The Independent Ambulance Association ('IAA')

Closing Written Submissions to Module 3 of the Covid Inquiry,

Impact of Covid-19 on the Healthcare system,

chaired by Baroness Heather Hallett KC

Introduction

1. These submissions echo and expand upon the closing oral submissions made by counsel for the IAA to Module 3 of the Inquiry on 28 November 2024. The IAA are grateful to the Inquiry for granting it Core Participant status, and with it the opportunity to contribute, and make recommendations, to the Inquiry.

2. These submissions are set out in the form of numbered recommendations, supported by evidence. We focus on what we believe are achievable and constructive recommendations for an improved healthcare system so far as it affects the ambulance sector, and in particular the independent ambulance sector. In summary, the recommendations are for the following:

    (1) Establishing a national NHS protocol for dealing with the independent ambulance sector

    (2) Formation of a permanent national non-emergency transport service ('NEPTS') team

    (3) Key worker status to be granted to all front-line health workers in any future national health emergency

    (4) Future health guidance to include specific guidance for the ambulance sector

    (5) Diversification of oxygen and other medical gas supply

    (6) Recognition of the role played by the independent ambulance sector

3. We consider that these are essential, achievable and largely cost neutral recommendations. They should not be difficult to implement. They are all based upon the evidence provided to the Inquiry, either in written or oral form.

4. In our view implementation of these recommendations will ensure that the NHS and ambulance sector generally is better placed and better equipped to deal with any future pandemic or equivalent national emergency. Their implementation will ensure increased responsiveness, co-ordination and flexibility in dealing with such an event.

The IAA

5. The IAA was formed in 2012 as a not-for-profit trade association to be the national voice of the independent ambulance sector. It seeks to liaise with other bodies including NHS England, the Care Quality Commission ('CQC'), the Department for Transport and the Association of Ambulance Chief Ambulance Executives ('AACE').

6. Alan Howson is Executive Chairman of the IAA. He is also a member of NHS England's Improvement Board. The IAA is also represented on expert advisory groups[1]. Mr Howson was not called upon to give live evidence to the Inquiry but has provided a detailed statement setting out his views regarding the future provision of ambulance service, and we have drawn on his written evidence[2]. He sets out how all members must be registered with the CQC, and are expected to uphold a Members Charter. In 2019 the IAA was an active participant in the review of NEPTS, leading to publication of the final report[3].

7. During the pandemic IAA members pivoted from their NEPTS role to support frontline emergency services and Covid response teams[4]. The scale, disruption and impact of the pandemic required providers to find new ways of working[5].

(1) National NHS protocol

8. There should be a national NHS protocol for engaging independent sector ambulance services. Such a protocol would include, for example

    a. an approved list of independent ambulance providers[6];

[1] INQ000474232/3
[2] INQ000474232
[3] INQ000273758
[4] INQ000474232/2
[5] INQ000474232/4
[6] INQ000474232/16

b. it would ensure that any independent providers are properly and thoroughly regulated;

c. that there is reliable quality control;

d. that there are established terms of engagement;

e. and that there is provision for contingency planning, to address emergency and surge demand.

9. With the advent of, and demand required by the pandemic, the NEPTS sector shrank to 40% of its usual capacity in the space of two weeks, which had an unforeseen practical and financial impact on providers[7].

10. When the former Secretary of State for Health and Social Care Sir Sajid Javid was asked directly in this Inquiry whether such a national protocol would be helpful he responded categorically *'yes'*[8].

11. The background to this is important and the Inquiry heard firsthand from witnesses regarding the pre-existing difficulties and further difficulties presented by the pandemic.

12. Mark Tilley is an ambulance technician. He spoke of the impact the pandemic had on his work, albeit mostly working behind the scenes and only occasionally in a patient facing role.[9] He spoke of the problems in the first winter in 2020 and the lack of regularly available PPE, lack of proper procedures in ambulances and the problem of supply.[10] He said they had to effectively *'beg, borrow and steal'* ambulances[11] and PPE often not in a fit state for use,[12] 10-hour ambulance shifts, waiting in queues at hospitals and running out of oxygen.[13] He mentioned that because crews hadn't eaten they ordered pizza direct to their ambulances.[14] There was an inadequate supply of equipment, masks, gloves and hand gel.[15] Sometimes the air conditioning didn't work, it became too hot. There were problems with inappropriate NEPTS guidance, unsuitable vehicles, no separation between driver and patient, and a general lack of

