Witness Name: William Warrender, CBE
Statement No.: 1
Exhibits: INQ000221549 – INQ000221553; INQ000221561; INQ000221562; INQ000221546 – INQ000221548; INQ000221565; INQ0002211566
Dated: 27th July 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF SOUTH WESTERN AMBULANCE SERVICE NHS FOUNDATION TRUST (SWASFT)

I, William Warrender, will say as follows: -

1. Introduction

1.1 As with other NHS organisations, South Western Ambulance Service NHS Foundation Trust's (we/us/our) response to the Covid-19 pandemic had wide ranging impacts. We acted in decisive and new ways, creating new ways of working, developing and bringing in new roles and processes and embracing wide-spread working from home.

1.2 We ensured that it had the best possible resourcing during the pandemic, in order to facilitate the implementation of national guidance, understand the impact of Covid-19 and protect our service users and staff.

1.3 The evidence provided in this statement is reflective of our operational experience at the time of our response to the Covid-19 pandemic. The information referenced has been taken from our Covid-19 report which we maintained in real time throughout the incident. Whilst this statement reflects a largely positive position, we cannot underestimate the amount of effort and pressure that a small group of

individuals in our command team were under, and the impact of the pandemic continues to be felt by those staff.

2. Organisational, incident management, decision-making structure

2.1 Our Executive Medical Director was identified as the Executive Lead for our Covid- 19 response.

2.2 In response to the Covid-19 pandemic, we implemented our Constant Care Business Continuity Plan, with the following command structure:

2.3 From **March 2020**, daily strategic command calls were held whilst more resilient arrangements were being established.

2.4 From **6 April 2020**, we introduced a **GOLD Strategic Command Group** comprised of four key roles and operational seven days a week between the hours of 08:00 - 18:00:

- **Strategic Commander** - responsible for leading our planning and response to the Covid-19 pandemic. In addition to the core hours of 08:00 – 18:00, the Strategic Commander also provided out of hours on call. The role was shared between:

  John Dyer, Deputy Director of Operations;
  Ceri Smart, Assistant Director of Operations - Resource Management;
  Wayne Darch, Deputy Director of Operations;
  Will Lee, Assistant Director of Operations – Emergency Operations Centres

- **Strategic Staff Officer**: this role was shared between:

  Vicki Howard, Head of Emergency Preparedness, Resilience and Response
  Rob Horton, Paramedic
  Neil Lentern, Head of Education and Professional Development
  Verity Trawford, Head of Clinical Hub, Exeter

- **Strategic Medical Advisor** - providing senior clinical support, remote advice, complex decision making, support and advice to commanders and senior clinical leadership.

  This role was shared between:

  Dr Andy Smith, Executive Medical Director
  Dr Phil Cowburn, Acting Medical Director
  Dr Simon Scott-Hayward, Medical Director, Primary Care

- **Loggist:** This role was shared by members of the Executive Assistant Team.

2.5 **Internal County Coordination Centres** (CCC) were also established in each county to include engagement with Strategic Command Groups/Tactical Command Groups. These effectively coordinated command decisions during a major, complex, or business continuity incident to maintain service delivery.

2.6 A weekly **Trust Strategic Co-ordinating Group (SCG)** was established to co-ordinate the strategic level implementation and delivery of actions as described within the Covid-19 Strategy, Trust Pandemic Disease Outbreak Plan, the UK Transition (D20) Plan and the Annual Resilience Plan. It provided:

i. strategic direction, command, and control to deliver a coordinated response in order to maintain patient and staff safety and ensure the continuation of service delivery.
ii. support to our Tactical Coordinating Group (TCG) to deliver the relevant plans and actions required to maintain patient and staff safety and ensure the continuation of service Delivery.

2.7 The Strategic Co-ordinating Group was chaired by the Strategic Commander for the Covid-19 response. The Deputy Head of Emergency Preparedness, Resilience and Response (EPRR) and Specialist Practice was the Deputy Chair and Deputy lead strategic commander for Covid-19 response.

2.8 Membership of the Strategic Co-ordinating Group comprised:

- Executive Directors, including Chief Executive Officer
- Deputy Directors
- Strategic Commanders
- Heads of Departments

2.9 **From 1 October 2020,** our Strategic Co-ordinating Group was reinstated and moved from weekly to twice weekly from **21 October 2020** (Mondays and Thursdays).

2.10 A number of internal **Constant Care Tactical Groups** reporting to the Strategic Constant Care Command Team were established in **March 2020**, as follows:

- Emergency Preparedness, Resilience and Response (including Patient Transport Service and Recovery)
- People and Resourcing
- Clinical Hub (including the Covid-19 Co-ordination Service)
- Clinical
- Operational Services (including stores and supplies and fleet and estates)
- Information Management and Technology
- Nightingale Planning; and
- The Incident Coordination Centre with County Coordination Centres

2.11 To ensure regular engagement with Union colleagues, **a People and Resourcing Group** was established that met twice a week and was responsible for the following:

i. Supporting the Communications Sub-Group by responding to employee and management queries.

ii. Support the Wellbeing of Staff through:

- Promotion of internal and external sources available on a weekly basis
- Ensuring available support was promoted locally via County Commanders and Heads of Department

- Implemented targeted support for groups of employees or individuals experiencing difficulties in response to the COVID pandemic.
- Utilising and communicating charity funds.
- Ensuring accurate reporting of the workforce from when they either contract the virus or are required to self-isolate.
- Working in partnership with Unison to ensure clear and consistent messaging across the Trust.
- Planning for the recovery phase.

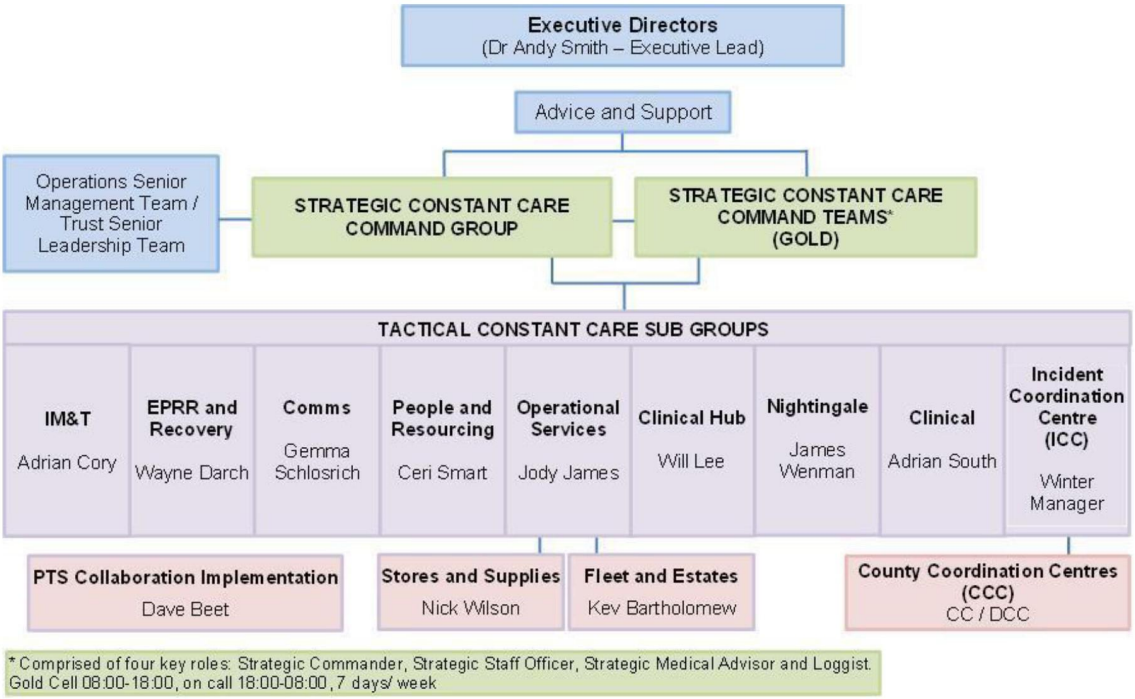
2.12 These responsibilities were successfully discharged which enabled us to respond to the unprecedented demand of the pandemic.

2.13 As part of our Command Structure (Constant Care) a formal subgroup, the **Stores & Supplies Sub-group** was established to review the procurement and supply of Personal Protective Equipment, Respiratory Protective Equipment, and infection control products such as hand sanitiser, cleaning products, waste bags, etc. and their adequacy and suitability for use. The Terms of Reference is **Exhibit WW/1 INQ000221549 – Stores and Supplies Sub Group Terms of Reference.** This Exhibit sets out the terms of reference for planning, preparedness, and response of the Stores and Supplies Sub-Group within the Constant Care Command Team in response to the outbreak of COVID19.

2.14 A working group was established as part of this formal command arrangement specifically to review incoming/new products to us prior to allocation to frontline services for use. The panel consisted of infection control, stores, clinical and our procurement leads.

2.15 Our Incident Co-ordination Centre (ICC) was operational on a 24/7 basis with our Winter Room Manager as the Incident Control Centre Commander. The Incident Co-ordination Centre provided a point of contact to focus on intelligence gathering, links to county teams and departments and a focal point to 'trouble shoot' issues as they arose, supporting commanders and the clinical hub.

Fig. 1 – Our Organisational, incident management, decision-making structure



3 National and Regional Decision makers

3.1 On the **25 March 2020**, all English ambulance services moved to a single command and control structure under the leadership of Professor Anthony Marsh, National Strategic Adviser of Ambulance Services, NHS England/Improvement. The National Ambulance Coordination Centre (NACC) became the single point of oversight for assessing, determining, and communicating the national level of ambulance service escalation to all services in relation to Covid-19.

