Witness Name: Ben Holdaway
Statement No.:
Exhibits: 17
Dated:

UK COVID-19 INQUIRY

WITNESS STATEMENT OF BEN HOLDAWAY

I, Ben Holdaway, will say as follows: -

Background

1. East Midlands Ambulance Service NHS Trust provides emergency and urgent care services across the six counties of Derbyshire, Leicestershire, Lincolnshire, Northamptonshire, Nottinghamshire and Rutland. We also provide Non-Emergency Patient Transport Services (NEPTS) in Derbyshire and Northamptonshire. We do not provide any NHS 111 services but receive calls directly from the NHS 111 provider in our area, where they consider that the patient requires an ambulance response.

Organisational Structure and Responsibilities

2. The Trust is organised into a number of directorates each with an Executive Director who has responsibility for a specific remit. Our Operations Directorate is organised into divisions at county level and an Emergency Operations Centre function. I have provided our current organisational chart at exhibit INQ000216633. The current division of functions has not changed since 1 March 2020, although our current Medical Director did not join the Trust until January 2023.

3. In exhibit INQ000216639 I have set out details of the key decision-makers between March 2020 and June 2022 in relation to the provision of ambulance-related services.

4. The Trust Board has oversight of the governance of the organisation and is supported by a structure of committees and sub groups. I have provided details of this structure in Exhibit INQ000216640. We continued to operate these decision-making and oversight arrangements during the pandemic with some changes to streamline processes by shortening agendas and suspending some meetings where they were not significant to the pandemic response. We held most meetings virtually during the pandemic to assist in streamlining the processes and in line with social distancing requirements. Our existing governance arrangements were supplemented by establishing additional groups or meetings to deal with specific aspects of the pandemic and I refer to these in the relevant sections below.

5. In addition to our Trust Board and committee meetings, which continued during the pandemic, the Chief Executive met weekly with our Non Executive Directors to provide a briefing on the latest position with regard to the Trust's response to the pandemic. Our Executive Team meets weekly and the frequency of those meetings was increased to ensure that the Chief Executive and Executive Directors had oversight of the situation and were able to provide the necessary strategic direction as required.

6. The Trust Board approves the financial plan at the start each financial year. Budgets are then allocated to individual budget holders across the organisation who are responsible for managing expenditure and income within those budget allocations. The Director of Finance has overall responsibility for the Trust's finances.

7. We produce a workforce plan which is used to determine the number of staff required to deliver the service which we are funded to provide. The Director of Human Resources and Organisational Development has responsibility for the workforce plan but its development is informed by all of the Executive Directors. The number of staff required in each area of the organisation is the responsibility of the relevant Executive Director. As the Director of Operations I determine the

number of ambulance clinicians we require and requirements for support staff are determined by the Director responsible for the respective function. Call handlers are part of the Operations Directorate and therefore as Director of Operations I determine the number of call handlers required.

8. The Fleet function is part of the Director of Finance's portfolio and he is responsible for the number of ambulances and other vehicles we need.

9. Performance against the national response time standards for Accident and Emergency Services, which the Trust is required to meet, is my responsibility as the Director of Operations. The Director of Strategy and Transformation has responsibility for performance against the NEPTS targets.

10. Our Command and Control Policy sets out the processes we follow for incident management. We use the Joint Emergency Services Interoperability Principals model for incident decision making known as the Joint Decision Model and the National Ambulance Resilience Unit's (NARU) command doctrine known as NARU National Command Guidance.

11. EMAS operates an on-duty and on-call command and control model 24 hours a day, all year. This model covers command at the three recognised levels Operational, Tactical and Strategic and is supported by expertise from non-operational functions such as the Communications Team and the Medical Directorate.

12. As Director of Operations I was the Accountable Emergency Officer for our response to Covid-19. The Senior Responsible Officer reported to me and was the single point of contact in relation to managing the Covid-19 response. He chaired the Covid Co-ordination Group which consisted of representatives from across EMAS and was set up to oversee the pandemic. This allowed our Strategic Commanders to concentrate on operational delivery of our services within our county areas and to take part in the Local Resilience Forum and local health meetings which met frequently during the pandemic. When multi-agency Strategic Coordinating Groups and Tactical Coordinating Groups were established in

response to the pandemic by all Local Resilience Forums in our region, EMAS representatives attended these meetings.