[7] INQ000474232/17
[8] Day 38, 108/16-109/1
[9] Day 14 4/4-7 and 15-17
[10] Day 14 9/11-18
[11] Day 14 13/12-13
[12] Day 14 8/1-9
[13] Day 14 13/21-25 and 14/1-6
[14] Day 14 14/7-8
[15] Day 14 15/1-2

suitable equipment. He spoke of the impact of this, not least exposing family to an element of risk.[16]

13. Anthony Marsh, the National Strategic Advisor for AACE, in his evidence spoke of a lack of co-ordination between public health bodies. He mentioned the ambulance trusts generally finding themselves at REAP levels 3 and 4 in March 2020, ie the highest levels[17]. Level 4 indicates the potential for service failure; by July 2021, all ambulance trusts were at level 4.[18]

14. By 20 March 2021 emergency 999 call capacity had been reached, to the extent that he advised that university students should be used to assist the service.[19]

15. Mr Marsh said that 45% of paramedics and 55% of GPs said that a barrier to emergency care was the lack of ambulances.[20] Staff absence increased to 30%, peaking in 2021[21]. He spoke of a number of problems, leading to him writing on 7 March 2020 to ambulance trusts with new suggestions regarding call handling, and proposals for a shortened course to qualification. He spoke of how localised decision making, rather than on a national scale, could lead to more dynamic decision making[22].

16. The pressures were such that by March 2020 half of 111 calls were not answered. Individual trusts developed their own ambulance guidance. He mentioned how national IPC guidance for hospitals was not necessarily appropriate for ambulances[23] and a review by AACE revealed problems in particular with inadequate PPE.[24] The decision on 6 March 2020 by the UK IPC to downgrade PPE for ambulance services led to him raising his concerns.[25]

17. In 2021 there was an increase in national ambulance handover delays, with patients and crew stuck in ambulances as a result[26]. He stated that it would have been much better to use more straightforward language in guidance, leading the Chair to the Inquiry herself observing *'it doesn't seem to be an NHS thing speaking in plain English'*[27]. He raised concerns regarding handover delays on a regular basis[28], and the

[16] Day 14 18/5-7
[17] Day 14 36/5-9
[18] Day 14 36/3-18
[19] Day 14 37/3-8
[20] Day 14 41/5-12
[21] INQ000412354 and Day 14 42/23-25 and 43/1-3
[22] Day 14 60/14-18
[23] Day 14 43/18-20 and 81/25 and 82/1-4
[24] Day 14 82/15-25 and 83/1-5
[25] Day 14 85/3-11 and 24-25
[26] See graph @ INQ0004190041
[27] Day 14 89/19-20
[28] See bullet points at INQ000412354

practical difficulties faced by ambulance staff including actually using available PPE[29]. He stated that he *'truly believed'* ambulance staff should be involved in early testing.

18. The general nature of the difficulties was addressed in the report from Lord Darzi[30], where it was observed among other things that *'A&E is in an awful state'*, that in 2010 94% of people attending in type 1 incidents (for major A&E matters) were seen within an hour, and that this figure reduced to 60% by May 2024, and 10% waiting over 12 hours. There was a spike in waiting times for all age groups[31].

19. Professor Rachael Evans spoke of the better efficiency and flexibility in the private sector, and in relation to flexibility and getting people back to work *'the private sector seemed to get that a bit better'*[32].

(2) Establishing a permanent national NEPTS team

20. From the evidence provided to the Inquiry we recommend that a permanent national team with oversight of Non-Emergency Patient Transport Services should be established to manage this service. This team should be comprised of representatives from the NHS and the independent sector.

21. There are approximately 11-12 million individual non-emergency patient journeys undertaken each year, covering 140 million patient miles, at a cost in excess of £500 million. Half of these journeys are carried out by the independent sector[33].

22. The scale of this service requires structure, organisation and coordination especially when emergency demand diverts resources. Understandably when the pandemic hit the pandemic had to take priority over the non-emergency sector, impacting services for those who were seriously hurt or unwell, e.g. those who needed treatments like dialysis or cancer visits and services, transport of the elderly and the infirm, and others requiring assistance with travel due to disability or for other reasons. Resources were diverted from non-emergency to emergency service. We may never know the true cost of diverting resources on such a scale.