3.2 In addition, this became the single point of escalation for agreeing mutual aid arrangements, including liaison at national level with other emergency services and the coordination of Military Aid to Civilian Agency (MACA) requests to the National Head of Emergency Preparedness Resilience and Response (EPRR).

3.3 During the pandemic period, the National Ambulance Coordination Centre remained a key point of oversight for assessing, determining and communicating with all ambulance services in relation to Covid-19. However, in line with the national decrease in the Covid-19 alert level during the summer of 2020, escalation within a service moved to being regionally coordinated.

3.4 However, this position changed on the **5 January 2021**, due to increasing pressures across ambulance trusts, when the National Ambulance Coordination Centre assumed responsibility for the national coordination of Mutual Aid between Trusts to support call taking. It was accepted that whilst London Ambulance Service (LAS) had been in the most need initially, the national situation was deteriorating, and several other Trusts were also beginning to come under pressure. Any request for activation had to be submitted directly to the National Ambulance Coordination Centre.

3.5 It was further agreed that the National Ambulance Coordination Centre, supported by Association of Ambulance Chief Executives (AACE), would act as the honest broker and work to agree what support was needed, who should provide it and in what form. This principally involved Trusts supporting another Trust or Trusts by taking a predetermined percentage of calls per hour on their behalf in line with the agreed plan. The National Ambulance Coordination Centre hosted two calls a day, at 11:00 and 17:00 to set the strategy, with representatives attending from each trust.

3.6 BT was provided with direction by the National Ambulance Coordination Centre for any changes in call flow that were agreed each day as part of the overall plan.

3.7 Nationally, the National Directors of Operations Group (NDOG) and the National Ambulance Service Medical Directors (NASMed) continued to meet as did the Association of Ambulance Chief Executives (AACE) and Ambulance Chief Executives Group (ACEG). We had representatives at all of these meetings.

3.8 At all of the forums that we attended; we were able provide feedback. Some of these processes were effective, however, due to the pace at which changes to guidance were made, it sometimes resulted in more than one iteration of guidance in a short space of time, i.e., daily.

WW/8 Exhibit INQ000221548 – COVID Clinical and IPC Change Log. This Exhibit is a chronological list of clinical and infection prevention control change log. This exhibit is a chronological list of clinical and infection prevention control change log.

4 Collaboration

4.1 We were engaged in all system resilience and command groups / calls including via Local Resilience Forum (LRF) Strategic and Tactical Coordinating Groups (SCG/TCG), Local Health Resilience Partnership forums and daily / weekly at all levels. There was also a Regional Coordinating Group that was established to support the health response which sat above the Local Resilience Forum and Strategic Co-ordinating Groups. Our Senior staff represented and engaged in these arrangements to protect service delivery and critical services.

4.2 Communication with NHS Trusts within our area was predominately through Strategic Coordinating Groups (SCGs) across each of the Local Resilience Forums (LRFs) and the Regional Co-ordination Group and Regional Health GOLD calls (three days per week). In addition, we supported local health and resilience systems on a daily basis through the establishment of command groups at an operational level.

4.3 Examples of collaboration included:

4.3.1 As part of the national programme, we supported the roll out of the Covid-19 anti-body blood test for staff, in partnership with local hospitals. Testing commenced on **29 May 2020** and continued to be in place until the **12 July 2020.**

4.3.2 We approached our partner agencies, including Fire and Rescue Services (FRS), to request the provision of mutual aid to further support our response to Covid-19. This was agreed and, in partnership with Cornwall, Devon and Somerset, Dorset and Wiltshire and Avon and Gloucestershire Fire and Rescue Services, 20 Fire

and Rescue Services individuals were trained in FFP3 Respirator mask fit testing and provided ongoing support with FFP3 fit testing capacity.

4.3.3 We introduced a 'combined crewed' fleet of Emergency Ambulance or Patient Support Vehicles crewed by 1 Fire Fighter and 1 South Western Ambulance Service NHS Foundation Trust Paramedic or Emergency Care Assistant. 15 second hand vehicles were secured by us from West Midlands Ambulance Service NHS Foundation Trust to support this scheme. Further details are shown in 4.4.2 Fire and Rescue Service - Operation Braidwood.

As at the **29 July 2020,** there were a total of 5,099 allocations to Fire and Rescue Services supported resources.

4.3.4 We established procedures for adequate supplies of Personal Protective Equipment in respect of stock not 'bought' by the Trust, including mutual aid between ambulance trusts. For example, throughout 2020 onwards, we focused on using the 1863 and 8833 3M masks provided, although other products were 'pushed' to us. We then agreed switches between the ambulance services to enable increased volume of stock to be available, avoiding additional training burden as each specific mask required fit testing.

4.3.5 Products were at times donated to the NHS by other commercial and private sector organisations. Assessment of these products were also subject to the same assessment process and documentation maintained on suitability for use. One such example was that hand sanitiser had been purchased by the Glastonbury Festival. As the festival was cancelled, they offered the sanitiser to us. (approx. **June 2020**)

4.3.6 We also provided details to NHS Supplies on where to source products, as they reported that they were unable to secure products.

4.3.7 Communication with NHS Trusts in the region was predominately through the Regional Co-ordination Group and Regional Health GOLD calls (three days per week).

4.3.8 The National Ambulance Coordination Centre (NACC) remained a key point of oversight for assessing, determining, and communicating with all ambulance services in relation to Covid-19. However, in line with the national decrease in the Covid-19 alert level in the summer of 2020, escalation within a service moved to be regionally coordinated. This remained the case from the **1 October 2020**.

4.3.9 Our Medical Directorate was engaged in numerous activities at a national, regional and Trust level in support of the response to Covid-19. Regional collaboration included:

i. Engagement with regional medical and nursing directors through twice weekly conference calls to support the regional response. This included developing ethical guidance for treatment decisions during the pandemic

ii. Provision of medical expertise in establishing, at short notice, the public swab booking and results service

iii. Engagement in professional multiple disciplinary clinical calls regarding the response to Covid-19;

iv. Leading on behalf of us, the development of the South West Critical Care Transfer Service as part of a multi-agency project

v. Engagement with acute hospital colleagues as key services were switched back on;

vi. Engagement with emergency department acute colleagues to ensure the efficient flow of patients into the units, whilst maintaining appropriate Infection Prevention Control measures;

vii. Working with regional NHS111 providers to scope the establishment of a two way transfer of patients to ensure that the right patient was seen by the right service.

4.4 During the COVID-19 response we secured, had on stand-by and actively utilised a number of sources of additional capacity, for example:

4.4.1 Patient Transport Service (PTS) Provider Resources

4.4.1.1 Following a national request for Ambulance Trusts to take responsibility for the delivery of patient transport services during the Pandemic, during the first wave, we commenced conversations with local Patient Transport Service providers to ensure that robust plans were in place for the deployment of these resources to lower acuity incidents in support of us. A Standard Operating Procedure (SOP) governed these arrangements through Phases 1 and 2.

4.4.1.2 During the second wave Patient Transport Service providers were utilised as per their standard contracts to support acute trusts in maintaining, as far as possible, business as usual / elective activity. However, we engaged with Patient Transport Service Providers and Commissioners on a monthly basis throughout the second wave to keep the position under regular review.

4.4.1.3 On **12 January 2021**, Patient Transport Service providers confirmed that as elective services remained in place and had not been stood down as part of the third lockdown, they did not have any spare capacity to provide support to us. This support therefore ceased.

4.4.2 Fire and Rescue Service - Operation Braidwood

4.4.2.1 During Phases 1 and 2 of the response we were supported by all five Fire and Rescue Services (FRS) within the region who all provided drivers to assist as part of surge planning. Firefighters who held a blue light driving qualification formed a crew with a Trust Paramedic to staff an emergency ambulance. At the peak of the Covid-19 first wave, 15 vehicles were supported across the Trust and in total provided over 6,000 responses.

4.4.2.2 All 15 Patient Support Vehicles were operational **by 2 May 2020** at the following locations:

County	Locations
Cornwall	Newquay, Launceston
Devon	Torquay, Middlemoor, Bideford
Dorset	Dorchester, Bournemouth
Somerset	Taunton, Glastonbury
Wiltshire	Warminster, Swindon
Avon	Nailsea, Bristol
Gloucestershire	Staverton, Gloucester

4.4.2.3 On the **10 June 2020** a strategic decision was made to move from Phase 1 to Phase 2, effective from **1 July 2020**, in order for us to be able to increase the number of front line double crewed ambulances on the road.

4.4.2.4 All 5 Fire and Rescue Services supported the move to Phase 2 and with support from Logistics the Fiat PSV's were upgraded and/or Fire and Rescue staff were deployed onto normal Trust double crewed ambulances.

4.4.2.5 As part of the ongoing surge planning, on the **7 July 2020,** the County Coordination Centre made a further request for this project to continue until **31 August** at which point this mutual aid was stood down.

4.4.2.6 As the UK entered the second wave of Covid-19, and we experienced surges in demand for ambulance services across the South West, we sought to reactivate this mutual aid from the five Fire and Rescue Services. We requested an additional period of Fire and Rescue Service provision of mutual aid (Operation Braidwood), based on predicted and modelled Covid-19 related demand and activity. This operation was in line with the conditional options that are outlined in the Tripartite Agreement between the Fire Brigades Union, the fire service national employers and the National Fire Chiefs Council.

4.4.2.7 Operation Braidwood was stood up from **1 November 2020** for an initial period of four months. The Operating Model consisted of Fire Fighters that hold a blue light driving qualification who, wherever possible, formed a crew with one of our Lead Clinicians to crew an emergency ambulance. Where a Lead Clinician was not available, Fire Fighters were crewed with an Emergency Care Assistant, to crew a Patient Support Vehicle.

4.4.3 South West Critical Care Transfer Service

4.4.3.1 NHS England South West commissioned us and the South West Critical Care Network to collaboratively develop an urgent temporary solution to the anticipated surge in critical care transfer requirements within the region.

