Witness Name: Dave Williams
Statement No.:01
Exhibits:
Dated:040723

UK COVID-19 INQUIRY

WITNESS STATEMENT OF David Williams

I, David Williams, will say as follows: -

Structures, Roles, People and Processes

1. The South East Coast Ambulance Service NHS Foundation Trust (SECAmb) is the main pre-hospital ambulance provider for Sussex, Surrey, Kent and North East Hampshire covering 3,600 square miles. SECAmb covers 999 ambulance calls for Surrey, Sussex, and Kent, and 111 calls for Sussex and Kent. The trust employs 4000 staff, 90% of whom are classed as operational.
2. At the beginning of the Pandemic, SECAmb had an Operations Directorate, Finance Directorate, Safety and Quality Directorate, Business Development and Medical Directorate. This main organisational change was the amalgamation of the Business Development team into other directorates.
3. The initial Pandemic incident response structures that were established took the form of a standard Strategic, Tactical and Operational hierarchical structure with executive oversight from the Director of Operations. These initial response structures proved to be complex and cumbersome, restricting the flow of information and decision making considering the developing pandemic.
4. As an attempt to mitigate this everchanging situation, enhanced COVID-19 governance and communication arrangements were introduced to SECAmb. Initially this took the form of the COVID Management Group (CMG), a team of senior decision-makers, led by an executive director and able to convene in an

effective response mechanism 24/7. To bolster this oversight group, an operational delivery team was also established in the COVID Management Team (CMT) in 2020/21 under the Nursing and Quality Directorate.

5. Further to this new series of management structures, in February 2020, the Trust assumed responsibility for the regional COVID-19 Coordination Service – this continued for 2 months. The primary function of the service was to contact members of the public to report on their COVID-19 test results and administer community testing bookings for patients and trust staff. Additionally, we managed and coordinated requests for the critical care transfer and retrieval of COVID-19 cases. As the occurrence of infections became commonplace, the response fell under the Trust COVID-19 Command Hub situated within the Trust headquarters.
6. Each Integrated Care Board set up Incident Coordination Centre's and disseminated information through the Covid Management Group. This information was originated by NHSE and was a push system, with very little ability for us to offer feedback on the decisions that had been made. This may have led to some less than effective decisions being taken at too high a level and reducing the amount of subsidiarity. Eventually, this process moved to a single ICB ICC providing the information, which reduced the impact and time required, but still allowed little interaction in the decision-making process or feedback.

Funding

7. The Trust continued to follow its governance process and its Standing Financial Instructions (SFIs) and although authority by CMG allowed quicker processing of key decisions on additional costs due to Covid, business leads still had to complete a business case for formal approval. The budget areas that managed spend on Covid costs were Executive Director of Operations; Deputy Director of Operations, Associate Director for Urgent and Emergency Care, Head of Estates and the Head of Fleet & Logistics. Budgets were monitored and reported by the Financial Management team led by the Head of Financial Management. To ensure the Trust was not unjustly allocating costs to Covid, benchmarking with other Ambulance Trusts was undertaken in addition to Internal Audit conducting a review of the approval process. A regular Covid report was produced for review

by Non-Executive Directors through the Finance and Investment Committee (FIC) a committee of the board.

The Trust's involvement in the response of healthcare systems to pandemics/the Covid-19 pandemic

Policies

8. In the period running up to the Pandemic, the National Risk Register had placed the Pandemic Influenza as High risk, and SECAmb had an established Influenza plan and structures in place to manage the response. This plan, however, proved to ineffective in dealing with the Pandemic. The continually changing impact of new guidance, aligned with some confusion on the actual response required led to the plan being superseded.
9. As the impact of the Pandemic began to take effect, it became obvious that SECAmb would be heavily involved in all aspects of the response. Indeed, one of the first incidences of COVID-19 infection in primary care occurred in February 2020, in a Sussex GP surgery. Following that incident, the SECAmb 111 service which covers Sussex was subject to a 200%+ increase in demand. This increase in volume became an issue for recruitment and funding through the period of the Pandemic.
10. Clinically, to ensure that patients with suspected COVID received a consistent response, a national approach was implemented using NHS Pathways to generate a standard category as per the patients' symptoms. In both 111 and 999, some patients could not be referred to specific downstream services if the patients identified as potential COVID positive during their NHS Pathways triage assessment.
11. NHS England changed the Interactive Voice Recognition (IVR) Front End Message (FEM) when you call 111, to prompt patients to access different numbers and to "hive off" specific activity with regards to COVID. SECAmb trained up additional call handlers (called Service Advisors (SAs)) to handle these non-triaged calls and direct them appropriately based on the IVR FEM prompts.
12. To work effectively with the wider NHS, regional/ICB communications were supported by weekly meetings with Commissioners to provide situational

awareness. This was further supported with regular meetings with the wider system partners. These varied in regularity dependent on system pressures and escalation.

