Witness Name: Dr Fenella Wrigley
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF DR FENELLA WRIGLEY

I, **Dr Fenella Wrigley**, will say as follows: -

1. My name is Dr Fenella Wrigley. I am a Deputy Chief Executive and the Chief Medical Officer for the London Ambulance Service NHS Trust ('**LAS**'). I have worked for LAS for 14 years.

2. I graduated from St George's Hospital Medical School, University of London in 1996 having achieved an upper second class intercalated BSc (Hons) in 1995. I undertook my postgraduate general professional training in paediatrics successfully passing postgraduate examinations and achieving membership of the Royal College of Paediatrics and Child Health in June 2000. My subsequent speciality training in Emergency Medicine included completing the Diploma of Immediate Care (Royal College of Surgeons of Edinburgh) in March 2003 and specialist training on London's Air Ambulance in 2005. I became, through examination, a Fellow of the College of Emergency Medicine in April 2006 – this changed to Fellow of the Royal College of Emergency Medicine when the College was awarded Royal Charter in February 2015. I achieved my certificate of completion of training in Emergency Medicine in January 2007. I was awarded the role of civilian Queen's Honorary Physician in 2009 (which transferred to a civilian King's Honorary Physician in 2022).

3. In 2008 I joined LAS as Assistant Medical Director for Control Services. I was subsequently appointed Deputy Medical Director in 2010 and I have held the

position of Medical Director (now known as the Chief Medical Officer) since March 2016 having been acting in the interim role since January 2015. Since October 2021 I have, along with the Chief Paramedic, been the deputy Chief Executive sharing responsibility for operational delivery alongside my original portfolio. I am responsible for the delivery of clinical safety and the clinical strategy across LAS. The portfolio includes clinical safety, clinical audit, research, advanced paramedic practice, Medicines Management, Integrated Urgent Care ('**IUC**') and LAS111. I am also the Caldicott Guardian, Director of Infection Prevention and Control and the Controlled Drug Accountable Officer for LAS.

4. I am a trained and experienced Strategic Medical Advisor having provided strategic medical advice to multiple significant and major incidents (including the London 2017 terrorist attacks and Grenfell Tower Fire) and major internal events including the implementation of a new Computer Aided Dispatch ('**CAD**') system. The role of a strategic medical advisor is to provide clinical advice to the Strategic Ambulance Commander.

5. I have also been a Consultant in Emergency Medicine since 2006 and retain my clinical role working as a Consultant in Emergency Medicine at the Royal London Hospital, which is part of Barts Health NHS Trust.

6. My wider professional experience includes:

   a. Volunteer doctor with St John Ambulance (1995 to Present). In September 2020. I was promoted to the Commander in the Order of St John;
   b. Clinical Advisor to the Ministry of Justice (2013 to Present);
   c. Chief Medical Officer to the All England Lawn Tennis Club (2018 to Present);
   d. Elected Chair for the National Ambulance Service Medical Directors group which is a subgroup of the Association of Ambulance Chief Executives (February 2021 to Present); and
   e. NHSE/I London Region 999 Ambulance Advisor (2022 to Present).

7. I make this statement in response to the request LAS received under Rule 9 of the Inquiry Rules 2006. As requested by the Inquiry, this statement predominantly focuses on the period of time between 1 March 2020 and 28 June 2022 ('**the Relevant Period**').

8. I am the only member of the Executive Team employed by LAS who was a Board member for the duration of the Relevant Period and who remains in post today. Due to the passage of time, all other members of the Executive Team employed during the Relevant Period, including the former Chief Executive, have left LAS to pursue other roles and have been replaced by new Executive members.

9. Within this statement I outline LAS's experience of the Covid-19 pandemic, including the emergence of Covid-19, how LAS responded during the Relevant Period and the ongoing impact on LAS.

10. It is important to begin this statement by paying tribute to all LAS people who have showed unrelenting selflessness and stoicism in the face of danger, embracing new ways of working to enable us to care for the population of London; adapting and learning; and saving lives. The peaks of the pandemic were certainly some of the most difficult times LAS has experienced; but the way our people rose to the protracted and unprecedented challenge and worked relentlessly to provide care for Londoners was extraordinary and showed them at their very best.

Background

11. LAS is the only acute NHS provider Trust to serve the whole of London – one of the world's most dynamic and diverse cities. We deliver a range of services across Urgent and Emergency Care and Emergency Planning, Resilience and Response, including;

- Emergency and Urgent Ambulance Response (See and Treat, See and Convey, See and Refer inclusive of specialist response vehicles for critical and urgent care, mental health and tactical operations.)
- Non-Emergency Transport Service (NETS)
- Critical Care Transport Service (CCTS)

- Emergency Bed Service (Regional Bed State Oversight, Safeguarding and PREVENT referrals)
- 999 Emergency Clinical Assessment Service (Hear and Treat, Hear and Refer)
- NHS 111 and Urgent Clinical Assessment Service (Hear and Treat, Hear and Refer)
- Emergency Planning & Incident Management (Major Incidents, Significant Incidents and Events)
- Hazardous Area Response Team (HART)

12. A detailed summary of the services LAS is commissioned to provide are set out in **Exhibit FW/1 – INQ000217287**.

13. The LAS is one of the busiest ambulance services in the country. Demand for LAS services have increased year on year as have the challenges and complexities of their delivery. LAS answers, prioritises and responds to 999 calls across London, attends more than 3,000 emergencies a day and provides the majority of the 111 urgent care service for the 9 million people who live in London. In addition, LAS plans for, and responds alongside our partners to, major and significant incidents. LAS also educates the public in life-saving skills and the use of public access defibrillators and engages with partners to encourage a healthier population, reduce inequalities and make London a safer city.

14. LAS has a substantive headcount of nearly 7,000 staff but with contractors, students and volunteers, there are today around 9,600 people working for LAS. Together the service strives to provide the best possible care for patients across London, whether that is a face to face ambulance response or providing an enhanced clinical assessment on the telephone and helping patients access the high quality care which is available closer to home. LAS is governed by the LAS Board made up of: a Non-Executive Chair, Non-Executive Directors ('**NEDS**') and Executive Directors, including the Chief Executive. Our Executive Committee leads and manages the performance of LAS within the framework established by LAS Board.

The emergence of Covid-19

15. A pneumonia of unknown cause, detected in Wuhan, China, was first reported to the World Health Organisation ('**WHO**') on 31 December 2019. On 10 January 2020, WHO issued a tool for countries to check their ability to detect and respond to a novel coronavirus.

16. The first meeting of the LAS Strategic (Gold) Commanders team was on 23 January 2020 at which, in addition to winter planning, emerging information in regards to the virus was reviewed. Consideration was given to FFP3 Fit Testing and ambulance cleaning.

17. From the end of January 2020, intensive planning and preparation was being undertaken across LAS as it became evident the virus had spread beyond mainland China. There were twice daily Gold Commanders Team meetings taking place to oversee preparation from the 28 January 2020.

18. Whilst the surge of Covid-19 cases for the rest of the UK was yet to come, London was several weeks ahead of the rest of the country (as confirmed by the Prime Minister in his briefing of 16 March 2020). The London health system was therefore already under significant pressure before the start of the Relevant Period.

19. As the first line of response for the NHS, LAS was at the forefront of responding to this national emergency.

20. On 29 January 2020, the first two patients in the UK (two people from the same family) tested positive for Covid-19. The outbreak was declared a Public Health Emergency of International Concern ('**PHEIC**') on 30 January 2020 and NHS leaders declared a serious (level 4) incident the same day.

21. On 31 January 2020, the news of the first two patients who had tested positive for Covid-19 was announced to the public. A surge of generic Public Health England ('**PHE**') (which was to become the UK Health Security Agency '**UKHSA**' during the

pandemic) guidance followed. This included various updated versions of guidance relating to the identification and management of possible Covid-19 cases, Infection Prevention and Control ('**IPC**') guidance and the first Covid-19 related guidance specifically for First Responders (released on 5 February 2020). This national guidance was implemented locally and shared with staff via, for example, LAS updated operational and clinical bulletins (**Exhibit FW/2 - INQ000252603**).

22. From late January 2020, LAS saw demand increasing in both the 999 and 111 / IUC service. NHS 111 is a national service and provides first point triage of calls from people with urgent, non-emergency, health needs. These patients are directed to a local service, are given self-care advice, have a face-to-face appointment arranged, are connected to a clinician or referred to the ambulance service.

23. By 10 February 2020, there were 8 confirmed cases of Covid-19 in the UK. London's first case of Covid-19 (the 9th in the UK) was confirmed on 12 February 2020. LAS's 111 / IUC service alone had already seen a significant increase in demand. There were unprecedented demands being placed on the service from mid-February 2020 onwards.

Containment Phase (February 2020 – Community Testing)

24. Whilst the rest of the UK had a few confirmed cases of Covid-19 in February 2020, London's position as an international transport hub with a diverse international population, as well as the broad 'catch all' case definition needed for containment, resulted in increasing demand on health services.

25. The initial experience across London was that the majority of those referred for testing had mild symptoms without severe disease. These patients did not require an emergency ambulance or review in secondary care facilities which were already under record strain prior to this outbreak due to winter pressures. The patients were able to safely isolate themselves at home, but to support containment and isolate the patient and immediate contacts, definitive diagnosis was required.

26. On 18 February 2020, guidance from NHS England and NHS Improvement ('**NHSE/I**') outlined that the public should call NHS 111 if they had been to a region affected by Covid-19, or in close contact with a person confirmed to have the virus. The same guidance also stated that NHS 111 should not refer suspected Covid-19 cases to GPs or community pharmacies but there was no recommended change in management for non-COVID-19 callers. This very quickly resulted in extreme levels of 111 activity and, consequently, additional calls in the Clinical Assessment Service ('**CAS**') queue. The immediate response taken by LAS 111 was to work collaboratively with Out of Hours providers to distribute the telephone consultation workload to be able to provide patients with clinical assessment and support. Examples of some practical steps taken by LAS to address this included:

a. Direct calls with the LAS's Director of Integrated Urgent Care (IUC) and Out Of Hours GP Director/Clinical Leads to identify any additional clinical capacity within the system that could be made available for telephone assessment.

b. Working with those providers who were able to mobilise additional clinical capacity to agree processes to refer patients to their service including the transfer of clinical accountability.

c. Working collaboratively with IUC Commissioners and Regional Leads to mobilise additional capacity above contractual levels including those providers who had signalled they were seeking financial security prior to enhancing capacity in their service.

d. Working with commissioners and providers to expand appointment availability to enable referrals directly through the Directory of Services ('**DoS**').

27. Ambulance transport to and from the earliest available testing facilities within hospitals was challenging. Each ambulance that transported a suspected Covid-19 patient for testing was then out of service for a number of hours while it was deep-cleaned. This resulted in the 'out of service' rate for LAS's emergency

ambulances significantly increasing at a time when LAS was facing very high levels of demand and needed all of its fleet available.

28. London worked collaboratively to rapidly implement community-based testing for Covid-19. Those patients who met the UKHSA case definition were referred to the new 'community testing hubs' where the patient was clinically assessed by telephone to confirm that they met the case definition and were well enough to remain at home before community testing was performed within 24 hours by a healthcare professional with appropriate personal protective equipment ('**PPE**'). Patients were left with appropriate advice. Patients who tested positive and who were either unwell, had significant co-morbidities or were unable to isolate at home, were referred to LAS for conveyance to a pre-designated hospital. These transfers were undertaken as Category 4 High Consequence Infectious Disease ('**HCID**') transfers by the LAS Hazardous Area Response Team ('**HART**') who are part of LAS's specialist operational capability.

29. In order to manage the significant demand in LAS 111, operational and clinical changes were required.

30. On 27 February 2020, the Covid-19 Clinical Assessment Queue ('**CCAS**') was implemented, this introduced a separate queue, filtered by coronavirus selector questions, at the start of an assessment. It combined all North East London ('**NEL**') and South East London ('**SEL**') patients with Covid-19 symptoms into a single queue to be managed in priority order by clinicians from across sites.

31. The following day, discussions took place between LAS's Chief Executive Officer, NHSE/I, the National Director of Urgent and Emergency Care and the National Strategic Ambulance Commander regarding a request to look at the Metropolitan Police Service call taking support and to work up a proposal for military support of fleet and logistics operations and communications activity in the call centres.

Delay Phase (12 March 2020 to 23 March 2020)

32. From the beginning of March 2020, Covid-19 related demand started to have a significant impact on our 999 call handling and ambulance operations. Emergency calls to LAS grew from around 5,800 calls a day to over 7,900 999 calls on 16 March 2020. Over 15 and 16 March, LAS saw 500 patients awaiting dispatch of an emergency ambulance. This put extreme pressure on Emergency Operations Centre ('**EOC**'). The pressure was compounded by increasing staff absence levels over this period due to sickness, the need for staff to self-isolate due to personal and household Covid-19 symptoms, and the fluctuating and sometimes extreme levels of the demand. By the end of March 2020, 20% of LAS's EOC staff were either off sick or in Covid-19 related self-isolation. As a result of this, call handling times were extended (this is an issue which is dealt with in detail later in this statement).

33. As the country moved from the '*containment'* to the '*delay'* phase of the response, Covid-19 patient numbers started to increase significantly. The need for clinical road staff to 'don and doff' PPE, as well as the decontamination of vehicles, and hospital capacity pressures, meant that overall patient episodes of care were significantly extended. This was further compounded by the level of frontline staff with Covid-19 sickness and self-isolation related absence with over 650 road staff off sick or in self-isolation by the end of March 2020. This meant that, with the exception of the response to our sickest patients, our response times were significantly longer.

34. On 13 March 2020, following discussion between the LAS Chief Operating Officer and NHSE/I, permission was given to rationalise the ambulance cleaning regime with the assurance that safety would be maintained, but with the intention of being able to respond to patients more quickly. Prior to 13 March 2020, ambulances which had conveyed a Covid-19 possible patient were required to attend a remotely located hub for a deep clean. Following discussion with NHSE, the guidance for ambulance cleaning was updated and, with the exception of where a patient had undergone an aerosol generating procedure ('**AGP**') the ambulances were cleaned by the attending crew. This included a thorough decontamination of all exposed surfaces, equipment and contact areas with 'Clinell' universal

sanitising wipes before returning to normal operational duties. The ambulance crew:

a. Wore appropriate PPE whilst decontaminating the vehicle including an apron, integrated face mask and gloves;
b. Decontaminated all contact surfaces (cupboards, walls, ledges etc.), working from top to bottom in a systematic process including the cab area of the vehicle; and
c. Decontaminated the vehicle floor with a detergent solution.

35. Where AGPs had been undertaken for Covid-19 possible patients, vehicles required enhanced decontamination of all exposed surfaces, equipment and contact areas with a chlorine-based product at a cleaning hub before they could be returned to normal operational duties. The ambulance was identified to the ambulance hub cleaning team by way of a sticker that was placed in a window to ensure all personnel were wearing appropriate PPE prior to entering the vehicle. The attending crew were able to change their uniform at these cleaning hubs if required. Each ambulance which was removed from service for a deep clean was unavailable to respond to patients for up to 2 hours depending on the number requiring cleaning.

36. From 20 March 2020, the LAS estate was consolidated so there were fewer but larger hubs. This increased access to managers for staff, facilitated access to clinical support for frontline staff, efficient pairing up of single crews and the effective deployment of ambulances.

37. In response to this unprecedented national health emergency, LAS took a number of immediate and substantial actions to enhance the organisation's overall response capability, which built on the comprehensive Emergency Preparedness, Resilience and Response ('**EPRR**') plans. The Head of EPRR provided an update to the Executive team around the emerging situation on 18 March 2020. Actions included:

a. Ensuring clear lines of communication with NHSE/I and with partner NHS Trusts were established to support the decision making.

b. Creating a dedicated Covid-19 999 call-handling centre within our EOC at Waterloo.

c. Working closely with regional and national 999 and 111 teams to share information, contribute to continually evolving care pathways, implement IPC measures and support new ways of working to maintain an emergency service alongside responding to Covid-19 patients.

d. Opening additional 111 capacity by converting existing LAS training areas to allow more health advisors and clinicians to respond to Covid-19 calls. This was possible as routine face to face training was ceased in line with government guidance.

e. Coordinating bringing in 900 volunteers, including student paramedics and former members of staff, to help.

f. Training hundreds of London Fire Fighters to drive ambulance and support our crews.

g. Increasing the fleet by over 100 additional ambulances.

h. Developing partnerships with the military and other organisations such as the AA to help us keep more ambulances on the road.

i. Helping design the NHS Nightingale London Hospital and creating the critical care transfer service ('**CCTS**').

j. Access to testing and the Covid-19 vaccine for staff and volunteers as early as possible to protect the emergency service.

k. Rapidly developing services to support the mental and physical health of staff and volunteers.

Governance and Structure of LAS

38. LAS's Board of Directors ('**the Board**') during this time comprised a Chair, NEDs and our Chief Executive Officer ('**CEO**'), Chief Operating Officer ('**COO**'), Chief Finance Officer ('**CFO**'), Chief Medical Officer ('**CMO**') and Director of Quality. The Chief Paramedic post replaced the Director of Quality role in May 2021. The Board is responsible for setting the strategic direction, culture and organisational performance of LAS and is accountable for ensuring that LAS delivers safe, high-quality care. This was also the position prior to the Relevant Period.

39. The CEO leads LAS's Executive Committee. The Executive Committee, until September 2021, consisted of eight executive directors and directors, including the five executive directors on LAS's Board. The purpose of the Executive Committee is to lead and manage the performance of LAS within the strategic framework established by the Board. The Executive Committee make proposals to the Board on key policy and service issues for the Board to decide upon. This includes:

a. The development and implementation of strategy, operational plans, policies and budgets;
b. Oversight of patient safety, clinical governance and quality assurance for both 999 and 111 services;
c. The monitoring of operational and financial performance;
d. The assessment and control of risk and issues;
e. The prioritisation and allocation of resources;
f. Staff recruitment and retention; and
g. Staff welfare and wellbeing.

40. The Executive Committee meet as LAS's Strategic Workforce Planning Group to ensure that all aspects of people management and organisational development are appropriately addressed. The Executive Committee also meet as LAS's Portfolio Management Board to monitor delivery of LAS's portfolio of

programmes and significant projects, by resolving any issues that may compromise progress and subsequent benefits realisation.

41. The organisational structure at the start of the Relevant Period is as shown in **Exhibit FW/3 – INQ000217288**. A description of each of the roles referred to therein is provided at **Exhibit FW/4 – INQ000217289**.

42. As Covid-19 was emerging, the structure of LAS evolved to ensure LAS was best placed to respond to events as they unfolded. This included robust clinical and operational oversight for 999 and 111 services. At all times when implementing change, consideration was given to quality and safety, which remained priorities for LAS. A chart outlining the evolution of the structures in place for Covid-19 oversight during the Relevant Period can be found at **Exhibit FW/5 – INQ000217290**.

43. In line with the legislative requirements to fulfil the NHSE/I EPRR Core Standards, LAS has contractual obligations to provide an overarching EPRR policy statement. This is set out in its Business Continuity Management Policy ('**BCP**'). It defines the roles and accountabilities and scope of each role in any incident which deviates from business as usual. Further details are set out later in this statement. LAS's Incident Response Procedures, including the Business Continuity Policy, detail the specific command roles when an incident is declared. The overall command structure is designed to work on three levels: Strategic (Gold); Tactical (Silver); and Operational (Bronze). These levels are addressed in detail in LAS's '*Incident Response Procedures'* document (**Exhibit FW/6 – INQ000217291**) but can be briefly summarised as follows:

    a. **Operational (Bronze):** to implement the tactical plan in response to an incident or operation. The operational level at which the management of immediate hands-on work is undertaken at the site(s) of the emergency or other affected areas. An Operational Commander will carry out one of a range of specific functions either stand alone or under the direction of the Tactical Commander to ensure efficient clinical care response to an incident by LAS.

b. **Tactical (Silver)**: to develop a tactical plan which follows the Strategy and implement it through the operational command tier. The purpose of the tactical level is to ensure that the actions taken by the operational level are coordinated, coherent and integrated in order to achieve maximum effectiveness and efficiency. The Tactical Commander provides a tactical level of management for a specific incident, once the Tactical Commander is in position to, they will take command of the incident. The function of the Tactical Commander is to determine priorities in allocating resources, to plan and coordinate when tasks will be undertaken in order to deliver the effective resolution of the incident from a LAS perspective. This may involve obtaining, via the Strategic Commander, additional resources for the incident.

c. **Strategic (Gold)**: to consider the emergency or incident in its wider context; determine longer-term and wider impacts and risks with strategic implications; define and communicate the overarching strategy and objectives for the emergency response, establish the framework, policy and parameters for lower level tiers (i.e. Silver and Bronze); and monitor the context, risks, impacts and progress towards defined objectives. The Strategic Commander is the most senior person available (with the delegated authority of the Accountable Emergency Officer ('**AEO**') who has total control over the organisation and its assets during any specific event requiring strategic management. The Strategic Commander is a formal job role, with a set specification that defines the education and experiential requirements of the role (as set out by National Ambulance Resilience Unit – '**NARU**' – National Ambulance Service Command and Control Guidance). Strategic Commanders are empowered to commit funding and resources for all LAS Directorates for the duration of the incident. The Strategic Commander is able to discuss and assess political and national requirements and liaise if required with Central Government Department, principally, but not exclusively, the Department of Health and Social Care ('**DHSC**'). The Strategic (Gold) Commander is supported by advisors,

including the Strategic Medical Advisor and an Emergency Planning Strategic Advisor. These officers have all undertaken specialist training.

