about the differences in guidance and I, along with separate letters to the AACE core team, received correspondence from Unison on 27 March 2020 Exhibit AM/11 [INQ000410585] and GMB on 29 March 2020 Exhibit AM/12 [INQ000410586] regarding this and other COVID-19 related PPE issues. The concerns raised included ensuring risk assessments are in place across all ambulance

services, that suitable PPE is provided to ambulance staff, that staff are provided with suitable training in the use of PPE, and that testing is provided with supporting guidance for ambulance staff. I addressed these important concerns in my immediate responses of 27 March 2020 Exhibit AM/13 [INQ000410587] & 1 April 2020 Exhibit AM/14 [INQ000410588]. The measures I took as National Ambulance Adviser included requiring all ambulance services to comply with national IPC guidance, liaising with other ambulance service CEOs to provide support and guidance where needed, maximising the opportunity for staff testing to protect our staff, and produced a video for all ambulance staff across the Country which is discussed at paragraph 222.

60. AACE were represented at the NHS England IPC cell and PPE Cell but had no direct link with other 'covid cells' e.g. 'track and trace' or 'testing cells', which led to challenges in interpretation and the need for clarification when trying to apply those processes in the ambulance setting which would have been dealt with by individual ambulance services.

61. AACE subject matter experts and national groups, and APAAG helped to add clarity and order, as much and as quickly as possible, to the process of managing NHS England guidance in a rapidly evolving situation. APAAG allowed a 'sense check' prior to publication on emerging guidance by SMEs and representatives of the key leadership roles in ambulance services who subsequently had responsibility for implementing guidance at ambulance service level.

Role of the AACE Chair in development of decision making and clinical tools

62. National decision-making and clinical support tools were discussed and reviewed throughout the pandemic by the national groups, such as NASMeD and NDOG, and APAAG, but this is not something that I was directly involved in, either as AACE Chair or National Strategic Adviser for Ambulance Services to NHS England.

63. The ambulance workforce is skilled at assessing patients and recognising those who are unwell and require further medical intervention. Ambulance clinicians use diagnostic equipment and tools such as National Early Warning Scoring (NEWS) tools which help to identify deteriorating patients based on physiological parameters, however COVID-19 posed a new challenge for ambulance staff who required clinical guidance regarding patients who were safe to remain at home and those who would require hospital treatment.

64. It is not possible to assess how widely specific clinical decision making tools were used, other than the fact that all guidance and tools were discussed within the national groups, and all ambulance services aimed for a consistent approach.

65. AACE became aware of a small number of Trusts intending to shorten and simplify the 999 call handling training process, so they could recruit additional temporary call handlers to support the management of a significant increase in demand at times of high levels of absence of their substantive 999 call handling workforce. The 'normal' length of a 999 call taking course has some variation across ambulance services, however it is usually circa five weeks. It was not confirmed with me how long any alternative process training time, just that a small number of Trusts were intending to shorten their courses.

66. This was discussed with NHS England ECPAG and the Central Ambulance Team, and to mitigate any potential negative impact on mutual aid support for 999 call-handling, agreed principles were drawn up to inform how any such measures were to be implemented. As the National Strategic Ambulance Adviser at NHS England, I also wrote to all ambulance services on 27 March 2020 in relation to this matter Exhibit AM/15 [INQ000410589]. I did also confirm in the email that I remain available to provide any advice or support as necessary. I did follow up my email by discussing this matter at AACE CEO meetings, for example on 30 March 2020 and 2 April 2020. I reiterated that any proposed shortened training courses must be approved by the accrediting and licencing body for the prioritisation system in use for each respective ambulance Trust.

67. NHS England recognised the demand for clinical guidance at the early stages of the pandemic, guidance was drafted dated 10 April 2020 Exhibit AM/16 [INQ000410590] including guidance around 999 ambulance conveyance protocols for adult patients. However, following initial release, this specific ambulance non-conveyance section was removed from the updated NHS England guidance that was released dated 14 April 2020 Exhibit AM/17 [INQ000410591]. Despite some internal concerns expressed by NHS England's COVID19 Strategic Incident Director in connection with the use of "non-conveyancing" terminology on 10 April 2020 NHS England briefly and erroneously published a version of the "Specialty Guide for Emergency Medicine" that contained the non-conveyancing and frailty score infographic set out in the draft ambulance conveyancing guidance that had not been cleared for publication. The mistaken inclusion of the "non-conveyancing" infographic was identified shortly after publication – with a new version of the specialty guide without the non-conveyancing infographic being re-published on 14 April 2020. To the best of my knowledge, the draft ambulance non-conveyancing guidance

Exhibit AM/16 [INQ000410590] was not formally published, implemented or acted upon by any ambulance Trusts. NHS England subsequently issued a tool in January 2022 to support ambulance clinicians with conveyance decisions for patients with suspected or confirmed COVID-19 infection Exhibit AM/18 [INQ000409776]. Other than this tool, no other guidance on ambulance service conveyance was issued by NHS England.

68. AACE provided significant input, working with NHS England Central Ambulance Team and national groups, into developing improved 999 call handling mutual aid plans. At the peaks of the pandemic AACE subject matter experts provided direct support to Trusts in enacting those mutual aid plans, co-ordinating national meetings, negotiating levels of support from buddying Trusts, communicating with British Telecom (BT) as required, and supporting Trusts who had invoked mutual aid with mitigations to enable them to stand down mutual aid requirements at the earliest safe opportunity.

AACE's Role in arranging and overseeing the coordination of mutual aid

69. The Inquiry has requested that I comment on specific areas of how AACE supported ambulance services workforce with mutual aid, training, recruitment, volunteers and Community First Responders (CFRs).

70. AACE did not arrange or oversee mutual aid in relation to ambulance crews, however AACE did provide some assistance co-ordinating the distribution of PPE across ambulance services. There was also collaboration through the AACE national groups which supported design, development and procurement of PPE such as aprons and coveralls.

AACE's Role in supporting recruitment, training and wellbeing support for temporary staffing groups

71. AACE facilitated Human Resources Directors (HRDs) Group meetings, where matters relating to staff and volunteer recruitment were discussed and shared. AACE did not establish common processes for recruitment including staff recall, student redeployment or volunteer recruitment or training. These were dealt with by local ambulance Trusts.

72. One aspect of workforce support that AACE facilitated on behalf of the sector were discussions with National Fire Chiefs Council (NFCC) and National Police Chiefs Council (NPCC) in terms of their potential for providing assistance in the form of additional ambulance drivers and co-responding with Fire and Rescue Services. Members of the AACE

core team met on a weekly basis with the NFCC and NPCC leads for COVID-19 response, to share information, knowledge and learning in respect to the pandemic response. The extent to which each ambulance service took up mutual aid from fire and police services was determined locally by individual organisations and uptake varied.

73. All NHS Trusts were requested to increase resources through recruitment of additional staff and volunteers. AACE had no direct involvement in any processes established to recruit volunteers, university paramedic students, returning retirees or the redeployed staff. In addition to this AACE were not made aware of any issues in relation to these actions.

AACE's Role in relation to Community First Responders (CFRs)

74. The risk to CFRs attending patients was discussed by NASMeD on 18 March 2020 Exhibit AM/19 [INQ000410593]. The AACE core team were aware that some CFR schemes in some ambulance services were paused in the early stages of the pandemic due to issues of distributing PPE to some volunteers and concern relating to their deployment to patients in cardiac arrest. Such advice given to CFRs, to pause if they did not have standard PPE, was appropriate, however ultimately this decision would have been dealt with by individual ambulance services.

75. AACE were not involved in securing or procuring PPE for ambulance staff or CFRs as this is a matter for individual ambulance services who maintained responsibility for ensuring they have sufficient PPE for their staff and volunteers.

76. It is not possible to know or assess what impact pausing the deployment of CFRs may have had on patient care. CFRs can be deployed as an initial response to a patient and will usually be backed up by an employed ambulance service response. In the event that a CFR is not available an ambulance resource is always deployed anyway.

77. CFRs followed the same clinical and PPE guidelines as the employed ambulance workforce and were protected in the same way and referred to in national guidance Exhibit AM/20 [INQ000410594].

AACE's Role in relation to stay at home messages

78. No specific issues or concerns were raised within AACE about the impact of 'stay at home' messaging on the willingness of patients to be conveyed to or attend hospital to seek medical attention during the pandemic period.

79. It was clear that demand on ambulance services reduced for some time during national lockdowns, and I heard stories from staff within WMAS about how patients were more reticent to attend hospital in order to protect the NHS, themselves and loved ones. I believe that the instructions given as a public health campaign were successful, it was promulgated frequently, and people understood clearly what action they needed to take and who would benefit from the steps and sacrifices that every one of us made.

80. I will now focus my responses in my capacity as National Strategic Adviser of Ambulance Services at NHS England. My role as National Strategic Adviser for Ambulance Services at NHS England is in the Urgent and Emergency Care Directorate, therefore I am not requested to provide advice on every ambulance service matter from other Directorates within NHS England as I am not always involved in all ambulance related matters at NHS England.

Role and responsibilities as National Strategic Adviser of Ambulance Services at NHS England

81. I have held the role of National Strategic Adviser of Ambulance Services at NHS England in the UEC Directorate since 2018. The purpose of the role is to support the NHS England UEC Director and their team at a national level and where necessary to support individual ambulance Trusts, local health systems, regional Directors and other key stakeholders to improve and transform ambulance services across England. The key focus of the National Adviser role at the time of appointment was to Exhibit AM/21 [INQ000410595]:

- Provide operational support, advice and leadership to national leaders for the ambulance sector over the winter period
- Oversight and advise on the professional aspects of the Carter Recommendations and support sustainable transformation of individual Trusts where appropriate
- Supporting and driving improvement in performance, efficiency and media coverage including key stakeholder's engagement where necessary

- Providing local system advice to the new regional Directors and their senior teams
- Support and provide advice to National Winter Room and input whenever required
- Facilitating dialogue and communications between National Team and individual organisations to support sustainable transformation change and improvement

Brief Summary of working relationship with key stakeholders

82. The Inquiry has asked me to define the nature of my working relationships as National Strategic Adviser with key stakeholders and I have set these out below:

NHS England and its equivalent bodies in Wales, Scotland and Northern Ireland.

83. I was engaged by NHS England as the National Strategic Adviser for Ambulance Services and therefore the nature of the relationship is that I provide advice as required in line with my role and responsibilities previously described. I did not liaise with NHS Wales, Scotland or Northern Ireland, however my advice may have been made available to them by others.

The Secretary of State for Health and Social Care and the equivalent Ministers in the devolved nations.

84. As National Strategic Adviser for Ambulance Services at NHS England, I attended several meetings with The Secretary of State for Health and Social Care in support of the National Director of NHS England, to provide a general update. These meetings were not specific to the pandemic. I had no working relationship with equivalent Ministers in the devolved nations. The slides which were prepared prior to the meetings by NHS England are exhibited and summarised below:

- On 25 September 2020 Exhibit AM/21a [INQ000470165] there was a deep dive of ambulance performance and activity, the NACC, Pandemic triage changes, hear and treat, clinical validation pilots and winter challenges
- On 22 July 2021 Exhibit AM/21b [INQ000470166] ambulance demand, constraints and handovers, utilisation of the additional £55 million investment in ambulance Trusts, which is discussed at paragraph 113, to increase 999 call handlers, operational response capacity, managing demand for lower acuity ambulance dispositions from NHS 111 and exploring an extension to the time allowed for clinical validation, making recommendations regarding clinical validation of lower

acuity ambulance calls and reducing avoidable conveyances to emergency departments were discussed

- On 9 September 2021 Exhibit AM/21c [INQ000470167] ambulance performance, the NACC, progress on utilisation of the £55 million, hospital handover delays, and extension of 111 clinical validation times from 30 minutes to 60 minutes was discussed
- On 26 November 2021 Exhibit AM/21d [INQ000470168] there was a deep dive of ambulance escalation pressures, which included a review of ambulance Resource Escalation Action Plan (REAP) levels Exhibit AM/21e [INQ000470908], ambulance performance, the additional measures being taken to ease pressures on services, the operating model of the NACC and utilisation of the £55 million and progress against each of the five priority investment areas. The 5 key areas were recruitment of 999 call handlers, increasing ambulance capacity on the frontline, providing additional clinicians in EOCs, extending hospital ambulance liaison officer cover and retaining emergency ambulance fleet through the winter

Ambulance Trusts in England and the equivalent in the devolved nations

85. As National Strategic Adviser for Ambulance Services at NHS England I maintained regular contact and engagement with all English ambulance Trusts and their Chief Executives. At the height of the pandemic weekly meetings were held organised by AACE and I attended in my capacity as National Adviser to provide an update on the national response to the pandemic and to address any questions. Ambulance CEOs from the devolved administrations also attended these meetings but my involvement and advice generally only directly related to English ambulance services.