13. In line with our existing incident management arrangements and business continuity plans, at the start of the pandemic we quickly established an Incident Command Centre, staffed on a rota basis by managers from across our operational teams. This was set up to manage the Trust's response to Covid-19 and deal with all national and regional communications, including guidance, directions and responses to requests for information. This worked well in providing direction within the Trust, facilitated clear decision-making and ensured workload was shared. We also established tactical cells in each of our operational divisions to manage our response to the pandemic in individual counties.

External Guidance and Requirements

14. Throughout the pandemic we received national and regional instructions and guidance by email from the Regional Operations Centre at NHS England. We established a dedicated email address for receipt of this information which our Covid Incident Command Centre monitored regularly and ensured the information was forwarded to the relevant person within EMAS for action. Where data or other information was required by NHS England or the National Ambulance Coordination Centre, requests were made by email to this generic email address, with templates provided for provision of data as appropriate.

15. We were able to provide feedback or request clarification from NHS England by responding to the emails issued by the Regional Operations Centre, for example where we were asked to complete a return on oxygen supplies we were able to seek clarification on what information was required from ambulance trusts. There was also an opportunity to provide feedback or seek clarification on specific matters through various meetings held at county level with commissioners, or regional and national meetings with NHS England. For example there was a regional Chief Operating Officer and Director of Operations meeting hosted by NHS England where I had the opportunity to ask questions or gain clarity on any change in the Covid-19 requirements or any changes in service delivery, including

changes in guidelines relating to PPE or Infection Prevention and Control guidance. National webinars were also held to provide updates and clarity related to the national response to the pandemic. Meetings of existing subject matter groups at county, regional and national level were used to discuss and relay information. Where there was a need for a particular focus on a specific area of the response to the pandemic subject specific groups were established, for example our lead commissioners, the Clinical Commissioning Group in Derbyshire established a group at county level to oversee access to Covid-19 testing which an EMAS representative attended, along with other NHS providers and representatives from local authorities in the area.

16. Due to the nature of and pace at which the pandemic developed and the need to respond quickly to these developments, we received frequent and numerous requests for data and other information and notifications of changes to the requirements and guidance. Examples of the data requested included the number of staff and volunteers vaccinated and twice weekly lateral flow test results for all of our frontline staff. We found this challenging at times, particularly in ensuring we kept our frontline staff informed of the changes. Guidance and requests for information were not always specific to the ambulance sector and required interpretation and adaptation for our organisation. The guidance tended to be focused on the acute sector with limited understanding of other environments. In particular the working safely guidance did not recognise the environment in which we worked and the understanding of high risk non-clinical areas such as our Emergency Operations Centre or staff rooms at ambulance stations and the risk of staff to staff transmission.

Funding

17. In addition to our existing funding for 2019/20 of £217.851 million we received support to assist in our response to the pandemic. We claimed additional costs of £800,641 from NHS England at the end of March 2020, in respect of responding to the pandemic in 2019/20. This claim was paid in full.

18. The usual contract negotiations for annual funding were stopped during the pandemic and instead funding for 2020/21 was received via the Clinical Commissioning Groups (CCG) in a block monthly amount based on our expenditure levels in December 2019, uplifted by an inflationary element. In addition to this we were invited to claim additional funding if our estimated costs for the year, based on an average of our actual costs between November 2019 and January 2020, were likely to result in a deficit. We identified a funding gap on the basis of this calculation and made monthly claims in arrears to NHS England. This related to part of our NEPTS which we did not start operating until December 2019 and therefore this was not fully accounted for in the original funding calculation. In the second half of 2020/21 all funding was received from the CCGs as a block contract amount, based on the Trust's expenditure claimed in the previous months, including the additional funding provided to address the funding gap.

19. Our costs associated with Covid-19 and incurred in 2020/21 were collated separately and claimed from NHS England on a monthly basis. We claimed £4,219,774 in the first quarter of 2020/21 and £3,570,636 in the second quarter of the year. We received the full amount claimed. In the second half of 2020/21 Covid-19 funding was paid as a standard block amount based on the previous six months funding. The amount received in this period was £6,689,328. In addition to this we received Personal Protective Equipment (PPE), valued at £4,859,765, from NHS England which we have treated as a Covid-19 expense in our accounts.