44. LAS's initial response to the emerging situation which Covid-19 presented was overseen by the Strategic Commander's team which set the strategic aim and objectives, took strategic command of LAS and ensured that service policy was adhered to. From 23 March 2020 to 17 May 2020 the Strategic Commander's team was present 24 hours a day to provide additional resilience and capacity. Strategic (Gold) Command sat daily until the end of December 2021.

45. In March 2020 it became clear that more rapid and streamlined decision making was required and the CEO and COO assumed leadership for the pandemic response. From this point, the Strategic Commander's team focused on immediate service delivery, oversight and response and remained available to respond to any traditional significant or major incidents. However, alongside that, LAS established the COVID Operational Leadership Team ('**COLT**') to provide Strategic oversight for the delivery of 999 and 111/IUC services. A diagram outlining the structure of COLT is at **Exhibit FW/7 – INQ000217292**. COLT was in place in shadow form from 20 March 2020, with terms of reference issued to formalise these meetings on 29 March 2020. The change to the structure was endorsed by the Board at its meeting on 31 March 2020.

46. COLT was led by the CEO and COO of LAS, who jointly assumed the role of the Covid Operations Strategic Commander. Each senior role within the COLT was duplicated for resilience purposes.

47. COLT met daily from 20 March 2020 to discuss key actions with focus on critical areas such as quality and patient safety for 999 and 111, staff and volunteer welfare, growth in staff numbers and availability, vehicle requirements, equipment requirements (including availability of PPE), estate requirements and IPC. Each directorate was represented by the Executive Level Director or a named deputy.

48. Sitting alongside and reporting to COLT, by way of tactical oversight, was the Strategic Coordination Centre ('**SCC**') which incorporated existing Strategic

Incident Room functions. The SCC operated on a 24 hour basis providing strategic planning support, logging and action tracking to the Covid Operations Strategic Commander's team. Covid hubs were created to allow specific task groups, such as those for staff wellbeing and recruiting volunteers. The Head of Resilience and Specialist Assets (who became the Director of Resilience and Assets during the Relevant Period) was responsible for the SCC.

49. On 7 December 2020, COLT was replaced with the Daily Strategy Leadership Team ('**DSLT**'). The focus of DSLT was to try to return to a 'new normal', rather than focusing specifically on Covid-19 challenges. Whilst Covid-19 patients remained a significant amount of LAS's clinical activity, LAS needed to ensure that the response to non-Covid-19 patients was equally considered. So, while there was still consideration of Covid-19 related matters, the focus included overall operational delivery. DSLT had representation from each of the directorates across LAS with a defined agenda and agreed terms of reference. Its purpose was to manage and respond to immediate operational issues. From a Tactical perspective, the SCC was replaced with the Daily Performance Group ('**DPG**'). The role of DPG was to ensure short-term resource planning for IUC, EOC and Ambulance Operations, to ensure such plans were understood and owned by operational leads and scheduling, to ensure operational performance was being monitored, issues identified and mitigations put in place, to consider medium term performance and resourcing and to monitor the REAP level (see below) and Covid-19 escalation plans.

50. In March 2021 DSLT was replaced by the Senior Leadership Delivery meeting ('**SLDM**'). SLDM provided an enhanced governance structure to oversee coordination and response. It brought together the Gold Commander's team, EPRR and planning activities into one Strategic meeting which reported into the Executive Committee. There was a prioritisation matrix that detailed LAS key priorities for recovery at that time. All directorates had priority themes they would update the meeting on. From a tactical perspective, DPG was replaced with the Daily Covid Response ('**DCR**').

51. In July 2021, SLDM was replaced with the Strategic Response Group ('**SRG**'). The purpose of the revised approach was to bring together the work streams supporting LAS's response to the ongoing incident under the leadership of an appointed Incident Director whilst tightening the governance arrangements. The objectives of SRG were to provide a safe organisational response to London throughout the sustained period of increased demand on the ambulance system, provide the environment and conditions to safely flex the organisation's response to meet the prevailing demands within agreed safety parameters, optimise the available assets to provide a safe service in so far as was reasonably practicable in the circumstances, capitalise on LAS's resilience plans and build in recovery planning to the incident response, mobilise support for front line staff and ensure LAS was doing everything possible to protect staff welfare. SRG was in place until 1 November 2021. The DCR was replaced with the Service Delivery Group ('**SDG**'). SDG provided oversight and focus on service delivery for 999, 111 and ambulance services. It comprised key representatives from across the multiple divisions and directorates within LAS and was tasked with coordinating new and developing work streams, with assurance and governance frameworks.

52. In September 2021, with the arrival of a new CEO, the Executive Committee was strengthened to include a wider range of senior operational leaders in LAS – around 25 people. It has remained in this form to date, meeting every week for 3 hours. The new CEO also appointed the CMO and Chief Paramedic as Deputy CEOs when the COO left in October 2021. These individuals assumed the clinical operational portfolio with the CFO assuming the operational support functions of strategic assets, property and estates.

53. In December 2021, the Winter Delivery Group ('**WDG**') was created at a Strategic level in response to an emerging Covid-19 surge (primarily resulting from the Omicron variant) and the Level 4 Incident declared by NHSE/I. The purpose of the WDG was to bring together the work streams supporting LAS's response to the winter demand whilst enhancing the governance arrangements. Its objectives were to provide a safe organisational response to London throughout the period of increased demand, provide the environment and conditions to safely flex the organisations response to meet the prevailing demands within agreed safety

parameters, optimise the available assets to provide a safe service in so far as reasonably practicable under the circumstances, mobilise support for front line staff and ensure LAS was doing everything possible to protect staff welfare. The Winter Coordination Cell ('**WCC**') supported the WDG from a tactical perspective by coordinating, administering and ensuring effective escalation and communications of working activity, producing daily outputs and tracking outstanding issues. These groups replaced the SRG and SDG previously in place but did not replace the role of the usual Command team who remained responsible for LAS's day to day service delivery and significant / major incidents. The WDG met twice daily to discuss the evolving picture, including the operational status of LAS, to consider regional and national updates and identified risks, and to make decisions around operational delivery, plans for change, internal and external communications and mitigations to delivery of service. The WDG was led by the Winter Director (the Deputy Chief Executives) and was attended by Directors and their delegated representative with authority to make decisions. It was supported by key Heads of Department as required. The duty WCC Lead and duty Strategic (Gold) Commander also attended the meetings.

54. In January 2022, the WDG converted to the Winter Recovery Group ('**WRG**'). The WRG oversaw activities required for LAS to return to business as usual service delivery. From a tactical perspective, the WCC was stood down. The tactical function was handed back to the Incident Management and Delivery Team which delivered (and continue to deliver) management and operational oversight of routine service delivery on a 24 hour basis.

55. The WRG was stood down at the end of February 2022. For the remainder of the Relevant Period LAS reverted to business as usual operational assurance and delivery oversight, i.e. a more traditional hierarchical structure with the CEO and reporting directors (the Executive Committee) meeting daily in a 'huddle' format and engaging in a formal meeting weekly and the tactical function operating as above. LAS continued to work with the region to address operational challenges such as hospital handover delays which was led by the NHSE/I Regional Director for Urgent and Emergency Care and the Regional Medical Director.

56. The members of the groups outlined above, including the Board and the Executive Committee, were key decision makers within LAS during the Relevant Period. For ease, they are identified at **Exhibit FW/8 – INQ000217293**.

57. During the Relevant Period, Executives and Directors were required to make many decisions relating to issues and actions for which they were accountable, for example temporary structural changes within their teams, changed working arrangements and re-focussed priorities. The Chair and CEO of the Board were able to exercise their powers with regards to emergency or urgent decisions as set out in Standard Order 5.2. This states "*the powers which the Board has reserved to itself within these Standing Orders may in an emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two non-officer members*". Any decisions made using emergency powers was logged and reported to LAS's Board.

58. In May 2020, in recognition of the continued pressure under which LAS was operating, and the need for rapid decision making, a process was agreed for internal decisions supported by non-executives who were able to provide oversight and guidance to the executive team (**Exhibit FW/9 – INQ000217294**).

59. Where changes had to be shared and endorsed at national level (for example implementation of Card 36 for 999 call handlers – see below), this took place through the subgroups of the Association of Ambulance Chief Executives ('**AACE**') including the National Ambulance Service Medical Directors ('**NASMeD**'), the National Quality Governance and Risk Group ('**QGARD**') and National Directors of Operations Group ('**NDOG'**). Additional national clinical networks such as the National Ambulance Service IPC Group and National Ambulance Service Chief Pharmacist Group fed into NASMeD and NDOG. Members of the Executive Team attended the meetings in which these decisions were discussed and they in turn cascaded information to the relevant people at LAS through COLT.

60. Throughout the pandemic, LAS's leadership team was supported by LAS NEDs. In addition to continuing to chair focused board assurance committees, NEDs provided significant support and advice to individual executives and the whole

executive team. They were involved in reflective discussions, identifying lessons learned and advising on change. Where required, NEDs also took concerns to regional and national meetings.

61. LAS was also supported internally by a Specialist Ambulance Advisor seconded from NHSE/I from 6 April 2020.

62. Externally, oversight was provided by the lead commissioning team for 999 services (North West London '**NWL**'), the 111 commissioning teams (NEL and SEL), the NHSE/I London Region and the NHSE/I national team.

63. There were key stakeholders within NHSE/I who provided support to LAS. This was via integrated regional teams who play a major leadership role in the geographies they manage and make decisions about how best to support and assure performance in their region, as well as supporting system transformation and the development of sustainability and transformation partnerships and integrated care systems.

64. The key stakeholders within NHSE/I for LAS were:

    a. Director of Urgent and Emergency Care, NHSE/I, London;
    b. Covid Incident Director, NHSE/I, London;
    c. Regional Director of NHSE/I, London;
    d. Regional Medical Director NHSE/I, London;
    e. The National Director of Urgent and Emergency Care; and
    f. National Strategic Advisor for Ambulance Services.

65. The London Regional Director of NHSE/I convened an almost weekly meeting of the London CEO community during the Relevant Period.

66. Communication was also maintained with the Care Quality Commission ('**CQC**') throughout the Relevant Period.

The Impact of the Covid-19 on the Provision and Operation of Ambulance Services

67. The initial impact of the pandemic on LAS was substantial and required rapid change in the way LAS worked and made decisions. These initial structures evolved as the Covid-19 pandemic progressed and as the challenges changed.

68. LAS's EOCs took 214,000 calls in March 2020; an increase of 27% on the previous month. Performance of its call answering mean average, rose from 4 seconds in January 2020 to 200 seconds in March 2020 with a peak of 585 seconds on 26 March 2020. LAS responded to its first recorded COVID-19 patient on 16 March 2020.

69. The total number of incidents also peaked in March 2020 with 121,000 cases, 21,000 of which were resolved over the phone and 99,000 which were attended by LAS ambulance staff. The remaining 1000 cases would have been cases where the initial 999 request was cancelled. Performance standards for LAS's sickest patients deteriorated by circa 3 minutes (Category 1) and 39 minutes (Category 2) between February and March 2020.

70. LAS's 111 services saw similar increases of circa 17% in call volumes between February and March 2020, there were consistent ongoing increases in call volumes across the Relevant Period.

71. Call answering performance and call abandonment rates within LAS's 111 call centres substantially deteriorated from mid-March 2020 due the increased pressure at this early stage in the pandemic. The Covid-19 119 service, developed in Wave 1, diverted high volumes of general enquiry calls. However, demand continued to be high in all areas with symptomatic patients unable to reach their own GP.

72. The unprecedented increase in the demand on LAS at the start of the pandemic; coincided with a spike in sickness absence of LAS staff with 1,429 individuals (20%) off sick during March 2020. Havering Borough was one of the worst hit areas for infection in the first London peak. The LAS 111 call centre was similarly affected as many staff lived in the local area.

73. Decisions were taken by LAS to refocus support and resources to ensure that LAS could provide the best operational response possible during the period of unprecedented pressure whilst maintaining good governance and assurance. This was discussed by Executives with the Extended Leadership Group at a meeting on 17 March 2020 and agreed in principle by the Executive Committee on 18 March 2020. As of 27 March 2020, decisions had been taken by Executives acting as Senior Responsible Officers ('**SROs**') for LAS projects and programmes to either pause, stop or progress these projects depending upon the impact that this would have on LAS's ability to respond to the Covid-19 pandemic.

74. There was a focus internally at LAS on governance, assurance and safety, leadership, workforce (capacity and wellbeing), IPC and communications to enhance its ability to meet the challenges of the pandemic.

75. LAS implemented daily Covid Leadership meetings which enabled quick, effective decision making to support patient care and staff welfare, whilst remaining within the required regulations of the NHS. Examples of rapid changes made included:

a. Enhanced communications to ensure support to staff through the pandemic;

b. Building capacity through collaborative working arrangements with other agencies such as London Fire Brigade, Metropolitan police and the Military;

c. Consolidation of operational estate to reduce supply lines and support the management and wellbeing of our operational staff;

d. Recruitment hub to streamline recruitment practices;

e. Welfare Hub providing support and assistance to our staff and providing welfare interventions;

f. Rapid increase in purchase of new and pre-owned ambulance vehicles;

g. Commercial arrangements with the Automobile Association ('**AA**') to enhance maintenance of vehicles; and

h. Introduction of home/agile working to support vulnerable staff or those who had additional commitments when schools closed for instance.

Information Sharing

76. From the outset of the pandemic LAS worked collaboratively with NHSE/I and partner provider Trusts across the wider London region. This ensured that it could support the decision making process centrally, enhance guidance and deliver improvements to patients and our staff.

77. As Covid-19 emerged, and throughout the Relevant Period, national and regional decision makers with responsibility for ambulance-related services reviewed the emerging intelligence and conveyed updated information and guidance to LAS and other NHS providers.

78. The ambulance sector in England has well established methods for collaborating and sharing information, risks and good practice. There were various ways in which LAS were able to provide feedback to national and regional decision makers.

National Groups

79. *The Association of Ambulance Chief Executives* ('**AACE**'), of which LAS is a member, is a central membership organisation that supports, coordinates and implements nationally agreed policy. It is not a decision making body but works closely with the NHSE/I National Ambulance Cell. AACE provides coordination for the work programmes of many key national director groups including Ambulance Chief Executives, Medical, Finance, Human Resources, Operations, Strategy and Transformation, Digital, Quality Improvement, Governance and Risk and Communications. The work programmes of AACE include critical national projects on emergency resilience, clinical practice guidance, clinical and operational

performance and the development of new services. It is through these established national director groups that collaboration routinely occurs and this was extremely important during the Relevant Period. The frequency of the AACE meetings was increased during the Relevant Period as required (sometimes daily).

80. *National Directors of Operations Group* ('**NDOG**') increased the frequency of meetings from once per month to twice weekly during the peak periods of the pandemic. The meetings were attended by either the LAS's Director of Operations or the COO. The purpose of NDOG is to provide specialist operational advice and support to AACE and carry out specific work associated with the delivery of operational ambulance service. During the Relevant Period, this included the review of pandemic protocols within the 999 triage system such as Card 36 (addressed in subsequent paragraphs). As with many leadership groups across all areas, NDOG would convene exceptional meetings as and when required.

81. *National Ambulance Service Medical Directors Group* ('**NASMeD**') is made up of Medical Directors from UK ambulance services (including LAS) and is designed to improve clinical safety and quality of care by reducing unwarranted variation and sharing best practice across the ambulance service. Medical Directors from all UK ambulance services are either members or co-opted members. Members of NASMeD (CMOs and Medical Directors) met virtually from 10 February 2020. The meetings took place twice weekly, and increased or decreased in frequency depending on demand over the Relevant Period. The meetings provided a valuable opportunity for LAS and other ambulance services to discuss issues and concerns and, where necessary, seek consensus with regard to decision making. The forum facilitated shared situational awareness, collaborative problem solving and collective decision making regarding the provision of clinical care, development of new pathways, clinical approval of rapid guidelines and any changes to the UK Clinical Practice Guidelines that were required. Examples of where NASMeD provided input included the ambulance decision support tool, choking during Covid-19, Oximetry@Home and health and wellbeing advice for staff. During Christmas and New Year 2020/21, where the Delta variant had become the dominant strain, oxygen guidance was produced by NASMeD which was shared within LAS.

82. ***NHSE/I -*** The NHSE/I Central Ambulance Team Clinical Advisor attended both NDOG and NASMeD meetings in order to feed information directly into the daily NHSE/I Covid-19 Ambulance Cell. LAS was also part of a distribution list via which the NHSE/I Central Ambulance Team distributed specific ambulance service guidance as and when this was produced or updated. There was an opportunity to provide feedback during these meetings.

83. In addition, senior NHSE/I clinical and operational colleagues would join NASMeD meetings as required either to communicate information directly to Medical Directors or to be made aware of issues that required national oversight and support. By way of an example, the challenges over the suitability of PPE in community settings were discussed in this meeting and this was, as a result, fed back to the national coordinating team so action could be taken.

84. Once or twice a week, a Webinar was hosted by NHSE/I, led by their National Strategic Incident Team. These meetings were open to attendance by executives from all NHS Trusts. During the meetings, providers were updated as to the national picture. The meetings provided LAS with an understanding of how the rest of the system was managing the pandemic. Whilst this was predominantly a briefing, there were opportunities to contribute to the discussion. For example, there was an opportunity to share and learn best practice between Trusts, particularly as many Trusts experienced the same pressures, albeit at different times. Wherever possible, an Executive Director attended on behalf of LAS and fed back to the senior team through the daily Covid-19 meetings.

85. For ambulance services specifically, a NHSE/I National Ambulance COVID Cell was established and met daily during the working week. This group focussed on the specific challenges faced across the Ambulance Sector including hospital delays, requests for Mutual Aid, and operational performance oversight and data collection such as 999 demand to assist with planning. For example, a trend of

increasing 999 call volumes in one particular area could be used as an indicator of an emerging outbreak and to be shared with other national groups.

Regional Groups

86. *The London Covid-19 Regional Oversight Group* provided the health and care sub-group function of the London multi-agency Strategic Coordinating Group ('**SCG**'). It was responsible for providing regional strategic direction and oversight of the health and social care response through appropriate input and information sharing. It provided an opportunity to engage with partners, to cascade information and receive feedback on issues and queries. Internal NHSE/I directorates and teams were represented, with regional multi-agency partners involved in the response.

87. *London Clinical Advisory Group* ('**LCAG**') - London already had in place arrangements for senior clinical leaders across all five ICS' and the central NHSE/I regional clinical team to collectively consider strategic clinical issues through the LCAG. The terms of reference for LCAG were amended to respond to the Covid-19 pandemic and address the emergent clinical issues. The role of the Covid-19 LCAG was to provide advice to the Incident Coordination Centre and the London Regional Executive through the London Region Medical Director and the Chief Nurse. LCAG acted as a source of expert clinical advice relating to the Covid-19 response. LCAG did not have an executive role but was influential as the 'guiding coalition' of senior clinical leaders in the capital.