National Ambulance Resilience Unit (NARU)

86. WMAS were commissioned to host NARU during the relevant period and the NARU Director remained under my management for the duration of the pandemic. NARU played an important role during the pandemic and the nature of my relationship as National Strategic Adviser was to provide oversight, support and direction alongside the NHS England EPRR team.

National Incident Response Board (NIRB)

87. As National Strategic Adviser for Ambulance Services at NHS England I attended NIRB a couple of times to provide a general update.

National Ambulance Coordination Centre (NACC)

88. WMAS commissioned by NHS England to operate the NACC and this remained under my management for the duration of the relevant period.

89. I maintained a close relationship with the NACC as they provided a single point of contact for ambulance services and important information from me and other colleagues at NHS England was regularly communicated through the NACC to ambulance services. The NACC also collated daily performance and capacity information which was then sent to the EPRR team at NHS England and National Directors and various teams of NHS England.

National Ambulance Service Medical Directors (NASMeD)

90. NASMeD is a group within AACE and in my role as National Strategic Adviser for Ambulance Services at NHS England I did not have a formal relationship with this group, but I did attend their meetings from time to time to provide a general update.

National Director of Operations Group (NDOG)

91. NDOG is a group within AACE and in my role as National Strategic Adviser for Ambulance Services at NHS England I did not have a working relationship with this group, but I did attend their meetings from time to time to provide a general update.

Ambulance Policy Assurance Advisory Group (APAAG)

92. APAAG is a group within AACE and in my role as National Strategic adviser for Ambulance Services at NHS England I did not have a working relationship with the APAAG, this group was chaired by the AACE managing director, who provided me with regular updates on programmes of work.

Emergency Call Prioritisation Advisory Group (ECPAG)

93. As National Strategic adviser for Ambulance Services at NHS England I continued to chair this group on behalf of NHS England. ECPAG advises NHS England on issues of ambulance call prioritisation. Its principal remit is to recommend which dispositions from established ambulance triage systems should receive a Category 1-5 or other response based on robust clinical evidence. The group also considers recommendations from a number of clinical experts regarding changes to any pre-triage questions to identify

immediately life-threatening emergencies and Healthcare Professional/Inter-Facility Transfer response code categorisations. Membership of ECPAG consists of clinical experts and other subject matter experts from the English ambulance services and other relevant organisations.

94. ECPAG maintained its purpose and objectives in line with its terms of reference Exhibit AM/21f [INQ000470169]. The exhibited terms of reference also include the responsibilities of the group, and therefore the Chair. The Chair's main responsibility was to consider and agree recommendations from the group on ambulance 999 call categorisations, unless required to be referred for further scrutiny to NHS England and/or the Department of Health and Social Care (DHSC). The Chair is also responsible for ensuring expert representatives present their papers including supporting evidence in order to inform effective decision making of the group. A number of extraordinary meetings were held in the early stages of the pandemic to agree or approve specific items in relation to the COVID-19 response, such as the implementation of Protocol 36, approval of revised EOC call flow processes for COVID-19 assessment and questions, the introduction of additional disposition codes for COVID-19, and the revision and approval of revised code sets against national pandemic levels (this was applied to both triage platforms AMPDS and NHS Pathways). These are examples of matters I dealt with as Chair of the group.

NHS England National Ambulance COVID Cell

95. This internal cell within NHS England was jointly chaired by me with Emma Hall or Ciaran Sundstrem and held with the NHS England Central Ambulance Team AM/21g [INQ000470909]. We held a daily COVID cell meeting. Over time these meetings reduced in frequency and membership also reduced. The Chair was responsible for taking all necessary action to prepare and maximise capacity of all ambulance services in order to save as many lives as possible during the pandemic. The key objectives of the 999 Cell's responsibilities and therefore those of the Chair were:

- To respond to changes to national ambulance policy and guidance to ensure ambulance services are supported and coordinated and are able to most effectively respond during the COVID-19 pandemic. Ambulance policy and guidance was refreshed and updated in line with the latest national and government guidance
- To direct the Ambulance Policy Advisory and Assurance Group (APAAG) to quality assure any national operational or clinical policy relating to the pandemic response prior to publication

- Review latest data and intelligence from ambulance services with a view to making recommendations to National Directors of Operations Group (NDOG) and the National Ambulance Service Medical Directors (NASMeD) on movement between the Pandemic Protocol levels
- To record the recommendations of NDOG and NASMeD in relation to escalating and de-escalating through the Pandemic Protocols and communicate decisions to the National Incident Response Board for final approval prior to implementation
- To lead on and coordinate the management of and resolution of any risks and/or additional issues identified which relate to the operational delivery of the ambulance service

96. There were many topics discussed at these meetings including (but not an exhaustive list):

- Pandemic Protocol levels
- National group updates/ decisions (NASMeD, NDOG, ECPAG)
- Review of latest NACC data, sitrep and BT 999 call data
- PTS guidance
- Hear & Treat
- Frequent callers
- Triage systems

97. As National Strategic Adviser for Ambulance Services at NHS England I did not have a working relationship with the following organisations: - College of Paramedics (CoP), National Ambulance Service Infection Prevention and Control Group (NASIPCG), Chief Medical Officers (CMOs) in England, Wales, Scotland or Northern Ireland or Public Health England (now UKHSA) or the equivalent bodies in the devolved Nations.

Consultation and advice provided to NHS England

98. During the relevant period I attended many meetings, some were ad-hoc attendances to provide a specific or general update, whilst attendance at many meetings was more regular. I have set out below an example of some of the meetings which I attended:

- Minister of State for Health.
- National Urgent & Emergency Care (UEC) Director and their Director Teams.
- National UEC Directorate Operations Team with the Regional UEC Teams.

- AACE Ambulance Chief Executive Group.
- NHS England Emergency Call Prioritisation Advisory Group (ECPAG).
- AACE NDOG and NASMeD.
- NHS England Ambulance Cell.
- Various Meetings with individual ambulance services and their respective regional teams when they were under pressure for example London Ambulance Service and Yorkshire Ambulance Service.

99. I first began to provide advice to NHS England on matters relating to the novel virus in February 2020 which I consider was sufficiently early enough. Letters to ambulance Trusts on 7 February 2020 asked them to prepare for COVID-19 and increase their capacity and emergency preparedness Exhibit AM/22 [INQ000410596]. On 22 February 2020 I also addressed transportation by ambulance of COVID-19 patients Exhibit AM/23 [INQ000410597]. Requests were made to ambulance Trusts to detail their capacity Exhibit AM/24 [INQ000410598] and individual Trust responses were consolidated and are shown Exhibit AM/25 [INQ000410599].

100. The advice I provided to NHS England and to ambulance services was based upon my main objectives which was to ensure we protect our staff in order that they were able to maintain a safe 999 emergency ambulance service across the country. Due to the scale of the challenge that the pandemic was presenting at various stages, the main basis of my advice concentrated on increasing capacity in ambulance EOCs and ambulance crews. This strategy I believe offered the greatest chance of saving as many lives as possible. Advice was also provided in relation to the requirement of reducing delays in handing patients over to clinicians at hospital emergency departments. My advice sought to mitigate the possibility of ambulance services becoming completely overwhelmed by the pandemic.

101. My input or advice was sought on almost a daily basis throughout the pandemic although some periods were much more intense than others and I was often attending to both National and local issues. The frequency of advice was heightened by the initial preparations which were required, followed by the initial surge in cases and then subsequent surges prior to National lockdowns.

102. I was invited and participated in an NHS England COVID-19 Preparations webinar on 27 February 2020 which dealt with PPE, Training, IPC, Seasonal Flu Vaccination Programme and COVID Surge Levels.

103. Much of my advice was accepted, particularly in relation to increasing capacity of ambulance crews through the mobilisation of St John ambulance volunteers, the mobilisation of paramedic university students, funding requests and the priority investment areas, which are summarised in the checklist I asked ambulance Trusts to complete so that they could review and increase their capacity depending on their local circumstances presented at Exhibit AM/25 [INQ000410599]. An example of where my advice was not rigorously applied was the requirement for ambulances to be offloaded at hospital within the NHS England guidance (15 minutes). This is described in more detail at paragraph 203. I also advised ambulance services to recruit sufficient 999 call handlers to ensure ambulance services were able to cope with the expectant increase in emergency demand from the pandemic and to mitigate against potential staff sickness absence in order to protect the critical national infrastructure of the 999 system. This was not actioned by all ambulance services which led to poor 999 call answering performance in some ambulance services and an increase in over 2 minute call answering delays.

104. Despite my advice to NHS England regarding the need to urgently reduce hospital handover delays, this is an area which continues to be a significant challenge and despite people's best efforts remains the largest contributory factor undermining ambulance service performance achievement in several regions of the Country.

New National Ambulance Service Governance Arrangements

105. On 23 March 2020, following a meeting of NIRB where I understand that Sir David Sloman NHS England Regional Director for London requested national oversight of the ambulance sector. I was subsequently asked by Pauline Philip UEC National Director at NHS England and Stephen Groves National head of EPRR at NHS England to take control of ambulance services and a letter drafted by NHS England Director colleagues and I was issued on the 25 March 2020 describing these new arrangements Exhibit [INQ000249080].

106. These temporary governance arrangements were communicated to all ambulance Trusts through the NACC and the drafting of these instructions were completed by Director colleagues at NHS England and myself.

107. Ambulance Trusts maintained their statutory responsibilities for the delivery of ambulance services in their area.

108. The role of the NACC in supporting me in the introduction of these new governance arrangements were:

- Single point of oversight for assessing determining and communicating the national level of ambulance service escalation.
- National liaison with other emergency services.
- National collection of ambulance service data relating to COVID-19.
- Co-ordination of Military Aid to the Civilian Authorities (MACA) requests to the National Head of EPRR at NHS England.
- Co-ordination, review and agreement to mutual aid arrangements.

109. Ambulance Trusts were also asked to make requests through the NACC if they required additional National support from St John Ambulance or were making a request for mutual aid from other ambulance services further afield from bordering services to the ambulance Trust seeking further additional mutual aid. These types of requests were considered a last resort after local and regional options had been exhausted.

110. The new governance arrangements and the operation of the NACC under my direction had many benefits, one of the key positives was the ability to have a single point of contact for information dissemination. Similarly, it was an opportunity for ambulance Trusts to communicate and provide feedback to me on national decision making. The NACC could be contacted by Trusts at any time to highlight concerns, and the NACC had a direct communication line to me, which facilitated rapid escalation and feedback to national decision-making Directors within NHS England.

111. Questions and concerns raised with me either directly, or through the NACC, were promptly responded to and where necessary escalated to the most appropriate colleague, Director, department or group within NHS England.

Ambulance Service Funding During the Pandemic

112. The issue of funding was examined with NHS England to assist in the completion of this advice. On 17 March 2020 Exhibit AM/26 [INQ000087317], NHS England wrote to all Trusts regarding the Next Steps on the NHS Response to COVID-19. This letter advised of the suspension of the National tariff payment architecture and a move to block payment contracts, in addition to this all NHS Trusts were also provided with assurance that extra funding would be made available "to ensure financial constraints would not stand in the way of taking immediate and necessary action."

113. Following my advice in relation to preparing for a potential winter surge, in July 2021 NHS England also made additional non-recurrent funding of £55 million available to help the ambulance service reach all patients as soon as possible, recognising the extreme operational challenges Exhibit AM/27 [INQ000410601]. The funding was specifically aimed to help recover and stabilise ambulance service performance, and allow support services to make improvements in readiness for winter to respond to patients quicker, reduce waiting times and deliver or sustain performance improvements against the national standard response times.

114. The additional funding was agreed for services to implement one or more of the following priority investment areas Exhibit AM/27 [INQ000410601]:

a. Recruitment of 999 call handlers

b. Expanding capacity through additional crews on the road

c. Additional clinical support in ambulance EOCs

d. Extended Hospital Ambulance Liaison Officer (HALO) cover at the most challenged acute Trusts

e. Retention of emergency ambulances to increase the fleet for winter

115. I do not recall any issues or concerns raised with me in relation to lack of funding.

Nightingale Hospitals

116. On 30 March 2020 I was asked by Mark Brandreth the National Director of the Nightingale Expansion programme to provide an ambulance representative to the National Team supporting the programme especially with regards transport modelling and building on

the work already done by ambulance Trusts, and I provided the NARU Director Keith Prior. Keith attended all meetings and met with relevant people and attended various Nightingale sites, Keith provided me with regular updates. Based on these updates I was able to brief Directors at NHS England as required. The specific Nightingale site operational arrangements were determined and implemented locally between the local ambulance service, the Region and the host hospital provider for each Nightingale hospital.

National Incident Response Board (NIRB)

117. I have been asked by the Inquiry to provide details of the purpose, aims and examples of the work of NIRB and their relationships with key stakeholders, which has already been described at paragraph 15.

118. There were a small number of occasions when I was invited to attend a NIRB meeting as National Strategic Adviser for Ambulance Services, in order to provide a specific update, however I was not part of the NIRB team. Any further information requirements relating to the work of NIRB and their key relationships should be directed to the most appropriate person at NHS England.