20. In 2021/22 the block contract payment arrangements were continued for all NHS Trusts. The funding we received was based on our expenditure levels between October 2020 and March 2021, uplifted for inflationary pressures and changes in non NHS income such as commercial income from providing ambulance service support at events. As these events were not taking place we were not receiving the associated income.

21. In 2021/22 we received block contract funding to meet the costs of our response to the pandemic. The amount received in the first half of 2021/22 was £6,600,000 and in the second half of the year was £6,602,969. In addition we received PPE

valued at £465,942 from NHS England which we treated as a Covid-19 expense in our accounts.

22. For the first half of 2022/23 funding was agreed with the new Integrated Care Systems based on our previous funding levels with adjustments for the national efficiency requirement, inflation and changes to service provision levels. We received funding for Covid-19 expenditure in 2022/23 on a block contract basis, which was 40% of our expenditure in 2021/22, based on the premise that the impact of the pandemic was reducing. The amount received in this period was £1,314,175.

Management of the Covid-19 Response

23. We have a suite of policies and plans relating to emergency planning and business continuity which were in existence prior to the start of the pandemic. These documents include a Major Incident Plan, Command and Control Policy, Business Continuity Plans, a Pandemic Influenza Plan and a High Consequence Infectious Diseases Plan. This provides a framework for decision-making which is risk-based and supports an effective response during a time of crisis.

24. At the start of the pandemic we used the Trust Pandemic Influenza Plan and High Consequence Infectious Diseases Plan to assist in planning and implementing our response but very soon national information and instructions relating specifically to Covid-19 were issued which informed our ongoing approach to the situation. As the nature of each incident varies the plans are not specific in how an individual incident will be dealt with, in particular with regard to matters such as the scaling up or down of ambulance services, identifying priority areas, allocation of staff and other resources, staff welfare or use of private providers. As testing would be different for each pandemic and possibly not available initially, details regarding availability of Covid-19 testing for healthcare staff was not included in our plans other than references to considering the requirements for testing when dealing with a High Consequence Infectious Disease.

25. In terms of allocation of operational staff during the pandemic we used our existing resource planning arrangements which are dynamic and take account of the

current situation and anticipate the impact of future issues such as weather or major local events. We have ongoing arrangements in place to review our resource levels on a daily basis and adjust these as necessary. These were in place prior to March 2020 and we were therefore able to use these arrangements during the pandemic to determine our resourcing needs. Resourcing availability and demand for services is monitored by a Regional Operations Manager on a 24 hour, 7 days a week basis, supported by our on-duty and on-call command arrangements.

26. Our overarching strategy during the pandemic was to continue to provide the same service to our patients as we had previously, adapting only where necessary for example in relation to use of PPE. Due to the spread of the virus across the region there were no specific areas of greatest priority or need. In the early part of 2020 when Covid-19 cases in the United Kingdom were very small we did provide some support to other areas in terms of conveying those who had tested positive. This was undertaken by our Hazardous Area Response Team. This work was done in accordance with our High Consequence Infectious Diseases Plan and Pandemic Influenza Plan and national requirements.

27. We observe the National Ambulance Mutual Aid Plan should we need to request and/or consider providing mutual aid to/from other ambulance trusts. We also have locally developed processes in relation to mutual aid via both the Local Health Resilience Partnerships and other multi-agency groups such as the Local Resilience Forums and through direct requests to and from organisations.

Policies and Guidance

28. We have a framework of policies and procedures setting out various aspects of the Trust's work and providing guidance and instruction for staff. These were in place prior to the onset of the Covid-19 pandemic and in the main it was possible for us to continue following these processes during the pandemic. It was necessary to introduce some additional documents, including policies, procedures, guidance, and advice, in response to the pandemic and in other cases amendments to existing documents were necessary. I have listed the new documents generated

during the pandemic in exhibit INQ000216641 along with details of the existing documents which were amended.