4.4.3.2 This was established as the South West Critical Care Transfer Service (SWCCTS) and was a truly collaborative project involving us, Emergency Preparedness Resilience and Response, The Hazardous Area Response Team (HART) and clinicians from air ambulance charities, voluntary aid organisations and military drivers. This service was solely for Level 3 Intensive Care patients that were required to be moved.

4.4.3.3 The South West Critical Care Transfer Service went live from **Friday 10 April 2020** and effectively moved over 30 critically ill patients between intensive care units, within the region and nationally. This ensured capacity within units and enabled patients to receive tertiary and quaternary level critical care. The service also provided critical care transfers into and out of the NHS Nightingale Hospitals if required.

i. Hazardous Area Response Team provided much of our initial staffing working from Nightingale Hospitals for the duration of their shift times, supported by critical care doctors and Specialist Practitioners - Critical Care
ii. It utilised other emergency response drivers to assist with resourcing, such as fire service drivers or military drivers
iii. The Helicopter Emergency Medical Service (HEMS) desk in the Clinical Hub controlled all ambulance resources undertaking transfers

iv. A Tactical Commander was co-located at the South West Critical Care Transfer Service call handling centre in the Bristol NHS Nightingale Hospital to oversee daily operations.

v. Operational Commanders were deployed once the NHS Nightingale Hospitals become operational and provide liaison with hospital operations as well as with crews.

4.4.4 NHS Nightingale Hospitals

4.4.4.1 In response to the projected high levels of critical care demand placed on the NHS by Covid-19, NHS Nightingale Hospitals were introduced across the UK to provide increased capacity for patients with a range of critical and serious healthcare needs.

4.4.4.2 Within the South West there were two NHS Nightingale Hospitals introduced. A third was planned for, supported by us in Bournemouth, however this was stood down as the first phase of Covid-19 progressed.

5 Policies and Plans

5.1 We produced a Surge Management Plan in response to the Covid-19 incident. This was in addition to existing Resource Escalation Action Plan Documents, Demand Management Plans and Business Continuity Plans and focused on maintaining the SWASFT 5; Clinical Hubs; Frontline Operations; Regional Operation Centres, Information Management and Technology and Fleet. Examples of plans also included:

i. **Pandemic Disease Business Continuity Plan**: providing us with guidance and actions to be taken in the event of a declared pandemic. The plan set out a coordinated and evidence-based approach for planning and responding to a pandemic and accounts for the learning from the COVID-19 pandemic

ii. **Annual Resilience and Capacity Plan 2020/21**: set out the overall approach to managing pressure and outlined some of the key assumptions in terms of

expected activity during the period. This Plan built on the COVID-19 Surge Plan that was updated weekly between **March and July 2020**. The Surge Plan, although specifically addressing COVID-19 related actions, did set out a number of key strategic priorities that we would seek to protect.

iii. **Internal Outbreak Control Plan**: outlined our internal management processes that required implementation to control and manage an infectious disease outbreak within the organisation. This included Covid-19, but also included concurrent risks such as winter pressures and adverse weather and the end of the EU Exit transition period. Each of these risks were considered independently and collectively and a plan was developed for each.

6 Our Staff

6.1 Our initial response to Covid-19 focused on maintaining resources where possible and putting in place actions to ensure staff could remain working. We undertook a number of activities including:

i. Offering overtime and incentives
ii. Offering annual leave buy-back to staff
iii. Securing hotel accommodation, in line with national guidance, to enable frontline staff to remain working
iv. Securing agency staff to provide additional resilience and support
v. Increasing Trust bandwidth to support remote working and access
vi. Securing additional Tableau licenses to enable all our staff to access web reports and information management

6.2 In parallel, we produced a Surge Management Plan in response to the Covid-19 incident. This was in addition to existing Resource Escalation Action Plan (REAP) Escalation Documents, Demand Management Plans and Business Continuity Plans and focuses on maintaining the SWASFT 5; Clinical Hubs; Frontline Operations; Resource Operations Centre, Information Management and Technology and Fleet.

6.3 On **1 March 2020**, our staffing levels for ambulance-related staff (both emergency and non-emergency), including frontline ambulance staff and control room staff. Please note that we do not provide Patient Transport or 111 Services:

	Staffing Levels
Frontline ambulance staff – both emergency and non-emergency	3043 plus 384 bank
Emergency Operations Centres (Control Room) – excluding admin based roles	365 plus 30 bank

6.4 Following discussion at our Strategic Group, we undertook an exercise to establish the potential capabilities of all staff within the organisation who held a clinical qualification but did not work in a frontline role. This was to provide additional frontline resource if required as part of surge planning.

6.5 This informed an offer in terms of additional surge resource from each department. The data was reviewed by our Head of Education and Professional Development, to identify the training provision required. In response, three training sessions for non- frontline clinicians were offered from the **18 January 2021,** with sessions covering both clinical and driving practice.

6.6 All blue light lease car owners who identified that they did not carry the necessary Personal Protective Equipment were contacted to highlight the items required.

6.7 Subject to any further support required the roles of responding Officer, Rapid Response Vehicle and Double Crewed Ambulances moved to green 'ready' by **29 January 2021**, with staff made available on request. However, on **9 April 2021** we had not required support from this group of staff.

6.8 Within a 6-week window our Human Resources team worked collaboratively with Learning and Development, the Regional Operations Centre and Operations to recruit over 400 additional people to support our response. The dynamic response required recruitment practices to be adjusted to ensure that people were brought into

the Trust at pace, whilst maintaining compliance with the temporary NHS Employer Covid-19 recruitment check guidance and Disclosure and Barring Service (DBS)guidance.

i. **Covid-19 Call Centre**: Around 130 people were recruited within a one-week window and booked onto training courses;
ii. **Emergency Response Assistants:** Targeted at our existing Community First Responders, 40 were recruited and booked onto courses within a 2-week window;
iii. **Clinical Hub Dispatch Assistant and Call Assistant:** 83 people recruited and trained in these new roles over a 4-week window. We contacted all leavers within the previous 12 months, and as a result 20 Emergency Care Assistants/Paramedics were recruited and trained to return on bank contracts;
iv. **Student Paramedics:** Working closely with partner universities, we recruited 138 year 3 and year 2 students on bank contracts as either Emergency Care Assistants or Temporary Newly Qualified Paramedics. We worked with the DVLA to open up C1 driving places to support students to become blue light drivers:
v. In addition to these numbers, over 20 other people were recruited to support Fleet, Make Ready and Emergency Preparedness, Resilience and Response;

6.9 Alongside the Covid-19 response the team ensured that operational business as usual was maintained, with 45 Emergency Care Assistants and 30 Emergency Medical Despatchers commencing during April and May.

6.10 We do not consider that these changes had any impact on care or capacity as the additional resilience and surge arrangements provided sustainable capacity to allow us to ensure service continuity was maintained. Ensuring that the patient received the right clinical response. Throughout the response, we held a weekly surge management meeting chaired by our Executive Director of Operations where resourcing, capacity and surge management activity was reviewed and agreed. This remained under constant strategic, tactical and

operational review. We are therefore confident that these changes only had a positive impact.

6.11 The funded number of Lead Clinicians for the frontline 999 service was 1738 (as at **1 March 2020**) and 1788 (as at **28 June 2022**)

6.12 The funded number support staff, such as call handlers was 1122 (as at **1 March 2020** and 1320 (as at **28 June 2020**)

6.13 The funded number of Emergency Medical Dispatchers was 164 (as at **1 March 2020**) and 206 (as at **28 June 2020**)

6.14 The total funded establishment (Trust wide whole-time equivalents) was 4,233 (as at **1 March 2020** and 4,541 (as at **28 June 2022**)

6.15 Please note that these figures are for permanent employees only. There were a significant number of bank staff recruited during the covid period, as explained in point 6.8 above, to undertake a variety of roles including responding and call assisting which we reported on as part of our national updates during the covid period.

7 Roles Introduced

7.1 During the relevant period, the following specific roles were introduced:

i. A bank role for Emergency Response Assistants (ERAs) that was offered to our Community First Responders (CFRs). This was a band 2 role, designed and introduced to increase the resources available to work with lead clinicians.

ii. The Emergency Operations Centre (EOC) recruited Emergency Medical Despatcher (EMD) and Dispatch Assistant roles to provide more support and resilience into our Clinical Hubs.

iii. We utilised Fire Response Assistants (FRAs) working alongside our colleagues to help crew Double Crewed Ambulances (DCA) and Public Service Vehicles (PSV) and we added a Private Provider Manager to help focus the additional Double Crewed Ambulances and Public Service Vehicle resources we procured.

iv. Emergency Preparedness, Resilience and Response took a more prominent lead role during the Covid-19 Pandemic.

v. Strategic Commanders worked differently on a rotational basis; they focused fully on command and not on their business-as-usual roles during this rotation.

8 Staff Testing

8.1 Testing commenced on **29 May 2020** and continued to be in place until the **12 July 2020** at which point, we aimed to have tested 4,000 staff. In total 100% of staff were approached regarding a test, with 81.4% of staff being tested and 7.5% of those staff testing positive on the results that were received back. We met our trajectory for testing overall.

8.2 We commenced with two testing centres at Avon and Somerset Operations Centre and North Bristol Operations Centre on an appointment only basis and by the **20 April 2020,** swabbing was available to our staff and their families in each County Command area.

8.3 Test results were obtained via laboratories at Southmead or the Royal Devon and Exeter Hospitals. Results were then fed back via our Tactical Doctor accounting for the full clinical picture and enabling a bespoke plan.

8.4 On the **24 April** the national swabbing service went live for a wider range of key workers and symptomatic members of their households.

8.5 In **early May** we participated in a national project testing asymptomatic frontline operational crews to ascertain if there were silent carriers of Covid-19.