88. *Pan-London 111 Oversight* – London already had in place a pan-London 111 governance group which oversaw the implementation of changes required during Covid-19. In addition, twice weekly meetings between the 111 / IUC teams from NHSE/I London, commissioners and providers were held to monitor service delivery and changes. As the region initially impacted by Covid-19, LAS 111 clinical and operational managers supported the development of many of the

pathway enhancements which were subsequently adopted nationally. This included the use of service advisors, outsourcing to "*In-Health*" for additional call answering capacity and the development of direct access to a secondary care consultant for a remote consultation ('**REACH**')

89. *The London Regional Incident Management Team* was charged with the coordination of Covid-19 data and information for the London Region. Members of LAS's EPRR team attended these meetings so any issues LAS were facing could be escalated. This was also an opportunity for information to be shared with providers.

90. LAS also effectively fed back information and learning via the NHSE/I regional office. There was ongoing dialogue with the Regional Director, Medical Director and Director of Urgent and Emergency Care and their teams by the LAS CMO. Information was shared about call volumes for high risk groups and changes in demand which were suggestive of a further peak in London.

91. Overall it is clearly challenging to get the balance right between the need for national directions and the importance of recognising local differences (in our case the principal difference being, as has been explained, that London was generally running ahead of the rest of the country). This challenge was exacerbated by the speed with which events were moving during the pandemic.

Financial Matters

92. In ordinary times, LAS (as part of the NWL Integrated Care System ('**ICS**')), sets a financial plan and agrees an income and expenditure control total, which forms part of the overall ICS control total. LAS's financial plan includes activity, workforce whole time equivalents ('**WTEs**') and financial forecast. LAS's financial plan builds on the previous year's contract for delivery of activity and is uplifted for anticipated

changes, for example, predicted activity growth, inflationary pay and non-pay costs, efficiency requirements and service developments.

93. LAS directorate leads are responsible for working with their teams to prepare their directorate budget for consideration by the Board. The directorate budgets are combined to form the LAS annual budget.

94. The COO played a key role in ensuring LAS's budget allowed for the required number of ambulance clinicians, support staff, call handlers and ambulance vehicles.

95. When making decisions in respect of staffing, the COO was advised by the relevant Directors. The Board's sub-committees (for example, People and Culture Committee and Finance and Investment Committee) also had oversight of the decision making process and the Quality Assurance Committee oversaw the quality impact assessments.

96. Draft and final financial plans are agreed by the Board and submitted to NHSE/I in January and March respectively, with a requirement for contracts to be agreed with commissioners before the end of March.

97. The 2020/2021 draft budget for LAS had been prepared before the Relevant Period and was submitted to NHSE/I by its deadline of 5 March 2020. However, understandably, this budget did not account for the unexpected and exceptional changes in demand that were going to occur.

98. At the start of the Relevant Period, NHSE/I suspended the existing financial regime (outlined above) and replaced it with a system under which LAS was reimbursed for all of its costs incurred on a monthly basis. In order to obtain the reimbursement for revenue and capital spend under the regime, LAS reported its monthly expenditure to NHSE/I setting out the COVID-19 specific costs across a number of pre-determined categories. The reimbursement followed in subsequent months.

99. From 24 March 2020, LAS implemented a Covid-19 resource request and approval process to ensure all Covid-19 related resource requests were approved by COLT and deemed necessary for the response to Covid-19. The process ensured LAS fully documented all requests to allow for comprehensive identification and full reimbursement of costs.

100. For the second full year of the pandemic (2021/22), LAS planned for the first half of the year (H1) and then for the second half of the year (H2) in line with the national NHS financial regime set for the financial year. This largely continued the arrangements in place to top up funding above baseline contracts to cover Covid-19 related costs. As noted above, LAS was reimbursed for all costs incurred throughout.

101. The financial regime introduced by NHSE/I during the Relevant Period resulted in a significant increase in the income LAS received as compared to the financial year 2019/20. Funding in 2020/21 represented a 30% increase compared with the prior year. Funding in 2021/22 represented a 38% increase compared with 2019/20.

102. During the Relevant Period, LAS used the additional funding to increase frontline resources. The frontline staffing provision was increased by 10% in 2020/21 and 13% in 2021/22 (calculated as WTEs) when compared with the pre-pandemic year (2019/20). LAS also increased support staffing levels (including Call Handlers, Call Coordinators and Resource Dispatchers) by 35% in financial year 2020/21 and 37% in 2021/22 when compared with the same period (2019/2020).

103. In addition to the above, increased capital funding was made available. In 2020/21 LAS spent almost double the pre-pandemic capital expenditure (£43m in 2020/21, compared with £22.5m in 2019/20).

Pre-Existing Policies and Guidance

104. Prior to the Relevant Period LAS had a number of well-established policies and procedures in place to assist when responding to incidents and health emergencies. A number of these are detailed below.

The Resource Escalation Action Plan ('REAP')

105. There is a nationwide system used by ambulance services to recognise and respond to operational pressures. REAP identifies the level of pressure any ambulance service is under at any given time and gives a range of options to deal with the situation. The principle of REAP is that all ambulance services in England, Scotland, Northern Ireland and Wales will operate at REAP Level 1 when the service is operating within normal parameters. This means when there is a 'steady state' and the service is meeting national or commissioned standards of performance. The additional three levels reflect increasing pressure on the organisation all the way through to Level 4 where there is the potential for service failure.

106. The table at **Exhibit FW/10 – INQ000217295** illustrates the metrics used by Strategic Commanders and LAS's leadership team to evaluate the current and forecast level of operational pressure that would give cause to consider a change to the REAP level.

107. Actions to be considered by LAS at REAP Level 3 include reviewing all non-contractual attendance at private events, cancellation of all non-contractual / non-statutory training, actively contacting staff for additional overtime shifts and deployment of any staff working alternative duties to patient facing duties and roles supporting front line activity. Actions to be considered at REAP Level 4 include requesting external support in the form of mutual aid or support from NHSE/I; withdrawing all clinical training and all clinicians from meetings and returning them to front line duties; and reviewing options regarding the cancellation of annual leave and time off in lieu in line with policies.

108. As noted in the introductory paragraphs to this statement, LAS experienced the impact of Covid-19 on the service several weeks earlier than the rest of the country.

LAS was already at REAP Level 3 prior to the Relevant Period due to seasonal pressures.

109. Escalation to REAP Level 4 was recommended by the Strategic Commander's team to the COO on Thursday 19 March 2020 and was implemented on Sunday 22 March 2020. This enabled LAS to mobilise additional clinical and operational capacity in order to protect its response to the sickest patients.

110. The REAP Level remained under close review for the remainder of the Relevant Period with governance processes in place to ensure any decisions to change the level were appropriate.

The Clinical Safety Escalation Plan ('CSEP')

111. CSEP is a clinical plan designed to ensure that an appropriate response is maintained at times of unexpected increase in demand and that the sickest and most seriously injured patients receive a timely response. Implementation of the plan facilitates patients who do not immediately require an emergency ambulance being further clinically assessed and signposted to suitable alternative health care pathways where appropriate. This releases ambulances for the highest priority patients to enable the sickest patients to be responded to in the quickest way, whilst providing the safest possible management of all patients.

112. There are four levels of the CSEP; at the baseline is Level 1 / Green. As LAS moves up through the levels of the CSEP, increasing numbers of patients will be given enhanced clinical assessment by a clinician from either the LAS Clinical Hub ('**CHUB**') or NHS 111. Authority for progression to escalation levels lies progressively with the tactical or strategic command teams. .

113. Triggers exist for the escalation of the CSEP, enabling a review of the current situation and anticipated demand, with a view to agreeing the appropriateness of implementation. CSEP triggers being met do not automatically mean that an increase in level will be invoked and are primarily intended to prompt a patient safety review and provide supporting information for decision making. The number

and age of calls holding in each category are also considered and contribute to the decision making process.

114. Escalation of CSEP Level at LAS was undertaken regularly during the Relevant Period. Each time, the decision to adjust the level was part of a clinical review and the decision logged.

The Demand Management Plan

115. A similar plan, the Demand Management Plan, was in place prior to the Relevant Period for managing unexpected demand for 111 services. The purpose of the Demand Management Plan was to maintain clinical safety when demand exceeds the available resource. As a large 111 provider for London, and significant provider of the 111 integrated CAS, a plan was necessary to ensure patients requiring the most urgent assistance were prioritised.

Incident Response Plan for Major and Significant Incidents

116. The Incident Response Plan for Major and Significant Incidents outlines the framework that exists within LAS that supports a high level of preparedness to any business-disrupting event or major incident, regardless of source. All LAS staff are required to familiarise themselves with the contents of the plan. The plan is supported by action cards, contingency plans and site specific action cards.

117. Full adherence to the plan ensures there are arrangements in place to enable LAS to respond to major incidents/business disruptions, continue its critical functions and essential services, provide support to patients and provide and receive mutual aid on a local, regional and national level. The framework supports a whole health economy approach to resilience where critical and interdependent healthcare systems are prioritised to ensure the ongoing delivery of the services stakeholders and community rely upon, regardless of circumstance.

118. The Incident Response Plan for Major and Significant Incidents outlines the operational arrangements to be undertaken by LAS at the time of a major incident

or emergency as defined in the Civil Contingencies Act (2004). LAS, along with its partners, the Fire Brigade, Police and Local Authorities, is a Category 1 responder as defined in the Civil Contingencies Act. The plan has been written in conjunction with partner agencies, and takes into consideration the overarching principles set out in the London Emergency Services Liaison Panel manual and the Joint Emergency Services Interoperability Plan ('**JESIP**').

119. In the early planning for the emerging pandemic, the principles of the Incident Response Plan for Major and Significant Incidents were utilised to provide structure for the response.

LAS Strategic Planning Framework for Pandemic Influenza ('the Flu Plan')

120. Also in place prior to the start of the Relevant Period was the Strategic Planning Framework for Pandemic Influenza which had initially been created to prepare for a possible Swine Flu pandemic. LAS's preparedness for an influenza pandemic had been exercised through regional table-top methodology led by NHSE/I London Region on 19 January 2017. The plan recognised that a key function of LAS would be the delivery of pre-hospital emergency care, incorporating call taking, and the dispatch and management of calls received from the public. Further, it was recognised that this would require different working practices. The Flu Plan outlined that there would be an increase in '*hear and treat*', and less '*see and treat*', care. This would be provided by CHUB staff, as well as NHS 111 / IUC providers in order to reduce the level of exposure by staff where clinically appropriate to the patient's condition. During an influenza pandemic, the intention for LAS was to maintain safe clinical delivery to London, whilst recognising that it may not be a full service. Staff welfare would be prioritised and LAS would ensure that all staff had the appropriate PPE, and vaccinations or prophylaxis would be made available to them where necessary.

121. The Flu Plan was adapted to form the initial Covid plan. The first guidance released for staff was published on 25 January 2020 and was based on the national guidance for ambulance trusts that had been released on 21 January 2020 (**Exhibit FW/11 – INQ000252607**).

122. The Flu Plan included a Flu Pandemic Protocol Triage Tool ('**Card 36**') which was originally designed to be used by the EOC to triage patients calling 999 with flu symptoms. It was recognised by LAS the start of the Relevant Period that there were key similarities in the early clinical presentation of flu and Covid-19, in particular those patients presenting with breathing problems, chest pain and sickness. As such, there would be significant benefit in utilising Card 36.

123. Changes to the triage and outcome of 999 calls at this level are normally ratified by a national governance group. LAS presented the proposed approach to implement Card 36 to the national governance group in the week commencing 16 March 2020, however as the emergence of Covid-19 in England had not yet reached other regions, the proposed deployment of Card 36 was not supported by all represented ambulance trusts. In order to protect patient safety, staff and the ability to respond to patients, LAS deployed Card 36 in London from 07:00 on 27 March 2020, three weeks ahead of the rest of the country, with the permission of the National Strategic Advisor of Ambulance Services for NHSE/I. This was in addition to the extra questions added to the 999 call flow process by NHSE/I which were focused on recent travel to an affected area.

124. Card 36 is supported by the Emerging Infectious Disease Surveillance ('**EIDS**') tool of which there are 4 levels of response categorisation. This comprised Level 0 surveillance and Levels 1, 2 and 3. The levels were set nationally by the Emergency Call Prioritisation Advisory Group ('**ECPAG**') and approved by the NHSE/I Ambulance Covid-19 Cell. This level was set at Level 1 on 25 January 2020, the first escalation level beyond the business as usual surveillance level. This escalation was primarily aimed at increasing the number of low acuity calls that could be referred from call handling to an alternative service, for example by signposting the caller to NHS111 Online.

125. On 26 March 2020, a proposal by LAS to create a dedicated additional 999 call handling facility to relieve pressure on EOC call handlers by answering these 'Covid-19 only' related calls identified via Card 36 was approved by external stakeholders. These actions were implemented over the weekend of 28 and 29

March 2020, increasing call answering capacity and frontline operations and therefore reducing the clinical risk. As guidance was issued via the regional and national teams, this was responded to and implemented.

126. From 30 March 2020 the new facility and process was in place. When patients called 999 they were asked to confirm the reason for the call. If the patient said their call was Covid-19 related, or they met the symptom criteria, they were transferred to a call handling facility, leaving the EOC to manage the usual cohort of non-Covid-19 calls. Serious calls (Category 1 and 2) from the new hub were logged in the CAD to dispatch a response vehicle. Call that were triaged as not immediately life threatening were transferred to the 999 CAS queue for the Covid-19 cell who were set up to handle such calls. Card 36 was updated as further Covid-19 symptoms were identified, for example the loss of smell and taste.

The Business Continuity Plan ('BCP')

127. The BCP provides details of LAS's overall response and the actions required to maintain services during a business continuity event which impacts on LAS's ability to provide critical service functions. Business continuity ensures that healthcare organisations can maintain an acceptable level of service in the face of an incident or, at least, recover to an acceptable level as soon as possible. There are five components of a BCP: the risks and potential business impact; planning an effective response; roles and responsibilities; communication; and testing and training.

128. The aim of the BCP is to provide a detailed, LAS-wide, coordinated plan, compliant with statutory requirements and the business continuity requirements set out within the NHSE/I EPRR Assurance Process to ensure LAS can respond to any business continuity event, maintain critical services and, where possible, business as usual.

129. The BCP provides detailed plans for the first 48 hours of disruption following an event, after which guidance is provided for ongoing planning.

130. The BCP applies to all services provided and managed by LAS. Contractors are referred to in the plan but have their own local BCPs which have been reviewed and assessed as compliant by LAS.

131. LAS has a dedicated senior manager who is an experienced healthcare professional and an expert in Business Continuity. They provide support to each directorate within LAS as well as to the Senior Leadership and Executive team.

132. Each individual department within LAS has a local continuity plan which details individual departmental response to a disruptive event. Local plans may be invoked independently of the wider LAS BCP, where incidents are contained within individual departments and do not impact on the critical functions of LAS.

133. LAS 111/ IUC (located in NEL and SEL) and the EOCs have detailed local BCPs due to the complexity of the services they provide. The BCPs detail responses to a range of risks specific to those areas.

134. The development of the BCP included significant review and testing of departmental and local BCPs. Specific potential crises have been identified, such as the simultaneous loss of both EOC sites located in Newham and Waterloo. The response to such an event surpasses the requirement and scope of a BCP and separate plans have been developed to manage such an event.

135. The BCP is implemented in response to business continuity events and not major incidents, however in some circumstances a major incident may trigger a business continuity event and vice versa – it is the responsibility of the On Call Strategic (Gold) Commander to identify if this is the case, and ensure that the appropriate plan is invoked.

136. While the actual response will be governed by the type and impact of the event, the BCP provides guidelines so that all parties concerned can be clear with regards to their role and appropriate response.

137. Throughout the pandemic the principles of the BCP were utilised to provide the structure for the response and the learning after each Covid-19 peak.

Viral Haemorrhagic Fever Guidance

138. LAS's Viral Haemorrhagic Fever ('**VHF**') document was introduced in 2016 in response to the Ebola outbreak in West Africa. It provided guidance on the risk assessment and management of patients in the United Kingdom in whom infection with VHF should be considered or is confirmed, and has been implemented for use during periods of epidemics at home or abroad, and for routine screening for patients with travel history to a VHF endemic country.

139. Guidance was aligned to the NARU Ambulance Requirements for Confirmed VHF Patient Transfer. LAS's HART team is trained to undertake Category 4 HCID transfers which was utilised in the early stages of the Pandemic in London.

140. In the early stages of the Covid-19 pandemic very little was known about the clinical course of the virus and whilst much information could be drawn from previous influenza pandemics, learning from the management of VHF patients was considered as well.

Personal Protective Equipment Policy

141. The PPE policy covers all LAS employees (including voluntary workers), contractors and visitors. It details the processes by which LAS will effectively manage the provision, use and maintenance of PPE where it is deemed a necessary risk control measure as required by the PPE Regulations. Its purpose is also to ensure that all PPE is suitable and assessed as appropriate prior to being issued to staff, that staff are aware of their responsibilities, training requirements and compliance.

142. The policy and guidance addresses routine/general PPE provisions. Where specialist PPE is required by certain staff groups, for example HART who are trained to work where there are specific hazards for example work near water or

HCID, this is provided over and above the requirements specified as part of the policy. This is subject to a separate risk assessment and standard operating procedure ('**SOP**') which is completed and communicated to all relevant staff prior to the provision of specialist PPE.

143. In addition to the PPE Regulations, there are other sets of Regulations that cover the provision of PPE for work with specific hazards such as hazardous substances, working at heights and noise.

144. Information about how LAS developed its PPE guidance and policies in response to Covid-19 during the Relevant Period is outlined later in this statement.

145. The Uniform and Work Wear Policy applies to all LAS staff and defines acceptable dress code for uniformed and non-uniformed staff. One of the objectives of this policy is to support the control of infection between staff and patients. In this regard, the policy (amongst other things) contains LAS specific requirements for tight fitting Respiratory Protective Equipment ('**RPE**'). In particular, FFP3 Fit Testing and LAS's position on facial hair and the provision of PPE for staff with protected characteristics.

146. As national guidance was released around the use of PPE for IPC, bulletins were issued which superseded the policy.

Covid-19 National Policies and LAS Guidance

147. Due to the novel nature of Covid-19, its mode of transmission and the densely populated landscape of London, not all national and regional policies and procedures were immediately suitable for out of hospital use. Instead, bespoke plans were developed and put in place, ensuring the national and regional principles were adhered to and that LAS plans aligned with its system partners' plans, and the developing national picture. LAS continuously reviewed new and existing advice, guidance and policies to ensure they were consistent, fit for purpose and reflected local learning and the emerging national guidance. As

guidance and information was shared by the NHSE/I National 999 Ambulance Cell, it was acknowledged and implemented by LAS.

148. Prior to the Relevant Period, in January 2020 when information regarding Covid-19 was emerging, LAS issued a number of initial guidance documents to staff across both EOCs (*999 Operations Bulletin: Novel-CoV Guidance for Call Handling and Dispatch Staff - Issued 31 January 2020* – **Exhibit FW/12 - INQ000252608**) and frontline clinicians (*Bulletin: MDB 249 - Coronavirus (CoV) Guidance version 1.0 - Issued 25 January 2020* - **Exhibit FW/11 – INQ000252607**).

149. The 999 Operations Bulletin provided guidance for both call handling and dispatch staff on the process to be followed when managing a case for a patient with suspected Covid-19. It was to be read in conjunction with MDB249. Guidance included a list of respiratory symptoms (shortness of breath, cough, sore throat, fever or flu-like symptoms) that, if reported by the caller, would trigger a supplementary call management pathway to identify if the patient had recently travelled to a known outbreak area (at this time Wuhan province for Covid-19 or Bahrain, Jordan, Iraq, Iran, Saudi Arabia, Kuwait, Oman, Qatar, United Arab Emirates, Yemen or South Korea in the case of MERS-CoV) and who had close contact with someone with a confirmed case of Covid-19 within 14 days of onset of symptoms. If the caller answered yes, the patient was advised to self-isolate and reduce contact with others. The call would be highlighted to dispatch staff and clinicians within our control rooms. If the call achieved a Category 1 response profile, Dispatch staff would seek to send a resource immediately and contact the attending crew to advise them of the potential case of Covid-19 to allow for the pre-arrival fitting of PPE.