29. We created the following policies and procedures expressly in response to the Covid-19 pandemic:
    - NEPTS Resource Allocation and Infection Prevention and Control During Covid-19 Pandemic Standard Operating Procedure
    - Covid-19 Vaccine Handling and Management Policy
    - Ordering and Preparation of the AstraZeneca Covid-19 Vaccine Standard Operating Procedures
    - Safe Handling of the AstraZeneca Covid-19 Vaccine Standard Operating Procedure
    - Home Working Policy
    - Daily Lateral Flow Testing following Covid Test and Trace Notification Standard Operating Procedure.

30. We issue Clinical Bulletins to communicate changes in clinical practice or equipment usage to staff, and to pass on information from external agencies. I have listed those issued in relation to Covid-19 at exhibit INQ000216641. In addition we published regular updates and briefings including the answers to frequently asked questions in the weekly staff and volunteer digital magazine (Enews) and a dedicated weekly Covid-19 bulletin. We issue EOC Bulletins specific for staff in the Emergency Operations Centre. A number of these were issued during the pandemic relating to Covid-19 and are listed in exhibit INQ000216641.

31. Early in the pandemic we established a Covid Transport Response Services (CTRS) desk in our Emergency Operations Centre to oversee situations where callers were suspected of having Covid-19 symptoms. On 4 March 2020 we issued a bulletin to staff with information on the use of the Emerging Infectious Disease Surveillance Tool. This allowed staff to ask callers whether the patient had travelled in the previous 14 days and whether they had been to any areas of known infections. A series of other questions relating to Covid-19 symptoms were also asked. If the response to these questions was affirmative, the CTRS desk

was notified and handled any dispatch of an ambulance crew to the patient. As the virus spread and more individuals developed symptoms we dispatched crews using our normal procedures and the CTRS desk was no longer required.

32. In June 2020 we implemented our own Covid-19 Clinical Decision Tool, which I have attached at exhibit INQ000226495, to assess Covid-19 positive patients and determine whether they should be conveyed to hospital. The tool was a three-step process which included signs and symptoms associated with Covid-19, physiological parameters needed as part of the assessment and an emphasis on shared decision-making where a decision regarding the best patient pathway or conveyance to hospital was not clear. Once the national Covid Decision Support Tool, which is available to frontline staff on the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) online application, was introduced we used that instead to assist in assessing patients suspected as having Covid-19 symptoms.

33. Protocol 36 was introduced on 3 April 2020 as a national directive and is a specialist protocol that helps with the management of pandemics, epidemics and outbreaks of influenza, including Covid-19. The protocol provides a series of questions that the Emergency Medical Dispatcher is prompted to ask given the chief complaint and the symptoms displayed by the patient. This is to identify potentially infected patients and assign them a Determinant Code, which is used for dispatch decisions, dependent upon the patient's condition and level of the pandemic or outbreak. The aim of the protocol was also to ensure the Trust prioritised higher acuity patients.

34. The scripts for Emergency Medical Dispatchers to use when taking 999 calls in the Emergency Operations Centres are contained within the Clinical Safety Plan (previously referred to as the Capacity Management Plan). A number of changes were made to Clinical Safety Plan scripts during the pandemic period. Many of these changes were not specifically designed to respond to Covid-19 but were introduced as a response to increasing demand or prolonged patient waits for a response during the pandemic period.

35. We complete Equality Impact Assessments and Wellbeing Impact Assessments when producing policies and procedures to determine whether the arrangements set out in documents would have an impact on particular groups of staff or patients, including those with protected characteristics under the Equality Act 2010. We introduced the requirement to complete a Wellbeing Impact Assessment in October 2022.

36. In revising the Infection Prevention and Control Policy during the pandemic we took into account the importance of correct PPE usage for older staff and those with underlying clinical risk factors. In producing the Covid-19 Vaccine Handling and Management Policy we recognised the need to prioritise the vaccine for staff who are clinically extremely vulnerable or clinically vulnerable due to age and ethnicity.

37. Throughout the pandemic we were consistent in the approach taken so all patients received a consistent response and we did not seek to treat patients differently unless there was a significantly increased risk to that patient, meaning they needed more care than the standard level at the time. . An example would be where during periods of high demand we provided signposting advice for patients to seek alternative assistance for their health needs if they were identified as low acuity. Individuals in certain age categories or who had certain conditions were excluded from this as they were potentially higher risk.