8.6 From **Thursday 28 May**, following a request from Public Health England, in addition to the county based symptomatic testing programme, we rolled out testing to all asymptomatic staff who attended Weston General Hospital between the 5 and 25 May.

8.7 Testing facilities continued to be in place indefinitely with a total of 2,234 staff and household members tested as at **15 July 2020**.

8.8 As part of the national programme, we supported the roll out of the Covid-19 antibody blood test for staff, in partnership with local hospitals. We prepared a standard operating procedure providing mandatory guidance on the process of obtaining blood samples from staff.

8.9 The lab blood test offered to our people was independently evaluated by Public Health England at its reference laboratory at Porton Down with the test being one of the most reliable on the market. Individuals were informed personally of the result of their test with anonymised results used by us and reported nationally as part of the NHS screening programme.

8.10 At the beginning of the pandemic, we worked closely with local hospitals to ensure that sufficient Polymerase chain reaction (PCR) testing capacity was available. We are not aware of any instances where a lack of testing capacity impacted on our staffing levels. The move to Lateral Flow Tests simplified the testing process, with kits available to all staff through their local County Co-ordination Centre. Regular online stock checks were carried out to move kits between locations. We are not aware of any instances where insufficient Lateral Flow Test kits were available.

9 Additional Support for Staff

9.1 Early on in the pandemic, we issued three bulletins every week, outlining key Information around Covid-19 and the associated safety measures that were

introduced. We stressed the message through our Executive Directors and Staying Well Service that our people were not alone, and we were facing this pandemic together.

9.2 We understood that there would be an unequal impact to employees who had a disability, were pregnant and/or were from an ethnic minority. For our employees who were required to shield for health reasons, we appointed specialist Wellbeing Supporters who linked in with these employees directly to offer them additional support and to help them remain connected to the Trust.

9.3 We released a statement and frequently asked questions to all our employees describing the Covid-19 impact on high-risk groups, including our Black, Asian and Minority Ethnic colleagues. All line managers were asked to complete an individual needs review, which was a risk assessment completed jointly with the member of staff, to determine whether additional supportive measures or redeployment was required.

9.4 Correspondence was also shared directly with our black and Asian minority ethnic colleagues in **May 2020**. The letter outlined the following message:

i. Asking colleagues to identify themselves to their line manager if they considered themselves to be at risk, in order to ensure they could be fully supported with any specific needs and individual concerns;

ii. To feel confident to discuss any concerns that they had regarding Covid-19 and the impact that it was having on them and their family;

iii. To share, in confidence any concerns they have regarding any underlying health conditions so that these can be taken into consideration.

9.5 Following the completion of the review, reasonable adjustments were considered and implemented to ensure their safety. This included the appropriate PPE, fit testing, use of powered hoods, as well as additional

reasonable adjustments including alternative employment where this may have been necessary. This also included the opportunity for high-risk employees to work from home in a redeployed role.

9.6 All operational colleagues had level 3 PPE available to them, with higher risk colleagues being advised that if they would like higher levels of PPE then this could be provided for them.

9.7 Following the government's advice that shielding will be stood down from **1 August 2020** further correspondence was shared with operational employees in **July 2020**. The government advice was shared, and employees were advised they can return to work from **1 August 2020** following a further risk assessment and assurance that their work place had undergone a Health and Safety and Infection Prevention and Control audit and risk assessment to ensure their workplace was compliant.

9.8 A Covid-19 return to work process was designed, which placed the employees' mental and physical health and wellbeing as the main priority as we supported them to return to work. If it was not possible for them to return to work, then medical advice was received from Occupational Health and redeployment options were explored.

9.9 High risk employees within Support Services received separate correspondence to confirm that they would continue to work from home, alongside all other Support Service workers until **October 2020**.

9.10 Our Black, Asian and Minority Ethnic colleagues were supported through our Race Equality Network, which enabled us to learn about their experiences and hear their feedback and then respond with supportive measures and reasonable adjustments. The Race Equality Network remains embedded in the organisation today.

9.11 For all colleagues adversely impacted throughout the pandemic, we supported the to complete a risk assessment, which we launched as 'Your Needs Review'. This was a supportive discussion with the persons line manager where we understood why they were at higher risk in the pandemic, based on the following criteria:

i. Notified as on 12 weeks shielding, very high risk group
ii. Age >65 years
iii. Age >50 years for Black, Asian and Minority Ethnic employees
iv. Diabetes
v. Chronic lung disease
vi. Chronic heart disease
vii. Cancer
viii. Pregnancy
ix. Immunosuppression
x. Pre-existing disability that impacts respiratory morbidity
xi. Black and Asian Minority Ethnic background
xii. Gender

9.12 To ensure the discussions were as meaningful and supportive as possible, the Human Resources Team trained 170 managers so they understood why they were completing the document, and how the message should be positioned.

9.13 We then determined how we could best support an individual, which ranged from working from home (shielding) to working in an alternative non patient facing role and/or continuing to work in their substantive role with additional supportive measures/reasonable adjustments with clear guidance and Infection Prevention control measures in place. Each discussion and outcome was individualised, however, it was based on the national principles set out by NHS Employers.

9.14 We engaged with local communities and signposted employees to foodbanks or provided vouchers for food through our charitable funds in extreme circumstances. We have since introduced Wage Stream which is an external provider that enables employees to draw on their next month's wage, should they face any financial hardships.

9.15 We also promoted, and sign posted to domestic abuse charities, because we understood through external briefings that the pandemic had resulted in an increase in domestic violence. This had resulted in a dedicated Domestic Abuse Policy, for widespread signposting and shared understanding.

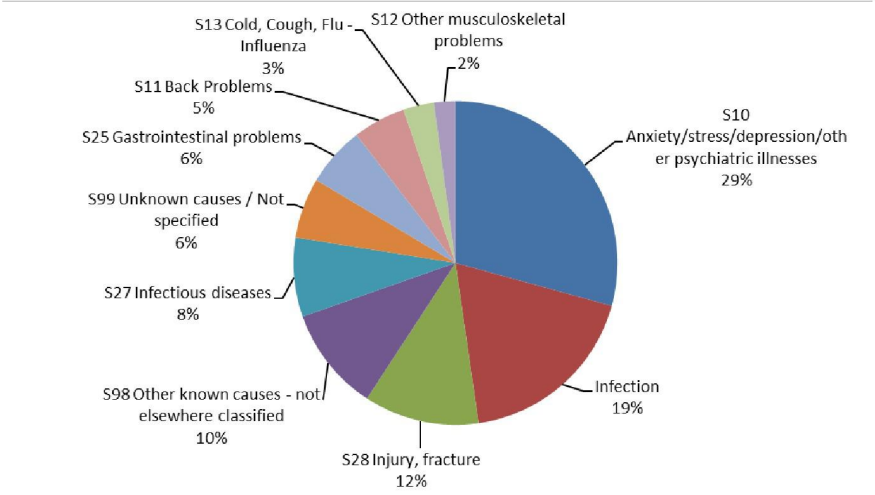
9.16 Throughout the pandemic, and to date, examples of our Staying Well Service's wellbeing measures included:

- Increase in Wellbeing Supporters covering the whole organisation, offering ground level support
- 24/7 Employee Assistance Programme with trained counsellors
- Health and Wellbeing Support app on self-help and learning
- Introduction of additional wellbeing offerings, including the Health and Wellbeing Catalogue, Alternative Therapy Fund, Emotional Freedom Technique and other holistic offerings; supporting needs led intervention
- Mental Health First Aid training delivered on a monthly basis in-house
- TRiM (Trauma Risk Management) - a trauma-focused peer support system designed to help people who have experienced a traumatic or potentially traumatic event.- training rolled out
- Invest in Yourself relaunch in April 2022, seeing 48 bulletins being shared about National Campaigns such as Stress Awareness Month including launching Five Ways to Wellbeing, Cervical Cancer and financial wellbeing
- Launch of new Health and Wellbeing logo on the intranet, reviewing all resources and making it more accessible for our people
- Continuation of Staff Wellbeing Engagement Group
- Supporting the introduction of Clinical Supervision
- Suicide First Aider Tutors being trained to deliver suicide prevention training, 12-month plan in place
- REACT Mental Health train the trainer, 24 individuals trained and will then train in their local areas
- Continued presence and engagement at Emergency Departments and Emergency Operations Centres

- Introduction of a Wellbeing Supporter role for Student Paramedics and Newly Qualified Paramedics
- Good engagement with NHS England/Improvement and reviewing our provision against the Health and Wellbeing Framework
- Attendance at National Ambulance Wellbeing Forum to gain shared learning
- Freedom to Speak Up month encouraging our people to speak up about concerns they may have
- Continued delivery of Just Culture and introduction of the Just and Learning Culture Forum
- Increase in staff networks, including the Neurodiversity Network

10 Sickness Levels

10.1 Overall, our sickness absence levels were 3% to 2% higher than prior to the pandemic. We ended 22/23 financial year at 8.07% which is broken down into the following categories.



FTE Lost by Absence Reason - Trust

10.2 We are still experiencing the lasting impacts of the pandemic. We are supporting employees who suffered with long Covid through the Sickness Absence Policy, and sought them suitable alternative employment where possible. We also facilitated phased return to work and amended duties, for those employees who

suffered with long Covid and subsequently felt able to return work.

10.3 The current guidance and associated testing has also resulted in extensive challenges, where employees have isolated if they have test positive for Covid-19, but have felt well enough to work.