150. For cases that required further clinical assessment before dispatch (i.e. Category 2-5 calls), a clinician from the control room would first review the details of the case on the electronic call receipt and then proceed to contact the patient. Following this assessment, if it was believed the patient may be Covid-19 positive, Dispatch staff would be notified in order for the attending crew to be made aware so they could don PPE in advance of arriving on the scene.

151. If any on scene assessment resulted in a high suspicion of Covid-19, the crew would report their finding to Dispatch staff in order for the receiving hospital to be made aware in advance of their arrival. An Incident Response Officer (IRO – mobile manager) would also be notified so they may contact the crew to ensure any welfare requirement can be addressed.

152. Patients who did not trigger this pathway or who were assessed by either a control room or frontline clinician as an unlikely case of Covid-19 received their care as per normal operating procedures.

153. MDB249 was superseded by MDB251 (*WN-CoV Guidance for CHUB and patient facing staff*) on 28 January 2020. Over the next 6 weeks MDB251 was regularly updated until all the information was brought together into the COVID-19 LAS Guidance for Patient-Facing Staff document which was first issued on 18 March 2020. This document consolidated all information available to LAS at this time including guidance issued by UKHSA on 27 January 2020 relating to the initial clinical management of possible cases. Its purpose was to provide further knowledge and understanding to staff on the origins of coronaviruses, routes of transmission, risks and definitions (e.g. 'close contact') with the aim of eliminating or reducing the risk of transmission to healthcare workers and to ensure effective and safe delivery of patient care. It also detailed the procedures to be followed when attending a possible case of Covid-19 including IPC procedures, PPE guidance and post incident procedures (including decontamination and contact tracing). Staff were also provided with reference links to relevant UKHSA guidance.

154. Initially, any laboratory confirmed cases of Covid-19 were overseen by senior leaders including the duty Clinical Safety Manager, Senior Clinician on-call, Duty Incident & Delivery Manager ('**IDM**'), the on call EPRR Tactical Advisor and on-call leadership from NHSE/I London Region (call sign NHS01). If attendance at any confirmed case was required, a Category 4 ambulance with suitably equipped staff would be dispatched.

155. LAS issued multiple updated versions of these guidance documents for CHUB and patient-facing staff in relation to Covid-19. This guidance relates to both the recognition and treatment of Covid-19 patients, patients at particular risk of severe disease and how staff should protect themselves from the transmission of Covid-19. This guidance was continually updated in order to ensure the changing nationally-issued guidance was incorporated into guidance for LAS staff.

156. In respect of both the 999 and the 111 services, there was a focus on increasing the percentage of patients assessed and treated via the telephone. One aspect relating to the 111 service not already covered in this statement is the switch from booking patients face to face appointments with out of hours GP services, into telephone assessment and treatment appointments. From 27 February 2020, all potential Covid-19 patients were managed by LAS's dedicated Covid -19 CAS.

157. The Covid-19 pandemic placed even greater importance on the IUC CAS for many patients including, for example, end of life ('**EOL**') care patients. Remote prescribing of medicines for use in EOL care was introduced to LAS IUC Sites in May 2020. This facilitated timely access to medicines for patients during the Covid-19 pandemic, whilst simultaneously reducing the need for out-of-hours home visits by GP services. Clinicians were able to prescribe for patients that had been assessed as being EOL and required either additional supplies of already prescribed medicine or newly initiated medicines for symptom relief. Approximately 470 face to face out-of-hours appointments were prevented in an 18 month period through this prescribing change. The majority of these consultations took place on a weekend, releasing a minimum of 3 appointments each weekend to other patients requiring face to face clinical care. This has now been adopted into business as usual practice, with the governance forming part of the Controlled Drugs Policy.

158. In respect of decision making around which patients were to be conveyed to hospital and which patients were to remain at home, LAS regularly reviewed and updated guidance in line with the latest evidence and best practice from the National Institute of Health and Care Excellence ('**NICE**'), UKHSA, NHSE/I, AACE and NASMeD, as well as learning from incidents and guidance from other relevant

bodies such as the Medical Royal Colleges. Specialist teams within LAS were tasked to support the development of relevant guidance relating to specific patient groups. This guidance sat alongside a range of clinical support tools available to LAS staff to assist in their clinical decision making, recognising that clinical assessment took precedence.

159. Throughout the Covid-19 pandemic, clinicians were able to use a range of supportive tools to guide their clinical practice including the Joint Royal Colleges Ambulance Liaison Committee ('**JRCALC**') guidelines and Paramedic Pathfinder. At the start of the pandemic, as the nation was dealing with a new disease, there was no national guidance available in respect of the management of the pre-hospital management of Covid-19 to assist with decisions around risk assessing a patient's presentation.

160. It was evident from the onset of the pandemic that patients were increasingly more fearful of attending healthcare settings. During the period February 2020 to January 2021, LAS saw an increase in the number of patients who, after a face to face assessment by an ambulance clinician, declined conveyance or aid against clinical advice. Between February and November 2021, the number of patients declining conveyance was comparable to January 2020. Following the spread of the Omicron variant in December 2021, the numbers of patients declining conveyance or aid again rose and then fluctuated for the remainder of the Relevant Period. Details in respect of this can be found at **Exhibit FW/13 – INQ000217296**.

161. By March 2020, demand had significantly increased. In the third week of March there was a significant rise in Covid-19 cases – on 21 March 2020 there were 5,018 confirmed Covid-19 cases in the UK, compared with 1,061 confirmed cases the week prior.

162. In response to a request from the Secretary of State for Health and Social Care, a temporary service for the NHS111 response to the Covid-19 pandemic was commissioned in March 2020. South Central Ambulance Service NHS Foundation Trust hosted a Covid Clinical Assessment Service (CCAS) which was operational from late March 2020 until May 2021. LAS was able to refer patients with Covid-

19 who contacted NHS 111 to CCAS for further assessment and telephone based consultation.

163. As noted in the preceding paragraphs of this statement, London was three weeks ahead of the rest of the country in terms of the volumes of patients and demand. In the absence of any validated national pre-hospital guidance this extreme pressure necessitated LAS developing and implementing additional Covid-19 specific guidance in mid-March 2020 to assist with the assessment of the very large volume of patients with this new virus and ensure non-Covid-19 patients continued to receive an emergency response.

164. From the emerging clinical picture, it was becoming evident to LAS that certain patient groups were more likely to suffer severe symptoms. These included the elderly and patients with diabetes or chronic lung conditions. A locally defined Decision Support Tool ('**DST**') for patients with acute respiratory infection / illnesses was developed and added to the guidance. A Clinical Assessment Flow Chart was adapted by LAS from a draft version shared at the NASMeD Group. This utilised two well established assessment tools to increase the sensitivity – NEWS2 and CRB-65. NEWS2 is a physiological observations and risk assessment tool which looks at the total derangement of the clinical observations, as well as looking at observations that fall grossly outside of the normal range. The secondary tool used, where a patient's NEWS2 score was less than 7, was the modified CRB-65 score. The original score (CURB) was developed in Nottingham for predicting mortality from community acquired pneumonia. The original scoring included consideration of uraemia as a component of the assessment. However, this was modified and validated where blood urea levels were not available. The CRB-65 tool has been reviewed and validated by NICE for the assessment of mortality, at 30 days, for community-acquired pneumonia. The results of these assessments would form a component of the decision making with the patient, family members and carers as to whether the patient needed to be conveyed to hospital or could be managed at home following a referral to a community clinical team or their GP / 111 GP.

165. The DST was added to the continually updated MDB251 on 14 March 2020 and then incorporated into the COVID-19 LAS Guidance for patient facing staff which was released on 18 March 2020. (**Exhibit FW/14 - INQ000252597**).

166. Despite the significant operational and performance challenges, patients presenting with life threatening illnesses and injuries received the same level of response they would have before the emergence of Covid-19, notwithstanding this may have been outside of national ambulance response standards. However, in light of the extreme demand placed on the NHS, LAS enhanced its clinical telephone assessment capacity and processes to ensure patients presenting with minor illnesses and injuries were supported to receive their care at or closer to home via clinical telephone assessment and advice as far as possible and where appropriate. The guidance for these patients remained the same and was located on the JRCALC app, unless a clinical update was recommended by the Patient Safety and Clinical Effectiveness Committee, after which the JRCALC app would be updated.

167. By Easter 2020, there was a developing understanding of the risk profile of patients with Covid-19, through working with healthcare partners and LAS's own clinical observations, there was emerging picture that:

a. Patients were presenting with a sequelae of signs of and symptoms which one would not classically associate with respiratory sepsis/pneumonia. This included patients who presented with marked hypoxaemia without overt respiratory distress (silent hypoxia).

b. There was a much broader range of symptoms described including fatigue/lethargy and abdominal pain.

c. There was emerging evidence that patients with specific medical conditions where at higher risk of severe illness. These included patients with co-morbidities, immunocompromised, respiratory history, poorly controlled diabetes, and obesity.

d. It was also recognised that children were presenting atypically with abdominal pain.

In light of these rapidly observed changes, the clinical guidance was updated to include an illness severity assessment, high risk patients groups and guidance in respect of children. The guidance was updated and shared with patient facing staff. There remained a lack of national evidence based guidance specific for ambulance clinicians at this stage.

168. LAS guidance continued to develop on a frequent basis over the subsequent months in line with the national guidance, the emerging clinical picture and continuous review of available evidence.

169. By early 2021, a lot more was known about Covid-19. Through existing partnerships with regional/national health bodies and other UK Ambulance Services (for example NASMeD, NDOG, AACE and UKHSA). Ambulance services worked with NHSE/I to develop an updated national DST for adults with suspected or confirmed Covid-19 based on emerging evidence and best practice which was specifically tailored to the ambulance setting. A national ambulance decision support tool was agreed to the National Covid-19 Pathways on 14 January 2021 (**Exhibit FW/15 – INQ000252598**).

170. To provide a safe response to all patients, including the sickest and most seriously injured during the Covid-19 pandemic, the pan-London Clinical Directors for the clinical pathways, NHSE/I London Region, and LAS agreed temporary adaptations to the tertiary pathway patient flow. In addition, support was provided by LAS to facilitate transfers between tertiary units to ensure patients were able to benefit from specialist care whilst recognising this did, at times, mean slightly longer ambulance distances. Specific pathways were implemented at either a regional or Integrated Care System (ICS) level for Cardiac, Fractured Neck of Femur, Maternity and Neonatal, Mental Health, Paediatrics, Renal, Stroke and Older adult patients in North East London (NEL).

171. A chronological table setting out the key advice, guidance and policies relevant to the above is at **Exhibit FW/16 – INQ000217297**.

172. For patients whose presenting condition was unlikely related to Covid-19, their case would be managed in accordance with normal (pre-Covid-19) procedures, notwithstanding the shift towards telephone assessments as opposed to face to face appointments, and the extreme pressure faced by the service which meant many patients waited longer for a clinical telephone assessment often outside of contractual service level performance agreements.

Collaborative Working

173. LAS was integral to the NHS London Regional Response to Covid-19 and had open lines of communication with NHSE/I and other NHS Trusts and partner organisations in London in order to support the collective effort to provide a safe as possible response to the crisis in the region. Communication with NHS partners in London was through existing networks such as the CEO group and the CMO group, both of which had regular calls chaired by NHS London Region CEO and CMO. LAS also had an active role in LCAG sharing information and clinical data.

174. Communication with NHS partners, including with other NHS Trusts in London, also occurred through LAS's membership of the London Resilience Forum. During peaks of the virus these meetings were happening at least once a week.

175. LAS worked with partner NHS Trusts to co-create and implement protocols across a number of key developments:

a. In January 2020, LAS worked with NHSE/I – London Region and UKHSA to develop a process for community based Covid-19 testing (*Wuhan Novel Coronavirus (WN-CoV) proposed community screening model for individuals in London. Document created on 29 January 2020*). This process was designed to enhance the patient experience and minimise any exposure risk to the wider public, healthcare professionals and simultaneously minimise disruption to busy Emergency Departments

('**EDs**') by avoiding the need to convey patients who were not acutely unwell to ED solely for the purpose of testing. Patients were able to self-isolate at home and have a clinician visit them to carry out an assessment and gather the necessary samples. As well as improving the patient experience and reducing the overall time taken to take the samples, it reduced the impact on the Ambulance Service undertaking wait and return journeys and post incident procedures including vehicle deep cleaning.

b. In January 2020 LAS, in collaboration with NWL hospitals and NWL Health Protection Team, introduced a process for community based testing of patients who following clinical telephone assessment were assessed as likely being Covid-19 positive. This process saw clinicians from our control room contact the duty Infectious Disease Consultant at Northwick Park hospital to agree an attendance at the patient. An LAS vehicle would collect the hospital clinician, take them to the patient in order for testing to be undertaken then return the clinician and the sample for testing.

c. LAS worked in partnership across all acute trusts to redistribute PPE to ensure safety of all frontline clinicians.

d. LAS worked closely with Frimley Health NHS Foundation Trust, to ensure from 13 March 2020, that the medicines supply chain included contingencies for the pandemic. The Pharmacy Production Manager and Chief Pharmacist reviewed stock.

e. LAS had a key role in the design, development and rapid implementation of the NHS Nightingale London project. From 21 March 2020 LAS worked closely with NHS London and the wider London healthcare system to create and operate a temporary Covid-19 field hospital capable of caring for up to 4,000 patients at the Excel Centre in East London. LAS's role was to design, develop and provide the CCTS necessary to take patients to and from this facility and move Covid-19 patients between other acute hospitals. To do this, LAS set up and operated a transport coordination facility in NHSE/I Headquarters, Wellington House, Waterloo and a field

ambulance deployment centre at Excel, deploying up to 20 vehicles, utilising our HART specialist assets and specialist military medical teams to ensure the safe and efficient transfer of patients to and from Nightingale Hospital.

f. Following direction from NHSE/I nationally, in common with all other regional ambulances services in England, to aid the smooth and effective movement and discharge of patients in and out of hospital, on 27 March 2020 it was agreed LAS would coordinate (but not deliver operationally) all patient transport services in London. This involved twice daily teleconference calls chaired by LAS which provided support, guidance (including IPC guidance) and oversight for all patient transport service provision throughout the period.

g. The process for patients and staff entering hospital premises changed from conventional methods. The patient's condition and likelihood of having Covid-19 dictated which access channel was used. These differed across London and regional engagement was required to ensure, as far as possible, a consistent approach was adopted across the 5 ICSs of London.

h. In April 2020, and in preparation for an unknown number of potential deaths in the community as a result of Covid-19 infection, LAS worked with NHSE/I– London Region and other partners to introduce a process for patients who had died in the community as a likely result of Covid-19 infection. Known as '**P-MART**', this was a pandemic multi-agency response team that saw a LAS clinician working alongside the police service, London Fire Brigade and HM Coroner. Where a patient had been confirmed deceased (either through attendance by a clinician or following an assessment of the call by a clinician in one of our control rooms), the call would be referred to the Metropolitan Police Service who would then coordinate the attendance by P-MART.

i. In May 2020, the LAS took part in an antibody testing programme in partnership with University College London Hospital. This saw 2,000 LAS

staff, across all sectors and departments being offered the opportunity to take part in the initial screening programme and to understand the extent of which Covid-19 had spread and evolved across the country. The antibody test was designed to show whether people have had COVID-19 and to help track the extent to which the virus spread.

j. As part of the NHS response to Covid-19, a supported self-isolation facility was established in close proximity to Heathrow Airport. The facility was designed to reduce the workload on the wider NHS by reducing unnecessary admissions to acute hospitals and provided a safe environment for Covid-19 hospital patients who did not have accommodation in the UK where they could self-isolate. LAS provided transport to the facility from all London ports of entry, along with other London locations meeting the acceptance criteria. LAS also provided emergency medical services to the facility in the event of acute illness or injury to the residents or staff working there.

k. LAS supported the request from the region by undertaking the transport of patients who had tested positive in hospital and were being discharged back into the community to continue their recovery but who did not have their own mode of private transport. This was to support the reduction of community based transmission by avoiding the use of public transport.

l. On 20 November 2020, all NHS Trusts were asked by NHSE/I to work in partnership to deliver the Covid-19 vaccine within the NHS and to the public. The first vaccine to be approved was manufactured by Pfizer. Due to certain limitations to delivery, such as temperature control and pharmacological stability of the vaccine, it was not possible to vaccinate staff through a programme within LAS as we do for Influenza. In order to support the national vaccination rollout, and ensure our staff were vaccinated, LAS partnered with other NHS Trusts in London providing clinical staff access to the vaccination centres and providing a range of staff to work in the vaccination centres. This partnership working enabled LAS staff to be vaccinated as soon as possible at an NHS Trust close to either

their work place or residence. The vaccination rate was recorded internally and shared as part of the national database. It was important LAS did not deploy anyone who was otherwise able to provide a frontline emergency response however, as in normal times, we often had a number of colleagues who were unable to undertake their full operational duties. All five ICS's indicated they would welcome LAS staff to be vaccinated on their sites. In order to fulfil the partnership request, LAS was asked to provide staff to the ICS's to assist with the delivery of the Pfizer vaccine. This was possible under the pan-London Staff Movement Agreement, formulated as a response to Covid-19 and updated on 1 October 2020. LAS staff were seconded.

m. During late December 2020 and early January 2021, the new variant of Covid-19 had begun circulating in the community and many more patients were presenting requiring oxygen. This placed an extreme demand on oxygen supplies across London and coincided with the festive season and London being placed in Tier 4. LAS liaised with the NHSE/I London Region Oxygen Cell and provided guidance to crews on optimising oxygen therapy. Collaborative working was undertaken to support Trusts where oxygen supplies were under pressure. Examples of the collaborative work undertaken included redistribution of ambulance conveyance toward acute Trusts who were not experiencing oxygen supply pressures. A specific example was supporting the flow of patients from St Helier NHS Trust to Croydon University Hospital NHS Trust and Epsom General Hospital. In addition, the Trust worked closely with BOC Ltd to increase the delivery of cylinder oxygen for the ambulances and with NASMeD to agree oxygen guidelines. The Trust prepared to be able to support a critical situation where the transfer of patients from one acute Trust to another may be required.

n. The introduction of community-led Oximetry@Home pathways on 7 January 2021 were designed to provide a clinical pathway to safety net lower risk patients with Covid-19 in the community and identify early deterioration, reducing pressure on EDs and LAS as well as facilitating

supported discharge from ED for patients not needing a General and Acute bed. LAS worked closely with NHSE/I London Region to align objectives and ensure the pathway was patient focussed and resulted in improved patient flow and capacity within the Urgent and Emergency Care system.

Mutual Aid

176. All mutual aid requests are coordinated by the National Ambulance Coordination Centre ('**NACC**'), hosted by NARU. Formal mutual aid arrangements are in place for all UK ambulance services. The deployment of mutual aid is at the discretion of the National Strategic Ambulance Advisor to NHSE/I who coordinates the re-deployment of resources from other ambulance services or from any national pool of resource such as St John Ambulance.

177. Mutual aid arrangements ensure that resources can be drawn from neighbouring ambulance services to provide support to an ambulance service which is managing a major incident. Seeking mutual aid is an action associated with REAP Levels 3 and 4.

178. Mutual Aid in terms of ambulance resource response is provided to LAS from neighbouring ambulance services, namely the East of England Ambulance Service ('**EEAS**'), the South East Coast Ambulance Service ('**SECAmb**') and the South Central Ambulance Service ('**SCAS**'). It can also be from third party ambulance providers, i.e. private or voluntary ambulance service ('**PAS**' / '**VAS**') contracted to undertake emergency response duties in EEAS, SECAmb and SCAS operational areas, as well as their own operational resources (core fleet and staff). Wider NHS ambulance services may also provide mutual aid support where coordinated at a national level, in the form of ambulance resources or 999 emergency call-handling support.

179. LAS incident management logs show that the decision to explore the possibility of mutual aid was made by the Strategic (Gold) Commander's team on 13 March 2020. This was not taken forward at that time by the COO, who was in regular contact with regional and national colleagues.

180. The next action taken in relation to mutual aid was on 22 March 2020. LAS had moved to REAP Level 4 on this day due to significant and sustained demand. From 15 March 2020, the EOC had been holding large numbers of emergency calls (peaking at over 500 on 15 and 16 March 2020 compared to an average of 120 calls) and it was recognised that, as there were inconsistent levels of demand being experienced by other Trusts nationally, assistance via mutual aid may be available.