Communication Arrangements

38. In March 2020 we agreed a structured approach to communications relating to the pandemic, including how we would keep our staff updated and we informed them of these arrangements. We followed this approach consistently throughout the pandemic so all staff knew where to check for any changes in practice or advice. To avoid overloading staff with information, communications were only issued outside of the timescales agreed at the start of pandemic if there was an immediate safety need.

39. Our communication arrangements consisted of twice weekly written Covid-19 updates to support staff and volunteers in keeping up to date with the latest

information covering a wide range of themes. One update was included in our existing weekly staff and volunteer digital magazine. This was supplemented by a weekly Covid Bulletin issued by email to all staff and volunteers, to reiterate important messages to clinicians and other staff. We issued occasional ad hoc emails referred to as eshots for urgent non-clinical matters, for example we issued an eshot in October 2020 to inform staff of the Government's stay at home policy in response to increased transmission rates. We also issued an eshot to inform staff of arrangements for being vaccinated at the point we set up our in-house vaccination hubs. Weekly meetings were established between myself and the Director of Nursing, Director of Human Resources and Organisational Development and the Medical Director to confirm the key messages to give staff and to agree the contents of the Covid Bulletin before circulation.

40. Prior to the pandemic we already had established communication methods in place for disseminating emergency alerts and policies on healthcare matters to our staff and we were able to use these to disseminate information during the pandemic, supplemented with additional arrangements. Our main mechanism for informing staff of changes to healthcare practices is through Clinical Bulletins which are issued as required. Clinical Bulletins are highlighted as red bulletins where they relate to urgent matters and need to be read immediately and green bulletins for other clinical changes or information. Staff are informed of new policies and procedures or changes to existing documents through notifications in the weekly staff and volunteer magazine. Notifications of changes to clinical practices and clinical policies and procedures are provided on the JRCALC application which all clinical staff have access to on their electronic devices. The JRCALC application is an application used by a number of ambulance services to give staff easy access to clinical reference material. A Covid-19 section was added to this application to make it easy for staff to find guidance which was specific to Covid-19.

41. Our existing communication arrangements for issuing emergency alerts or policies relating to clinical matters were supplemented during the pandemic with the weekly Covid Bulletin I referred to above.

42. We accelerated our planned introduction of Microsoft Teams at the start of the pandemic to facilitate communications across the Trust. This significantly improved our ability to communicate to a wider audience at the same point in time and facilitated homeworking to meet social distancing requirements and to protect those staff who were able to work remotely.

43. As Director of Operations, I chaired a daily call with our operational mangers to communicate any immediate changes for cascade to their teams and to answer any queries from local teams. In addition I held weekly meetings with operational managers. New guidance or policies were communicated through these meetings and then cascaded to staff by operational managers as well as being referenced in the appropriate written communication which I outlined above. Other Executive Directors attended these meetings on an ad hoc basis to explain changes as appropriate.

44. We already had out of hours communications arrangements in place within the Trust which we enhanced during the pandemic and used to deal with any urgent matters requiring support from our Communications Team.

45. Existing staff engagement events referred to as Conversation Cafes, whereby Board members and senior managers attended hospital emergency departments and other locations to engage with our staff on particular topics evolved during the pandemic, due to the requirements to socially distance. These were held as virtual events using the EMAS Colleagues Facebook closed group platform. The video briefing consisted of a presentation from the panel, followed by an opportunity for staff to post questions and have them answered. A video recording from the session was then published in the weekly staff and volunteer magazine, with a transcript summary of the discussion and the questions and answers given. In the main these were held on a monthly basis, however when urgent information needed to be shared, the sessions became fortnightly.

46. We used our existing meetings with Trade Union representatives to provide information and assurance regarding Covid-19 matters. The union representatives assisted in providing support and information to staff.

47. The Trust produced videos for staff providing guidance on certain matters for example how to put PPE on and take it off safely and how to wear PPE when responding to a cardiac arrest. I have provided examples of these videos at exhibits INQ000226493 and INQ000226494.