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[29] See eg INQ000499523
[30] INQ000474367
[31] INQ000474367/3-4; graphs in annex INQ000474366/70-71
[32] Day 21 150/21-22
[33] INQ000474232/2

23. When the suggestion of such a team was put directly to Sir Sajid Javid he commented that *'…first of all…the independent sector played an important role in helping to deal with the pandemic…I think it would make sense to have more co-ordination between the public sector and independent sector broadly, much more broadly, but including on non-emergency transport services'*[34].

24. Professor Helen Snooks spoke of the whole system needing addressing. She spoke of the practice of ambulances queuing outside hospitals[35] and that the knock-on effects were damaging and the system needed reforming[36].

25. She mentioned the huge increase in waiting times for answering 999 and 111 calls, and the waste of resources, delayed response time for further emergencies, and general lack of efficiency[37]. There was a need to consider a triage-drop off system.

26. Evidence from West Midlands Ambulance Service University NHS Trust indicated that *'it has been a struggle to put out the peaks required for the demand for this pandemic with the number of fleet we have, however I cannot provide a quick solution of how we could have fixed this quickly without borrowing or recommissioning older vehicles'*[38]

27. There were significant problems regarding unregulated ambulance providers carrying out what should have been regulated activities. IAA members are required to adhere to strict Care Quality Commission guidance. These unregulated providers are not subject to the same rigor of CQC inspection, or accountability, they cannot provide the same level of professionalism and service, and this in turn put patients and workers at risk. Some of the non-regulated providers were opportunistically advertising for staff in response to the Covid crisis, having circumvented the normal approvals process by being sub-contracted by Care Quality Commission regulated providers[39].

28. One consistent concern highlighted by Mr Howson was the lack of a clear line of communication as the scale and impact of the pandemic developed. Non-emergency patient transport does not have a permanent national team providing oversight and leading the work. In his view the establishment of a small but permanent national team, with powers of oversight and delegation, would bring consistency in approach to commissioning of services, whilst also providing innovation, equality of access, and ensuring value for money.

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[34] 38, 107/20-108/15
[35] Para 175 of statement
[36] Call volumes spiked in 23, 30 March 2020 [Snooks 'figure 3' in report, INQ000474285]
[37] Graphic eg INQ000226605.
[38] 1INQ000226616/2
[39] Howson statement INQ000474232

29. In an expert report provided by Mr David Heymann[40] it was observed that *'some of the failures in the epidemic and pandemic preparedness could have been prevented by focussing on preparedness activities that include, but are not limited to, the public health system. These activities include ensuring a surge capacity within the NHS that is available from the start…'*

30. Further issues were identified by Professor Philip Banfield[41] who mentioned the fact that between 17 March and 15 April 2020 approximately 25,000 hospital patients were discharged into care homes without being tested, and that even after 15 April 2020 some patients were still being discharged without being tested. This inevitably endangered all those involved in their transport, including ambulance and paramedic staff.

31. Tracy Nicholls. the Chief Executive of the College of Paramedics, observed that of all paramedics at this time 50% felt burnout, 87% felt depersonalisation. 1 in 10 left their job in the 12 months to June 2020. Some suffered long Covid and can no longer work, some even requiring stairlifts.[42]

(3) Key Worker status for all frontline health workers

32. One of the fundamental recommendations of the IAA is that key worker status is designated on the basis of an individual's role not the name of their employer. Frontline health workers from the independent sector should share the full benefits of key worker status enjoyed by NHS staff. The virus doesn't discriminate between employers. All frontline health workers should have equal access to PPE, testing and other priorities to make their job easier to do and safer for them to carry out.

33. Professor Philip Banfield agreed with the proposition that *'all healthcare workers should have been provided with respiratory protective equipment during the pandemic'*[43].

34. When Jeanne Freeman, Cabinet Secretary for Health and Sport in Scotland until May 2021, was asked whether she agreed that in any future pandemic anyone working as a front-line health worker, whether employed by the NHS or otherwise, should be

[40] INQ000226616/2
[41] INQ000477304, paras 420-423
[42] Day 9 121/ 4-6 and 122/19-24

[43] Day 20 161/21

provided with the same access to testing and PPE, she immediately and unequivocally responded *'yes'*[44].