National Ambulance Resilience Unit (NARU)

119. This section will provide a brief description of the purpose, aims and examples of the work of NARU.

120. The strategic aim and objectives of the National Ambulance Resilience Unit are set by the National EPRR Team at NHS England. For the relevant period in question, those aims and objectives were Exhibit AM/28 [INQ000410602]:

Strategic Aim of NARU

121. The strategic aim of NARU is to support the NHS ambulance Service to maintain an effective and consistent response to high-risk or complex emergencies improving clinical outcomes.

Strategic Objectives of NARU

- Provide a well governed, patient focused, service that offers value for money and is delivered through a motivated workforce
- Maintain the nationally interoperable capabilities ensuring they remain safe and operationally effective
- Increase ambulance service preparedness for dealing with major and complex emergencies through the provision of high-quality training and education aligned to the national risk register and current doctrine
- Ensure all NARU activity remains patient focused and promotes the best patient outcomes

122. The mandate for NARU comes from the following primary sources:

- The Civil Contingencies Act 2004 and its legislative requirements for specified responders, including NHS ambulance Services, to be prepared for complex and major incidents
- The National Risk Register which identifies the main risks or threats to the United Kingdom that emergency services, among others, should prepare to deal with effectively
- The NHS England Emergency Preparedness, Resilience and Response (EPRR) Core Standards. These include contractual obligations for ambulance services
- The NARU Contract specifies what services are required to be delivered within the context of the three principal documents set out above

123. NARU has a key strategic role in supporting the NHS Ambulance Services to provide an effective response to the major or complex emergencies, envisaged in the national risk register.

124. One of NARU's fundamental functions is to nationally maintain and coordinate a set of 'interoperable' capabilities. These represent specialist capabilities designed to provide lifesaving emergency care to patients caught within high-risk situations. In England, the NHS Ambulance Services have 15 interoperable capabilities:

- Water Operations – an example would be rescuing people from rivers
- Safe Working at Height – an example would be treating and rescuing people from scaffolding

- Confined Space Operations - an example would be treating and rescuing people from collapsed buildings
- Unstable Terrain - an example would be treating and rescuing people from rubble piles
- All-Terrain Vehicle Operations - an example would be treating and rescuing people using a specialist vehicle from moorland
- Support to Security Operations - an example would be supporting the Police in a terrorist incident
- Marauding Terrorist Attack (MTA) - an example would be treating and rescuing people from a Manchester Arena or London Bridge type attack
- Chemical, Biological Radiological Nuclear (CBRN) Casualty Decontamination - an example would be treating and rescuing people from a chemical incident
- Hazardous Materials/CBRN: Powered Respiratory Suits (PRPS) – use of specialist personal protective equipment
- Hazardous Materials/CBRN: Next Generation Personal Protective Equipment -¬ - use of specialist personal protective equipment
- Hazardous Materials/CBRN: Extended Duration Breathing Apparatus and Gas Tight Suits - use of specialist personal protective equipment
- High Consequence Infectious Diseases (HCID) – an example would be transporting patients with Ebola using specialist equipment
- Command and Control Major Incident Courses
- Mass Casualties - an example would be treating and rescuing people from an aircraft accident
- Small Unmanned Aircraft (SUA/Drone) Operations – Operating drones to support HART operations

125. During the relevant period NARU was hosted by WMAS and received its funding from NHS England under the provisions of the contract. Most funding is transitioned through NARU to support the effective maintenance of the interoperable capabilities by each of the English NHS ambulance Services. The funding retained by NARU allows them to deliver the national services specified in the NARU contract including the work programme detailed in the Annual Business Plan agreed by NHS England.

126. NARU had several work stream trackers that were used during the COVID-19 pandemic for the relevant period. Those trackers set out, in detail, all of the work programmes and activities that NARU undertook during that period.

127. One of NARUs work streams is to produce national supportive guidance for the interoperable capabilities. As part of that work, NARU produced national guidance for Ambulance Service Command and Control, but that is not specific to a pandemic. Rather it is generic guidance covering principles for ambulance Commanders during all major and complex incidents.

128. During the COVID-19 Pandemic, NARU added the following activities to its normal day-to-day commissioned work streams:

- Closely monitor the impact of the pandemic on the interoperable capabilities and take steps to maintain their state of readiness throughout the pandemic period.
- Drafting a set of derogations or exemptions to some of the existing national standards governing the interoperable capabilities in response to the impact of the pandemic, particularly in relation to wider ambulance service pressures and increase staff absence within the interoperable capabilities e.g. Hazardous Area Response Team (HART) deployments and safe systems of work Exhibit AM/28a [INQ000470177].
- Support to ambulance services to establish operational use of the Nightingale Hospitals.
- Internal NARU plans and mitigations to ensure service continuity throughout the Pandemic period.
- Provided some NARU staff to support the work of the National Ambulance Coordination Centre.
- NARU coordinated HART teams nationally which were used to transport COVID-19 positive patients while the virus was still considered a High Consequence Infectious Disease (HCID) from 16 January 2020. When COVID-19 was subsequently downgraded from a HCID on 19 March 2020 all frontline emergency ambulances were then approved to provide such transport and transfers.
- Supported NHS England EPRR to implement a new HCID 'Epi-Shuttle' infectious patient transport solution as a national interoperable capability for use by Hazardous Area Response Teams (HART).

129. As the pandemic progressed it was clear that the existing safe systems of work and deployment procedures and process for Hazardous Area Response Teams needed to be re-appraised. For many of the Interoperable Capabilities, the Safe System of Work process requires six members of HART to be in attendance at the incident, however as COVID-19 sickness affected HART staff, many HART teams were unable to ensure six team members were on duty at all times. Therefore, derogations to existing procedures were devised to ensure that a safe system of work was still in place for incidents but with reduced numbers of HART staff. This for example could be by utilising other competent members of other emergency services in place of HART staff at an incident such as Water Operations where two HART staff are normally nominated as the upstream spotter and downstream spotter while four members of staff support the actual rescue. One such derogation was to be able to utilise Police or Fire officers as spotters allowing only four HART operatives to attend the scene and effect rescue safely Exhibit AM/28a [INQ000470177].

130. NARU did not have a working relationship with the following organisations:

- National Incident Response Board (NIRB)
- National Ambulance Service Infection Prevention & Control Group (NASIPCG)
- Ambulance Policy Assurance Advisory Group (APAAG)
- Emergency Call Prioritisation Advisory Group (ECPAG)
- NHS England National Ambulance COVID Cell
- College of Paramedics

131. There were established and organised relationships with the NACC, NASMeD and NDOG.

132. The NARU Clinical Adviser is a member of NASMeD and provided regular updates of the activities of NARU to the NASMeD group.

133. The NARU Director is a member of NDOG and provided regular updates of the activities of NARU to NDOG. The NARU Director provided day to day leadership and oversight to the NACC.

134. When examining the working relationship NARU had with key stakeholders, it is first important to explain the context of NARU's constitution.

135. NARU is not a legal body. It is a service that is created under a temporary contractual agreement between NHS England and WMAS. Under that arrangement, the service and work provided by NARU is set or specified by NHS England EPRR Team and corporately delivered under the governance of the host ambulance Trust. Therefore, any liabilities arising from the work or activities of NARU, rest with either the host ambulance Trust or the overarching authority, in this case, NHS England.

136. I have already set out in detail the role and function of NARU. NARU also liaised with partner agencies such as Police, Fire Service, NHS England and Homeland Security to develop Joint Operating Principles for a Marauding Terrorist Attack. There was also liaison with key stakeholders such as ambulance Trusts, The Department of Health and Social Care, NHS England and high level infection units for High Consequence Infectious Diseases (HCID) during the roll-out of the EpiShuttle isolation transport units across England. This engagement and liaison was broadly limited to the scope of the interoperable capabilities.

137. NARU is an essential service for the delivery of EPRR policy in NHS ambulance services in England. It contributes to and supports the UK's civil resilience and counter terrorism (CONTEST) strategies and the Department of Health and Social Care (DHSC) commitments under the UK's National Security Strategy and the National Security Council.

138. NARU works on behalf of NHS England to provide a coordinated approach to EPRR and specialist capabilities across NHS ambulance services in England. NARU works with English NHS ambulance services to support the development of appropriately trained, equipped and prepared ambulance responders to deal with hazardous or difficult situations, particularly mass casualty incidents, that represent a significant risk to health.

139. Special Operations Response Teams (SORT) comprises of CBRN and MTA trained ambulance staff. All these staff are employed by individual English ambulance Trusts but work under the policies and guidance set by NARU on behalf of NHS England EPRR.

140. During Covid, NARU continued to operate business as usual as far as possible to deliver the objectives as articulated in the Work Plan set by NHS England EPRR (now NHS Resilience). NARU continued to work with key stakeholders including:

- NHS England Resilience formerly NHS England EPRR
- Ambulance Trusts
- Department of Health and Social Care (DHSC)
- The National CBRN Centre
- National Fire Chiefs Council (NFCC) Operations Group
- Homeland Security at the Home Office
- Joint Emergency Services Interoperability Programme (JESIP)
- Care Quality Commission (CQC)
- PHE (now UKHSA)
- United Kingdom Search and Rescue (UKSAR)
- National Ambulance Commissioning Group
- Wider NHS
    - Various Blue Light & Multi Agency Partners

National Ambulance Co-Ordination Centre (NACC) during the pandemic

141. The NACC maintained regular contact with all English ambulance services through their Chief Executives and operations Directors. Each individual ambulance service maintained responsibility for its own day to day operations and performance.

142. The NACC was based within WMAS Headquarters and operated 20 hours each day with the remaining hours covered through on-call arrangements. This was increased immediately when required to provide 24-hour cover.

143. The NACC collated and monitored national operational data on ambulance services (ambulance performance, handover delays, resource availability, call demand) to assess relative service by service pressures.

144. The NACC was able to access ambulance and wider NHS on-call systems including NHS England's on call director, myself, the NARU Director and NARU on call structures. This access allowed immediate escalation of significant issues for coordination of a national

ambulance response to system failures or major incidents. Examples of escalations by the NACC include significant incidents, hospital handover delays and the impact on ambulance performance and 999 call answering performance. Exhibit AM/28b [INQ000470910] sets out a summary of the issues that were escalated and dealt with by the NACC.

145. The aims of the NACC were to Exhibit AM/29 [INQ000410603]:

- To alert and escalate to the NHS England National Operations room and the NHS England National Director as required
- To monitor the status and performance of English ambulance Trusts during the National Pandemic Emergency and winter pressure period of 2020/21
- To provide live data and regular situation reports with analysis to NHS England and NHS Improvement
- Collated information presented on a summary screen within the National Operations Room at NHS England Skipton House and available to National Directors and other approved persons on their mobile devices
- To facilitate the national coordination of English NHS ambulance Trusts as directed
- To monitor, alert and escalate hospital handover delays from ambulance crews to hospital staff
- To monitor, alert and escalate corridor care and congested emergency departments
- To monitor, alert and escalate rising tide pressures
- To scope and develop where possible an automated system

146. The NACC would facilitate ad-hoc and temporary data collections on behalf of myself, NHS England National colleagues and Regional teams, Urgent and Emergency Care (UEC) teams, NARU and DHSC. Examples of this include audits of ambulance service fuel stock levels, stock levels of High Consequence Infection Disease PPE Exhibit AM/28b [INQ000470910].

147. In the early stages of the pandemic the daily data collection was focused on the impact COVID-19 was having on resourcing and each ambulance Trust was required to provide data on the number of staff in each service area; Emergency Operations Centre (EOC), NHS 111, Non-Emergency Patient Transport Services (NEPTS) and Emergency and Urgent Care. The data collection included the number of staff who were; self-isolating (and well) due to close contact with a positive case, the number of staff who were off work due to testing positive for COVID-19 and finally the number of staff who were off work with another

type of illness. A template daily situational report (sitrep) has been exhibited to assist the Inquiry Exhibit AM/30 [INQ000410604]. They were introduced in April 2020, and I believe they ceased in May 2021. The sitreps were used for daily situational awareness, therefore we did not undertake data analysis over a period of time. In general, I noted that trends of staff absences due to covid followed the waves and peaks of infections in the wider population. The SitReps were also sent to NHS England, and I believe that the People Directorate in NHS England collated and analysed some of the data sent by the NACC. I did not have any involvement with the analysed data, nor did I receive it.

148. This daily sitrep was enhanced over time Exhibit AM/31 [INQ000410605] and information requested from Trusts increased to include:

- 999 Activity current v last year including see and treat, hear and treat and see and convey %
- Maximum number of staff on duty the following day in EOC, Accident & Emergency (A&E)
- Fleet % unavailable
- PPE availability (lasting a minimum of 72 hours)
- PTS Support
- Operational Data including Resource Escalation Action Plan (REAP) level, Surge Demand Management Plan (SDMP) level, waiting cases in despatch stack
- European Union (EU) Exit Risks

149. Information requests would be collated and were designed to highlight issues that some or all ambulance Trusts may be experiencing. Although the information that was being requested from each Trust was relatively basic in nature and could help inform their own preparedness, some ambulance Trusts may have had some limitations to provide it in the way that the NACC were requesting the information and this was sometimes evident within the data submissions.