48. We established a new category in our incident reporting computer system in January 2020 to identify any incidents or issues relating to Covid-19. This enabled staff to highlight concerns relating to Covid-19, allowed us to identify trends, take appropriate action and communicate information to staff. Concerns regarding Infection Prevention and Control were one of the highest categories of incident reported in the early stages of the pandemic and led to our decision to introduce level 2 PPE in all cases, in advance of national guidance changes. Violence and aggression incidents experienced by staff were consistently one of the most frequent categories of Covid-19 related incidents reported throughout the pandemic. These incidents included examples of spitting and verbal abuse of our staff due to dissatisfaction with the outcome of assessments and unrealistic expectations of the ambulance service, for example requesting our staff to provide Covid-19 testing or vaccination. We encouraged our staff to use face visors where appropriate and our Local Security Management Team worked with the police to respond to specific cases as appropriate. We also provided a virtual learning from events session for our staff to provide them with advice on de-escalating situations.

49. In line with Department of Health and Social Care, NHS England, UK Health Security Agency and local NHS and Local Resilience Forum announcements, we published advice and updates to the public to encourage them to seek treatment where needed, via our public facing website and social media network channels. In addition we provided ongoing engagement and briefings to local, regional, and national media for publication. I cannot comment on the impact of national messaging on patients' willingness to seek care as we did not record these details.

Communication and Collaboration with Other Organisations

50. There were existing meeting arrangements in place across our region which were used to deal with issues arising from the pandemic and were one of the main

mechanisms we used for communicating with other NHS Trusts in our area. The frequency of existing groups was increased where it was needed because of the fast pace of the pandemic. Technology was used to allow the meetings to move from in-person meetings to virtual events.

51. In each of the counties in which we operate, groups were established to respond to the pandemic and we used these as a means of communicating with NHS Trusts in our area. These groups include Local Resilience Forums, Strategic Coordinating Groups and Tactical Coordinating Groups. In addition weekly regional briefing sessions were held by NHS England for all NHS organisations in the area and were attended by our Chief Executive.

52. Where an operational issue arose which fell outside of the work which the established groups were overseeing, we worked directly with individual NHS Trusts to address those specific issues but limited this as far as possible as it was more appropriate for issues to be considered by the formal groups.

53. Regional Chief Nursing Officer meetings for the Midlands involving all providers and commissioners were already in place and were used for the response to the pandemic. When new national guidance was issued it was discussed by this group to ensure a common local interpretation. The meetings were useful in understanding what was happening elsewhere in the region.

54. Our Corporate Communications team liaised with other NHS Trusts through regular and ad hoc meetings set up by NHS England (national and regional teams) and Local Resilience Forum communications groups. This ensured collaboration and the production of consistent messaging.

55. An example of where we worked collaboratively with other healthcare providers in our region was the implementation of the Covid-19 vaccination programme for healthcare workers. This included in-house delivery of the vaccine to part of our own workforce, alongside signposting our colleagues to vaccination delivery sites across the healthcare systems within our region. Also our fleet team worked closely with other NHS Trusts to share or swap PPE when shortfalls were

identified. This happened on a number of occasions but due to pressure of work at the time we were unable to keep detailed records of what we received or shared.

56. Ambulance Trusts worked together nationally as a sector, utilising established national forums through the Association of Ambulance Chief Executives (AACE). Each of our Executive Directors used their respective national director groups during the pandemic to share best practice and resolve issues. The frequency of meetings increased as needed to address the requirements of responding to Covid-19. These groups include the National Director of Operations Group, the Human Resources Directors Group, Heads of Emergency Operations Centres Group, the Communications Group, Quality Improvement, Governance and Risk Directors and the National Ambulance Strategic Partnership Forum comprising Human Resources Directors and Trade Union colleagues.

57. Working together as a sector and in partnership with our Trade Union colleagues enabled us to collaborate, share knowledge and information, and develop a range of guidance documents to provide information to our staff and ensure consistent application of national guidance in the ambulance sector.

58. Through the National Ambulance Co-ordination Centre formal arrangements were set up to support Trusts who required call taking support due to staff absence and vacancies. We did not need support in call taking but were able to support a number of other Trusts during the pandemic through taking some of their 999 calls.