35. Alan Howson in his statement speaks of the normal supply chain being usurped by government and NHS demand. A system of accessing PPE through portals was often reported as problematic and difficult for providers to access[45].

36. The failure to grant immediate key worker status to IAA members had an immediate and practical impact on the ability of our members to provide an effective service alongside the NHS to support the Covid response.

37. Professor Kevin Spong[46] spoke of the stress and suffering of those on the front line, including eg those doing transfers and sitting in ambulances dealing with dying elderly patients. Clearly there should be no differentiation between individuals doing the same job and offering the same service, whether employed by the NHS or someone else.

38. Vaughan Gething, former First Minister of Wales, told us how *'the ambulance service were on the front line throughout the pandemic'*[47]. Baroness Eluned Morgan mentioned people breaking down when she went out with ambulance drivers to see what conditions were like. She said that *'no graph is going to tell you that'*[48]. She spoke of persistent issues with ambulances and long response times and high absence rates[49]. In June 2021 she requested a meeting with the emergency ambulance committee, as they had failed to hit their targets since July 2020, and set out a plan to address this. She considered the *'time for talking was over and the time for action needed'*.[50] However, ambulance performance continued to decline, and she agreed an extra £5m funding on 22 November 2021. In the absence of known alternatives – again indicating the need for four nations co-operation – she then requested assistance from the military[51]. Two hundred and fifty-one drivers were requested, *'to prevent significant risk to life…have explored other commercial alternatives'*.[52]

39. She spoke of an ongoing *'capacity issue'*[53], with staff sickness being a persistent problem, and a generally higher absence rate than other areas. Ambulance crews

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[44] Day 34 95/1
[45] INQ000474232/15-16
[46] Day 12 17/19-25 and 28/11-14
[47] Day 35 5/10
[48] Day 35 132/20-133/5
[49] Day 35 167/24
[50] Day 35 168/1-6 and 20-21
[51] Day 35 169/6-9 and 19-20
[52] INQ000480061 and Day 35/170 11-12
[53] Day 35, 173/10

were more exposed in their vehicles, and maybe also disillusioned[54]. She did think to turn to St John's Ambulance, but they could not carry out emergency work; again perhaps indicating her lack of awareness of options to utilise independent sector resources[55].

40. The risk to the paramedic and ambulance sector is highlighted in the evidence of Tracy Nicholls[56], who said that they had the highest rate of illness and death of all healthcare professionals.

41. Robin Swann, MP for South Antrim, spoke of the difficulties in meeting ambulance targets in Northern Ireland. Between April 2020 and March 2022 mean targets were not met in any month. He recognised the pressures on the ambulance service, commenting that *'pressures on the ambulance service are not specific to the pandemic'*[57].

42. On the question of key worker status, Nick Kaye of the National Pharmacies Association stated that the benefits of key worker status, including testing, should not only be extended to pharmacists but to others across all healthcare settings, including GPs and hospitals[58]. Professor Banfield agreed that *'all healthcare workers should have been provided with respiratory protective equipment during the pandemic'*[59].

43. Jeanne Freeman spoke of the experience of the Scottish Ambulance Service. They had concerns regarding supply and observed that *'if we actually had that stock we needed to get it to the front line'*[60]. Her comment was that healthcare workers in Scotland did not have the access to PPE they should have had. Further there were ambulance capacity issues but despite this they did not use private ambulance providers, as she said, there was legislation for this. When she was asked whether she was ever asked to consider the merits of working with private providers, she responded *'I don't recall being asked that'*[61]. She observed that a protocol *'might have advantages'*[62].

44. When Ms Freeman was asked directly whether she agreed that in any future pandemic anyone working as a frontline health worker, eg as a paramedic in an ambulance,

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[54] Day 35 174/13
[55] Day 35 175/10
[56] INQ000281189/13, 257958, table 9 of TN/28
[57] Day 33 105/24-106/9
[58] Day 25 131/22-133/6
[59] Day 20 161/21
[60] Day 34 33/19-34/0
[61] Day 34 54/2-13
[62] Day 34 55/1-8

whether employed by the NHS or otherwise, should be provided with the same access to testing and PPE, she responded immediately *'yes I do agree with that'*[63].