150. Any issues identified from the NACC shift report, COVID-19 Surge preparations checklist or the COVID-19 HART Mitigation Report were escalated to NHS England Strategic Ambulance Adviser and other NHS England colleagues.

151. As well at the sitrep which is discussed above, implemented and approved by me, a number of other processes were put in place that allowed the NACC to collate information,

refer decisions to appropriate decision makers so that support could be provided, these included:

- A Mutual Aid flow chart Exhibit AM/32 [INQ000410606] to support decision making
- A MACA requests process Exhibit AM/33 [INQ000410607] included the requirement for oversight and support, or not, by me prior to submission to National Directors at NHS England including the Head of EPRR at NHS England for requests that were made through the NACC. During the relevant period a number of ambulance Trusts made MACA requests through the NACC, and these have been listed Exhibit AM/34 [INQ000470911]. I have records of 12 formal MACA requests being made through the NACC. I was aware that a small number of MACA requests were submitted directly to NHS England EPRR and not through the NACC and are therefore not included in this number. Due to this, and considering that once the MACA request was submitted, military colleagues and NHS England EPRR colleagues liaised directly with the requesting ambulance Trust, I do not hold information on whether ambulance Trusts received the military aid they requested, National NHS EPRR colleagues coordinated this. I understand however that for MACA request number 12 of Exhibit AM/34 [INQ000470911], the records of the NACC indicate that 11 ambulance Trusts requested MACA of 637 personnel in total, and four ambulance Trusts received MACA of 87 personnel in total.

152. Ambulance services would also make requests to the NACC for additional support from St John Ambulance (SJA) auxiliary service or mutual aid from other ambulance Trusts however this was considered a last resort after local and regional options had been exhausted for example by seeking the assistance from fire service personnel.

153. The national SJA resource deployment was coordinated by the NACC during the relevant period, with decisions for deployment of resources being made jointly in consultation with ambulance Trust Chief Executives, ambulance operations Directors and SJA senior operational managers. Support given was based upon the ambulance service request for assistance, relative pressure service by service and ability of SJA resource to be deployed across the Country.

154. The NACC however did not coordinate private ambulance services, this was locally determined by individual ambulance services and their commissioners, in line with usual pre-pandemic arrangements.

155. The Inquiry has asked me to summarise the nature of the working relationships between the NACC and key stakeholders and I have defined these.

156. There were no direct relationships between the NACC and National Ambulance Response Board (NIRB), National Ambulance Service Medical Directors Group (NASMeD), National Director of Operations Group (NDOG), National Ambulance Service Infection Prevention and Control Group (NISIPCG), Ambulance Policy Assurance Advisory Group (APAAG), Emergency Call Prioritisation Advisor Group (ECPAG), NHS England National Ambulance COVID Cell, NHS 111, PHE/UKHSA, Chief Medical Officers (CMOs) or The College of Paramedics (CoP). The NACC did communicate with NDOG colleagues from time to time to collect or disseminate information and other correspondence.

157. The NACC did maintain close relationships with me and other NHS England colleagues including the NHS England UEC Operations Room by supplying data and also through their work acting as a single point of contact.

158. In normal circumstances, the NACC is ready to be set up in the event of a significant incident such as a mass casualty incident requiring mutual aid, however at this time the NACC had been specifically commissioned on a temporary basis by NHS England to support the NHS during winter pressures and had its own staff seconded from WMAS, the NARU Director managed the NACC day to day. This support was extended by NHS England to cover the pandemic period. In the initial stages of the pandemic NARU staff worked within the NACC covering shifts and supported the NACC staff by producing documentation and spreadsheets that were used by the NACC to gather and disseminate information, however as time progressed NARU officers returned to their important substantive roles and Officers were provided by WMAS. In addition the NACC also maintained a relationship with St. John Ambulance and British Telecom for 999 call handling.

159. I consider that the NACC was a focal point for providing national situational awareness within the ambulance sector. Ambulance Trusts provided frequent updates to the NACC in relation to issues or concerns, and these were shared with relevant key stakeholders. The NACC was a key part of the ambulance sector response to covid and was hugely valuable.

160. The additional benefits of these arrangements was the logging of decisions and actions and the visibility of regular data and performance metrics from within each individual ambulance service. These performance indicators ranged from 999 call answering

performance, response time performance and hospital handover delays. Much of the information provided by the NACC was essential for national decision makers to understand ambulance sector performance and pressures in real time.

161. The NACC initially collated data from English ambulance services via email and input data onto a excel spreadsheet for regular distribution on a daily basis. This was significantly improved by the introduction of the NACC dashboard hosted on NHS Foundry in December 2021, which is an automated, 15-minute feed from ambulance services Computer Aided Dispatch (CAD) systems. This dashboard continues to be used daily by stakeholders across the NHS. This has been beneficial in other recent challenges for ambulance services, such as the recent episodes of industrial action. The dashboard provides near real time data on ambulance call answering performance, response times and hospital handover delays.

162. In addition to NACC co-ordination, national ambulance service Director groups as part of AACE also became more co-ordinated by meeting more regularly, sharing more information and considering which issues to collaborate. The benefits of strengthened relationships between Trusts continues to be seen outside of the pandemic as groups appear stronger, more confident and empowered as a result of their work during the pandemic.

163. At the point NHS England de-escalated from a National Level 4 Emergency to Regional Level 3 Emergency in September 2020 the arrangements of co-ordination and oversight by me were reviewed and amended. At that time ambulance services had been through the first wave of the pandemic and had already implemented many of their preparations and were working to prepare for any future surges over the winter.

164. Changes that were introduced following de-escalation were confirmed to all ambulances services in writing by myself and Emma Hall on 2 September 2020 Exhibit AM/35 [INQ000410617] and the following processes were taken over by individual regions of NHS England:

- Co-ordination of MACA requests to the National Head of EPRR
- Co-ordination, review and agreement to mutual aid arrangements, ensuring equal treatment of all requests

165. Support to each ambulance service was maintained by myself as National Ambulance Adviser and other national NHS England colleagues and continued to:

- Oversee and advise on ambulance service pandemic planning and operations, including delivery of decisions relating to call handling and pandemic escalation levels as recommended by the Emergency Call Prioritisation Advisory Group (ECPAG) and expert reference groups
- National liaison with other emergency services
- National collection of ambulance service data relating to COVID-19
- Nationally led voluntary sector deployment of St John Ambulance Auxiliary

166. I viewed these arrangements as beneficial as they provided a consistent approach by supporting preparations being implemented at pace, enabled sharing of best practice, mitigating risks through: - mutual aid of PPE, ambulance crews and 999 call handling. A summary of the ambulance cell decisions were retrospectively collated in a document Exhibit AM/36 [INQ000410610] and this timeline may help the Inquiry.

Protocol 36, Ambulance Triage Systems, Clinical Codes, Patient Prioritisation, Call-Filtering and 'No Send Scripts.'

167. Protocol 36 and the NHS Pathways equivalent introduced temporary and tiered changes to the 999 telephone triage systems which are used by all English ambulance Trusts. The systems currently in use are called NHS Pathways and Advanced Medical Priority Dispatch System (AMPDS). Triage systems are broadly described as Clinical Decision Support Systems (CDSS) and are used by all ambulance services. Protocol 36 describes the changes to AMPDS and NHS Pathways changes were described as the NHS Pathways Covid-19 pathway. The changes in both systems will be referred to as Protocol 36 in this statement.

168. Although NHS Pathways and AMPDS are distinct and separate systems, they both perform the same task and contain a series of algorithms, or pathways, that links clinical questions and care advice and lead to clinical endpoints which may involve an ambulance dispatch with an additional determination relating to the priority or target time in which an ambulance should arrive with the patient (response category).

169. Mapping triage outcomes and their respective response categories is completed by an expert group who make their recommendations to ECPAG.

170. Changes within triage systems were being made from March 2020 to deal with COVID-19. On 12 March 2020 ECPAG approved the introduction of two new ambulance disposition codes which helped ambulance services identify COVID-19 patients from 999 calls being received. On 17 March 2020 a new COVID-19 pathway was introduced which prioritised patients who were contacting 999 and complaining of breathing difficulties.

171. In March 2020 Exhibit AM/37 [INQ000410611] & Exhibit AM/38 [INQ000410612] a new ECPAG expert task and finish pandemic protocols subgroup was formed and met which comprised of key staff from the AACE, NHS England, NHS Pathways, the National Directors of Operations Group (NDOG) and the National Ambulance Service Medical Directors Group (NASMeD). The task and finish pandemic protocols subgroup described working at pace and in close co-operation, to develop improved triage processes within both AMPDS and NHS Pathways in readiness to manage the expected significant surge in demand of suspected and confirmed COVID-19 patients. This task and finish pandemic protocols subgroup reported into ECPAG.

172. Recommendations to changes to NHS Pathways and AMPDS were proposed on 23 March 2020 and the following rationale provided Exhibit AM/39 **INQ000281180**

a. As the pandemic approaches its peak in the UK ambulance services will, under existing triage arrangements, soon be in a position where demand outstrips available resources. The revised triage processes seek to mitigate this effect through preserving front line ambulances to respond to the most seriously ill and injured patients.

b. The revised processes represent a significant escalation in that some patients who would normally receive an ambulance response may instead be directed to appropriate and safe alternative care pathways or advised in respect of appropriate self-care. Example conditions that this may have applied to are chronic conditions that do not require an emergency ambulance, a patient with flu like symptoms, or frailty which may be more appropriately treated through an alternative pathway. Alternative pathways may include a patient making their own way to an urgent treatment centre or primary care centre, or receiving support from community nursing.

c. Some patients that would receive an ambulance response under these arrangements will be allocated to a lower response category than their condition would warrant under normal circumstances. This will allow ambulance services to better manage demand and resources in order to save as many lives as possible.

d. The consequences of not implementing these arrangements promptly when they are judged to be required is that ambulance services may be overwhelmed by rising demand associated with incidents where symptoms fit the PHE case definition for COVID-19. Ambulance services will not be able to triage or respond to incidents appropriately in this context due to the likely scale of 'call stacks'.

e. The new processes set out four distinct levels of escalation which would apply to both AMPDS and NHS Pathways consistently.

173. The Emergency Call Prioritisation Advisory Group (ECPAG) were asked to approve the following on 26 March 2020:

- The AMPDS process and code set to support a significant increase in activity related to COVID-19
- The NHS Pathways process to support a significant increase in activity related to COVID-19
- The escalation process (set out in this statement at paragraph 184) which details how NHS England would monitor activity levels and approve implementation of the AMPDS and NHS Pathways processes and the escalation levels
- The decision to implement the Pandemic Triage processes with immediate effect

174. The proposal also set out the following important information; normal triage procedures were intended to continue for patients contacting the ambulance service for reasons other than COVID-19 symptoms, although ambulance services would be required to ensure normal demand management procedures are in place when demand exceeds available resources.

175. Additional principles included fever that has responded to medication would no longer be classed as fever, and chest pain can be assessed on the basis of previous history of heart attack/angina and for other associated features of cardiac chest pain, rather than chest discomfort often associated with flu like illness. A developmental draft of Protocol 36 is attached in Exhibit AM/40 [INQ000410614].

176. There was broad consensus within the expert reference group, which I agreed with, that the decision to implement AMPDS Protocol 36 and the aligned NHS Pathways processes must be taken Nationally and applied consistently and concurrently by all ambulance Trusts in England. To do otherwise would introduce unwarranted variation and potential clinical risk – particularly in the context of mutual aid support and routine practice of ambulance Trusts taking high numbers of 999 calls on behalf of one another.

177. Similarly, there was broad consensus that decisions to escalate and de-escalate through the levels set out later in this statement at paragraph 184, should be taken nationally and applied consistently and concurrently by all ambulance Trusts. This decision was taken recognising that some ambulance Trusts who were still maintaining normal performance standards would be at a level of escalation higher than they might deem appropriate for their local conditions.

178. The expert reference group were of the view that the benefits of consistency are compelling and that the Trusts in a stronger position would be able to provide an ambulance response to patients that other Trusts were not responding to at that level of escalation. In principle this is in line with current Ambulance Quality Indicators (AQI) practice which sets a nationally consistent expectation without curtailing the ability of Trusts to exceed it. On 24 April 2020 I wrote to all ambulance Trusts and highlighted this Exhibit AM/41 [INQ000410615]. Therefore, there would be no disbenefit to patients in those areas where ambulances were available to be immediately sent to help patients.