10.4 We also understand that our employees have suffered with moral injury from the pandemic, and our referrals into the Staying Well Service have seen an upward trajectory since 2020. To respond to this, we have:

i. Introduced Trauma Risk Management (TRiM) , with a new structure and process to support our people exposed to trauma
ii. Supported specific teams to access psychological supervision and clinical supervision
iii. Introduced REWIND therapy - a non-intrusive, safe and highly effective psychological method for detraumatising people, which can also be used for removing phobias - through Red Poppy
iv. Expanded our trauma therapy and support offerings to include Emotional Freedom Technique coaching, as well as holistic therapies such as acupuncture
v. Increased self help support via our Health and Wellbeing logo on the intranet, housing a section on trauma, signs and symptoms and when to access support
vi. Continued engagement with Emergency Operations Centres and virtually with teams to understand need and to provide support
vii. Attended all inductions to provide information on the Staying Well Service and Freedom to Speak Up
viii. Launched of the new health and Wellbeing Strategy in **January 2023**
ix. Provided our people with lunch bags and drink bottles to ensure they are hydrated and have access to food whilst at the back of Emergency Departments due to handover delays

11 Communication with Staff

11.1 We developed a 30,60 and 90 day and onward communication plan to ensure that the correct messages and most up to date guidance was shared across all areas of the Trust. Each messaged shared, recognised how difficult this time was, the support that was available and thanking our people for all their efforts.

11.2 To inform this work, in late **April 2021**, we issued an engagement letter to all corporate services staff around what a return to normal may look like. This was in advance of the Governments' proposed date of **21 June 2021** for an exit out of lockdown. The letter sought feedback from staff on how the previous 12 months had felt for them, their reflections on the support that had been offered, and whether there were any recommendations about what a phased return may look like for them and their colleagues. The results from this engagement exercise were used to develop proposals as to the way forward for the Trust.

11.3 This messaging and guidance included a Covid-19 Policy, which stipulated specific guidance around special leave, Covid-19 sickness absence, shielding, bank workers etc. This enabled us to respond to the challenges and changing picture of the pandemic in a consistent and fair way. This way of working was managed through the People and Resourcing Group which had 20 members from across all areas of the organisation, alongside Unison colleagues. This forum enabled us to share latest guidance and updates, develop new policy principles and discuss implementation and feedback from employees.

11.4 Feedback was also collated through local intel and this shaped ongoing communication and frequently asked questions.

11.5 In terms of health and wellbeing, every Friday, we shared a Health and Wellbeing bulletin, with important resources from our internal Staying Well Services and promoting NHS Employers resources.

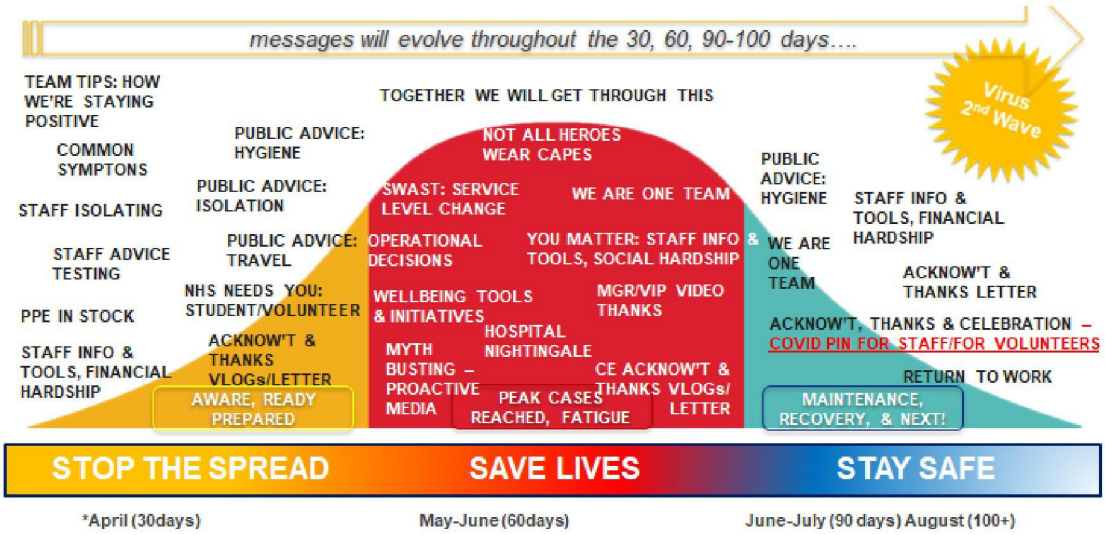


Fig 2: Key communication activities included:

i. Video Blogs covering frontline and support services with updates and information on Personal Protective Equipment, Swab Testing, operational forecasts, the Regional Operation Centres, Electronic Records in Ambulances updates and wellbeing support. At the peak we delivered a minimum of one video blog in every bulletin. Ken Wenman, former Trust Chief Executive, also provided a weekly Wednesday update.

ii. Encouraging all of our people to share their stories for inclusion in Trust wide communications channels and to share positive news stories with their colleagues;

iii. Development of a letter of thanks for all staff and volunteers that was sent to over 6,000 people

iv. Issued almost Bulletin updates to our people on a range of topics including Covid-19 specific stories, staff testing, Personal Protective Equipment, policy decisions, support to mental health and wellbeing stories and tools;

v. Development of proactive Covid-19 media statements on potential Resource Escalation Action Plan level changes, 999 call pressures, resources, response times, staff sickness and Personal Protective Equipment;

vi. Managed around 160 Covid-19 related press enquiries and focused on the front line and community issues as supported by the Strategic Command Group;

vii. Support for Government messages, including 'Stay At Home', 'Stay Alert' and the lockdown easing messaging on **4 July**, and supported other NHS messages on topics including Personal Protective Equipment, Clap for Carers, NHS charity donations, NHS' 72nd birthday and thanks to the public;

viii. Launch of two successful virtual town hall sessions with our Chief Executive and Executive Director Team providing our people with a virtual opportunity to ask questions that were concerning them;

ix. Re-launch of the #Unacceptable campaign to highlight the rise in violence and aggression towards SWASFT colleagues during Covid-19;

x. Supported the 'You Matter' campaign designing and sharing posters across the Trust to support the Covid-19 response;

xi. Creation of a wellbeing section on our external website to share guidelines, frequently asked questions and updates to ensure all colleagues can access our information and support;

xii. Creation of multiple forms on the intranet including Powered Hoods, Personal Protective Equipment, Patient Experience Feedback Form, Staff Fit Testing FFP3 Respirators and Covid-19 Antibody Testing;

xiii. Creation of the Covid-19 pages on the intranet and website and recently we created the Working Safely in Covid-19 page which has all of the information on what SWASFT is doing to support working healthy during Covid-19.

11.6 From **February 2020**, we increased Covid-19 communications related activity via the Chief Executive's Bulletin from one day to three days a week through to the beginning of May. From Wednesday **4 May** the decision was taken to reduce bulletins to two per week, in line with the new 'business as usual' Covid-19 approach. This continued through to the **June 2020** when the Bulletin reverted back to being issued once a week.

11.7 Using over ten internal and external communication channels, the communications team pushed out messages that reflected the rapid pace of change. This included communication via social media channels, where we posted and shared Government and NHS guidance on Covid-19 and posted around seven times a week on topics including information on staying at home; how to look after your

mental health whilst being at home; hand washing advice; social distancing guidelines; and information on the symptoms and how to get tested.

12 Safe Social Distancing

12.1 During our response, our estate provided challenges in terms of enabling the safe social distancing of crews and responders outside of the patient setting. This created a number of challenges, including overcrowding in our crew rest areas which ultimately led to a decision to take student paramedics out of clinical practice to ease congestion whilst not over-using PPE and in order to protect critical services and minimise crew to crew transmission.

12.2 This situation was compounded by reduced ambulance activity in our region which led to more time being spent in crew rest areas. Ultimately our decision impacted the satisfaction of our student workforce, whilst hampering our future clinical workforce recruitment and confidence. The decision was made in response to unrest from our patient facing staff at that time and whilst difficult, was taken in best interests of sustaining our future capability and minimising transmission.

12.3 Nationally we were one of the few Trusts to take this decision and we have subsequently reviewed how we could better handle this situation in the future.

13 Our Service Users

13.1 We considered how its advice, policies or guidance would impact upon at-risk and vulnerable groups, including but not limited to, those with protected characteristics under the Equality Act 2010 or the equality categories contained in the Northern Ireland Act 1998.

13.2 The face to face management of patients was supported through the introduction of the SWAST Clinical Guideline COVID-19 Clinical Assessment and Management. The guidance increased the priority provided for certain actions, such as referral to virtual wards, for patients with characteristics which may have increased the risks associated with COVID, for example:

i. Black, Asian and Minority Ethnic
ii. Comorbidities, for example active cancer treatment, significant immunosuppression, diabetes/chronic lung disease/hypertension
iii. Mental Health/Learning Disabilities
iv. High risk professionals
v. Shielded
vi. Care workers

13.3 Process and guidance went live on **Friday 3 April 2020,** to introduce a new triage Protocol for Pandemics at Level 1 of 3, known as the 'Card 36 Protocol'. All calls to 999 continued to be screened for any obvious signs of Covid-19 and any callers presenting with breathing difficulties, chest pain, headache or general sick person complaints was triaged through Protocol 36 for more screening, before any standard triage. Further updates were issued nationally on the **20 April 2020**, including clarification on the use of 'no-send' markers that required clinical recommendation.

13.4 On the **22 February 2020**, NHS England published the Covid-19 Ambulance Case Transport Response Service Framework, requesting that all ambulance services implement as soon as possible an Ambulance Case Transport Response Service. Each Service was required to be embedded in, or adjacent to, an Emergency Operations Centre (EOC) to enable call receipt and dispatch and be scalable as demand increased.