45. Professor Helen Snooks stated in her statement[64] that *'paramedics and other frontline emergency pre-hospital care staff should be prioritised for early vaccination in future pandemics'*.

(4) Guidance specific to the ambulance sector

46. One important recommendation for the future is that any future guidance regarding health risks, whether from the government or the health service, should include guidance specific to the ambulance sector, and must involve consultation with the independent ambulance sector. Many witnesses have spoken and agreed with this essential proposition.

47. Tracy Nicholls spoke of the lack of clear guidance to paramedics from the IPC, and a lack of common sense in the guidance. She wasn't just disappointed, she expressed what she called her *'horror'* at how inappropriate the guidance was for her members, which was unbending even after she made representations regarding the particular challenges faced by paramedics and other ambulance workers[65]. Such was the inadequacy of the guidance that she said her members felt like *'cannon fodder', 'canaries in a coal mine'*[66]. There appears to have been a fundamental inability to understand the demands and unique working environment in which paramedics work.

48. She commented that there was a *'lack of clear guidance'* to paramedics from the IPC, and a lack of common sense in realising their position is different to other aspects of healthcare sector. There was a *'one size fits all'* strategy.[67] She said there was so much to assess, regarding the environment and surroundings, access and danger, even before you assess Covid. In the first and second lockdowns the College was never consulted. Members were saying it didn't feel right to be in front of patients and treating them, when getting information from the IPC Cell. Around 20 March 2020 the College raised concerns regarding the unique environment with Matt Hancock, but

[63] Day 34 95/1
[64] INQ000474285 para 169

[65] Day 9 82/8-15
[66] Day 9 82/22-23
[67] Day 9 76/6-18 and 22

there was no response. At this stage ambulance workers were already at the stage of sitting in the back of ambulances for long stretches.

49. She spoke of how the guidance would change often very quickly during a day regarding stock, and logistics were a *'real nightmare.'*[68] It was difficult because ambulance staff work remotely, not centralised like in a hospital. Some staff were in ambulances with patients for hours.[69] There were practical difficulties; you couldn't change in an ambulance, there was no loo, no food, so it was a *'logistical nightmare'*.[70] The hierarchy of controls was not suitable for the ambulance sector. The situation created *'such anxiety and fear'*; one woman stripped off after work in her garden, and others were hiring shepherd huts in which to live rather than go to family. There was no guidance on how to conduct dynamic risk assessment for covid as opposed to dangers and hazards. Frontline member managers felt they were going *'under the radar'*. FFP3 masks could only be used by staff if fit-tested and fit-checked.[71]

50. Regarding NEPTS, there was no national guidance until September 2020. There was no national guidance regarding ambulance areas, although these were produced by AACE in due course. There were concerns because of increased handover delays, and they were asking for guidance on handover and enhanced PPE. Meantime staff were falling ill so they were unable to provide the full service[72]. The response to this was there were no changes made to the PPE guidance, but a doubling down on existing guidelines. The College was *'completely unsatisfied*[73]' with this response; there was a failure to understand the unique nature of the work. They needed to see the conditions in the back of an ambulance. Most ambulances didn't have a window to open and when cold outside, you couldn't just open the back.[74] The overall effect was that you will have a generation of workers who are affected by this. In summary there was *'little confidence in IPC guidance'*. She expressed the view that the *'ambulance sector is often a bolt on or afterthought'*.[75]

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[68] Day 9 824/21-23
[69] Day 9 85/19-20
[70] Day 9 86/4-11
[71] Day 9 88/20-5 and 89/1-10
[72] Lord Darzi report INQ000474366/304 annex – graphic illustration shows work days lost due to ambulance handover delays, then spike in 2021-2024

[73] Day 9 100/1
[74] Day 9 8100/19-25
[75] Day 9 118/5-6

51. Her final recommendations included that there should be a single source of guidance, clearly communicated policies, active listening involving others in the decision making, support for mental health and wellbeing[76].

52. Jeanne Freeman agreed that it was *'reasonable'* for any future guidance should include specific and clear guidance for the ambulance sector given its unique working environment[77].