179. Four levels of escalation were proposed by the expert group. The following information would be assessed to determine the most appropriate level of escalation:

- The number of emergency calls that are held in the stack by category
- The level of resources that are available to respond
- The number of staff who are self-isolating and sickness levels
- The proportion of incidents by category i.e. acuity
- 999 call answering performance (mean and 90th centile)
- Current REAP and demand management plan surge level

180. In addition, the following issues should be considered by NDOG and NASMeD in order to assist them in arriving at a consensus judgement as subject matter experts. Issues to consider would include Exhibit AM/39 **INQ000281180**

- Is demand relating to suspected cases of COVID-19 approaching a level where your best judgement is that patient safety for those with other conditions of equal or great acuity will be compromised?
- Is the frequency with which your Trust is using ambulance EOC plans to manage high levels of demand such that your judgement is that escalation to the next level of the COVID-19 triage process is warranted?
- Is it your best judgement that escalating to the next level of the revised triage process will mitigate that risk?
- Is it your best judgement that the benefits of escalation in terms of patient safety are greater than the risks inherent in escalating to the next level of the process?
- If data is not available to support your judgement, or if the emerging picture is not clear, have you taken views within your Trust and does the consensus of the views you've received support the judgement you are making?

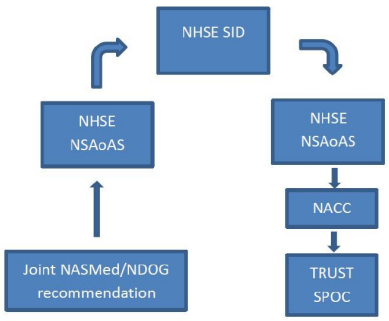
181. In summary these new triage processes were designed to maximise the availability of ambulances for those who were most unwell or injured. With in certain escalation levels some patient categories who would have previously received an ambulance response would now be directed to an alternative appropriate and safe clinical pathway and provided with clinical advice. This tiered approach based on demand allowed ambulance services to focus their resources on those patients most in need.

182. The following table describes the changes within triage systems that would be introduced at each change in escalation level. NHS pathways Covid-19 'work arounds' were operational notices that were issued by individual ambulance services to their 999 call taking staff in the absence of formal NHS pathways updates. This would have happened due to the speed at which updates to pathways were required. AMPDS alpha, bravo, charlie, delta and echo case codes indicate the priority of the incident, with alpha being the lowest priority and echo being the highest. Some of those codes are referenced in the table below.

	Level 0	Level 1 Moderate Pressure	Level 2 Severe Pressure	Level 3 Extreme Pressure
MPDS	Surveillance only - in place currently through additional key questions	Refemal (Clinical Assessment home management) of ALPHA cases	Reduced response Category to CHARLIE cases	Referral Of some CHARLIE cases and reduced response Category for some DELTA cases
NHS Pathways	NHSP COVID.19 work around	NHSP COVID-19 pathway is implemented	Altered response to some Category 3 DX codes and an increase in "speak to" dispositions	Altered response to Category 3 DX codes ard an increase in "speak to" and "home management" dispositions

183. Whilst I was not involved in the drawing up of the Protocol 36 proposal, it was presented to me as Chair of ECPAG. Revisions and amendments were considered and actioned where appropriate with consultation and liaison with the expert groups. I maintained a role in the approvals process when changes were suggested to escalation levels, these were considered by me and then escalated to the NHS England Incident Director and UEC National Director.

184. The process of approval in the proposal is documented below, however this process was formally documented in November 2020 Exhibit AM/42 [INQ000410616]. This Exhibit also documents how escalation and de-escalation through the pandemic protocol levels would take place.



185. Prior to the implementation of Protocol 36 code changes were subject to clinical and stakeholder scrutiny by:

- Clinical Coding Review Group
- NDOG
- NASMeD
- COVID-19 Out of Hospital Clinical Risk Panel (Chaired by CQC Chief Inspector of Hospitals)

186. Protocol 36 was introduced on Friday 27 March 2020 at level 1 within London Ambulance Service and by all other ambulance Trusts by 3 April 2020.

187. The impact of Protocol 36 meant that when patients contacted ambulance services more patients who were identified as having COVID-19 symptoms were triaged into a category 3 ambulance response as opposed to a category 2 ambulance response. A Category 2 ambulance response indicates potentially serious conditions that may require rapid assessment and urgent on-scene intervention and/or urgent transport. The average response time target is 18 minutes and 40 minutes at the 90th percentile. A Category 3 ambulance response indicates an urgent problem (not immediately life threatening) that needs treatment to relieve suffering and transport or assessment and management at the scene with referral where needed within a clinically appropriate timeframe. The average response time target indicator is 60 minutes indicator and the 90th Percentile target is 120 minutes.

188. On the 24 April 2020 I wrote to all ambulance Trusts explaining the rationale for remaining on level 1 of the pandemic protocol Exhibit AM/41 [INQ000410615]. I also reminded ambulance Trusts who were in a stronger position that they were able to choose to provide an ambulance response to incidents that other Trusts were not responding to at that level of escalation, due to not being in the same strong position. This is in line with current AQI practice which sets a nationally consistent expectation without curtailing the ability of Trusts to exceed it.

189. Following the introduction of Protocol 36, NHS England regularly monitored the impact of the changes. NHS England also examined feedback from Trusts regarding any issues or concerns that they found, where necessary changes were made. I recall a specific example of this taking place:

- In May 2020 North West Ambulance Service highlighted some cases of chest pain which initiated a review of the coding for ST Segment Elevation Myocardial Infarction (STEMI) patients. The review recommended a proposal for change form is submitted to the International Academy for Emergency Dispatch (IAED) by the NHS England Clinical Adviser for Clinical Coding, and that the findings were presented to NDOG and NASMeD. A proposal for change document was submitted to the Academy which identifies the concerns raised relating to incorrect coding of

some chest pain Exhibit AM/42a [INQ000470193]. Following the review, changes to coding were released by IAED on 2 June 2020 and Trusts were asked to implement the updated version by 8 June 2020.

- Protocol 36 was reviewed again on 3 August 2020, shortly after the national emergency level was reduced to level 3, at this point the Protocol 36 level was reduced to level 0 which maintained surveillance Exhibit AM/35 [INQ000410617]. This was formally agreed by NHS England on 22 August 2020 along with code change which meant that 'ineffective breathing' would require a category 1 response.
- Due to increasing demand on ambulance services in September 2020 the escalation level was increased to level 1 and this was communicated on 12 October 2020 and live within triage systems in ambulance service EOCs by 14 October 2020 Exhibit AM/43 [INQ000410618].
- There were times during the relevant period when individual ambulance Trusts or a small number of Trusts wanted to increase the pandemic protocol levels Nationally or Regionally which would mean a higher escalation level in their area than the rest of the Country, specific examples of this are October 2020 and January 2021 which are listed in the ambulance cell decision timeline Exhibit AM/36 [INQ000410610]. When these requests were made they were discussed and considerations were given however it was felt that operational mitigations could be as effective than a broader approach of utilising higher escalation levels within Protocol 36.
- Operational mitigations included maximising capacity though use of overtime, bank staff, agency and third party, mobilising University student paramedics and community first responders, utilising St John ambulance crews, patient transport services and high dependency crews. Services were also asked to minimise all other abstractions from frontline services and ensure that all available clinical capacity was deployed to the frontline. In the emergency operations centres, advice was given to use overtime, accelerate recruitment of new staff and reduce abstractions. Further mitigations included maximising ambulance fleet availability to reduce ambulance crew downtime, doing everything possible to reduce transmission of the virus amongst the workforce, requesting NHS 111 clinical call back time be extended from 30 minutes to 60 minutes. Services were also able to submit MACA requests where necessary and appropriate, and should consider fully implementing REAP and Surge actions as per existing individual ambulance service plans and procedures.
- In October 2021 the requirement to utilise Protocol 36 for chief complaint calls of 'chest pain,' 'breathing problems' and 'the sick person' was removed due to the fact

that COVID-19 symptomatic patients could be dealt with utilising existing protocols Exhibit AM/44 [INQ000410619].

- In December 2021 ambulance Trusts were asked to implement the full level 1 of Protocol 36 by the 23 December due to a surge in infections and an expected increase in demand Exhibit AM/45 [INQ000410620].
- In June 2022 ECPAG discussed the removal of Protocol 36 subject to ongoing reviews, however ECPAG determined at the time this should be maintained and monitored for a longer period so that data could be evaluated more carefully.

190. On 2 April 2020, I was provided with a summary of legal opinion (in the form of questions) about the introduction of Protocol 36 Exhibit AM/46 [INQ000410621] along with corresponding responses and suggested mitigations by NHS England.

191. The only 'no send scripts' that were mandated Nationally were part of agreed and approved Protocol 36 levels. Existing protocols within ambulance service REAP and Surge plans deal with circumstances when ambulances are not available to be sent to all emergencies immediately. REAP levels provide a framework to maintain an effective and safe operational and clinical response to patients, which reflect the level of sustained pressure on an ambulance Trust Exhibit AM/21e [INQ000470908]. The trigger definitions in the framework, are agreed Nationally, and govern escalation and de-escalation from one REAP level to another, which are determined by each individual Trust. The triggers include emergency activity, staff absences, hospital handover delays, other factors i.e. industrial action or inclement weather. The lowest level being one and the highest being four. The REAP framework is completely separate from the individual Trust Surge plans. Surge plans are not nationally agreed, however the use of Surge scripts during times of significant pressure are widely used in ambulance services. Therefore 'no send scripts' may be included as part of local Surge arrangements. An example of a Surge script could be, for lower priority 999 calls, informing the caller that it may be several hours before an ambulance is available, and asking the caller if the patient can be taken or make their own way to a hospital emergency department. In these cases advice is given about what to do if symptoms worsen and then advise them to have a mobile phone with them at all times.

192. During the pandemic the 'National Ambulance Service Medical Directors' and 'National Directors of Operations Group' reviewed the use of Protocol 36 and made proposals to escalate and de-escalate the level. One particular issue that emerged through ECPAG was around governance of 'no send' scripts, with a need to keep this as

standardised as possible across all services to ensure parity of response. A narrative was agreed and released nationally Exhibit AM/46a [INQ000470198], Exhibit AM/46b [INQ000470199] & Exhibit AM/46c [INQ000470200], which included the following:

- Category 5 / No Send represents a clinical recommendation that the call can be closed at call handler level within each pandemic level, subject to local governance arrangements being in place. Trusts are not mandated to close codes with a no-send marker at call handler level where an alternative response or methodology is available locally
- Ambulance Trusts should continue to use locally determined responses where these are in place for specific codings
- Ambulance Trusts should continue to deploy HART and/or complementary responses to MPDS codes as locally determined arrangements permit
- Ambulance Trusts should have specific scripts and governance arrangements in place where they choose to no-send on identified MPDS codes

193. My advice in relation to the escalation levels of the triage system, Protocol 36 and clinical coding was to always follow the clinical evidence and in the context of the pressure on the ambulance service in order to maximise patient safety and to save as many lives as possible. I also ensured we took into account the views and advice from the expert reference group, APAAG, NASMeD, NDOG and other NHS England colleagues.

999-Call Filters

194. Some of my advice to NHS England and ambulance Trusts in preparing for surges in demand, was to increase their 999 call taking capacity and resources, despite significant efforts there were times during the relevant period that demand unfortunately outstripped capacity. In the early stages of the COVID-19 pandemic the majority of emergency operations centres at English ambulance Trusts were receiving 999 calls from members of the public who required COVID-19 information and advice. Many of these calls did not require an ambulance response however the volume of calls for advice affected the speed in which actual 999 emergency calls could be answered and triaged. I approved, with agreement through ECPAG, the introduction of a call filtering system on 27 March 2020 in order to help reduce the number of COVID-19 advice only calls by referring patients requiring advice to NHS 111 online providing that they were not <5 years old or >70 years old. A flow diagram of the filter was contained within my letter to ambulance Trusts on 29

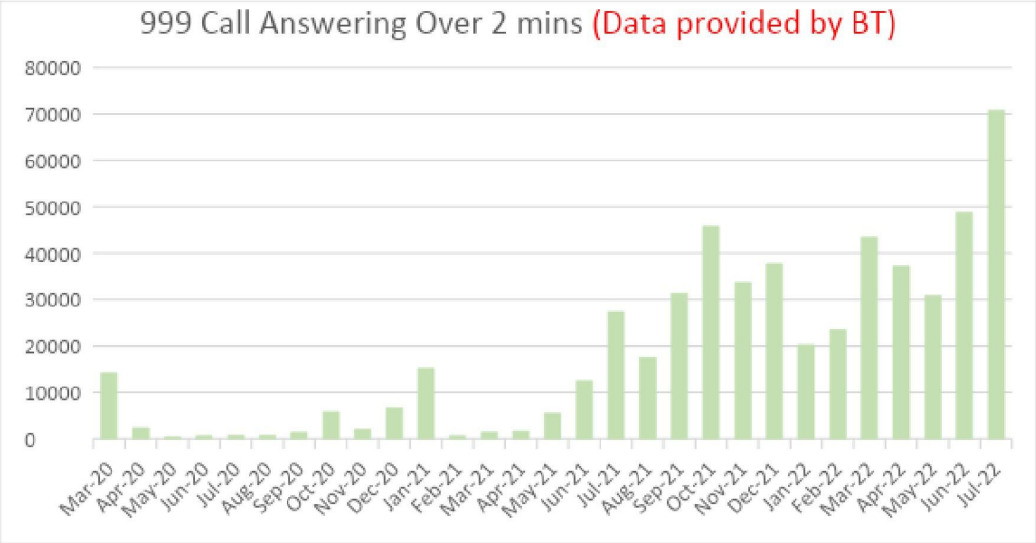
March 2020 Exhibit [INQ000249080]. The BT call filtering system was used until information on how to access COVID-19 advice was in the public domain.