13.5 The core requirements were that each Service would:

i. Be staffed 24/7 by a manager, paramedic and control room staff
ii. Provide advice to ambulance crews conveying suspected or confirmed cases
iii. Ensure patients are conveyed in accordance with national guidance in place at the time for Public Health England input, Personal Protective Equipment and decontamination
iv. Ensure patients are collected promptly including discharges, to maintain flow through the Covid-19 pod, etc

v. Co-ordinate all ambulance service resources used for conveying such patients

vi. Provide advice, maintain a log and report regionally and nationally as required

13.6 In addition, ambulance services were asked to develop transport capacity and capability to manage the immediate demand placed on it and for this to be scalable as demand increases.

13.7 Our service, known internally as the Ambulance Transport Cell, went live on a 24/7 basis in the Exeter Clinical Hub on the **6 March 2020.** The Cell was led by the Hub Operations Officer and, in addition to the above requirements, the Cell was responsible for ensuring that vehicles were decontaminated after transport as part of returning a vehicle for core business.

13.8 In addition, on **20 April 2020**, a revised BT call flow process was issued that redirected callers seeking advice regarding Covid-19 to NHS 111 online. This was for callers/patients who are over 16 or under 70 and not experiencing life threatening symptoms.

13.9 Please note that the ambulance service does not issue Do Not Attempt Cardiopulmonary Resuscitation (DNACR) notices for patients and therefore there was no change to any processes.

14 Funding

14.1 In line with the Standing Financial Instructions, the Chief Executive remained accountable for the budget during the period, but this was delegated to officers of the Trust. The decision on how the budget was spent was agreed by the Executive Directors, with the Director of Finance responsible for ensuring that the funds were spent in line with the Covid-19 related costs. Individual budget holders continued to be responsible for the budget that was allocated to them.

14.2 On **31 July 2020** NHS England/Improvement published a letter setting out the actions to be taken in the third phase of the NHS response to COVID-19. This stated that the current financial arrangements for Clinical Commissioning Groups (CCGs) and trusts would be largely extended to cover **August and September 2020**. This included the nationally-set block contracts between NHS providers and commissioners, and prospective and retrospective top-up funding issued by NHS England/Improvement to organisations to support delivery of breakeven positions against reasonable expenditure. The month 5 and month 6 block contract and prospective top-up payments would be the same as month 4.
The intention then being to move towards a revised financial framework for the latter part of 2020/21.

14.3 On the **15 September 2020** NHS England/Improvement published the contracts and payments guidance for **October 2020 to March 2021**, confirming the financial arrangements for the latter half of the year. Systems were issued with fixed funding envelopes including Clinical Commissioning Group (CCG) allocations and block contracts, top ups to support delivery of a system breakeven position, growth funding and additional funding to cover Covid-19 related costs.

14.4 On the **13 January 2021** NHS England/Improvement confirmed that, given the relentless pressure the NHS was facing, the 2020/21 planning and contracting round would not be initiated before the end of **March 2021**. Instead, the financial arrangements at that time would be rolled over for Quarter 1 of 2021/22. Funding for Covid-19 pass-through items, including testing and vaccinations, would remain outside of the financial envelopes.

14.5 Our funding did increase from 2019/20 and the NHS operated with an interim financial regime during this period.

14.6 Our increased funding was requested in line with the Interim Financial Regime through our Commissioners and NHS England, as follows:.

	2019/20	2020/21	2021/22	2022/23
Total income	**£ 262,235**	**£ 320,184**	**£ 334,026**	**£ 366,258**

14.7 A cumulative summary of the Covid-19 related costs during the interim financial regime for this period is set out below:

Area	2020/21						
	Q1 2021	Q2 2021	Q3 2021	Jan-21	Feb-21	Mar-21	Full Year
	£000	£000	£000	£000	£000	£000	£000
Income	**(9,467)**	**(8,969)**	**(8,508)**	**(2,836)**	**(2,837)**	**(3,236)**	**(35,853)**
National Service Requests							
Nightingale	73	0	0	0	0	0	73
PPE and other equipment	1,284	378	18	7	6	5	1,698
Swab test booking & results	0	0	0	0	0	0	0
Command and Control	204	55	50	15	17	13	354
NHS 111	192	0	0	0	0	0	192
SWASFT 5							
SWASFT 5 Operations	5,962	6,081	7,589	2,784	2,695	3,567	28,678
SWASFT 5 Fleet & Logistics	796	1,258	257	135	124	169	2,739
SWASFT 5 IM&T	403	142	70	8	41	19	683
Other							
Subsistence, training and other staffing costs	591	848	150	21	13	24	1,647
Fuel	(132)	40	39	13	(132)	(115)	(287)
Secure Working and Other Corporate Costs	93	168	118	67	73	(520)	(1)
Transfer	0	0	0	0	0	75	75
Total Cost Recovered	**9,466**	**8,970**	**8,291**	**3,050**	**2,837**	**3,237**	**35,851**
Total Cost (Under) / Over Funding	**0**	**0**	**(217)**	**214**	**0**	**1**	**(2)**

14.8 Our funding was increased in line with the interim financial regime, but the initial uplift in costs at the start of Covid were recovered in line with expenditure.

15 Capacity

15.1 As of the **1st March 2020** our emergency ambulance resourcing was 466 ambulances per day which is shown in the following table in resource hours in the Double Crewed Ambulance (DCA) column. The table also shows a breakdown of additional ambulance resources again in resource hours per day.

Measures	Operational Commander	DCA	PSV	Solo	SP	Grand Total
Actual	**365**	**5363.5**	**123**	**1037**	**216**	**7104.5**
Plan	**384**	**5384**	**84**	**1148**	**312**	**7312**
%	**95.05%**	**99.62 %**	**146.43 %**	**90.33 %**	**69.23 %**	**97.16%**

15.2 Response Time Targets and the extent to which response time targets were met are shown at;

WW/3a Exhibit INQ000221552 – Weekly Profile - calls Covid 19 Responses and WW/3b INQ000221551 - Daily Activity. These exhibits display the Daily and Weekly profile of Calls, Covid-19 cases and responses.

15.3 Our initial response to Covid-19 focused on maintaining resources where possible and putting in place actions to ensure staff could remain working. In parallel, we produced a Surge Management Plan in response to the Covid-19 incident, which was updated weekly through to the **31 July**. This is in addition to existing Resource Escalation Action Plan Documents, Demand Management Plans and Business Continuity Plans.

15.4 The primary strategic objectives of the Plan were to:

i. Protect call answering and provide a safe dispatching function;
ii. Maximise as far as possible clinical presence and availability within the 999 Clinical Hub;

iii. Increase 999 front line resourcing levels using capacity from all available sources;

iv. Support the development of Nightingale hospitals within the south west;

v. Protect the Clinical Hubs; Frontline Operations; Regional Operational Centres, Information Management and Technology and Fleet;

vi. Protect the command structure dealing directly with the outbreak focusing on command resilience.

15.5 In line with other ambulance services, our initial Surge Management Plan (SMP) looked 12 weeks ahead from week commencing Monday, **23 March 2020** (week 1 of 12). Phase 1 was based on the following planning assumptions:

Planning Scenario	**Expected Peak Date**	**Expected Call Volume**	**Expected Peak Number requiring Hospital Admission**
Social Distancing and Self Isolation Each individual infects 2.2 others 20% Covid-19 staff loss	**2 May 2020**	27,000 per week	682 Hospital admissions are being used as a proxy for the requirement for an ambulance resource although it is recognised that not all patients may require this

15.6 During early **May 2020** the planning position changed as clear evidence started to emerge that the first peak had passed in the South West. Therefore, our Surge Management Plan was updated to reflect actions over the 8 week period from week commencing **Monday 4 May 2020**, and focused the next phase of the Plan on an expected second peak. In addition, this version of the Surge Management Plan included an overview of all actions that has been implemented to date, or if not, a rationale stating the current position. It looked at modelling against two scenarios:

Planning Scenario	Expected Peak Date	Expected Peak Number requiring Hospital Admission
Scenario 1 = 2.6 infection rate	Worst Case 11/07/20	463
Scenario 2 = 1.8 infection rate	Best Case 01/08/20	156

15.7 An updated Version on **Friday 12 June 2020**, set out a range of actions covering the next month – **1 June through to 30 June 2020**. This included the likely requirement to extend surge planning beyond **June 2020**. At this point in time, we remained at Resource Escalation Action Plan Level 2 (Amber) and based on data over the previous week, we took the decision to revise down the assumptions in the forecasting model.

15.8 The two previous scenarios that the Plan had been tracking were stood down. The new scenario reflected the government's update that the R value was around 0.9 for the South West of England. However, due to a number of hotspots, our scenario was modelled to reflect the possibility of growth. The new scenario did not necessarily have a peak, rather the shape of future cases was much more elongated with a consistent level of activity. In addition, this version of the Plan set out a change in emphasis moving towards more granular level detail as our assessment was that it may start to see more localised increases in cases in line with recent government intel.

15.9 The final version of the Surge Plan was dated **17 July 2020** and ran until November 2020, after this date we embedded a number of these actions into Business as usual arrangements. A copy of these plans are **WW/2 Exhibit INQ000221550 – Surge management plan and Reactivation of Surge Actions.** From the 1 August 2020, monitoring occurred through a weekly Covid-19 early warning dashboard report. Activity forecasting was re-focused on 'normal' activity accounting for Covid-19 cases and, as part of this review, capacity on a rolling six-week basis.

15.10 During the very first lockdown the ambulance incident numbers dropped drastically falling to some of the lowest levels that we had seen over 4 years, with activity dropping below 16,000 incidents per week at times during **April 2020** (compared to an average of over 18,000 incidents per week prior to the Covid-19 lockdown being implemented). Restricted movement of the public, remaining at home with limited outdoor time, led to a huge reduction in incidents, for example, less road traffic collisions, etc.

15.11 Activity returned following the first lockdown as the restrictions eased, a staged recovery in line with the staged easing of the restrictions. The reductions in subsequent lockdown periods were not as significant .