181. On 27 March 2020, mutual aid was made available to LAS from SCAS (6 ambulances), EEAS (10 ambulances) and St John Ambulance (20 ambulances), thereby allowing LAS to increase vehicle operating capacity.

182. A further request was made for Mutual Aid to four neighbouring ambulance services on 3 April 2020, the request was for 10 ambulances from each Trust for a 2 week period. Due to overall national operational pressure this request yielded limited support. This amounted to a maximum of 16 DCAs per day from South Central Ambulance Service, NHS Nightingale Hospital and St John Ambulance.

183. Mutual aid from St John Ambulance continued for the duration of the Relevant Period. Mutual Aid from buddy site statutory ambulance services was provided in response to direct requests where their capacity allowed until January 2021.

184. Between Christmas 2020 and New Year's Day 2021 some medical support was provided to LAS from NHSE/I London Region to support clinical assessment during that peak. A dedicated senior clinical assessment hub was established with a small number (3 per day maximum) of senior doctors undertaking telephone assessment of patients. Following a clinical assessment, appropriate patients were able to manage at home. All patients were provided with safety-netting advice and support. This hub was set up remotely from the Trust EOC and Clinical Hub, recognising that many of the clinicians were also doing face-to-face clinical shifts and although prior to undertaking their LAS shift they evidenced a negative lateral flow, maintaining safety and integrity of the 999 EOC was critical. These clinicians were supported by an experienced clinical operational manager from LAS so that,

in the event of an emergency ambulance being required, there was no delay to the patient being transferred to the dispatch queue.

185. In addition to formal mutual aid arrangements, there is a long standing operation of cross border assistance where ambulance control rooms contact a neighbouring service directly to ask for assistance on their border. If an ambulance resource is available within an appropriate distance, they are asked if they could attend. This informal mutual aid occurs on a daily basis across the UK and continued throughout the Relevant Period.

186. For completeness, LAS confirm all initial requests for Mutual Aid were made using the established process through the Directors of Operations at the relevant Trusts. Once central ambulance command and control was established to oversee all requests, these were made through the NACC.

Disproportionate Impact of Covid-19

187. LAS recognises that Covid-19 had a disproportionate impact on certain demographic groups including people from ethnic minority backgrounds, disabled people, clinically vulnerable people, and those from socio-economically disadvantaged backgrounds and worked to minimise this impact.

188. LAS's '*Policy for the Development and Implementation of Procedural Documents*' requires that all of LAS's policies, procedures and guidance be reviewed in line with the Equality Act 2010. Under that Act, there is a duty to have due regard to the need to eliminate discrimination, harassment and victimisation; advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and to foster good relations between persons who share a relevant protected characteristic and persons who do not share it. As part of any policy creation process, policy approval paperwork is completed which includes an Equality Impact Assessment / Privacy & Dignity Checklist.

189. LAS employs specialists in maternity, End of Life Care, mental health, safeguarding and learning disabilities and autism who provide expert advice and support across the 999 and 111 services. These specialists formed part of specialist teams which oversaw the development of guidance relating to patient groups within their area of expertise prior to and throughout the Relevant Period.

190. London Ambulance Service provides Urgent and Emergency care for an ethnically diverse population where health and socioeconomic inequalities form part of the consideration in every care episode. Of note, a large percentage of all patients with Sickle Cell Disease are resident in London. As the Covid-19 pandemic spread through London, the impact on our different communities was part of each decision-making process. For the avoidance of doubt, LAS guidance in respect of vulnerable people and those with health inequalities was incorporated in to the main LAS guidance and was not addressed in separate policies specifically relating to these groups.

191. LAS regularly reviewed and updated 999 and 111 guidance in line with the latest evidence, as set out earlier in this statement and at **Exhibit FW/16 – INQ000217297**. This included changing the guidance where evidence-based recommendations were made by national groups. As more was learned about Covid-19 and clinical outcome data became available, the patient facing guidance included specific mention of those patient groups who were being identified as being at higher risk of developing complications of the virus.

192. Supplementary information as to which patient groups were at higher risk of developing complications and death from Covid-19 was also provided to staff, to ensure that best practice was being followed. As information became available to identify a high risk group, they were included in shared information. The groups included were:

a. patients who were immunocompromised or on immunosuppressive therapy (e.g. for rheumatological or autoimmune disease);
b. patients undergoing, or who had recently undergone, chemotherapy;
c. patients who had experienced a recent cardiac event;

d. patients with significant respiratory history such as asthma or COPD, or a cardiac history;
e. patients with poorly controlled diabetes, and
f. patients over 70 years of age.

193. Additional guidance was subsequently added around other specific patient groups including patients with morbid obesity, maternity patients, diabetic patients and children.

194. In May 2020 the DST was updated and the opportunity was taken to include specific guidance on high risk patient groups, silent hypoxia and individual care plans. Shared decision-making continued to be advocated where the outcome of using the tool was that transport to hospital may not be required. This was to ensure that decisions taken were the right one for the individual patient and took account of any factors that made the individual at higher risk from Covid-19.

195. By February 2021 a lot more was known about Covid-19. High risk groups were reviewed and updated in line with the latest available evidence to also include:

a. patients over 65 years of age;
b. patients with chronic obstructive pulmonary disease;
c. diabetic patients and patients with a high blood sugar on assessment;
d. patients from ethnic and minority backgrounds;
e. pregnant patients;
f. patients with cardiovascular disease;
g. patients with hypertension;
h. patients with obesity;
i. all patients with cancer, and
j. patients with learning disabilities and autism.

Shared decision making with a senior clinician was mandated if home management was being considered in these patient groups.

196. LAS worked with obstetricians to develop a specific DST for pregnant patients with confirmed or suspected Covid-19. This was introduced in May 2021 together with a strong emphasis on shared decision making (**Exhibit FW/17 - INQ000252599 and Exhibit FW/18 - INQ000252600)**. Additional guidance was also added on 13 September 2021 relating to patients with learning disabilities and autism. This highlighted that presentations of Covid-19 may be different in patients with a learning disability or autism. Adapted communication, information from those that know the patient well, hospital passports and shared decision making were advocated, especially in complex situations or where there was a concern that a DNACPR was non-specific or personalised. This means a patient should not have a DNACPR (do not attempt cardiopulmonary resuscitation) decision recorded on their clinical record simply because they have a Learning Disability and/or Autism. The decision must document an advanced, irreversible physical health condition(s) which a Learning Disability and/or Autism is not. Another example would be choking – this is a reversible cause of a sudden collapse and would not be covered by a DNACPR. Clinicians were made aware that if there were any doubts they should seek additional guidance from the Clinical Support Desk. In May 2021 the LAS employed a Learning Disabilities and Vulnerabilities Specialist who provided bespoke guidance for clinicians through educational sessions, clinical bulletins and updated.

197. In addition to the development of the DST, LAS also updated IPC guidance in line with the latest evidence and best practice from UKHSA. LAS cares for an undifferentiated group of patients, many of whom may be clinically vulnerable to infectious diseases. LAS guidance reflected the need to minimise the risk of transmission and comprehensive measures were put in place to provide appropriate PPE to patient facing staff and enhanced cleaning of vehicles and equipment where appropriate. In addition, staff were advised to provide PPE to patients (and anyone escorting the patient in the ambulance) if required. LAS acknowledged that PPE created a communication barrier, which has a profound and disproportionate impact on certain groups of patients and staff. However, LAS staff were provided with a number of communication tools to assist them (such as a clear fronted FFP3 mask, the Language Line British Sign Language service and the use of the LAS communication booklet – **Exhibit FW/19 - INQ000252601**).

LAS staff were also asked to write their names clearly on the front of their PPE so patients knew the name of the person who was treating them. This also assisted staff when communicating with colleagues.

Safeguarding

198. There was no change to LAS safeguarding policies and procedures during the Relevant Period and staff were encouraged to continue to raise concerns where appropriate. Safeguarding supervision and feedback on practice continued to be available to staff during this time. In addition, LAS took action to address specific concerns, recognising that certain patients, who in normal times would routinely engage with other health and social care services were likely to only have face to face contact with the ambulance service during periods of regional and national stay at home advice. For example, staff left stickers with patients with details on how to get support for people at risk of domestic violence. Staff were encouraged to continue to signpost patients to raise welfare concerns (or raise these on behalf of patients if required) including concerns related to social deprivation and housing. House management advice for patients in housing of multiple occupancy was aligned to guidance issued by UKHSA.

199. As hospitals went into lockdown and could not allow visitors into their premises, LAS supported this by not conveying relatives in the ambulance with the patient. The exception to this were for patients who were elderly, vulnerable or who were children. When relatives could not be conveyed with the patient, every effort was made to ensure the families were advised of the destination hospital.

200. LAS recognised that a number of NHS and social care services were reorganised to provide a response to Covid-19. LAS worked with NHSE/I and local services to ensure patients could continue accessing services and produced related guidance and tools for staff including maps of services and an updated Directory of Services. For example, in some parts of London, mental health services were reorganised and LAS worked with the services to ensure patients had access to face-to-face assessment where required in dedicated units away from EDs.

Patient Safety

201. Patient safety was (and remains) a priority for LAS and was considered at every juncture.

202. In respect of our EOCs, there were regular review calls involving the Clinical Safety Manager and the senior clinician on call, reviewing the patients awaiting for an ambulance, vulnerable person groups and interfacility transfers. LAS also expanded clinical support and oversight in the EOC with clinical floor walkers and a significant increase in the size of CHUB (18 to 44 clinicians). This was achieved utilising Clinical Team Managers, Advanced Paramedics in Urgent Care and Critical Care, Senior Sector Clinical Leads, Quality Assurance and Governance Managers and medical directorate senior clinicians. A senior clinician was always available to support staff (initially 24/7 in person, subsequently moving to 12 hour daily presence and 12 hours on call). Our senior clinicians also engaged in operational shifts to support crews, answer questions and provide advice.

203. LAS also introduced additional Clinical Navigators, GP leads and a Quality Governance and Assurance Manager to support clinical teams in the IUC.

204. To maintain oversight of quality and safety, the following measure were in place:

a. Daily safety report identifying the number of calls breached 2 x 90th centile, trends, and 5 longest held calls per category.
b. Daily report of safety and quality incident notifications to the Executive Team.
c. Re-contact audit which is continuous.
d. Clinical review of delayed patients which comprised a 2-stage structured judgement review.
e. Patient Safety and Clinical Effectiveness Group (PSCEG) to review and approve changes in processes. Quality Oversight Group to review quality and safety activity.
f. Triangulation of complaints, incidents (including serious incidents) and quality alerts.

g. Weekly Serious Incident Group ('**SIG**') meetings.

h. Joint decision making procedures to document decisions made by the tactical teams.

205. During the Relevant Period, due to the unprecedented level of demand placed on LAS requiring all clinical staff to be operational, and the increase in Covid-19 related absences amongst staff, the number of patient safety incidents being reported began to fall. As a result, the Quality Improvement and Learning ('**QI&L**') team decided to take action to maintain oversight of the patient safety incidents during this period. This was for incidents reported through the Datix system and was in addition to the clinical safety calls which were happening every 8 hours and the Clinical Safety Reports received by the clinical directorate and CHUB manager.

206. Additionally, the LAS Incident and Risk Hub was established on 23 March 2020 to collate all incidents, risks, complaints and other quality data. This was led by our Chief Quality Officer and relevant members from different directorates attended. The primary purpose of the Hub was to identify and maintain reporting of patient safety incidents throughout LAS during the period of high demand. Once a patient safety incident was identified, for example due to demand from Covid-19 patients may have a delayed response resulting in worse clinical outcomes or patient experience, the incident would be referred for review at the SIG.

207. As noted above, LAS SIG continued to convene on a weekly basis with key stakeholders from across LAS throughout the relevant period, and was run by the Quality Directorate, supported by the Clinical Directorate. A key patient safety theme had been identified regarding long delays (twice the 90th centile and above) occurring to patients due to the unprecedented demand on the service. The long delays were as a result of several factors, and not necessarily attributed to, for example, low levels of staffing. SIG agreed that these incidents would be presented at the weekly SIG meeting and would form a thematic style approach of investigation. Therefore these were not to be treated as individual serious incidents ('**SI**') and not be logged in StEIS (the system used to report and monitor progress of SI investigations across the NHS). However they were reported to the CCG via 72 hour reports and investigated accordingly. LAS worked with the CQC and

NHSE/I to agree a process for reviewing SIs and meeting regulatory requirements for our 'Learning from Deaths' process during this period, to ensure learning was captured and acted on.

208. All incidents where harm had been caused by care and service delivery problems (other than a long delay cause by Covid-19 demand) continued to be reviewed as business as usual.

209. From 6 April 2020 the Incident Response Hub sought the data directly from LAS's Business Intelligence ('**BI**') team and a specific daily report was established to provide the data in order to review whether the delays may have resulted in a patient safety incidents. The daily safety report provided the ability for the IR Hub to identify long delays and calls where there may be a possible deterioration in the patient's condition. Daily reports were also provided to COLT of incident notifications and LAS's Quality Oversight Group and SIG continued to meet regularly, triangulating complaints, incidents, quality alerts, and serious incidents. Re-contact audits (where patients are known to have deteriorated as the re-contact resulted in pre-alert or unexpected death) and clinical review of patient groups were also implemented. The decision to make these changes was taken by the Chief Quality Officer, in conjunction with the CMO.

210. A report was published internally by the Quality Directorate on 14 August 2020 that reviewed LAS's response to patients during the peak of Covid-19 between 9 March 2020 and 5 April 2020 including the dispatch process and the clinical care provided. The scope of this report included establishing whether any care and service delivery problems arose and identifying themes for the purpose of organisational learning, and was shared with the Board. Following this report, a Thematic Report into the delays to dispatch was undertaken every quarter for the duration of the Relevant Period. Changes in staffing levels were not found to impact on care or capacity

211. LAS continued to fulfil its Duty of Candour obligations throughout the Relevant Period.

Communications

212. From January 2020 LAS's Communications Team re-prioritised its aims and objectives in order to focus on the cascade and sharing of reliable and trusted communications about Covid-19 to staff. Internal communication arrangements were significantly enhanced and we communicated with staff and volunteers at a dramatically increased frequency and speed. In the first five months of 2020 alone, LAS hosted 31 question and answer sessions which were live streamed to colleagues (and also saved on the intranet for those who could not attend the live sessions) and issued over 200 bulletins. More than 1,700 questions via a dedicated email inbox and on the LAS staff and volunteer Facebook group were also answered.

213. A number of new approaches were introduced to ensure staff had up-to-date, timely information and the ability to access key leaders to seek further clarity and guidance, and to share any concerns or ideas for improved working. These new approaches also allowed managers and leaders to share information quickly in rapidly-developing circumstances (when misinformation can be most prevalent).

214. Key areas of focus were:

a. **Safety and clinical practice** – emerging Covid-19 guidance for caring for patients and protecting staff, including IPC.

b. **Wellbeing** - details on shielding, psychological support, accommodation, home working and vaccinations.

c. **Operational changes** - estates consolidation, resilience plans, health and safety, PPE, social distancing guidelines and safe working practices.

215. LAS re-shaped its communication channels during the pandemic introducing:

a. **Daily briefings** from the LAS Strategic Commander and an Executive lead via MS Teams available to all staff and volunteers to hear the latest

information and organisational position from a single source of truth. This also included an opportunity for staff to ask questions.

b. **Daily Covid-19 Response bulletin** providing latest updates from the Daily Briefing session, clinical guidance, Covid-19 case figures, LAS performance figures, signposting help and support.

c. **iPad Alerts** to all crews giving them succinct updates on changes to LAS guidance as and when it occurred, and links to the relevant documents. Every frontline member of LAS staff had been issued with an iPad. All information regarding clinical guidance, operational changes and staff welfare was located in one place and accessible to them on the move both when they were working or not.

d. **A dedicated intranet space** for latest clinical and HR guidance, wellbeing support and frequently asked questions.

e. **Dedicated COVID-19 mailbox** in place from 18 March 2020 for staff to ask questions, flag concerns or seek any clarification on guidance. This was monitored throughout the day and responses sought from relevant departments.

f. **New email newsletter for volunteers** - our Emergency Responders plus partner volunteers from Military, Police Services, London Fire Brigade, AA and airlines, who in various roles were supporting us to deliver safe patient care.

g. **Key information to digital screens** across all ambulance stations, control rooms and corporate buildings.

h. **Station Notice Boards** with hard copies of key documents.

i. **Subject-matter focused bulletins as required** which included specific guidance or instructions, published via our intranet.

j. **All staff broadcasts ('LAS Live') from a panel of experts which were livestreamed and subsequently posted to LAS internal social media channels.** These broadcasts took place three times a week with representatives of the leadership team as members of the panel who represented every aspect of LAS (Ambulance Operations, Urgent and Integrated Care, Clinical, Estates, Logistics, Fleet and HR). The audience could ask questions with the expectation of an immediate response. During the first five months of 2020, each session attracted approximately 1,500 viewers. A written summary of each session was disseminated through the intranet and, for any outstanding queries, answers sought and added to our questions page.

k. **Private LAS social engagement group on Facebook**, Listening in Action, provided another platform on which to publish the updates, with members receiving notifications about new posts.

216. After the Relevant Period, LAS TV Live continued, but changed its frequency to once per week. This has enabled continued engagement between staff and senior leaders to get immediate answers to questions and clarifications. In addition, LAS has embedded and improved processes for governance and bulletins issued to operational staff, ensuring there is always Director level sign-off. The intranet has also been upgraded to enable more opportunity for staff to comment on articles and new information.

LAS Workforce

217. Steps were taken at LAS to increase staffing levels before the commencement of the Relevant Period in response to the pandemic, and this continued throughout. The frontline staffing levels at LAS, including both emergency and non-emergency teams, changed in order to meet the unprecedented demand and adapt to the ever changing picture Covid-19 presented.

218. As LAS was at REAP Level 4 in March 2020 (outlined above) all training and meetings which were not deemed to be of immediate and urgent need were

cancelled to ensure current staff were available to assist on the frontline. Overtime was also actively promoted and enhanced overtime rates were introduced in recognition of the pressures faced by staff. Although annual leave cancellation was considered, it was never actioned.

219. Departmental BCPs were in place prior to the start of the pandemic to map provision of business critical activities at 25, 30, 50% and above 50% sickness absence. To support this, daily sickness absence monitoring and reporting of Covid-19 and non-Covid-19 sickness absence allowed for trend analysis once sufficient data was available. Resourcing plans were then adjusted in anticipation of trend.

220. A 12 to 18 month Workforce Plan was created by LAS incorporating additional skills types and volunteers to enable surge capability as required. This was created in conjunction with an Ambulance Operations Sustainability Plan to cover the operational response and was approved in May 2020. This included an operational and clinical response based on different levels of expected impact on the service.

221. The LAS ambulance operating model was optimised from early March 2020 to maximise double crewed ambulance ('**DCA**') capability by reducing a number of other types of response, for example cycle, motorcycle, non-emergency transport service ('**NETS**'), fast response units ('**FRU**') and other care based responses. LAS transferred staff ordinarily assigned to those types of response to work on DCAs or in the CAS. Volunteer Emergency Responders were also transferred on to DCAs.

222. LAS rapidly recruited and deployed over 900 additional staff and volunteers from 19 March 2020 onwards. This comprised around 650 road crew (i.e. frontline members of staff) and 250 call centre and control room staff. It included (but was not limited to) student paramedics, returning former members of staff, firefighters from London Fire Brigade, St John Ambulance volunteers, members of the Metropolitan Police Service and volunteers from Virgin Atlantic and British Airways. Bank staff were also used.

223. LAS was able to utilise the national 'fast track' arrangements put in place for NHSE/I with agencies such as the Disclosure and Barring Service ('**DBS**'), UK Visa and existing services such as NHS Passport to verify employment history, statutory and mandatory training, qualifications and registration.

224. With the support of 111 commissioners and NHSE/I London Region, steps were taken by LAS to develop shorter, but effective, training courses for new 111 Health Advisers and volunteers to enable rapid deployment. Additional Service Advisor training was also arranged to increase 111 / ICU call handling capacity quickly. These courses were developed with the oversight of Clinical Integrated Urgent and Emergency Care ('**IUEC**') team.

225. To ensure LAS was mitigating the risks which were presented by rapid recruitment each department conducted risk assessments to confirm supervision requirements, there was limited access to restricted areas and an established and accelerated occupational health declaration process was in place for new staff and volunteers.