195. The 'advice only' filter was first switched on in late March 2020. Thresholds for turning the filter on or off were agreed, and the filter was turned off or on at various intervals throughout the relevant period. The COVID-19 filter was turned off on 09 June 2020, but then turned back on in November 2020, it was again turned off in December 2020 (except for London), this was then switched off in January 2021.

196. It is important to note that there was more than one version of the BT call filter. A further surge in demand in the summer of 2021 again placed significant pressure on EOCs, resulting in a deterioration in 999 call answering performance. Following the filter described above, on 27 October 2021 BT added to this filter to support ambulance services who were receiving high amounts of duplicate calls. The filter was a short set of questions to be posed by the 999 BT call operator, which were designed to identify callers who are calling for an Estimated Time of Arrival (ETA) for an ambulance that has already been requested and where the patient's condition has not changed. The intention was to avoid passing through a proportion of these ETA calls to ambulance EOCs to reduce the demand on ambulance call handlers, increasing their capacity to answer new calls, and therefore reduce the clinical risk to patients caused by extended call handling delays. The October 2021 999 call filter system was introduced following liaison with NHS England, BT and AACE. If the 999 BT call operator was able to establish that there was no deterioration in the condition of the waiting patient, then the call would not be transferred to the ambulance EOC. This new filter enabled ambulance service EOCs to focus their attention on answering new 999 calls or making 999 call backs to identify any deterioration in a waiting patient's condition. This filter was switched off on 13 December 2022. The following Exhibits evidence the discussions that took place in relation to setting up the BT call filter arrangements between NHS England, AACE and BT Exhibit AM/46d [INQ000470201] & Exhibit AM/46e [INQ000470202]. I am not aware what training, if any, was provided to BT 999 call handlers other than familiarisation of the call flow chart process.

197. The graph below shows an increase in 999 calls which took 2 minutes or more to be answered. The data is provided regularly via email by BT's 999 emergency authority

relationship team to all ambulance services.



198. Call filters were regularly reviewed, and their use was activated and deactivated at various stages during the relevant period in response to surges in demand. On occasion they were activated for individual Trusts for example within London Ambulance service between 31 December 2020 and 14 January 2021 Exhibit AM/36 [INQ000410610].

199. The temporary introduction of 999 call filtering systems during the pandemic undoubtably contributed to saving lives as they helped to reduce call answering times by prioritising patients who were seriously ill or injured and allowing ambulances to be dispatched quicker to those in most need.

999 Call Assessor Training

200. I became aware that a small number of ambulance Trusts were intending to or had implemented a shortened 999 call answering training package for new staff, which I was concerned about. I therefore gave clear advice about these arrangements which I have discussed at paragraph 66. I wrote to ambulance service CEOs setting out my expectations on 27 March 2020. Exhibit AM/15 [INQ000410589].

The establishment, implementation, monitoring and cessation of additional services to respond to the COVID-19 pandemic

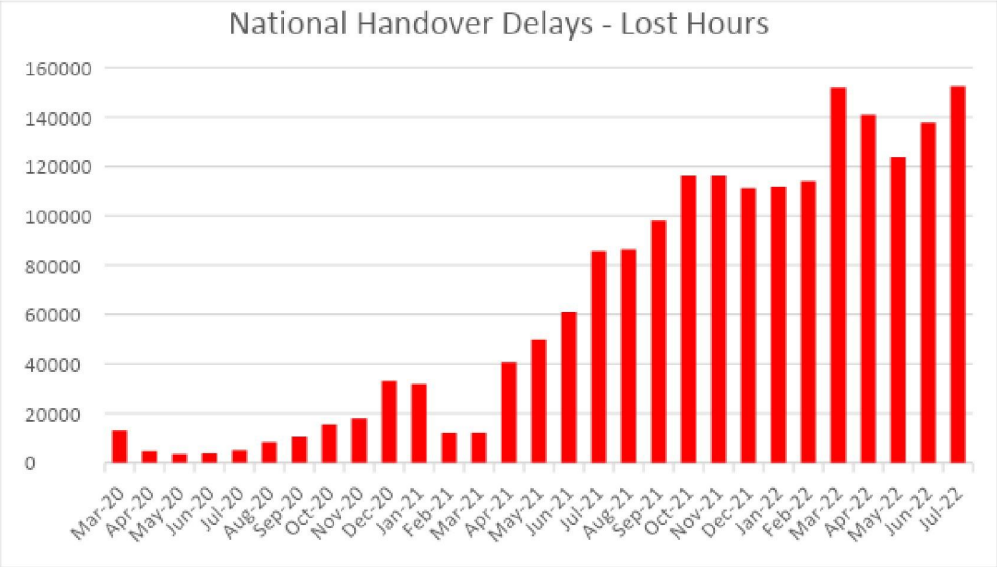
201. In my role as National Strategic Adviser to Ambulance Services at NHS England, I did not have any direct involvement with the following additional response services:

a) The Public Health England Helpline
b) The COVID Response Centres
c) The National COVID Response Service
d) South Central Ambulance Service Clinical Safety Net
e) COVID-19 Clinical Assessment Service
f) Repeat Prescription Service

COVID-19 and the Impact on Hospital Handover Delays

202. Ambulance handover times during the early part of the pandemic including the first National lockdown significantly reduced across the Country which was largely due to a reduction in operational demand and also an increase in bed capacity at hospitals, which assisted patient flow through hospital emergency departments. In summer 2021 ambulance handover times began to increase and unfortunately these even at the time of writing have not returned to pre-pandemic levels.

203. The following chart which was created from data provided by NHS England shows national ambulance handover delays over the Inquiry's relevant period. This national hospital handover data is calculated from submissions from each Trust to NHS England where there is a handover delay over 15 minutes i.e. each month shown on the graph indicates the total hours lost nationally where patients have waited over 15 minutes in an ambulance outside of an emergency department in England.



204. COVID-19 did have an impact on ambulance handover times and this in part was due to new social distancing requirements, the creation of zones within emergency departments to treat patients with and without COVID-19 and the increased requirement for healthcare staff to don and doff PPE between patient care episodes. In October 2020, I instigated data collection in respect of patients held on the back of ambulances outside hospitals. I presented a paper on this to the emergency and elective care senior management team and gained approval for the collection of this data, which could then be shared with national urgent and emergency care operations teams for analysis and tracking against other national data sources Exhibit AM/46f [INQ000470203] & Exhibit AM/46g [INQ000470204].

205. Because of the risk that I was raising in relation to hospital handover delays, on 26 October 2021, a letter was sent to Integrated Care System (ICS) leads, Acute Trust Chief Executives, ambulance Service Chief Executives and Acute Trust Chairs. The letter was signed by the National Director for emergency and elective care, National Medical Director and associated regional Directors Exhibit AM/46h [INQ000470205]. This contained information about national policy on ambulance handovers, actions to take to eliminate delays and examples of initiatives being used in systems to address handover delays.

206. In December 2021, 35 hospital sites of concern were identified by NHS England, with NHS England policy and clinical teams supporting through on-site visits to look at the initiatives and processes being used in those systems at that time and to identify further

solutions to eliminate all handover delays. Separately, and as part of wider national ambulance team governance, I co-chaired a group that reported into the Ambulance Transformation Forum Exhibit AM/46i [INQ000470206] and had a focus on ambulance hospital handover delays (including the 35 sites of concern). The group had key deliverables, including:

- Identify the most challenged Trusts per region on a quarterly basis and facilitate the sharing of best practice at monthly meetings
- Programme manage the national Hospital Handover Delays collaborative work programme including monthly national meetings
- Monitor the number of delays over 15 minutes, 30 minutes and 60 minutes in addition to the total number of ambulance hours lost due to hospital handover delays, through the development of an integrated data dashboard
- Work collaboratively with regional colleagues to facilitate the sharing of best practice in reducing hospital handover delays

207. Hospital handover delays have a significant impact on the ability of individual ambulance Trusts to respond to patients in need within their communities and there is a direct correlation between increased hospital handover times and a deterioration in ambulance response times. A Health Services Safety Investigations Branch (HSSIB) investigation found that ambulance hospital handover delays caused harm to patients. Exhibit AM/47 [INQ000410622].

208. There are several reasons why there is wide variation in hospital handover delays across the Country, including bed capacity in hospitals, clinical staffing in hospitals and discharge from hospital arrangements.

Non-Emergency Patient Transport Services (NEPTS) during the Pandemic

209. I provided NHS England with advice regarding the use of Non-Emergency Patient Transport Services (NEPTS), due to their role in transporting non-emergency patients and their potential to support ambulance Trusts. NEPTS contracts are held by both NHS and commercial organisations, and I felt that ambulance Trusts should work closely with all PTS providers to ensure there was co-ordination of patient discharges to maximise space and beds in hospital settings. I also offered my advice about how best to transport patients who were suspected or had COVID-19 as set out in Ambulance Case Transport Resolution 22 February 2020 Exhibit AM/23 [INQ000410597]. Guidance in relation to liaison and close

working with PTS providers was sent to ambulance Trusts by the National Ambulance Improvement Team at NHS England on 27 March 2020 and detailed the requirement for all ambulances Trusts Exhibit AM/48 [INQ000410623]. This specific PTS Guidance was updated by the National Ambulance Improvement Team at NHS England on 24 September 2020 Exhibit AM/49 [INQ000237269], and updated by the National Ambulance Improvement Team at NHS England to version 3 on December 2020 Exhibit AM/49a [INQ000237270].

Fleet Maximisation and Availability during the Pandemic

210. I provided advice to ambulance Trusts to maximise their fleet availability, which was included in the list of considerations that I asked all ambulance service CEOs to review as part of surge management in March 2020 Exhibit AM/24 [INQ000410598]. I also raised the opportunity to support vehicle availability i.e, extra mechanics and using third party vehicle mechanic providers to minimise ambulance downtime.

211. In the additional £55m which was made available for ambulance services to prepare for winter 2021, one of the 5 investment priority areas available to ambulance CEOs to invest was to increase their ambulance fleet.

212. I also provided advice to ambulance services about maximising vehicle availability by considering whether they could continue to utilise vehicles which were due for disposal and to also consider if they could use parts from vehicles that were off the road with no immediate prospect of return, for use in vehicles that could quickly and safely be repaired.

213. There were no significant issues or serious concerns raised with me directly regarding the availability or procurement of vehicles and if I had been made aware of specific issues then these would have been raised at the highest level. Operational advice was offered to ambulance services on an individual basis regarding maximising ambulance availability i.e cleaning arrangements.

Ambulance Quality Indicators

214. I have been asked to comment about whether I was consulted or involved in the decision to temporarily suspend collection of Ambulance Quality Indicators (AQIs) Clinical Outcomes in Quarter 1 (Q1) 2020-2021. During the early stages of the pandemic steps were being taken to free up management capacity and resources, this included the suspension of some data collection and reporting. A letter on 28 March 2020 titled Reducing burden and

releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic, from Amanda Prichard (NHS England CEO) listed the temporary suspension of some reports and data collection between 1 April 2020 and 30 June 2020 Exhibit AM/50 [INQ000410625]. Although I was not involved in the decision making, I do understand the reason and rationale provided in the letter on 28 March 2020. I understand from colleagues at AACE that this temporary suspension did not pose any issues as their own data analysis on AQIs began in January 2021, due to them not having the capacity or expertise internally at that time.

Infection, Prevention and Control Measures and COVID-19 Testing

215. The Inquiry has asked me to provide information about my role and involvement in the formulation, review and any subsequent amendments to IPC guidance. As National Strategic Adviser I did not assist or have any involvement with the formulation of infection prevention and control guidance. However, I am of the opinion that the IPC guidance was sufficiently clear for the ambulance sector setting, because it was clear what PPE staff should wear for level two and what additional PPE was required at level three. There was also clear definitions in place for what procedures constituted an AGP in the ambulance setting, that required level three PPE.

216. Ambulance Trusts were expected to follow expert IPC guidance from PHE/UKHSA regarding the correct use and level of PPE which was to be applied in the ambulance setting, social distancing measures and the implementation of changes and the use of PPE in non-clinical settings i.e. EOCs.

217. Ambulance Trusts were also expected to manage fit testing protocols for PPE and Respiratory Protective Equipment (RPE) products and ensure that all appropriate staff were trained in their use including any necessary refresher training. I have examined the list of documents that the Inquiry provided which relate to ambulance specific resources uploaded on the AACE website and clarify that as Strategic Ambulance Adviser I did not formulate, review or amend.