15.12 Immediately following the end of the third lockdown, we saw a surge in activity which continued throughout the summer of 2021 and activity reaching the highest levels in our history between the end of **July** to the middle of **September 2021**. High visitor numbers to the South West were a key element behind this increase, but also an increase in overall activity within the South West area as public movement returned to previous levels. Since that point activity has been much more variable than seen prior to Covid-19.

16 Infection prevention and control

16.1 A wide range of documents concerning Infection Prevention Control were published by NHS England during the pandemic. The translation of the national documents into practice was a matter for individual Trusts. Within the sector, the Association of Ambulance Chief Executives National Ambulance Infection Prevention and Control Group (NAIPC) played a vital role in aiming to reach a consensus view across England.

16.2 The overarching document used within our organisation was the national Infection Prevention Control Ambulance Guidelines, developed by Ambulance Chief Executives National Ambulance Infection Prevention and Control Group.

16.3 The guidelines covered all aspects of Infection Prevention Control:

i. Identification of possible cases
ii. On-scene clinician precautions
iii. Personal Protective Equipment (PPE)
iv. Definition and precautions during aerosol generating procedures
v. Conveyance and patient handover
vi. Post conveyance
vii. Decontamination

16.4 These guidelines were published and revised as below:

i. **13/03/2022** - Initial guidance published
ii. **20/01/2021** - Revised
iii. **01/12/2021** - Revised
iv. **21/04/2022** - Revised

16.5 All infection prevention control guidance matters were considered by our Clinical Group, with each version of the national ambulance Infection Prevention Control guidelines adopted in full.

16.6 The national Infection Prevention Control Ambulance guidelines also included detailed guidance on the use of Personal Protective Equipment.

16.7 In accordance with the guidelines, we introduced powered respiratory hoods for all vehicles and clinicians in early 2020. By **27 March 2020**, an additional 350 had been issued, to provide one on each emergency ambulance.

16.8 On **10 September 2020** further hoods were distributed to enable them to become personal, as opposed to vehicle issue. By 2021 there were three powered respiratory hoods on every emergency ambulance and two on every rapid response vehicle.

16.9 Guidance on the use of the units was provided by a Standard Operating Procedure on the use 3M Versaflo TR-300 Powered Respirator and S-133 Headcover.

17 Equipment and Infrastructure

17.1 During the relevant period, there were differing scenarios in which the procurement and supply of Personal Protective Equipment and Respirator Protective Equipment to us varied and impacted on availability of product. There phases are set out and could be described as follows:

17.2 Phases of Supply Challenge in General:

17.3 **Phase 1 – Challenged Supply**. There was concern around supply and some products reaching minimum levels or stock outs. Some unavailable for a period, for example, extra small/extra-large gloves.

17.3.1 Focus at this point was to obtain whatever products we were able to source. We created a fast clearance process with an internal panel including Health & Safety; Infection Prevention & Control; Procurement; Clinical and Stores, which developed a procedure for reviewing products on arrival at stores and to enable assessment of their suitability and quality before issuing for frontline use, which is at **WW/4 Exhibit INQ000221553 – Stores Supply Procedure.**

17.3.2 'Stock outs' of product were anticipated, and an internal protocol was developed for escalation of low stock volume products to both NHS Supply Chain (NHS SC) and internally to enable brokering of products between local NHS organisations and other ambulance services nationally. **WW/5a Exhibit INQ000221561 – NSDR Supply Disruption Notification COVID-19 form. WW/5b Exhibit INQ000221562 – Stores Escalation Process. WW/5c Exhibit INQ000221565 – Stock Shortages List part of Escalation**. These exhibits support reporting, protocol and process for the stock management of Personal Protective Equipment.

17.3.3 Products were at times donated to the NHS by other commercial and private sector organisations. Assessment of donated products was subject to the same assessment process and documentation maintained on suitability for use.

17.3.4 In this phase, we were unable to source sufficient quantities of FFP3 Respiratory masks and fit test solution, with eight different products received by us in total. This resulted in a switch of products nationally across the ambulance sector to try and secure the supply of single principle masks for each ambulance Trust. Smaller quantities of alternate FFP3 Respiratory masks were held as a contingency as alternate products in smaller numbers as an option for those who failed fit testing on the primary product.

17.4 **Phase 2 – Push stock** – this approach could be described as sending something to everyone (Trusts), with products provided whether or not it was suitable or practical for use in the pre-hospital ambulance sector environment. For example, large volume dispensers of hand sanitiser which we were not able to be accommodate in an ambulance. Whilst the quantity provided was in litres, we had no way to decant this into smaller bottles/personal issue bottles (which were not available) and no process to handle large quantities in bulk. Without smaller containers this could not be distributed for use across the 10,000 sq. miles of our geographic operational area.

17.4.1 A second example of the products being unsuitable for use in the pre-hospital environment was the provision of aprons, which were part of the nationally recommended Personal Protective Equipment. **WW/6 Exhibit INQ000221566. – PPE Dashboard.** This exhibit provides stock data and information of PPE across the Trust.

17.4.2 NHS Supply Chain as our contracted supplier (and others) was unable to supply body bags. National Infection Prevention Control guidance recommended Covid - 19 patients when deceased were 'double bagged' in body bags, but these were completely unavailable for supply throughout. Guidance was amended following inability to secure supply.

17.4.3 NHS Supply Chain was unable to meet supply requests for several products or would not honour orders. At the same time, they were unable to meet key supplies in volume of high turnover products. Body bags were not available despite guidance at the time that the bodies should be double bagged. We could not (and did not) rely on NHS Supplies to secure products and throughout also procured directly, until a national request for us to cease direct procurement. We also provided details to NHS Supplies as to where they could source products as they were reporting they were unable to secure, though at times we could identify suppliers.

17.5 **Phase 3 – Forecasting** – We developed a forecasting process using proxy data for usage based on activity levels and estimates of the amount of Personal Protective Equipment and Respiratory Protection Equipment that a frontline resource would utilise in responding to the mix of Covid-19 patients and other patients. **WW/7 Exhibit INQ000221546 – Stores Forecasting.** This exhibit demonstrates the the process associated with forecasting PPE usage, updating minimum and maximum stock levels in the Inventory Management System, and providing updates.

17.5.1 Going into the pandemic, we had no electronic system for capturing product holding as supplies previously were provided and contracted for delivery direct to stations with small volume holding capacity. We were unable to rely on NHS Supply Chain to deliver and took the decision to become self-sufficient with volume stock holding for distribution. This led us to redesign its stores operating model and in order to hold high volumes of Personal Protective Equipment products in a single location, moved to acquire new warehousing to enable product handling (reducing delivery sizes) and delivery from our new central warehouse to frontline locations. This also required a surge in recruitment activity. Initially, the warehouse was provided as a gift to the NHS for use during covid- 19 pandemic from a commercial provider.

17.6 **Phase 4 – Developed systems and process (approximately 1 year into pandemic)** – at this stage there was a regular rhythm around forecasting usage, internal process for volume ordering, receipting and review of products received.

Deliveries had become regular and whilst systems were substantially different to pre-pandemic, were operating effectively. Set out below is some of the specific challenges in relation to sourcing particular products:

17.7 FFP3 Respirator Masks & Powered Respirator Hoods

17.7.1 Initially there were concerns around our ability to secure both FFP3 Respirators, surgical masks and gloves. Prior to the pandemic, we stocked a small amount of FFP3 Respirator masks for the purpose of occasional management of patients with High Consequence Infectious Disease (HCID). A limited number of staff had been trained in the use of FFP3 Respirator masks. We were aware of the requirement to secure FFP3 Respirator masks for wider use as the cases of Covid-19 increased. Initially stocks were difficult (impossible) to obtain. We procured FFP2 Respirator masks at one point in full knowledge that these were not at the required standard but in recognition that FFP2 Respirator may offer better protection than nothing should the circumstance require. Please note that these were not used as the situation did not arise.

17.7.2 We took a relatively early decision due to the supply challenges with FFP3 Respirator masks and the significant practicalities of fit testing its workforce, to procure powered respirator hoods. These products were not available through NHS supply Chain. As there was a supply lead in time, we still needed to undertake fit testing of our staff and use the FFP3 Respirator masks provided through the 'push stock'. We moved to a position of personal issue hoods for frontline staff as soon as supply enabled.

17.8 Surgical masks

17.8.1 Prior to the pandemic, we only held a small quantity of surgical masks for use in specialised pre-hospital circumstances, such as in maternity kits. These were for single numbers of patients and hence stockholding was at a minimum. When we then sought to increase our procurement with NHS Supply Chain, it was declined. Our senior managers undertook significant intervention to explain that a single delivery of 100/200 units was of little use to us as a sector, as unlike a hospital

environment, we did not have the infrastructure of logistics mechanism to disseminate limited supply across our geography. 200 masks in a single location in a hospital can be easily distributed but we needed supply to reach each of our 94 stations across 10,000 sq miles. There was little appreciation of the difference in logistics management and distribution in the ambulance sector.

17.9 Type 2R masks

17.9.1 Initially we received supply from NHS Supply Chain, but they were unable to sustain supplies. As a result, we moved to source these directly.

17.10 Powered Respirator Hoods

17.10.1 We took an early decision to purchase. The hoods were provided on a personal issue basis, but these were sourced directly as they were not available via the NHS Supply Chain.

17.11 Goggles & Eye Protection

17.11.1 Single wear goggles. These came in two parts and had to be 'built' on receipt. However, these were often received with parts missing and hence unable to be used. This led to us securing its own supply of full face masks, commissioned and developed by a local manufacturer to a documented specification.