226. From 16 March 2020 Paramedic Science students who were on placement unfortunately had their placements suspended. Those who were already deployed on ambulances, remained on ambulances and others were directed to the volunteer hub for it to identify a suitable role, which included 1st year Paramedic Science Students being trained to assist in 999 call handling areas. LAS also worked with Higher Education partners to deploy 2nd and 3rd year paramedic students operationally alongside our experienced frontline clinicians. These student deployments were effective from 31 March 2020.

227. From 20 March 2020, revised skills mix arrangements were put in place to enable the deployment of additional resources whilst maintaining patient safety and care quality requirements. By way of an example, LAS introduced the '*Red Skill Mix'* on 31 March 2020 which paired different grades of clinicians together, or alternatively included the use of emergency service colleagues from the Metropolitan Police Service and London Fire Brigade who were trained to drive blue light vehicles. By

utilising the skill mix LAS was able to increase the deployment of ambulances during the initial peak (March 2020) from 250-300 deployments, to 450 deployments per day. This enabled LAS to respond to significantly more patients and do so in a timelier manner than would otherwise have been the case.

228. The '*Covid-19 Bank*' was created on the 21 March 2020 help support frontline resourcing, to on board staff (as above) and reduce the risk of co-employment exposure. All applicants for the Covid-19 Bank required ID checks, a DBS check, HCPC Registration (applicable to bank Paramedics) and references. Covid-19 Bank staff were issued with the Bank Terms of Engagement along with the payroll documentation to complete. In order for the Bank agreement to remain active, workers were required to complete a minimum of one shift every six months and remain compliant with statutory and LAS mandatory training requirements. Bank hours were audited twice per annum. If the worker did not undertake regular shifts, they were asked to evidence how they had maintained their skills sufficiently. If they were unable to evidence this, a decision would be made as to whether they should be removed from the Covid-19 Bank register. This provision remains in place today albeit it has been renamed the '*LAS Bank*'.

229. From early April 2020, as part of integrated working for Covid-19 PMART (involving the police, healthcare, London Fire Brigade and HM Coroners) was set up to attend community deaths where Covid-19 was suspected. This was agreed at NHSE/I – London level. The team undertook the verification of death (ROLE) by appropriately trained clinicians and the initial police actions including reporting the death. The team cared for the deceased patient using appropriate PPE, in line with guidance from HM Coroners, and then arranged for their bodies to be removed. This assisted in reducing the demand on LAS to attend to such calls increasing the number of LAS staff and vehicles available to respond to 999 emergency patients.

230. Details of LAS's monthly staffing levels (measured by the resource hours per month) from March 2020 to the end of the Relevant Period are illustrated in the charts at **Exhibit FW/20 – INQ000276037.** It must be emphasised that LAS staff worked tirelessly and were regularly willing to work beyond the hours they were

rostered to fulfil (and as set out in the exhibit) in order to support LAS colleagues and patients.

231. The Inquiry will note from the graphs provided that, at the start of the Relevant Period, there was a significant increase in overall staffing.

232. EOC resourcing peaked around April 2020 due to a combination of University Students being deployed to the EOC and high overtime uptake.

233. Staffing levels in our ambulance response and NETS service and CCTS peaked in May 2020. The peak was a result of mutual aid (St John Ambulance volunteers on non-emergency vehicles), London Fire Brigade assistance and overtime.

234. Staffing levels in the IUC peaked in May 2021 because of dedicated focus on recruitment and high uptake of overtime. It was at its lowest in March 2020 due to poor uptake in overtime hours and high covid-19 related sickness.

235. A rise in Covid-19 related absence was observed across all functions at LAS. The rates were higher for the EOC control room and particularly the 111 contact centre. The exact rates are difficult to confirm with precision due to the high proportion of sessional staff in the IUEC workforce. Where LAS saw short term variation in ambulance stations having higher Covid-19 isolations, those stations were dynamically targeted with overtime resource to mitigate effects. Generally, where there was an increase in the prevalence of Covid-19 illness and isolation in a particular geographical area, this coincided with increased Covid-19 abstractions of LAS staff who operated out of, or lived, in that area. Changes in government advice regarding self-isolation also affected staffing levels throughout the Relevant Period, particularly around guidance for healthcare professionals with direct patient care. Involvement in Covid-19 testing pilot schemes and early access to the national programme of lateral flow antigen tests enabled staff to return to work sooner if self-isolating and they had a negative result. Full details in relation to Covid-19 testing for LAS staff is set out in subsequent paragraphs of this statement.

236. LAS experienced its lowest staffing level in February 2022. The reason for this was low uptake in overtime due to staff fatigue (when compared to the preceding months) and an increase in Covid-19 related absences. A rigorous focus on recruitment and education was addressing the staffing shortfall with catch up courses being arranged and delivered.

237. LAS monitored staffing levels on a daily basis to ensure everything was being done to maximise operational resource. It is recognised, regretfully, that some patients experienced delays both for 999 and 111 call answering, clinical assessment and ambulance response times.

LAS Staff Testing

238. At the start of March 2020 LAS established a Staff Testing Team. This was led by a Business Support Manager from the CEO's office, a paramedic and other members of staff who were redeployed or who were on restricted duties.

239. LAS staff were first able to access externally established testing sites at designated locations including Chessington and Denmark Hill. These were operational from 27 March 2020. To further support staff LAS also set up an internal call centre operation, booking staff into testing locations.

240. At the end of March 2020, 817 LAS employees were self-isolating and approximately 670 staff had been tested. At this stage a significant portion of the first test results were awaited but LAS had already seen an increase in staff returning to work, approximately 100 people per day.

241. Polymerase chain reaction ('**PCR**') tests were made available to all staff from April 2020. Staff were advised to test if they became symptomatic in accordance with government guidance. They were instructed to attend one of the local centres and present their LAS ID badge to enable them to be fast tracked (where available). For a short period where PCR tests were not available, LAS utilised St John Ambulance personnel to deliver and collect tests from colleagues' homes. This service was available to all members of staff. LAS then used University College

London Hospital's ('**UCH**') rapid result facilities. In situations where LAS staff did not have transport, or were too unwell to drive to a test site, St John Ambulance Service, attended the staff members' homes to provide them with a home Covid-19 swab. This service was in place between March 2020 and April 2021.

242. From late May 2020, antibody (Serology) testing was made available to LAS staff and volunteers. By July 2020, over 5,500 LAS colleagues had taken part in testing.

243. In January 2021, LAS was involved in a new and innovative national NHS Test and Trace Lateral Flow Device ('**LFD**') pilot, also called the Daily Contact Testing pilot, which aimed to reduce the need for isolations. LAS was keen to take part in this pilot based on feedback from many colleagues about the frustration of self-isolating when they remained fit and well. The pilot was successfully delivered at other Trusts across the country including the Royal Free and Barts Health in London. The initial roll out of this pilot was in LAS 999 and 111 control rooms. In February 2021, LAS was in a position to expand the remit of the pilot to include its Ambulance frontline staff and then all LAS staff and volunteers. This gave individuals the opportunity to volunteer to participate in the 7-day testing pilot rather than self-isolating for 10 days as per the national guidance. As part of this process, the SOP outlined that staff may use their existing LFD kits if they are already participating in the LFD asymptomatic COVID-19 pilot. Staff who did not have LFD kits, or who had less than 7 tests remaining, were to be issued with additional kits by the Staff Testing Team. Staff who were at home and did not have access to the kits were able to request that kits be delivered to their homes.

244. From April 2021, the general public including LAS staff, were able to access LFDs for twice weekly testing via the government website. There was also an internal stock of LFDs from the national stockpile which the Staff Testing Team oversaw to ensure internal demand was met. The tests were made available to staff via stations 24 hours per day. Staff were provided with frequent reminders of how to access tests in the Routine Information Bulletin (a weekly newsletter), LAS wellbeing bulletins, pulse pages and via LAS Live.

245. The LAS Staff Testing Team was disbanded in May 2021. At this time, PCR testing was widely available and there was no longer a need for a LAS specific team. LAS colleagues were able to book tests via the GOV UK website.

246. Up until December 2021, LAS staff were asked to take a PCR test to confirm any positive LFD result.

LAS Staff Support and Wellbeing

247. LAS recognised that, whilst there was a need to maximise capacity across the service to respond to the challenge Covid-19 presented, there was a critical need to support the LAS team (including both employed staff and volunteers). LAS staff were naturally concerned about the impact of Covid-19 on them and their family and friends. They were receiving a broad range of information that was being shared with the public, and with them as healthcare professionals, which changed very frequently and with urgency.

248. In early March 2020, discussions were taking place across LAS as to how staff could be best supported during the challenging period.

249. On 23 March 2020 LAS considered the creation of an integrated and collaborative system to support the health, welfare and wellbeing of staff as part of the SIR and under the command of the Strategic Commander's team. On 31 March 2020 the creation of the 'Accommodation Hub' (later to become the 'Wellbeing Hub') was endorsed. The Hub was managed by the LAS People and Culture Team and comprised a dedicated team of people who were available to be contacted remotely and in person and who facilitated numerous initiatives in different areas to support LAS employees. The support included:

a. **Accommodation** - From late March 2020, LAS arranged hotel facilities for staff who needed to isolate from their families in order to continue to work. The same offer was also available to colleagues who were infectious, not requiring hospital admission but who were unable to self-isolate at home. In addition to other locations, LAS secured exclusive use of the Hampton

by Hilton hotel facing LAS Headquarters. This included access to meeting rooms. A floor was assigned solely to LAS staff working night shifts to help limit any disruption to them during their non-working hours. LAS also entered into an agreement with Love2Laundry to ensure staff who were staying in hotel accommodation were able to access a laundry service.

b. **Food packs** – the hand delivery of food packs to every colleague who was self-isolating from 26 March 2020.

c. **Virtual mess rooms on MS Teams** – introduced in April 2020 and provided a place for colleagues to get together to stay in touch whilst they were shielding.

d. **Restricted Duties** – colleagues on restricted duties (for example those who were pregnant and advised to shield due to specific clinical vulnerabilities) were temporarily redeployed from normal duties to wellbeing support, for example tea trucks and wellbeing cafes. This initiative was in place from March 2020 and has since become a permanent feature.

e. **Childcare Support** – from April 2020 LAS advertised childcare options for staff in NHS approved childcare facilities that had been made available. LAS also, where possible, arranged for people to work at home so they could look after their children who were not able to go to school.

f. **Agile working** – LAS undertook local assessments and made arrangements to support working from home. This included the purchase of 420 laptops and 210 mobile phones to enable flexible working arrangements in the middle of March 2020. Home working Health and Safety guidance was provided to those working from home for the first time.

g. **Commuting Assistance** – LAS offered a taxi service for colleagues who had a difficult commute to work due to lockdown and reduced transport services.

h. **Mental Health and Wellbeing Directory** - this was created on 21 April 2020, as a response to the pressures felt during the pandemic. It offered, and continues to offer, a comprehensive list of free support resources, tools and exercises to help staff manage their mental health. For example, it contains a link to Frontline19, a free independent, confidential and UK based service delivering psychological support to people working on the front line.

i. **Wellbeing Helpline** – LAS increased resources to enable it to respond to more queries via its wellbeing helpline. From 5 July 2020 this was available daily from 6am until midnight by both email and telephone. Since August 2022, the wellbeing helpline has been available for staff to contact daily between 8am and 6pm.

j. **LINC –** Prior to the Relevant Period, in 2009, LAS introduced this initiative which was organised by an LAS psychotherapist and involved more than 100 LINC workers. LINC stands for Listening, Informal, Non-Judgemental and Confidential and is peer support. This continued throughout the Relevant Period.

k. **Employee Assist Programme ('EAP')** – LAS has a 24/7 EAP line through which colleagues have always been able to access counselling. Since January 2022, there has been additional support in place via the EAP for colleagues who are suffering with complex or historic post-traumatic stress disorder. Since July 2022 LAS employees have been able to access counselling without the need for a management referral or authorisation.

l. **The Ambulance Support Charity ('TASC')** – TASC was launched in April 2015 but has a much longer history and grew out of the Ambulance Services Benevolent Fund. TASC is an independent charity that provides support to UK Ambulance Service staff, their families and volunteers including counselling, specialist bereavement support and financial guidance. Since July 2020, LAS's Wellbeing Hub has worked with TASC

(and other partners) to ensure all support options are available and promoted to LAS employees.

m. **Bank Holidays** –those members of staff who were absent due to sickness or abstraction during Bank Holidays received 7.5 hours of leave added to their annual entitlement.

n. **Enhanced Support** – from 12 April 2020 staff who were in hospital were assigned a support officer who would be their point of contact for any welfare needs. Further, LAS appointed a dedicated Family Liaison Officer for families when a death in service occurred.

o. **Wellbeing Wagons** – to provide refreshments out in the field to LAS staff operational within the different sectors recognising most businesses were closed as part of the Stay at Home guidance.

p. **Wellbeing Cafes** – to provide refreshments to LAS staff in the four LAS contact centres.

q. **Project Wingman** – a charity team of airline crew who, whilst furloughed, volunteered time supporting the wellbeing of NHS employees. A Project Wingman wellbeing lounge was set up in LAS's Waterloo Headquarters early in the pandemic to offer LAS staff and volunteers an opportunity to engage with others, unwind and de-compress, and have a refreshment away from their workspace.

250. LAS would like to thank the many local businesses who supported our staff during the pandemic.

251. On 16 July 2020 LAS tasked all line managers with undertaking Covid-19 Individual Risk Assessments. These were completed with a return rate of 98.08% (the remaining employees being those on long term absence or maternity leave). The risk assessments were used to identify and support colleagues who may be vulnerable to Covid-19, for example those who had been asked to shield, BME

colleagues (particularly those over 55 years of age), those aged 60 and above, pregnant colleagues and those with a chronic health condition. Based on the outcome of the assessments, suggestions were made as to actions which could be taken to reduce the risks the individual faced. This included working from home, redeployment to elsewhere within LAS, use of PPE and testing. During the assessment process, line managers were tasked with highlighting to all colleagues the wellbeing support available to them and the importance of accessing these services.

252. Where needed, there were individual Medical or Occupational Health assessments by referral for colleagues with medical conditions or who were shielding. These were undertaken in line with national guidance issued in April 2020 around shielding clinically vulnerable people. There were 268 individual cases between 27 January 2020 and 12 April 2020 alone for 'infectious diseases'. There is no data available for cases identified specifically as Covid-19 related.

253. When the vaccine was rolled out in December 2020, efforts were made to combat vaccine hesitancy amongst colleagues, especially those from high risk groups including those from ethnic minorities. This included hosting seminars with NHSE/I, looking at patient outcomes (especially around protected characteristics) and forums with our B-Me Staff Network Group co-chairs and LAS's Freedom To Speak Up Guardian, which attracted 600 colleagues.

254. LAS monitored the number of staff and volunteers who had each of the available vaccines and there is anecdotal evidence that a one-to-one conversation supported some colleagues who were vaccine hesitant to avail themselves of it. However, as vaccination was not mandated, LAS's approach was through education and support which were not measurable interventions.

255. A decision log and Equality Impact Assessment were completed in relation all our policies and guidance, including those which related to staff.

256. In the first week of April 2020, the HSE confirmed the RIDDOR arrangements for Covid-19 related cases for Healthcare workers. LAS Health & Safety Team, in

conjunction with colleagues across ambulance services, agreed the process for identifying confirmed Covid-19 cases. This process continued and the outcome is provided at **Exhibit FW/21 – INQ000217298**

257. In April 2021, the lack of guidance for managing staff members with Post-Covid or Long-Covid was discussed in the Operational Partnership Forum. The Operational Partnership Forum is a collaborative working group between LAS Trade Union representatives and LAS management teams. Following those discussions, it was agreed that a support group would be set up. The Post-Covid Support Group (facilitated by Wellbeing) was in operation from 20 April 2021. This built upon the 'Shielding Group' which had been in place since April 2020. The Group was an informal online meeting place where colleagues could share ideas, knowledge, solutions and learning based on personal experience of Post-Covid syndrome. There was also practical guidance given in terms of the formalities of work regarding post-Covid (for example, remuneration). Meetings were held fortnightly by colleagues who had experienced Covid and were still suffering with long term symptoms. From February 2022, when the group disbanded, participants were transferred to the NWL Keeping Well service for help, support and advice. Keeping Well runs a peer support group for NHS staff suffering with Long Covid symptoms. Staff are able to access a self-referral form on the LAS intranet and, via this service, can access Long-Covid CBT support (to learn about psychological techniques to manage the emotional impact of Long-Covid), Talking Therapy services, one-to-one navigation and support, an eight week recovery course, a Long-Covid mindfulness group and various online resources.

258. LAS continues to have provision for restricted duties for colleagues who have post-Covid syndrome and are unable to fulfil their substantive role. A number of these colleagues have been redeployed to our wellbeing cafes introduced during the pandemic and which have become a permanent feature as a place for colleagues to take a break and have a supportive conversation with their peers. LAS has also procured five Wellbeing Wagons to facilitate this provision.

259. In addition to the above provisions, between April and July 2022, LAS rolled out mental health first aid training to 75 members of staff and trained 50 more LINC

peer support workers. Since March 2023, the Centre for Anxiety Stress and Trauma has been also been running sessions in processing trauma for colleagues in the HART and Tactical Response Unit. LAS's Wellbeing Team also work with mental health professionals from Keeping Well NWL and have rolled out Wellbeing Conversation Training in person to more than 120 managers, with sessions arranged until October 2023, which will eventually reach more than 350 managers.

260. Colleagues also continue to have access to the LAS Mental Health and Wellbeing Directory (described above).

261. In addition to the above, LAS's Wellbeing Team have introduced a range of holistic activities including yoga and massage across LAS, as well as improving more than 25 wellbeing spaces to encourage rest and relaxation.

262. LAS staff worked tirelessly throughout the incredibly difficult period Covid-19 presented, and continue to do so. The long term impact of the pandemic on the mental and physical wellbeing of LAS staff is yet to be seen but it remains a key priority for LAS to ensure its team are supported. LAS will identify any lessons and learning which comes out of any research and academic studies to ensure it continues to provide the best care for its workforce.

LAS 999 and 111 / IUC Services

263. There were no national changes to the ambulance response time targets during the Relevant Period, albeit there was an acceptance LAS would not be able to meet the national ambulance response standards given the significant demand. Targets remained as specified in the Ambulance Response Programme ('**ARP**') and IUC contracts.

264. The target call answering mean time for 999 calls was 10 seconds.

265. The ambulance response mean time target for Category 1 calls (life-threatening injuries and illnesses, such as cardiac arrest) is 7 minutes (15 minutes 90% of the time). The response mean time target for Category 2 calls (emergencies such as

stroke patients) is 18 minutes (40 minutes 90% of the time). Category 3 calls (for urgent calls such as abdominal pain, and which will include patients to be treated in their own home) has a 90% response time target of 120 minutes. The response time target for Category 4 calls (less urgent calls such as diarrhoea and vomiting and back pain) is 90% of 180 minutes.

266. The target was to answer all 111 calls within 60 seconds 95% of the time.

267. LAS did not provide non-emergency patient transport as it did not have any patient transport contracts at the start of the Relevant Period.

268. The chart at **Exhibit FW/22 – INQ000217299** details the number of 999 and Healthcare Professional calls received monthly by LAS (measured by the total number of contacts per month) from January 2020 to June 2022. It also identifies the number of calls each month that were Covid-19 related. The table at **Exhibit FW/23 – INQ000217300** sets out the extent to which the call answering time target was met during this period. The table at **Exhibit FW/24 – INQ000217301** details the extent to which ambulance response time targets were met by LAS for each Category during the same period.

269. For completeness, mention should be made of a technical coding issue that arose in relation to the recording of response times to Category One incidents. It became apparent in late 2022 that there was an issue in relation to this recording. Following investigation, it was established that there had been a coding error when a change in code was implemented on 19 August 2020 (five and a half months into the Relevant Period). The effect of the coding error (in broad terms) was that an incorrect clock start time for Category One calls was applied. A subsequent independent report, commissioned by LAS in partnership with NHSE/I and its commissioners which has been made public, calculated that for most of the 25 months (until September 2022) for which the incorrect code was applied, the underreporting of actual performance was less than one minute.