218. My understanding is that UKHSA was providing the most up to date guidance which was in line with up-to-date science and this is why ambulance Trusts were aligned to UKHSA as the source.

219. When considering concerns relating to the appropriateness of IPC guidance and measures within the ambulance sector my advice was always clear, that staff must follow the minimum PPE instructions for the patient treatment being performed for example wearing level 3 PPE where AGPs were present. Staff were and remain empowered to dynamically risk assess each episode of patient care and where necessary enhance the level of PPE protection.

220. The AACE Hierarchy of Controls guidance, which outlines how to apply hierarchy of controls to undertake dynamic risk assessments, was published nationally to support staff in their decision making Exhibit AM/06e [INQ000257972]. This included guidance on effective controls including ventilation, space, hand hygiene and use of surface wipes. The approach to dynamic risk assessment was determined by individual clinicians and should have been considered in cases where the hierarchy of controls are difficult to maintain for example if waiting to handover at hospital in an ambulance for a prolonged period or in confined spaces. Local risk assessment processes were decided at Trust level, but at national level we re-emphasised the hierarchy of controls which supports the risk assessment process. The Chair of the National Ambulance Service Infection Prevention and Control Group (NASIPCG) served on NHS England's IPC Cell, ensuring that guidance was sufficiently clear and appropriate for the ambulance sector and aligned to national guidance. My advice was clear that staff should follow all national guidance, however they would be supported if they attended a patient and they considered that the risk involved in treating the patient required a higher level of PPE.

221. Prior to the pandemic ambulance Trusts obtained supplies of PPE / RPE through standardised procurement process, in line with their respective Trust Policies. During the early response phase to the pandemic, some PPE/RPE product lines migrated to the Department of Health and Social Care (DHSC) parallel supply chain, branded as 'push stock'. Some ambulance services raised issues with specific elements of push stock, relating to the quality, integrity, and assurance of some products. For example, some Trusts received items that had expired or were labelled incorrectly, some presented with integrity issues such as disintegrating facemasks and facemasks with mould spores. All issues relating to PPE quality were immediately escalated to NHS England EPRR.

222. In March 2020, some ambulance services and staff representatives highlighted that Type IIR surgical masks posed a stock issue with limited receipt of goods from push stock systems, this position remained a challenge for several weeks, these issues were escalated to NHS England EPRR. It is important to note that at no point was I made aware that any

ambulance Trust was completely depleted of any PPE/RPE product line and all front-line staff had continual access to all PPE and RPE relevant to their duties. I was aware, from the daily sitrep received from ambulance Trusts to the NACC, that some Trusts had low stock of some items of PPE, and this was reinforced by letters received by staff side representatives on 25 March 2020 Exhibit AM/11 [INQ000410585] and 29 March 2020 Exhibit AM/12 [INQ000410586]. I personally responded to staff side concerns in writing on 27 March 2020 Exhibit AM/13 [INQ000410587] and 1 April 2020 Exhibit AM/14 [INQ000410588] and also created a video shared with staff across the ambulance sector which has been transcribed Exhibit AM/51 [INQ000410626].

223. Ambulance services worked together and distributed PPE that they did not require and provided these items to services who did require them, examples of this was Filtering Face Piece 3 (FFP3) masks which not all Trusts used and may have been supplied through push stock. There were also mutual aid requests for FFP3 face fit test kits, which is equipment used to ensure the proper fit of workplace respiratory protection equipment. Due to the use of powered air purifying respirators in some areas of the Country, some ambulance Trusts were able to support other ambulance services and sent all available face fit test kits as mutual aid.

224. I was also aware of issues with the quality of some of the fluid repellent coveralls. Some products were so thin that they tore very easily whilst donning or doffing them. Whilst these items were likely to be suitable for stable clinical environments such as a hospital or General Practice (GP) surgery, some products were not suitable for use by ambulance crews working in an uncontrolled environment with lifting and handling of patients and a need to carry patients up and down stairs and performing extrication at road traffic collisions. Separate arrangements were put in place by some individual ambulance Trusts for appropriate quality coveralls to be sourced to meet the requirements of frontline ambulance crews through existing networks between Trusts.

225. I was aware of the issue of prioritisation of PPE for the ambulance sector. The NACC daily sitreps indicated to me and other National Director colleagues including NHS England EPRR where any items of PPE had less than 72 hours of supply in a particular Trust. Where a critical supply issue was raised in this manner, I informed the NHS England National EPRR team so that they could urgently follow this up. No ambulance service ran out of essential PPE supplies as far as I was ever made aware. Exhibit AM/51a [INQ000470213] is an example of my communication with ambulance services highlighting that coveralls were available centrally. I also made NHS England aware of the differing quality of Aprons and

requested that the thicker type of Apron was made available to ambulance services as it is better suited to the working environment. I also reminded ambulance CEO's to escalate any ongoing PPE concerns through their regional and national emergency PPE helpline.

226. The Inquiry has asked me about my role and involvement in NHS England's decision not to increase RPE levels in January 2021 and their recommendations that workers should "practice more diligence in applying the existing IPC precautions." The ambulance sector followed national guidance set out by NHS England Infection Prevention and Control Cell, which was determined nationally to reduce variation across all health and social care settings and align to the principles of the National IPC Manual. Ambulance crews were reminded to follow national IPC guidance. It was known to me, following discussions at various meetings, that one Trust, LAS, took a decision to take an approach that was different to the national IPC guidance, i.e. for clinicians to use FFP3 masks routinely rather than type IIR surgical masks, based on their own local risk assessments. Whilst this was discussed at national level, it was a case for each service of balancing staff concerns and mitigation of risks. National guidance set the minimum level of PPE required.

227. Throughout the pandemic response, the ambulance service remained aligned to national government guidance on all matters relating to personal protective equipment. When considering governance and approval processes relating to decision making of this matter, the National Ambulance Service Infection Prevention and Control Group (NASIPCG), a national subject matter expert group reported recommendations to the group of Quality Improvement Governance and Risk Directors (QIGARD), a subgroup of AACE.

228. Although the decision was taken in January 2021 not to increase RPE levels, provision remained for frontline ambulance crews to conduct dynamic risk assessments which allowed them to don level 3 PPE when appropriate. I therefore consider the guidance to remind ambulance crews to fully comply with IPC precautions to be adequate. I would like to make it clear that I was not involved in the decision linked to not increasing RPE levels. I was aware that staff were reporting some PPE fatigue and therefore regular reminders and communications to staff would have been important.

229. Although not defined as PPE, detecting COVID-19 through effective testing was an important protective measure and the Inquiry has asked about my involvement in improving access to testing arrangements for ambulance staff. As National Ambulance Adviser my involvement in establishing or determining access to COVID-19 test for front-line workers was limited to recommending that testing was made available to ambulance staff as soon as

possible, including EOC staff in order to protect staff and minimise the transmission of infection and therefore maintain EOC and operational crew availability to help patients. National testing arrangements began to be implemented from 29 March 2020 Exhibit AM/52 [INQ000410627].

230. I also advised on the best way that mobile Loop-mediated Isothermal Amplification (LAMP) testing facilities could be utilised within ambulance Trusts in January 2022 at a time when there was significant pressure and high levels of COVID sickness absence and isolation amongst ambulance staff. My advice was that testing facilities should be offered to all ambulance Trusts with an emphasis on co-locating near ambulance EOCs and/or larger ambulance stations with the highest COVID-19 infection rates. This advice was accepted nationally however individual ambulance services determined the location of their testing facilities.

Guidance surrounding Aerosol Generating Procedures (AGPs)

231. As National Strategic Adviser I did not assist or have any involvement with the formulation of public health guidance or clinical guidance in relation to the determination of an AGP, or the issues of inconsistency addressed by the AACE in their position statement issued on 04 May 2020 Exhibit AM/08 [INQ000257955].

232. I have described in more detail my involvement in the AACE position statement as AACE Chair and as CEO of WMAS earlier in my statement however these matters were not dealt with in capacity as National Strategic Ambulance Adviser at NHS England.

Risk Assessments for Ambulance Staff and Equality Issues and the Effects of long COVID-19 in Ambulance Staff

233. As National Strategic Adviser, I was not involved with the formulation or issuing of guidance on individual risk assessments for ambulance workers. The issue of risk assessment appears to have been addressed in a letter from Sir Simon Stevens and Amanda Pritchard at NHS England on 17 March 2020 Exhibit AM/26 [INQ000087317] which identifies at risk groups as being "older colleagues, pregnant women, returnees, and those with underlying health conditions," and recommends that local adjustments be considered in relation to locations of work and risks associated with specific roles. A further letter on 29 April 2020 Exhibit AM/53 [INQ000087412] also highlights that emerging evidence suggests that people from Black, Asian and Minority Ethnic (BAME) backgrounds are also being

disproportionately affected by COVID-19, again local risk assessments are suggested for all BAME staff.

234. I have seen examples of communications which provide more detailed advice on risk assessment introduction for all staff identified as at risk staff, however these were issued by NHS England People Directorate and NHS Employers who were responsible for any reviews and updates Exhibit AM/54 [INQ000410629] & Exhibit AM/55 [INQ000410630].

235. Knowledge about COVID-19 was developing early in 2020 however given the date that NHS England first asked Trusts to make preparations to develop risk assessments it is clear that efforts were being made to identify, communicate and reduce risks for colleagues who were deemed to be at greater risk of more serious complications associated with a COVID-19 infection.

236. Whilst I was not involved in the formulation or issuing of guidance, I did welcome the introduction of these individual risk assessments as they represented another step in protecting vulnerable and at risk staff and I was in full support of their implementation.

Inequality Issues and Support within the Ambulance Sector

237. NHS Confederation BAME Leadership Network reported that some BAME staff felt concern that risk assessments "had been tokenistic and failed to lead to sustained change or action." I was aware from media coverage and documentation issued to all NHS organisations that inequality issues and risks existed, particularly amongst BAME staff and local BAME communities, as an NHS Chief Executive dealing with and managing these risks in a meaningful way was a top priority. AACE colleagues engaged with our National Ambulance BME Forum (NABMEF) throughout the pandemic, directly and through the national ambulance diversity and inclusion forum.

238. An example of the work AACE undertook in conjunction with the NABMEF was in relation to the need for individual risk assessments for ambulance workers; the NABMEF provided a briefing in relation to the impact of COVID-19 on black and minority ethnic communities and health and care staff. This included links to further information available from NHS Employers in respect of risk assessments for staff, including those with a BME

background. As National Strategic Adviser, I was not involved with the formulation or issuing of guidance on individual risk assessments for ambulance workers.

239. I have been asked by the Inquiry to describe my involvement in the Health Inequalities Assessment Checklist in July 2020 Exhibit [INQ000249081]. I did not have any direct or indirect involvement in the formulation or implementation of the Health Inequalities Assessment Checklist in July 2020. I understand that this was completed by David Cunningham who was the AACE IPC Specialist Adviser, working with the National Ambulance Services Infection Prevention and Control Group (NASIPCG), and was approved by the internal AACE governance arrangements i.e. AACE Quality, Improvement, Governance and Risk Director Group (QIGARD) in August 2020. The completed checklist was returned to PHE and shared with ambulance services through the National Ambulance Service Infection Prevention and Control Group (NASIPCG).

240. I understand that COVID-19 affected our staff in many ways and following a COVID infection, some staff returned to work quickly without any notable symptoms where as some other staff suffered from longer term symptoms which were commonly described as long covid.

241. I am aware that NHS Employers introduced guidance in July 2022 to ensure that staff suffering from long covid were dealt with uniquely Exhibit AM/55 [INQ000410630]. Trusts were advised where possible to maintain full pay and protect their employment contracts, this advice was in addition to NHS Employers guidance relating to pay and conditions during COVID-19 related absence in September 2020 Exhibit AM/56 [INQ000410631]. This guidance was subsequently withdrawn on 07 July 2022.

242. As National Strategic Adviser, I did not provide any advice or information to either NHS England or Public Health England / UKHSA concerning long covid in ambulance workers.

243. Chief Executives from all ambulance Trusts including myself made a request through AACE in August 2021 for immediate additional support in relation to employee mental health and wellbeing. In response to this AACE and NHS England People Directorate met and funding was identified for ambulance services to invest Exhibit AM/57 [INQ000410632] in the health and wellbeing of staff to the end of the financial year 2022.

244. Each ambulance Trust was requested by AACE to detail the planned health and wellbeing initiatives or activity, provide timeline for completion, the funding required for the activity and the project lead. Exhibit AM/58 [INQ000410633].

245. As National Strategic Adviser I was not involved in the negotiation of these funds nor was I aware of any issues relating to the amount of funding or the activity introduced within each Trust. I have been asked to comment on whether the funding of circa £170k per Trust was sufficient. Supporting staff wellbeing programmes is essential and any activity which supports staff is beneficial, I was not aware of any financial constraints at the time.