53. Sir Stephen Powis said he *'agreed in principle'*[78] for there to be such guidance, albeit he qualified this by expressing his general view that guidance should *'only issue guidance where it's absolutely necessary'*. Rosemary Gallagher said guidance should include paramedics specific guidance. She stated *'I absolutely believe that these non-IP specialists are critical in terms of shaping guidance'* and that *'one-size-fits-all doesn't necessarily work'*[79].

54. When asked whether the ambulance sector should be consulted regarding future guidance, the former Secretary of State Matt Hancock said *'of course'* and went on to say that all on the ground should be[80].

(5) Oxygen and other medical gas supply

55. From the evidence heard in this module there was quite clearly an issue regarding the adequate supply of oxygen and other medical gases. We have heard evidence from a number of sources about the national shortage of oxygen and other gases for medical use. This supply needs to be made secure and reliable. The Chief Executive of NHS England Amanda Pritchard gave evidence of the lack of preparedness for a surge in demand for oxygen before the pandemic. The National Oxygen Infrastructure Programme ('NOIP') established in March 2020, at the outset of the pandemic, was set up to address this particular issue, but it had as its focus the NHS estate and its capacity. During the pandemic there was a chronic national shortage of portable oxygen cylinders in particular. Independent ambulance providers had to desperately scrape around to find their own sources.

[76] Day 9 125/6-10
[77] Day 34 94/4-9
[78] Day 29 4/14-25
[79] Day 25 79/2-4 and 18-19
[80] Day 36 199/1, 9-10

56. Many witnesses have spoken to this issue, but the evidence from Professor Charlotte Summers[81] highlights the problems of a limited and narrow supply base. She told us the main supplier, BOC, was unable to match the surge in demand of both cylinders and gases. She confirmed shortages of oxygen in NHS England generally, and of ventilators, of which they had 7,500ish when they needed c.59,000[82]. Supply of oxygen is one of most essential treatments.

57. Sir Chris Wormald spoke of the background of unstable international supply chains. He said that international supply chains were a weakness of the system, and that all those areas which were weak before the pandemic were highlighted in the pandemic.[83]

58. Alan Howson of the IAA says that problems were experienced in accessing portable oxygen cylinders from BOC early in the pandemic; BOC were simply unable to satisfy the sudden surge in demand. At one stage twenty new and otherwise fully operational ambulances sat idle for several weeks awaiting portable oxygen cylinders. Six recommissioned vehicles were unable to be used because, again, of a lack of new oxygen cylinders. The situation was only finally resolved when NHS England Estates intervened following representations from the IAA[84].

59. Professor Adrian Edwards[85] stated *'we've got issues of getting the protective equipment in the right place, getting oxygen cylinders and oxygen saturation monitors in the right place. So all that preparedness and planning could have been that much more specific for primary care.*'

60. The inability to source oxygen and cylinders in particular had an immediate and devastating impact, as it meant ambulances were often taken out of operation altogether. The answer is to expand the supply chain, as there is an over-reliance on one source as supplier.

(6) Recognition of the role played by the independent ambulance sector

[81] Day 15 2.10.24
[82] expert report, INQ000474255, para 173ff
[83] Day 30 24/9/7-14
[84] INQ000474232/14-15
[85] Day 9 37/1-7

61. There must be a clear recognition of the significant role the independent sector played in the pandemic and plays generally. The NHS cannot function without the involvement of and cooperation with the independent sector. All healthcare workers, regardless of their employer, played a critical role in the pandemic. People and not institutions need to be respected and protected.

62. The data shows that healthcare workers were five times more likely to die than individuals in other occupations, as Mr Stanton on behalf of the BMA mentioned in his closing remarks. Within the healthcare sector, ambulance workers as an occupation had the highest incidence of deaths per capita during the pandemic. The NHS relies fundamentally upon the independent ambulance sector, and as with NHS workers, individuals within the independent sector suffered personally in carrying out their work, and made huge sacrifices in order to keep other people safe and to do their job. Whatever one's overarching view of the national response, it would have been significantly worse without their commitment, involvement and good will. To mark their role is both the right thing to do, but will also assist in guiding preparation for any future emergency.

Richard Jory KC

Jessica Tate

Foundry Chambers

15 December 2024