13. To keep staff safe, both in front line operations and in support services, the trust followed the guidance that was issued around IPC by the government, especially with regards to those staff who fell into the high-risk category. To support trust managers and staff, action cards were produced to provide guidance in varying circumstances for staff considered high-risk. Action cards were made available to all staff via the trust's intranet and updated throughout the pandemic by the communications and COVID Management teams. All changes were approved by the COVID Management Group.

Disseminating policies and/or alerts

14. The trust held a daily Teams call with all staff at 1600 hours, briefing on any changes in policies or procedures. This continued throughout the Pandemic, with an Executive director leading the call. As the Pandemic progressed, the frequency of the call reduced to three times a week and then once a week, before being disestablished when the pandemic was stood down.

Staffing

15. From a frontline operations perspective, staffing at the 17th of March was at 2103 Whole Time Equivalents. Staffing has increased since that time to 2255 WTE, with an increased focus on recruitment and retention. This contributed to effective patient care as the demand on 999 frontline operations began to increase. No particular geographical areas experienced staffing issues.
16. From an EOC perspective, staffing numbers varied greatly across the period, so whilst the staffing requirements on the 01st of March were considered effective, an increase in the 999 demand meant that at periods, call demand surpassed the resource. This was also matched in the 111 service line, as the demand increased greatly across the pandemic. Additional call handlers were recruited for both 111 and 999, with a specific target of people who were furloughed. SECAmb modified its EOC recruitment process to fast-track applicants through to undertake the relevant NHS Pathways training. The Trust modified the NHS

Pathways training programme (content and format), to facilitate more rapid NHS Pathways training and to enable suitably skilled call handlers to start taking 111 and 999 calls more quickly.

17. To manage demand within the EOCs, daily reporting and live-time dashboards and wall boards were used to identify areas of greatest risk. Escalation plans were developed with multiple bulletins to mitigate risk and to protect staff. The Trust was able to source specialist clinicians from other providers/services to support the delivery of 111. Agile working kits were utilised to enable clinicians shielding to contribute their clinical support.
18. Multiple changes were made by NHS Digital to NHS Pathways, the triage Clinical Decision Support System (CDSS) used by SECAmb in 111 and 999. There were various iterations, workarounds and additional questions added, to enable non-clinical handlers to prioritise cases with specific symptoms, so that they could be directed to the right outcome.
19. Throughout the COVID-19 response, the Trust successfully facilitated several testing programmes for both Trust and other NHS staff located within its operational footprint. The CMT administered the Trust's Test & Trace Cell, which continued to offer an in-house support hub for staff, providing advice and guidance around self-isolation, testing, contact tracing and outbreak management through 2021/22. The Trust's test & trace and outbreak control management processes were shared regionally and nationally as examples of best practices, promoting an effective and coordinated approach to COVID-19 contact tracing and outbreak management. A single point of access for all COVID-19 information through the Trust's intranet remained available to all personnel throughout the COVID-19 pandemic response, including a range of topic-based, easy-to-read action cards to inform staff and managers of changes to government COVID-19 guidance and legislation that applied to the healthcare sector and bespoke resources which provided support to staff during different stages of the pandemic.
20. Changes were made to Human Resource policies to reduce the risk of infection, help staff financially and to support our people and their health and wellbeing. Consideration of at-risk groups of staff was discussed at the daily COVID Management meetings. The Trust equality, diversity, and inclusion lead, being a key member of the CMG, was fully consulted on all aspects of policy change

during the pandemic. The Trust developed a Risk Assessment for vulnerable and shielding colleagues in partnership with the Head of Health and Safety, Head of Infection Prevention and Control (IPC), EDI Lead and HR COVID Lead. The Trust also produced a BAME Risk Assessment, with guidance from IPC, HR, Inclusion, and H&S. HR Guidance was also produced on a regular basis to help managers to support vulnerable colleagues.

21. Whereas the majority of NHS Trusts returned to a BAU status in October 2022, with regards to "Long COVID" and the impact that this had on sickness and non-attendance, SECAmb chose to recognise COVID and the impact on colleagues' ability to work as special case, thereby offering additional support to all staff adversely affected by COVID. The issue as to whether the long-term effects of Covid on both mental and physical health presents a significant impact is difficult to quantify or to describe. The wellbeing hub is still extant and works actively with members of staff to offer assistance as and when they require it.