Independent Ambulance Workers and Volunteers Key Worker Designation

246. I understand that key worker designation during the pandemic was generally applied to those who worked in health and social care, education and childcare, key public services, people involved in the supply chain or food and necessary goods, local and national government, public safety and national security, transport and those in utilities and communication and financial services, however I accept that this list may not be exhaustive. Key worker designation in this context afforded workers the ability to move freely to and from work during periods of restriction. I do not recall providing specific advice to NHS England in relation to the designation of key worker status and furthermore I am unable to recall any concerns relating to this subject being raised directly with me.

247. I did communicate with Craig Harman who was the Ambulance and Community Response Director at St John Ambulance who kept me appraised of the capacity St John had to support the NHS. In July 2020 Craig Harman made me aware of a proposal which he had drawn up which looked to provide St John Ambulance with formal status of an NHS Auxiliary Group / Health Service Reservist.

248. National lockdowns and furlough scheme enabled volunteers at St John Ambulance to provide increased support and resources in certain parts of the Country, however following lifting of lockdown restrictions some of these staff and volunteers returned to their substantive roles and there was no provision available for employers to allow staff additional time off to continue to serve within St John Ambulance to support the NHS Exhibit AM/59 [INQ000410634].

Maximising the Ambulance Workforce - returning retirees, students deployed early, redeployed non-clinical staff or and volunteers

249. I provided advice as National Strategic Adviser that the ambulance workforce must be increased in preparation to deal with surges in demand expected due to the pandemic and specifically advised that ambulance Trusts should look at university paramedic students who were part way through their training and had already completed placements within ambulance services therefore having some experience of paramedicine in practice Exhibit AM/24 [INQ000410598].

250. The deployment of students to a role commensurate with their training and experience thus far was not a decision that I look lightly for a number of reasons; I accepted that their deployment may have an impact on the time it took to qualify, I accepted that this group of people were not, at the time fully qualified and I accepted that there would be limitations in their clinical practice and also their ability to drive an ambulance as most would not have completed an emergency driving course. I also accepted that university students may have felt anxious being asked to care for patients during the pandemic.

251. At the time I also considered the absolute priority was to ensure that all ambulance services had enough resources to be able to respond and care for patients who called 999 for assistance and also considered the pressures that would be placed on staff working in an inadequately resourced ambulance service. Understanding that university paramedic students had a desire to qualify as a paramedic and acknowledging their experience I felt that by utilising university paramedic students we would undoubtably be able to help more patients in a timely manner, save lives and ensure ambulance Trusts were not overwhelmed.

252. I am exceptionally grateful to all university paramedic students and also retired ambulance staff who were deployed and supported ambulance Trusts during the pandemic. In addition to the deployment of university student paramedics in the ambulance sector, on 19 March 2020, a national campaign was launched to "call on colleagues who have left the NHS in recent years to re-register and help the health service to tackle the greatest global health threat in a century". This campaign was predominantly aimed at doctors and nurses however I understand that many ambulance Trusts wrote to recently retired staff and asked if they would consider returning to duty to respond to the pandemic. Trusts increasing their workforce in this way would have maintained responsibility for training and support. Support for all ambulance staff was increased at the request of Chief Executives as described earlier.

253. Individual Trusts would have maintained responsibility for providing support and training to this group of staff and volunteers who helped during these difficult times. I do not recall being made aware of any issues or concerns regarding the support or training of these staff or volunteer groups by ambulance Trust Chief Executives.

Improvements, Recommendations and Lessons Learned

254. I have been asked to describe any improvements, recommendations or lessons learned from my involvement in the pandemic. AACE produced an ambulance review of the pandemic which consolidated feedback from individual colleagues in all ambulance Trusts Exhibit AM/60 [INQ000226613]. This document should be considered when planning significant incidents in the future. This learning exercise sought to identify some of the things that had gone well in the pandemic response and look at what would be needed to sustain things that had gone well. The 'What went well and how do we sustain the benefits' document summarises views from across all ambulance services. These were shared with NHS England through their Beneficial Changes Programme. Recommendations were not made, but key messages were drawn out:

- AACE played a crucial role in facilitating work delivered at pace on behalf of ambulance Trusts and NHS England through more effective ways of joint working and the ability to quickly establish shared, consistent sector level positions on important matters of policy
- Policy and guidance development was dramatically improved through a shared sense of purpose between AACE, partner organisations and NHS England
- Where 999 is already closely integrated with 111 and PTS at a system or regional level is provided by the ambulance service this provided advantages in resilience, flexibility and coordination of resources, as well as ensuring patients received the right response, first time, whether via 999 or 111
- Commissioning of integrated UEC systems needs a different, system-based ethos and structure, and 999 needs to be funded for sufficient capacity to meet demand
- Extensive and increased use of 111 made vital contribution to ensuring patients treated in right place at right time
- The ambulance service's pivotal role in delivering 111 Covid response service (SCAS) demonstrates benefit of sector's centrality to 111
- Joint research is needed to understand the rationales for changes in behaviour during the height of the pandemic, whether in relation to crews, system or patients –

identify positive behaviour changes that need to be sustained and how to sustain them

- Safely avoiding conveyance of patients to hospital Emergency Departments (EDs) is not something for ambulance services to resolve in isolation – it relies on integrated systems providing better alternative pathways and responses to patient needs and wishes
- Achievements through system-wide response have been realised because the pandemic has created a climate in which all partners have shown a willingness to come together to meet a common challenge
- We need to stop viewing public health (promotion / prevention) as a 'bolt- on' to a clinical role and build skill sets and expertise into Trust resourcing as the norm
- IPC capacity and competency varies across Trusts which can hinder achieving consensus at national level and implementation at Trust level
- Coordination of significant and protracted national crises, such as pandemics, would benefit from a step–up of national IPC lead role for the duration, rather than relying on the Chair of the national group to cover that and Trust remit. (NB. This was implemented by secondment of the chair to the AACE core team in November 2020. This role will end on 31 March 2024)
- Ensure End of Life guidance developed and used during COVID influences future updates and ongoing practice
- Ambulance services are well positioned to identify gaps in palliative care provision within communities and inform commissioning process for these services
- All health systems would benefit from integration of health and care data enabling timely, electronic access for Healthcare Professionals (HCPs) to patient information, support individual care, planning of services and research e.g. OneLondon Local Health & Care Exemplar
- Ambulance services are data rich and can make a significant contribution to population health management and planning of services in their regions
- Non-emergency PTS as a service has had to rapidly adapt significantly to accommodate changed activity due to virtual Outpatient services and social distancing
- The oversight role played by ambulance services of PTS provision has been of inestimable value in ensuring resources are used effectively and efficiently across a regional area
- Existing relationships with local partners and our volunteer base enabled ambulance Trusts to flex up resourcing at speed

- Digital working was integral to the effective operation and communications within Trusts during COVID-19 surge
- Staff networks have a strategic part to play in supporting staff and need to be viewed as part of the wider resilience
- The ambulance sector has networks to support the identified vulnerable groups in every Trust that have played a part in offering support during the COVID-19 pandemic

255. I believe that the following measures would assist if there were an incident of this scale or any other incident which required a co-ordinated approach from the ambulance service.

Latest Personal Protective Equipment

256. Adopting a consistent approach to personal protective equipment across the ambulance service is helpful when seeking to reduce variation and improve staff confidence and also ensure that staff and volunteers are offered the maximum protection and are able to maintain a safe and reliable 999 emergency ambulance service across our Country.

257. The use of Powered Air Purifying Respirators (PAPR) negated the requirement to undertake face fit testing due to the nature and design of this type of Respiratory Protective Equipment (RPE). This enabled some ambulance Trusts who used PAPR to overcome the logistical challenges associated with resourcing a double crewed ambulance with two staff who had successfully passed the face fit test and were in receipt of the specific brand and type of mask they were fit tested for. Therefore, it should be recommended that all ambulance services consider adopting the use of PAPR to offer a greater level of resilience across the sector in readiness to respond to a surge or increase in infectious disease prevalence and/or as part of routine pandemic planning.

Ambulance services having adequate resources to meet demand

258. The NHS both prior to the pandemic and particularly post the pandemic are operating under extreme pressure, because of increased demand and waiting list sizes, but also because of significant vacancy factors in key frontline workforce positions such as Doctors, Nurses and Paramedics. These large workforce gaps create an environment where normal operational performance is not achievable on an ongoing basis – which affects patients. It also means our staff are working under significant pressure daily (trying to do the job of several people whilst on duty) which is unsustainable and leading to staff leaving careers

early. In order to better deal with a future pandemic the NHS must ensure there is enough frontline staffing employed and trained to meet daily demand and reduce the workforce gap to near nil – this will allow the NHS to more easily stretch to meet periods of winter pressures or indeed any future pandemic. Making the NHS a better place to work and far safer for patients.

Major Incident and Pandemic Plans to include utilisation of university student paramedics

259. All NHS ambulance Service Major Incident Plans must include a section dealing with the deployment of university paramedic students as appropriate to their training and experience. This will also provide extra resource in the event of widespread absence due to a pandemic.

Log keeping and document control protocols and systems

260. Ambulance Trusts should ensure their commanders maintain appropriate decision logs and to ensure that documents are safely held/saved for use in any future Inquiry. Trusts must have an appropriate system that conforms to national best practice to ensure the logging of decisions and is able to provide document control.

Use of Information Technology (IT) to support individuals Trusts across the Country i.e. call taking and Interoperability ToolKit (ITK) links.

261. Adopting more technology and the use of common systems that can talk to each other has proven to be effective. More work must be done to aid NHS staff to deal with rising demand levels and assist staff in their difficult frontline roles and avoid risk and error. This can be achieved through the implementation of effective and robust IT systems and solutions where information can flow between clinicians and other frontline workers without delay. These systems can help to automatically distribute workload to where the available resource exist and also remotely in some cases, which will help with surge demand situations.

Memorandums of Understanding (MoU) with voluntary sector to provide mutual aid in the event of a major incident.

262. The purpose of these Memorandum of Understanding (MoU) is to underpin a consistent level of voluntary sector support to a pandemic/major incident. These would be pre-agreed and ready to be enacted at the appropriate time. Volunteers would need to be appropriately trained and competent and issued with the necessary uniform and PPE.

Surge capacity in all hospitals with Emergency Departments

263. During times of significant demand, hospitals should adopt processes and procedures allowing or insisting that they rapidly off-load patients from ambulances to ensure that ambulance crews are able to respond to the next 999 patients. It is acknowledged that hospital handover delays remains an issue outside of the pandemic period and I envisage that greater planning and investment is required to ensure that there are safe arrangements in place.

Greater standardisation of ambulances, equipment and training

264. Standardisation of ambulances and equipment is not a new concept within the sector and Lord Carter of Coles addressed this in a review of unwarranted variation in NHS ambulance Trusts published on 27 September 2018 Exhibit AM/61 [INQ000410574]. In a series of wide-reaching recommendations, Lord Carter suggested that a common ambulance both in terms of design and also in the standardisation of medicines, consumables and equipment, could provide cost efficiency and innovation. In addition, a common ambulance could bring more benefits by maximising vehicle interoperability and mutual aid across the Country whether this be through the sharing of vehicles and equipment or the sharing of staff, all of whom would be accustomed to universal equipment and vehicle design, which in turn would reduce the training requirements identified in the deployment of mutual aid resources or assets.

Staff Welfare – Health and Wellbeing

265. The pandemic was detrimental to the mental and physical well-being of some of our staff for many reasons both direct when colleagues may have been dealing with the symptoms of COVID-19 and long COVID and indirectly due to the effects of social distancing which reduced access to traditional face to face appointments to access care such as healthcare and physiotherapy services for themselves.

266. Trusts did respond to these issues by improving access to health and wellbeing services in alternative ways for example using on-line platforms, telephone and video calls. Additional funding was provided to ambulance services, this was an important step to support our workforce. It is important that there are significant local and national efforts to rapidly implement an enhanced and consistent package of support which involves national groups, staff forums, staff representatives, charitable organisations, considering any limitations to access and mitigating these as much as possible in the event of a major incident or pandemic.

Single 999 Call Prioritisation triage system standardisation

267. Adopting a single NHS 999 call prioritisation triage system across all ambulance services would reduce the steps required to update two different triage systems with adapted coding and provide a universally consistent approach to all ambulance 999 calls across the Country. This would also provide safer and easier provision of mutual aid across the Country.

Statement of appreciation

268. I would like to again place on record my praise, appreciation and thanks to all ambulance staff, colleagues, volunteers, and university paramedic students across the Country for all their hard work, dedication and commitment they demonstrated during what was an incredibly challenging period. I would also like to pay tribute and my sincere respects to NHS colleagues and members of the public who lost their lives to COVID-19. The impact that the pandemic had upon us all was profound, and I hope that the Inquiry can help shape learning so that harm can be reduced if ever a similar event were to occur.

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 cause to be made, a false statement in a document verified by a statement of truth without an honest believe in its truth.

Signed: Personal Data

Dated: 16 April 2024