17.11.2 We issued regular and updated rolling 'Clinical Advice Notices' to staff. Specifically notices. Guidance covered a wide range of Covid-19 subjects including infection control, Personal Protective Equipment use and other operational practices. Posters were developed to support donning and doffing of Personal Protective Equipment and use of National Ambulance Resilience Unit video on donning/doffing powered hoods. A total of 150 individual entries were provided.

17.11.3 We issued guidance as on ongoing Covid Clinical Notice specifically:

i. **20 March 2020** – Trust Response to UK Resuscitation Council

ii. **27 March 2020** – Trust statement on clinical practice in exceptional circumstances for aerosol

iii. 27/03/2020 – Clarification that the Trust do not consider chest compressions in isolation to be aerosol generating procedures

17.11.4 As part of our Command Structure (Constant Care) a formal subgroup, the 'Stores & Supplies Sub-group' was established to review the procurement and supply of Personal Protective Equipment, Respiratory Protective Equipment and infection control products such as hand sanitiser, cleaning products, waste bags, etc and their adequacy and suitability for use.

17.11.5 A working group was also established as part of this formal command arrangement specifically to review incoming/new products to us prior to allocation to frontline services for use. The panel consisted of infection control, stores, clinical, procurement leads within the Trust.

17.11.6 Internally, teams worked to assess products. If products failed the internal assessment process, we reverted to NHS Supply Chain 'push stock'. Some products were quarantined, because they were out of date or there were concerns about quality (internal recall of products by batch numbers, straps/nose piece disintegrate on use). **WW/9 Exhibit INQ000221547 – Approved Products Stock Receipt Process.** This exhibit demonstrates the process to follow where products were "pushed" to the Trust.

17.11.7 We assessed products on their arrival by our stores team. A document protocol for assessment of suitability was used (developed by the internal team described above) and an escalation process. Product was quarantined until either released by Infection Prevention Control or rejected and/or returned to NHS Supply Chain. Quarantined products were held in stock for several months until collection for disposal or other management by NHS Supply Chain.

17.11.8 Most products were not 'tested' on individuals but subject to an assessment in stores prior to issue. This included an assessment by our internal team before being 'released' for supply into our organisation. This included review of the spectrum of our staff not just age, sex, disability, pregnancy, but other characteristics such as size. We were unable to source extra-large Tyvek suits and extra-large/extra small gloves for a time. During this period, colleagues were utilising a product which was not completely satisfactory for their individual use, for example, use of medium/small gloves instead of extra small. The consequence of using large and not extra-large gloves was a greater tendency to split, but supported by advice around hand hygiene was also issued.

17.11.9 The exception to this was FFP3 Respirator masks which were assessed as a suitable product for use and then individually fit tested to our frontline users. As testing FFP3 Respirator masks suitability for use was on an individual basis, individual characteristics were reviewed for each frontline user.

17.11.10 We did determine risk factors by relevant characteristics and supporting Black, Asian and minority ethnic colleagues to wear higher level Protective Personal Equipment, as information became known on specific risk factors for exposure to covid. This was documented in a clinical notice **11th June 2020** – Trust statement that Black, Asian and minority ethnic staff were supported to wear a higher-level Personal Protective Equipment, if they personally deemed necessary.

18. Trust's future risks, reviews, reports and lessons learned exercises

18.1 An initial review of lessons identified was conducted across all of our Directorates with the following questions posed for consideration:

a. What three things have you stopped that you would not like to reinstate?
b. What three things have you started or implemented that you would like to continue?
c. What three things have you started, are the right things to do for our workforce and patients but you believe are not sustainable without the appropriate investment or removing a blocker that you may need support with?

18.2 From over 50 responses received, the following were consistent themes:

i. Increased home based / remote working
ii. Remote triage and clinical validation - patient safety / No Harm incidents
iii. Continue to maximise the use of Skype / Microsoft Teams
iv. 7 day Fleet and Logistics / Make Ready provision across all counties
v. Outward mindset - Support Service supporting operational delivery
vi. Process Review / Pace of decision making whilst maintaining governance.
vii. County Coordination including staff health and wellbeing support
viii. Clinical Hub structure – linked to the longer term sustainable Hub project.
ix. Corporate Communications
x. Collaboration with other services – with Patient Transport Services providers and Fire and Rescue Services, revised business as usual provision v support during surge.

19. Future plans for resourcing and prioritising the response of ambulance related services to any future pandemic.

19.1 As the UK came out of lockdown in June – July a review of the actions that we had implemented was undertaken by our Emergency Preparedness Resilience and Response Department to identify lessons learned to enhance both our position when it returns to business as usual and also to enable sound response to a second phase of the incident.

19.2 We continued to move into a new normal as Covid-19 restrictions lifted and case numbers fell but remained in a state of readiness to respond to the predicted second wave. Due to an increase in Covid-19 cases, a second lockdown was introduced between the **5 November and 2 December 2020.**

19.3 Following the relaxation in restrictions and cases again rising, **January 2021** saw the United Kingdom return to full lockdown as cases continued to surge across the country and throughout the lockdown. We again stood up various resources and processes to meet the challenges and demand placed upon us which were

significantly higher than the first phase. In addition to this we commenced the vaccination programme to vaccinate our 4000+ staff against Covid-19.

19.4 As the covid-19 case numbers fell, the government introduced a road map for the lifting the national lockdown and we took stock of its response to the second phase and identified a number of new lessons and reviewed the previous lessons identified during the first phase.

19.5 The following lessons were identified and changes to policies, procedures and processes implemented, enhancing our response to ongoing and future incidents:

LI Number	Theme	Summary of Lesson Identified	Actions Taken
524	Command & Control (C2)	Review of Trust Strategic Coordinating Group (SCG) and Tactical Coordinating Group (TCG) arrangements – devolve more from the strategic level to the tactical level with upward assurance briefings – consider the role of executives.	The Trust's Incident Response Plan (IRP) has been rewritten and captures more clearly the decision making process for the different command tiers
525	Command & Control (C2)	All departments fully engaged with the Tactical Coordinating Group (TCG)	It has been clarified that an Incident Management Team will focus on the business continuity response and the Business Continuity Steering Group (BCSG) will focus the recovery phase, both groups will

LI Number	Theme	Summary of Lesson Identified	Actions Taken
			encompass the right teams and departments. Review of pandemic disease plan is ongoing and this is one of the exceptions a Trust wide membership would be required. A Trust wide Business Continuity pandemic exercise is also planned for October 2021 to test plans and command arrangements.
528	Communications	A review of the cascading of communications requires reviewing i.e. who, what when etc. ensuring that support services are included.	There has been engagement with Communications team to agree how to formulate a communications plan for protracted Business Continuity incidents. This has been captured within the Incident Response Plan (IRP) with regards to warning and informing plus internal communications.

LI Number	Theme	Summary of Lesson Identified	Actions Taken
529	Recovery	Recovery was managed better after the first wave with a structure in place. It was felt that this needs to be replicated after subsequent waves.	Recovery Group Plan was produced and approved at the Business Continuity Steering Group (BCSG) in May 2021.
531	Clinical Advice / Advisors	The role of the tactical medical advisors and other clinical advisors needs further exploration. Clinicians fulfilling these roles need protected time to review guidance and translate it for commanders. Consider establishing a Trust Science and Technical Advice Cell (STAC) in future.	Other regional groups were set up to inform health more widely so it was felt that the Trust should not create its own 'STAC' but to link the right people with those groups in the future. Some form of advisory group should be formed to support commanders interpret the potential impacts of a public health emergency on the trust. Establish a Technical Advisory Cell and add this as an option within the Trust Incident Response Plan (IRP).
532	Local Resilience Forums	There was evidence of Local Resilience Forum (LRF) / Local Health Resilience Partnerships	County LHRP's and LRF attendance in relation to COVID produced notes submitted through strategic commanders to

LI Number	Theme	Summary of Lesson Identified	Actions Taken
		(LHRP) regional duplication	create shared situational awareness alongside membership of the regional group, this is inevitable and needs to be coordinated through single sources. The Common Operating Picture (COP) was produced to standardise information that was shared at LRF and LHRP meetings and internally and this model could be used in future incidents.
533	Strategic Medical Advisor	Lack of resilience for the Strategic Medical Advisor role	Subject to ongoing discussion with the Executive Medical Director and Assistant Director of Operations (Emergency Preparedness Resilience and Response and Specialist Practice). Ongoing discussions at Executive level and already captured as an organisational risk on Pentana

20. Internal or external review or lessons learned exercises/investigations since March 2020.

20.1 Care Quality Commission Inspections

20.1.1 In **November 2021,** we were part of the first system wide inspection of urgent and emergency care in the Gloucestershire area. Our core services of Emergency and Urgent Care (A&E 999) and Emergency Operations Centres (EOCs) were inspected as part of this. The CQC commented in their report on the "immense and unrelenting pressure from demand" on the Trust and despite this, "staff were kind, compassionate and supportive to patients".

20.1.2 In **March 2022**, a further system wide inspection of urgent and emergency care was conducted in the Cornwall system. Only our core service of Emergency and Urgent Care (A&E 999) was inspected.

20.1.3 We were inspected twice in **2021/22**; however, these inspections were not rated.

20.1.4 Following CQC inspections, we develop Quality Assurance Plans (QAPs) that are targeted to address any actions given to us by the CQC.

21. Conclusion

21.1 Our response to the Covid-19 pandemic has had huge and wide-ranging impacts. It has affected us all, the Trust, the Ambulance sector, the NHS, our society, communities, and the economy. Within the Trust we have had to change our strategy and act in decisive and new ways. We have created new ways of working, brought in new roles, processes, and had to embrace wide-spread working from home.

21.2 We have reconfigured services, forecast surges, managed demand, commissioned, co-opted, supported and collaborated. The Response to the national emergency has shown the very best of our people and supported our mission, vision and values. Having responded we must look towards Recovery.

Statement of Truth

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

Signed: Personal Data

Dated: 27 July 2023