270. As is evident from the above, the call answering mean time was not met in March 2020 and continued to be extremely challenging. The call demand has not yet consistently returned to pre-pandemic levels. The combination of a significant increase in call volume and challenging staffing numbers due to Covid-19 sickness and self-isolation were key factors in this. The absence of large increases in face to face incidents during the first year is very likely to be linked to lockdowns and the reduction in both injury and illnesses that would ordinarily occur when people are going about their daily life given the various hazards that presents.

271. The number of LAS ambulance and NETS vehicles (measured by patient facing hours her month) for the period January 2020 to June 2022 can be found in the chart at **Exhibit FW/25 – INQ000217303**

272. The chart at **Exhibit FW/26 – INQ000217302** details the number of 111 and healthcare advisers available across LAS (measured by the total number of resource hours per month) from January 2020 to June 2022.

273. Our CCTS was not in operation before March 2020.

274. To assist in expanding capacity (in addition to increased staffing) to meet the unprecedented demand during the Relevant Period, LAS took a number of steps. Examples of these are outlined below.

Call Handling Capacity

275. In line with LAS's priority to increase the call handling workforce to respond to the pandemic, work was required to ensure that the IT and telephony to support this was in place.

276. On 7 February 2020, additional phone lines ('**DDIs**') were purchased to manage the inbound volume of Covid-19 and Covid-19 swabbing calls. This also provided the ability for clinicians to make calls remotely and see patients via video calls.

277. A decision was taken to create a technical bridge between the 999 Command Point and the 111 / ICU Adastra systems. This enabled a process whereby Covid-19 related calls would be rapidly handled through the 999 system and passed into the 111 / IUC environment for a more detailed assessment.

278. On 18 March 2020, expenditure on 20 laptops was approved to enable clinicians to make IUC / Covid-19 calls remotely. In addition, expenditure on 60 laptops was approved for 999 services and 120 laptops for 111.

279. Over the weekend of 28 and 29 March 2020, LAS built an additional 999 call handling facility on the first floor of 220 Waterloo Road (HQ) to accommodate the increased number of call handlers being recruited and deployed.

280. The infrastructure and equipment required to meet the demand on LAS remained under review for the whole of the Relevant Period and steps were taken to increase this as and when required.

Vehicle Capacity

281. As at March 2020, LAS had 62 new ambulances on order. Completion of these vehicles was expedited by the supplier. They were shipped as a priority from the Republic of Ireland, rapidly fitted out (at a West Ham bus facility loaned to us by Transport for London and Stagecoach London Buses) and commissioned within 3 weeks (as opposed to the usual six months).

282. In addition to the new vehicles, 54 second-hand ambulances were procured by LAS and 53 NETS vehicles were converted into basic life support ambulances, further boosting LAS's operational response capacity. LAS also utilised Transport for London's Dial-A-Ride vehicles to respond to NETS patients.

283. To assist LAS with vehicles which required immediate mechanical input, LAS worked in partnership with the Automobile Association ('**AA**') from April 2020 who provided workshop based and roadside maintenance arrangements to improve overall vehicle availability.

Private Ambulance Service

284. Prior to the emergence of Covid-19, LAS had made a decision to end its PAS deployment at the end of the 2019/20 financial year. As the pandemic progressed and the call volume rose, it decided to review this decision and on 17 March 2020 LAS's incumbent supplier, Falck UK Ambulance Service, extended its contract with LAS for a further 6 months on new terms and conditions. The goodwill of the staff allowed LAS to increase deployment slightly by between 6 – 10 PAS vehicles. This was sustained from March 2020 to September 2020 when the contract with Falck UK Ambulance Service ended. At the end of the contract, the staff working under this contract were transferred to LAS by operation of the TUPE regulations.

285. In addition to the extended six month provision provided by Falck UK Ambulance Service, LAS also contracted with four new companies (Harley Street Ambulance Services, HATS, G4S and Savoy Ventures) for extra patient transport services to assist with hospital repatriation and inter-facility transfers, in anticipation of their being required for the Nightingale Hospital / CCTS once it was in operation. LAS also established through discussions that HATS and Harley Street were also able to provide a small number of Paramedic and EMT led crews, and they were tasked for a brief period to assist LAS on the frontline. On 17 April 2020, they were returned to Nightingale Hospital support work and transfers.

286. As Covid-19 cases increased in winter 2020, LAS's COO tasked the third party ambulance team at LAS to procure more PAS support for the coming winter. This request was made on 23 December 2020. The team had undertaken some research in the market and liaised with colleagues in neighbouring Trusts about which providers they were using and in what volumes. With this information LAS were able to quickly draw up a list of companies based in and around London that were CQC registered and were likely to be able to support. Following discussions with the potential providers, LAS reduced the list from 10 companies to 6 which were subsequently inspected. LAS on-boarded three of these companies via a rapid on-boarding process which was later validated through LAS's Quality

Oversight Group. Familiarisation training took place during the first two weeks of January 2021 and the first vehicles were mobilised on 11 January 2021

287. These aforementioned measures taken together enabled LAS to put on the road more than 100 additional ambulances, a near 20% increase on peak pre-Covid-19 DCA capacity.

Equipment Sharing and Maintenance

288. There were a number of difficulties with equipment due to cleaning measures that saw equipment damaged by the required IPC processes to prevent the spread of the virus. In addition, the requirement for deep cleaning resulted in increased equipment stock rotation. Mutual aid agreements with other ambulance services allowed for equipment to be shared nationally which mitigated some of the risk. Further, Military Aid to Civilian Authorities ('**MACA**') requests were put in place for The Corps of the Royal Electrical and Mechanical Engineers ('**REME**') to assist in fixing equipment that was not working, increasing available resources. A second MACA was used to assist in implementing a stock management system that allowed for better understanding of our available stock and equipment.

Collaborative working with providers

289. In line with the rest of the country, LAS's third party providers (such as medicine packing and vehicle preparation units) also experienced Covid-19 related staff shortages during the Relevant Period. Where appropriate, LAS supplemented their rotas with members of LAS staff who had been assigned to non-frontline to enable the ambulance-related service to continue to be delivered.

290. Whilst LAS did not have a patient transport ambulance service, it did develop and implement a CCTS for the Nightingale Hospital. The pan-London CCTS service was created on 30 March 2020 to ensure its responsiveness and flexibility to meet the priorities of individual ICSs in their local delivery of Critical Care services so patients could be transferred to a definitive place of care or to allow for Intensive Care Unit bed management.

The Impact of the 'Stay at Home' Messaging

291. As has been highlighted, London was impacted by the Covid-19 pandemic ahead of the rest of the UK and saw the first peak in late February through to the end of March. The peak 999 demand was seen on 16 March 2020.

292. On 23 March 2020, the Prime Minister announced a nationwide lockdown (to start on 26 March 2020) to curb a widening outbreak of Covid-19, closing many sectors and ordering the public to stay at home. Similar restrictions were introduced in late 2020 and early 2021 as infections rose.

293. The positive impact of the stay at home messaging was that it allowed demand to stabilise and then reduce, providing time for a vaccine to be created and implemented nationally.

294. LAS saw a slight reduction in overall 999 demand over the first two weeks after the announcement of the first lockdown with a more significant reduction from 9 April 2020 which was then sustained during summer 2020. LAS continued to respond to 999 and 111 calls throughout the period allowing patients to seek emergency and urgent help where needed

295. With the stay at home guidance, the reduction in the volume of 999 calls and the speed of the spread of the virus, LAS became concerned that some patients may not be seeking medical assistance for both Covid-19 and non-Covid-19 conditions. This concern was raised to the NHSE/I Regional Medical Director to help inform public messaging that the NHS was open.

296. Whilst LAS is not a public health body and, as such, does not have the necessary data to determine if there was a negative or detrimental impact on patients, it was able to monitor certain patient groups to ensure that patients were continuing to seek medical assistance. This was done through a weekly trend charts looking at patients' initial reason to call 999. These were reported to the Regional Medical Director as requested.

297. The stabilisation, and then reduction, in 999 call volume enabled LAS to support the roll out of the national vaccination programme with clinical staff being deployed to the mass vaccination centres.

298. For LAS support teams, which remained critical to the delivery of the services, the rapid roll out of home working to support Stay at Home was implemented. The change for many staff to working from home was challenging and undoubtedly had a significant impact on their wellbeing as they felt isolated and distanced from the emergency service and workplace they were a part of. Initially the technology was not in place to support home working and for colleagues who lived in a multi-occupancy dwelling they were frequently having to work, eat and sleep in one room – the longer term impact on their physical and mental wellbeing is not known yet.

Infection Prevention and Control

299. LAS aligned all of its local IPC guidance to national guidance released by NHSE/I and UKHSA respectively. This was the approach taken by all Ambulance NHS Trusts. Trusts were advised and able to undertaken dynamic risk assessments where guidance could not be implemented or where the guidance was not applicable to that service. Examples of where the LAS needed to undertake risk assessments and put in appropriate local procedures and mitigation included:

Social Distancing where safe working of over 2 metres apart was not always possible especially in ambulances and during the delivery of patient care. We mandated the wearing of masks to mitigate this. In the control rooms / call centres screens were placed between call handlers.

National guidance for acute Trusts (of which the Ambulance Service is considered in this context) included the use of disposable aprons when delivering patient care. We found this was not practical in the pre-hospital environment especially when outdoors as the wind would cause contaminated aprons to be blown into the faces of responders who were resorting to taping down the aprons to their uniform to prevent this from happening. As a result, LAS moved to stocking ambulances with

disposable paper Tyvek suits for use when treating patients where an apron would not be suitable.

300. Early communications and mandates (i.e. bulletins describing IPC measures and actions staff must implement) were sent to all colleagues regarding IPC in December 2019.

301. Initial guidance was developed by the NARU and disseminated on 8 February 2020. At this time Covid-19 was deemed a HCID with the expectation that HART would provide conveyance of cases.

302. Subsequent guidance produced by the UKHSA in February 2020 accelerated the dissemination of ambulance sector specific guidance. A sub-committee of ACCE– the National Ambulance Service Infection Prevention and Control Group ('**NASIPCG**') represented the ambulance sector at NHSE/I IPC Cell in the development of mandated guidance. The NASIPCG had representatives from all UK nations to form a consensus approach for adopting and implementing national IPC guidance and measures within the pre-hospital setting.

303. On behalf of AACE, the NASIPCG published guidance pertaining to *'COVID secure in the workplace including non-clinical areas*'. Guidance and document review was undertaken by the NASIPCG on a regular basis, with updates reflecting changes and/or amendments to national guidance.

304. As noted above, LAS aligned the IPC guidance documents to the guidance published by the UKHSA and NHSE/I. It also incorporated the guidance published by AACE. LAS local policies and guidance were approved by COLT, which included the CEO, COO, LAS's Director of IPC and the Strategic (Gold) Commanders team.

305. The guidance pertaining to "*Working Safely During Covid-19 in Ambulance Service Non-Clinical Areas"* produced by NASIPCG (**Exhibit FW/27 - INQ000252602**) was adopted in LAS non-clinical areas.

306. NARU guidance was written by the National Ambulance Service IPC Group in consultation with NHSE/I, UKHSA, Scotland, Northern Ireland and Wales.

307. The table at **Exhibit FW/16 – INQ000217297** demonstrates how LAS guidance developed in line with the national advice.

308. Throughout the relevant period LAS specifically considered IPC measures required to reduce the risk of transmission within ambulance vehicles. These measures were promoted in the LAS Covid-19 guidance which was published (and regularly updated) and implemented as standard practice. The guidance and recommended actions were underpinned by National Guidance relating to the 10 elements of Standard Infection Control Precautions ('**SIPCs**') and Transmission Based Precautions ('**TBPs**').

309. Covid secure measures were embedded at LAS, promoting the need for individuals to undertake dynamic risk assessments applying the hierarchy of controls. The following additional guidance via the LAS Covid-19 guidance for patient staff was produced:

a. **Hand hygiene** – 'Clinell' wipes including hand hygiene effective use of hand wipes and ABHR (19 May 2019, Medical Bulletin (MDB 223), reissued 24 July 2020).

b. **Novel Coronavirus (2019-nCoV) Guidance for CHUB and patient facing staff** - including decontamination of vehicles following AGP (7 February 2020 Medical Bulletin MDB 251) – vehicles were required to undergo a deep clean at hubs by a cleaning contractor.

c. **Your guide to effective routine cleaning of equipment and the immediate care environment on emergency vehicles, using green 'Clinell' wipes** (30 January 2020, IPC Information Bulletin).

d. **Implementation of temperature checks** - located at areas of high footfall.

e. **Effective use of disinfectant / detergent** wipes – contact times for use and process for cleaning.

f. **Physical distancing** – instruction to maintain 2m distance where possible incorporated into guidance as per working safely guidelines. In our desk based areas, including EOC and 111 centres, we put screens between each workstation. Access to our control rooms and contact centres was restricted to essential staff only.

g. **Occupancy** – vehicle occupancy instructions – e.g. no observers or unnecessary persons during conveyance. Subsequently amended to allow for dynamic risk assessment.

h. **PPE** – description of PPE packs content for vehicles and minimum levels.

i. **Mask wearing in cabs** – instruction for mask wearing in cab areas, including for all patients unless clinically unable to do so.

j. **Eating / Drinking in the Cab of an Ambulance** (24 February 2020, Health and Safety Bulletin)

k. **IPC Precautions During Hospital Handover Delays** (14 January 2021, AACE National Guidance). Guidance on steps to increase airflow through vehicles aimed at reducing the risk of transmission due to the saloon of an ambulance being considered a confined space. Where it was safe and appropriate to the patient's condition, staff were advised to remain in the front or outside of the ambulance but within sight of the patient.

l. **Vehicle ventilation systems** – confirmation of air changes within vehicles of 50+ and process to maintain effective air changes within the vehicles. Setting systems to extract (18 March 2020, LAS Covid-19 Patient Facing Guidance).

310. LAS mandated the use of Fluid Resistant Surgical Masks ('**FRSM**') for all patient contacts however were challenged by LAS's clinical workforce to upgrade this to the highest level of PPE (FFP3 and Tyvek suit). When the ambulance clinicians were conveying patients to the ED they were handing over the patient to ED colleagues who were routinely wearing a higher level of PPE – this caused significant anxiety for LAS clinicians.

311. Prior to Covid-19 there was no national requirement for a minimum or maximum level of PPE or RPE to be held in stores or on vehicles by individual Trusts. Guidance on the use of PPE was covered in the PPE Policy, the Policy on the Use of Tight-Fitting RPE and by mandatory training requirements delivered through Core Skills Refresher training ('CSR'). The UK Core Skills Training Framework ('CSTF') sets out statutory and mandatory training topics for all staff working in health and social care settings, IPC is a core requirement. It is the responsibility of the individual employer organisations to ensure that their workforce complete the appropriate training which should be delivered through a suitable modality e.g. face to face, eLearning or a blended approach of both. Other examples of mandatory training includes annual Information Governance refresher training, Safeguarding Adults and Children training every three years and Prevent refreshers every 3 years also.

312. CSR is an ongoing education programme available to all clinical staff in LAS. The programme is delivered annually through blended learning, and contents include a mix of mandatory modules, learning from incidents, refresher sessions, updates and new information, changes to practice and feedback from staff in regards to areas of interest. Infection, Prevention and Control training was covered in 2018 as a face to face module and then annually from, 2019 to 2023 as E-learning. The modules are reviewed and updated by the Infection Prevention and Control team.

313. PPE stock levels before March 2020 were minimal and were based on managing business as normal. There was no national guidance on a minimum stock level. This meant having a sufficient stock of gloves for patient care, aprons for managing gastrointestinal type illnesses and minimal levels of coveralls for managing infectious disease. The products routinely stocked included aprons, over-sleeves,

facemasks (FFP2), universal gowns, hooded coveralls, antibacterial hand wipes, goggles and examination gloves. For example, each ambulance and FRU vehicle was routinely stocked with an IPC kit which contained 1 Tyvek coverall (of each size), 2 long sleeve gowns, 5 disposable aprons, 2 face and mask shields, 4 pairs of overshoes and 2 FFP2 masks. Stock management was paper based and completed manually and as required across LAS.

314. LAS had a small storage unit at Greenwich Ambulance Station where this stock was held and this was pushed out to one of the fifteen Make Ready Hubs (where ambulances are cleaned and re-stocked) on request to re-pack the IPC kits held on ambulances. Make Ready Hubs were sub contracted by LAS and run by staff employed by Mitie / Interserve during the Relevant Period. Churchill provided the drivers to move ambulances between the stations where the crew finished their shift to the Make Ready Hub and then back to the station where the ambulance was needed to start the next shift. As the stock was pushed out to the hubs, new stock was ordered.

315. It became rapidly apparent that supply of adequate and appropriate PPE for frontline clinicians working in a pre-hospital environment and responding to undifferentiated patients was a major concern and was causing high levels of anxiety and fear amongst frontline staff and also managers trying to protect their staff and patients.

316. LAS started to increase orders from suppliers in January 2020 as Covid-19 emerged. The immediate change was to increase both Aprons and FRSM masks on all vehicles to 20 of each from 31 March 2020.

317. LAS encountered significant early challenges with the move to rapidly increase the volume of PPE required and ensure that staff had what they needed, when they needed it, to provide adequate protection. In addition, maintaining security of stocks was difficult with one known break-in occurring.

318. From January 2020, weekly meetings were held with the various project leads from NHSE/I and DHSC in regards to PPE availability, quality and ordering. Internal

meetings were also held from February 2020 involving logistics, IPC, H&S and procurement to ensure that adequate stock levels were maintained and to discuss any issues with stock.

319. There was a national stock of PPE and RPE, commonly known as the *'Push Stock'*. Until May 2020 only acute NHS Trusts (LAS is not an acute trust) were able to access the Push Stock of PPE and RPE that was rapidly being developed and deployed.

320. In light of this, LAS scaled up its orders, where possible, from its suppliers, relying on the good working relationships that were in place at the time. It also sought new supply routes. Additional difficulties included the ability of the wider supply chain to supply LAS suppliers, for example there was a shortage of FFP3 masks because the supplier could not get the component parts from their normal manufacturer.

321. For the aforementioned reasons, LAS faced sudden and extreme changes in the cost of products and the additional cost of air-freighting supplies when required, predominantly from China. In February and early March 2020 many suppliers were accepting orders but were unable to commit to when the delivery could be made, or if it would be made at all. Further, given that the majority of products required was made abroad, the delivery and transport costs were quoted separately by some suppliers which considerably increased the price at the last minute.

322. Where supplies, predominantly gowns and protective suits, originated from abroad, and from companies that did not have a previous relationship supplying the NHS, there were challenges with the labels not showing standards that were being met, expiry dates, and general language. This was relevant to the stock bought direct from suppliers. Towards the end of April 2020 LAS purchased 30,000 Tyvek suits (circa £500k including delivery costs) that were supplied by a UK based company. The goods were manufactured in China. When the goods arrived the writing on the packaging was in Chinese and therefore did not fully conform to the requirements of the EN standard (each suit should have the EN number on it or on the packaging). As we could not be assured that the suits were to specification /

EN manufacturing standards, we reverted to the supplier who was able to provide translated copies of the certification that we confirmed complied with the EN standards. Following this, the supplier added individual labels to the suit packaging per the certificate going forward.

323. Unfortunately, LAS's private supplier routes were impacted when its suppliers received instruction from the DHSC that they had to supply the NHS Push Stock first. LAS had not received formal notification of this and cannot therefore confirm when and how this direction was given. It was explained to LAS during regional PPE discussions that if LAS bought stock from such suppliers, it would be taken into the central stock for sharing. Up until this point, LAS had been working collaboratively with other NHS Trusts providing them with PPE and RPE from LAS stock when they were in need. As LAS had given a portion of its own stockpile to other NHS Trusts, when it was no longer able to procure from private suppliers or access the Push Stock, its supply was notably impacted.

324. LAS received a significant number of donations from multiple 'goodwill' sources such as organisations or members of the public. This included gloves and overalls. Whilst LAS were incredibly grateful for the efforts the community was making to support it, it was unable to use the majority of the donations as there was no documentation supporting their certification for use, they were beyond expiry dates, or they were not fit for purpose.