Capacity - infrastructure and equipment

22. 999 Service

Response time standards[1]

Category	Mean average definition	Standard for mean	Standard for 90th centile
C1	A25 = A24 / A8	≤ 7 minutes	≤ 15 minutes
C1T	A28 = A27 / A9		
C2	A31 = A30 / A10	≤ 18 minutes	≤ 40 minutes
C3	A34 = A33 / A11		≤ 120 minutes
C4	A37 = A36 / A12		≤ 180 minutes

C1T does not have a formal standard but the mean and 90th centile will be collected and published. Ambulance services should aim for a 90th centile of 30 minutes.

111 Service

KPI	Title	Domain	Freq.	%
1	Proportion of calls abandoned	Safety	Monthly	≤5%
2	Proportion of calls answered in 60 seconds	Pt Experience	Monthly	≥95%

23. On the 01st of March 2020 SECAmb provided 110 ambulances and 32 Single response vehicles (Cars) at 0700 hours and at 1900 hours 197 ambulances and 41 SRV's. SECAmb does not provide non-emergency ambulance services.

24. 999 calls and 111 calls made to the Trust in the full week up to 1 March 2020 (or the nearest recording period) and the extent to which response time targets were met;

a. 999 Calls – 15444

b. 111 Calls – 36372

c. C1 Mean – 00:07:52 – Target missed by 52 seconds

d. C1 90th – 00:14:20 – Target met

e. C2 Mean – 00:19:32 - Target missed by 1 minute 32 seconds

f. C2 90th – 00:36:18 – Target met

g. C3 90th – 03:17:48 – Target missed by 1 hour 17 minutes

h. C4 90th – 05:04:02 – Target missed by 2 hours and 4 minutes

i. 111 call assessors and healthcare advisers available across the Trust; and

4117 Staff Hours were provided across Health Advisors and Service Advisors for the 111 service on the 01st of March.

25. To assist in maintaining adequate staff numbers, frontline operations were supported by partner fire & rescue services, military personnel and voluntary organisations, assisting with driving ambulances and fleet and logistics functions. Working closely with the Fire and Rescue services especially increased the ability to work across organisational boundaries and has paid dividends with collaborative working post the Pandemic.

26. Anecdotally, there was some suggestion that during the initial lockdowns, patients were reluctant to seek medical care and attend hospital unless it was essential. There is also some suggestion that patients waited longer before reaching out for help, thus impacting on the severity of their condition.

Infection prevention and control

27. The National Ambulance Service IPC Group met weekly to discuss any issues or changes in the guidance. Guidance published by UKHSA was predominantly hospital-centric and therefore needed review and where necessary adjustment to meet the needs of the Ambulance Environment. We had a representative who sat on this group and was able to offer feedback on the trust view on the decisions taken. Overall, we followed national guidance on IPC.
28. Coordination became one of the main issues that faced the trust daily, with a prime example being the management of PPE. The trust had no stock management system in place at the beginning of the Pandemic, and thus it is hard to quantify the amount of PPE / RPE available. The guidance that was in place for use of PPE / RPE was the standard IPC guidelines, along with the specialist guidance issued to Hazardous Area Response Teams.
29. PPE was issued via push pallet, from the national program. This presented challenges, and in order to manage this, a specific manager was appointed to oversee PPE for SECAmb, supported by the IPC Team. One of the IPC Leads checked the PPE arriving by push pallet to ensure that it was of the required standard. Generally, the items met the required standard, but some items/batches that didn't were quarantined and sent back or passed to other organisations where it could be used.
30. Maintaining up to date staff fit-testing status was also problematic as the push pallet system regularly sent new/different models of FFP3 masks, which meant staff needed to be fit-tested on each individual type. The geographical challenges of SECAmb meant that standing staff down for 30 minutes each time to support fit testing impacted on the ability for the Trust to maintain its levels of cover.

Do not Attempt Cardiopulmonary Resuscitation notices

31. We did not issue DNACPR notices during the Pandemic and still do not as part of an operational process. There were no systemic concerns that were raised to the trust during this period.

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

32. As a reflection, the main elements that were identified as producing effective patient outcomes, were about the ease with which we were able to transition to an effective structure that allowed rapid decision making and flow of information. The support of our partner organisations, especially our FRS colleagues, proved invaluable in the delivery of patient care and the maintenance of safe staffing levels. Our ability to work closely with the ICB's and to have a weekly Tactical level problem solving meeting ensured that we were able to keep low handover delays in comparison to other UK ambulance trusts.
33. In the future, there is some discussion that a new and emerging Pandemic would present a variety of challenges that would not be as effectively managed using the same process as we applied during the Covid pandemic. The ability to flex and adapt is incredibly important, yet the organisation has moved back to a hierarchical model very quickly. Lessons identified across the system from Covid have quickly been forgotten, and there does seem to be a view that Covid has gone and everything is back to normal.

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: _____04 July 2023___