325. Around late April 2020 LAS was told by NHSE/I not to order direct from suppliers as it would now be able to access the Push Stock. NHSE/I had contracted with CEVA to distribute PPE to Trusts from the Push Stock. LAS began to receive supply from the Push Stock in May 2020. Initially LAS received one sixth of all available stock issued in London. However, this resulted in an over-stock of some items and LAS being issued with items that were not fit for the non-hospital environment. The decision was therefore made by NHSE/I to reduce LAS Push Stock by incorporating it into the NWL ICS.

326. Unfortunately, LAS encountered significant issues with some of the stock obtained though the Push Stock initially, for example the durability of the aprons. The aprons

were designed for in hospital use and did not withstand the rigour that the ambulance service operating environment would put them through. They were too lightweight to be worn outside, would often be easily damaged and would be caught in the wind, the apron blowing up into the face of the responder and the protection they provided could be further reduced by the outside weather conditions. The Fluid Resistant Surgical Mask ('**FRSM**') did not afford LAS staff the safety assurances they were looking for. In addition, LAS were supplied with 5 litre bottles of sanitizer which were unsuitable for staff to carry around. LAS was also provided with overalls with feet which were too small for boots and often received items that were beyond their expiry and which had to be sent back for re-certification before being be returned to us. Further, letters were not always received identifying that batches of stock supply had their expiry dates extended and this added complications with staff not having confidence in the equipment they were being provided (**Exhibit FW/28 - INQ000252604**). A formal concern was raised to LAS management on 14 May 2020 by staff through their Trade Union representatives that older expiry dates had been covered with labels stating new, extended dates (**Exhibit FW/29 - INQ000252605**). Another complication was the variety of the brand and models of equipment, such as face masks, that were issued for use. Where FIT testing was required for certain masks, different models and makes required new or product specific FIT testing and required staff to be re-assessed. This added complications when equipping vehicles.

327. The Push Stock adapted and from July 2020 LAS was provided with appropriate items after the issue having being raised and discussed in the Pan-London daily supply chain calls with NHSE/I.

328. To ensure LAS had sufficient supplies, it utilised the national stock and multiple suppliers to source the necessary equipment. LAS also moved to using a large purpose built warehouse allowing for additional stock to be held and the implementation of a full asset management system to monitor and manage the stock.

329. Any PPE stock that LAS purchased was tested for quality by asking for samples from the supplier. LAS did not procure stock from any supplier which did not offer

a sample. All samples were then visually inspected, tried on by LAS staff who were present for sizing purposes and then tested to destruction (i.e. zippers, permeability testing with water and potential for ripping when donned for all aprons, coveralls and gowns) prior to purchase. Some tests were undertaken at stations if staff were present and some in the warehouse. These were conducted by the H&S Management or IPC Management. No special provision was made for testing PPE and RPE in respect of any particular groups of individuals by reference to sex, race or disability (pregnant staff were all non-operational by this point). The tests related solely to sizing, robustness and ease of operation. Staff were encouraged and supported to provide feedback through their local management teams and the Covid Communication channels in operation.

330. The sample products provided usually met LAS requirements. Unfortunately, when the stock subsequently arrived, LAS sometimes had issues with labels being in a different language, certification and expiry dates being unreadable or sometimes the stock delivered being a different product to the sample. Sometimes the stock provided was therefore not appropriate for use.

331. For RPE no testing was carried out on disposable stock. However, EN certifications were requested and checked before use. Full face respirators were purchased and trialled on operational staff before use.

332. All PPE EN certification was also requested and checked where possible, albeit there was limited ability within LAS to undertake full quality assurance standards.

333. PPE and RPE which was later provided by the NHS national stock via CEVA (May 2020) was of better quality, reliable and a quality assurance scheme was put in place via NHSE/I and the DHSC we no longer checked certification or carried out our own testing.

334. There was conflicting advice from PHE and the UK Resuscitation Council as to whether resuscitation, specifically chest compressions, would amount to an AGP. This was relevant to an ambulance service because, if chest compressions were

an AGP, clinicians would need to don Level 3 PPE before commencing resuscitation. This may have led to a delay in commencing resuscitation. This concern had to be balanced against the danger of exposing our clinicians to an increased risk of COVID-19.

335. On 13th March 2020, PHE issued guidance that chest compressions, during cardiopulmonary resuscitation, were not considered an AGP. This had been agreed with the Health and Safety Executive, NERVTAG, the four nation public health and NHS authorities. This advice differed from the position statements from UK Resuscitation Council and College of Paramedics. After careful consideration, and consultation with Trade Union and Staff Side colleagues, the LAS Board decided it would continue to support LAS clinicians using FFP3 masks for cardiopulmonary resuscitation including chest compressions. This Board decision did not result in a change to LAS guidance as CPR was already defined as an AGP. The conflicting advice and the high number of covid-19 cases in London was causing significant anxiety to clinicians and therefore the LAS adopted the safest possible method of care both for our patients and our frontline clinicians.

336. To this end, LAS issued Patient Facing Guidance to clinicians which outlined the required level of PPE and how to minimise any delays in the commencement of resuscitation. Guidance was also given about how to manage an unexpected cardiac arrest (a 'running call' which means the crew come across a patient in cardiac arrest rather than having been dispatched to a patient in cardiac arrest). This guidance, which included infographics and photographs about the donning and doffing of PPE, was communicated to all clinical staff. The principles set out in the guidance (PPE during the management of cardiac arrest) are summarised below:

a. All cardiac arrests will have four pairs of hands to allow for one 'clean' runner.

b. In regards to donning Level 3 PPE:

c. The first on-scene clinician must don a gown rather than a Tyvek suit/ coverall. This is to reduce any delays and enable early defibrillation and chest compressions.

d. Additional resources arriving on scene to a confirmed cardiac arrest will don Level 3 PPE before involvement with the resuscitation attempt, unless they are nominated as the 'clean' clinician who wears an FRSM, eye protection, apron and double gloves. This 'clean' clinician remains more than 2m away from the patient and undertakes duties such as collection of kit and family liaison.

e. There may be rare occasions when a clinician attends a cardiac arrest without FFP3 masks immediately available e.g. a sudden deterioration in the patient's condition or a running call or within the immediate vicinity and the clinician does not have FFP3 mask/ gown. In this situation an apron, surgical mask and an eye protection should be worn and the clinician should place either a surgical mask or similar over the patient's mouth and nose and attempt compression only CPR and early defibrillation until further clinicians arrive wearing Level 3 PPE. This is in accordance with Resuscitation Council UK guidance.

DNACPR Notices

337. Ambulance clinicians do not issue DNACPR notices for patients. Proactive decisions regarding resuscitation is not within the scope of practice for ambulance clinicians. The decision of an ambulance clinician not to resuscitate a patient can be based on several factors. These are:

a. the presence of a valid DNACPR (where the cause of cardiac arrest is not reversible);
b. information provided by a Lasting Power of Attorney for Health and Welfare; and
c. on the basis of a Best Interest decision based on evidence of a palliative illness, such as an Advanced Care Plan, the presence of syringe drivers,

anticipatory medicines, patients who are bedbound and receiving domiciliary EOL care.

338. DNACPR records were held on an electronic care plan called Coordinate My Care ('**CMC**') which was used across London. Prior to the pandemic in February 2020 there were 6,126 CMC records. This increased to 7,203 plans at the start of the Relevant Period (March 2020), the majority of which included DNACPR decisions so ambulance staff could access this information quickly when needed. 10,179 new plans were created in April 2020, 5,125 new plans in May 2020, 3,907 new plans were created in June 2020 and an average of 2,400 per month for the next 3 months.

339. Over the subsequent months the number of new plans created was very high. LAS continued to access this information and support as many patients as possible to be cared for in their preferred place of care and/or death, recognising that understandably, many community teams were not operating as usual. From April to September 2020, LAS supported an average of 79% of patients to remain in their preferred place of care and/or death.

340. On 9 April 2021 a medical bulletin titled MDB299 '*Do not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions'* was issued (**Exhibit FW/30 - INQ000252606**). This set out the services procedures for managing patients for whom there had been a clinical decision by their primary physician that cardiopulmonary resuscitation ('**CPR**') would not be appropriate. This decision would have been reached following clinical review by the clinicians who knew the patient and their condition. It also reminded staff of the EOL Care Guidance on Advance Care Planning which was issued in May 2020 that all clinical staff would have been already aware of.

341. In the '*LAS Covid-19 IPC and Patient Facing Guidance'* Version 14.1 (issued 13 September 2021), there was advice to clinicians to "*gain additional advice from the Clinical Support Desk in complex situations or where there [was] a concern that a DNACPR [was] nonspecific / personalised*".

342. LAS has not had any reported concerns related to the use of DNACPR decisions during the Relevant Period, in areas such as the elderly, the disabled or patients with a learning disability.

Conclusions

343. As has been explained in this statement, the pandemic was experienced in London before the rest of the UK and, as the first line of response for the NHS, LAS was at the forefront of responding to this national emergency, with unprecedented demands being placed on it from mid-February 2020 through to early April 2020.

344. Major incidents were sadly not new for London, nor for LAS which has unrivalled experience at managing them. For example, in 2017 LAS responded to multiple major incidents including terrorist attacks and the Grenfell Tower fire. However, the scale, demands and timeframe of the pandemic were of a different order. LAS had to operationally and clinically meet unprecedented 999 and NHS 111 demands, review and adapt to emerging guidance, and design and collaboratively implement new pathways to keep its patients and workforce safe.

345. LAS took a number of immediate and substantial actions to enhance its overall response capability, which built on the comprehensive EPRR plans and the experience of the Strategic Command Team. Implementing daily COVID Leadership meetings enabled quick, effective decision making to support patient care and staff welfare, whilst remaining within the required regulations of the NHS. Additionally, clear lines of communication with NHSE/I and with partner NHS Trusts were established to support the decision making and to provide guidance and support.

346. Collaborative working with partner agencies including the military, the London Fire Brigade, the Metropolitan Police Service, St John Ambulance, the AA, and the airline industry helped to rapidly expand LAS's capacity on the frontline and in other key areas such as fleet and logistics. Streamlined recruitment processes were implemented and managed through a workforce hub.

347. Technological advances allowed for improved communication across health and social care providers, removing the need for unnecessary travel and face to face meetings. For support teams, who remained critical to the delivery of the services, the rapid roll out of home working and hybrid / agile working enabled more staff to remain at work when schools and childcare were closed. This has remained in place and provided opportunities which benefit the organisation in many ways.

348. Keeping patients and staff safe was a key priority for LAS throughout. As LAS saw high numbers of patients impacted early and ahead of the rest of the country, it sadly saw the same amongst LAS staff. LAS was committed to doing everything it could to support the learning about the disease and so, despite the operational pressures, it willingly engaged as early adopters of COVID testing, antibody testing, and vaccination and also engaged in research opportunities about the illness and staff wellbeing. Furthermore, LAS worked collaboratively with London partners to support the vaccine roll out including seconding clinicians and pharmacists to mass vaccination hubs.

349. LAS's logistics operation was completely redesigned and resized, delivering over a million pieces of PPE to stations by 30 April 2020. Frontline crews wore PPE throughout the pandemic for all patient encounters to minimise the risk posed to them and to reduce community spread.

350. Through rapid procurement of new ambulances and maintenance of older ones, LAS increased its vehicle availability considerably above peak pre-Covid-19 ambulance capacity. This increased the number of patients LAS was able to respond to and allowed for enhanced cleaning regimes between patients.

351. To maintain safety, additional clinicians were deployed into all call handling areas to provide support to non-clinical call handlers and undertake patient assessments using the latest clinical toolkits. Both the 999 and NHS 111 call handling operations were redesigned to create additional Covid-19-specific call handling capability. The ability to keep answering calls quickly was imperative for those patients who needed immediate assistance and early implementation of a specific triage protocol in EOC was critical and London was supported to implement this earlier

than other ambulance services. Buddy call answering support and electronic transfer of details between different regional ambulance services enabled the UK to support London at a national level.

352. Communication internally with the workforce and externally with local, regional and national colleagues was critical at a time when there was so much uncertainty and the need to share intelligence and information. Internally the consolidated estate enabled daily huddles where new information could be shared and critical welfare conversations could take place. The advances in technology enabled us to maintain contact with colleagues working remotely, many of whom were observing lockdown in total isolation.

353. The strong system partnerships and willingness to collaborate at local, regional and national levels enabled us to support each other in rapidly developing new ways of working and moving to new processes- for example, redistributing PPE and oxygen as required and providing pandemic call answering card and cleaning guidance. Before the pandemic, changes of this nature may well have taken months, not weeks, to implement.

354. LAS set up a Welfare Hub to support staff and volunteers both clinically and with their physical and mental health needs during what was inevitably an incredibly challenging time – this included accommodation, delivering food to those in isolation and providing testing for staff with symptoms. Communication with all LAS staff and volunteers was delivered by the senior leadership team using LAS Live Q&A sessions three times a week and we issued over 200 bulletins to keep staff up to date and hear their feedback. The change for many staff to working from home was challenging and undoubtedly had a significant impact on their wellbeing– the longer term impact on their physical and mental wellbeing is not yet known.

355. After each London peak LAS took time to reflect on learning and changes which were needed for future peaks. A key lesson for the future is the incredibly high level of fear a pandemic instils in the public and among frontline workers which in

turn leads to behavioural change, as well as the need to monitor changes in demand and hospital pressures and rapidly increase capacity.

356. During the initial weeks in London, before the virus had spread to the rest of the country, there was limited information about the virus and its clinical course and, understandably, national guidance had not been developed. Some external guidance was not translatable to the pre-hospital workplace or workforce and this resulted in LAS having to interpret and write bespoke guidance for our workplace. Guidance was frequently released late in the day and was not shared with healthcare providers before publication onto national websites. This was understandable given the rapidly changing picture but an alert of new guidance was not reliably shared and this meant frontline staff saw new information on websites and this added to their confusion and anxiety. The logistics of being able to update a mobile emergency workforce on new guidance multiple times a week was difficult despite using every means of dissemination we had available.

357. The senior leadership team at LAS was relatively small covering the only pan-London organisation and there were periods of sickness and isolation. The resilience of the team was a key concern as there were multiple meetings (internally and externally) which needed to be attended given the fast moving nature of the incident.

358. PPE was undoubtedly a challenge for the ambulance sector. Ambulance clinicians respond to an undifferentiated case mix of patients and the initial 999 call did not always identify that the patient with, for example, a traumatic injury also may have had Covid-19. Initial PPE obtained from the Push Stock was not fit for use in a community setting. For example, aprons were too thin and lightweight and not suitable for work outside in the wind or rain, or on the roadside. Those working in the community, including LAS, at the outset of the Relevant Period, were routinely wearing a lower level of PPE that the ED colleagues who they were handing over patients to which caused anxiety.

359. Over Christmas and New Year of 2020/21 the oxygen supply issues required very careful monitoring of the use of cylinder oxygen to ensure patients were rapidly offloaded and able to transfer to hospital oxygen.

360. Despite the multiple challenges the prolonged pandemic has placed on the ambulance and urgent and emergency care systems, there have been opportunities to future-proof some of the rapidly established ways of working. The pan-London collaboration in developing better pathways for patients and providing high quality care closer to home has continued with the development of increased alternative care pathways including:

a. Same Day Emergency Care ('SDEC')
b. Remote monitoring of patients at home e.g. virtual wards
c. Good, cross organisational relationships and collaborative working
d. Mental Health Joint Response Cars
e. Increased Hear & Treat opportunities
f. National 999 and 111 call balancing

These have been developed collaboratively, building on the transparent and trusting relationships which formed during Covid-19 and have been facilitated by the technological advancements.

361. Following any incident, particularly one as prolonged and significant as Covid-19, there are always important lessons to identify and learn in order to make changes for the future. Internally, LAS undertook a review after each London peak and also contributed to regional and national learning gathering. After each London peak LAS reviewed the response it had provided and made necessary adjustments in readiness for a future wave.

362. A great deal of thought has gone in to considering how best to equip LAS to respond to any future wave or pandemic, utilising the lessons it has learned from Covid-19. In particular in respect of resilience in relation to operational delivery, logistics, information management and technology, estate Medicines Packing Unit

('**MPU**') and how LAS can support its staff. The principal changes that have been made, or which are in the process of being made, can be summarised as follows:

a. *People and Resource Enhancement*

i. LAS has remodelled its operational capacity requirements and is in the second year of significant recruitment programme to frontline and EOC staff;

ii. LAS has supported staff to enable them to work from home with improved IT and other enabling equipment;

iii. LAS has procured a new occupational health provider and has established a permanent wellbeing team, including enhanced mental health support;

iv. LAS has trained non-clinical staff in roles to support the wider organisation; and

v. LAS has worked collaboratively with St John Ambulance, who continue to provide support.

b. *Funding and infrastructure improvements*

i. LAS has worked with Commissioners and NHSE/I to ensure that it is adequately funded to deliver a consistent service and to respond to peaks in demand;

ii. In 2022 a new, and more spacious, control room was opened which is compliant with Covid-19 related IPC guidance;

iii. LAS's fleet has been expanded and new ambulances are arriving in 2023/24;

iv. A large, bespoke, logistics unit has been built and opened to allow for the storage of stock, as well as improved stock management and asset tracing;

v. A bespoke Medicines Packing Unit was opened in 2021, and LAS has established apprentice training to ensure an adequate supply of pharmacists; and

vi. A new 111 site is opening in 2023/24 which will be larger than the current provision and which will meet all the Covid-19 related IPC guidance.

c. *Operating model*

i. In 2022 LAS implemented a new CAD System which is fully interoperable with other ambulance services;

ii. LAS is part of the national roll out of an intelligent routing platform ('**IRP**'). This is a telephony process which distributes 999 calls to other ambulance services semi-automatically, either at times of activity surges or telephony outages. IRP operates on a UK basis enhancing national resilience, infrastructure and intra-operability;

iii. LAS has been one of the two early adopters for Category 2 segmentation to ensure that ambulances are prioritised with clinical oversight. The underlying principle of the Category 2 segmentation pilot was to address patient safety concerns for the sickest patients (e.g. STEMI, stroke, sepsis patients etc.) who were, at times, not receiving a timely ambulance response. The pilot permits clinicians to undertake a further clinical assessment on a pre-agreed cohort of Category 2 calls;

iv. Learning from the Covid-19 pandemic and the ongoing Industrial Action in 2023 has enabled LAS to develop alternative ways of

managing its demand utilising immediate clinical assessment and different clinical response models;

v. LAS has continued to work collaboratively with other providers and develop remote assessment and community monitoring, in particular for respiratory illnesses;

vi. LAS has continued to review its CSEP for 111 and 999 to provide additional guidance for times where there is extreme demand; and

vii. The CCTS is now a commissioned service which LAS delivers in partnership with NEL and SWL ICBs.

d. *Health inequalities (workforce and patient)*

i. LAS has focused its clinical and LAS strategy on health inequalities and engaged with patients across London to understand how we can better serve them. We have published our next five-year strategy in September 2023, which we have co-developed with our staff, patients, the public and partners. A guiding principle of the Strategy has been to address the health inequalities across London, to ensure that future innovation in our care to patients takes into account the need for more individualised care plans and our role as an anchor institution. An example of this is the work being undertaken currently through the London Lifesavers programme, which is utilising data to ensure the focus is on providing public education in CPR in areas which are highest on the deprivation index.

ii. The Make Ready and Cleaning teams have been brought in-house to provide greater resilience and assurance.

e. *Emergency planning and preparedness*

i. All internal LAS business continuity plans have been revised and updated to reflect working from home, new technology and prolonged incidents; and

ii. LAS has a generic pandemic plan and continues to engage in activities relating to planning, learning and preparedness.

363. LAS aim to be a learning organisation and forward thinking NHS provider and continue to be receptive to new ideas and change, and act accordingly.

364. It is very important to end this statement by stating that no one should underestimate the bravery of LAS's front line staff who were continually faced with putting their own health at risk in assessing and treating patients with Covid-19 in their own homes whilst the full nature of the disease was being understood worldwide. Many staff left their families and lived remotely to minimise the risk of transmission. Nor should one underestimate the trauma faced by our call handlers in responding to very distressed people continually over a long period of time. The impact on staff welfare was very large and remains with people today.

365. In conclusion, and on behalf of LAS, I would like to take this opportunity to pay tribute to all members of the LAS team who lost their lives during the pandemic. The organisation's sincerest sympathies remain with their families, friends and colleagues.

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

Signed: Personal Data

Dated: 06 October 2023