Staffing Levels

59. The frontline staffing levels as at 1 March 2020 are included in exhibit INQ000216642. Overall workforce numbers remained stable during the pandemic, although our staffing levels in NEPTS were lower in June 2022 than in March 2020 due to natural turnover of staff. The overall number of staff in our Accident and Emergency Services remained the same between March 2020 and June 2022. The changes in numbers of staff in individual job roles in Accident and Emergency Services were as a result of our Reshaping Operations programme to refocus our management roles and planned changes to the operations structure. We introduced the Ambulance Support Crew role and consequently did not replace

Emergency Care Assistants and Urgent Care Assistants when they left the Trust or progressed into advanced roles. We also increased the number of Paramedics and introduced the Specialist Practitioner role to provide advanced level clinical skills.

60. We increased our call handling staff between 1 March 2020 to 28 June 2022 to fill existing vacancies prior to the pandemic and to provide some additional resilience within the team. This was done through our own recruitment campaigns and through the national campaign to recruit additional call handlers. In April 2020 we had 140 members of staff in a call handler role. This number increased gradually during the remainder of 2020 and 2021. Following a recruitment campaign we had 180 individuals in this role in November 2021 and this had increased to 194 staff members by April 2022.

61. We had some recruitment challenges in Leicestershire and Lincolnshire towards the end of the period and these counties have become an area of focus for our recruitment campaigns. We have seen an increase in staffing levels in Northamptonshire compared to the situation prior to the pandemic.

62. We implemented a Fast Track Recruitment and Education Onboarding Scheme between April 2020 and February 2021 to increase the number of bank workers. We issued an additional 46 bank worker contracts during that period. We also engaged in the NHS England initiative to encourage ex NHS staff to return to work in the NHS. We considered all 18 candidates referred to us via the scheme but could not employ them either because of their availability or because the skills offered were not suitable.

63. We agreed arrangements with Fire and Rescue Services in our area to provide personnel to support us between April 2020 and September 2021. We trained Fire and Rescue Service personnel from across our region to support our frontline staff in responding to low acuity patients. In addition we deployed 59 military personnel across our frontline operational areas during January and February 2022.

Covid-19 Testing

64. Obtaining access to Covid-19 testing for our staff was challenging at times during the pandemic. As an ambulance service we do not operate laboratories and therefore were unable to provide testing ourselves. We used our contacts in the local healthcare systems in the region to identify testing facilities they could make available to our staff. Initially booking of tests and informing staff of their test results was undertaken by the Trust. By redeploying staff from non-operational functions we set up a team to book tests for staff, receive results from the laboratories and inform staff using a combination of telephone calls and a text messaging arrangement already in place within the Trust for other communications. Access to testing became much easier for our staff once facilities were established for public testing.

65. There were some delays in obtaining test results which impacted on resourcing as, in accordance with national requirements staff had to self-isolate while they or a member of their household was awaiting test results. This was more of an issue in the early part of the pandemic when wide-scale testing arrangements were still being established but some problems were also experienced periodically at later stages in line with problems experienced nationally regarding access to testing and the speed in providing results.

66. Where our resourcing levels were impacted by staff absence due to individuals trying to access testing or awaiting results, we attempted to manage this by increasing resources where possible through the usual overtime arrangements and use of third party ambulance services where these were available.

67. Once lateral flow asymptomatic Covid-19 tests were available, in accordance with NHS England's requirements, we asked our frontline staff to undertake regular testing to protect their colleagues and patients. Initially stocks of test kits were provided by NHS England but once these became available to the public, NHS staff were required to order them from the online public portal or obtain test kits from pharmacies. We do not have a record of the exact time periods but when demand for tests from the public rose at certain points in the pandemic, staff in some areas experienced problems in obtaining tests kits. This meant that our staff

were not always able to complete twice weekly asymptomatic testing which may have put patients at risk and at times impacted on frontline staff resourcing where staff were unable to return to work without first obtaining a negative test result. Through our contacts with local authorities that had excess stocks we were able to obtain some test kits which helped. We also monitored availability of test kits across the organisation and where possible redistributed them where staff were experiencing problems in obtaining them. NHS England did provide some contingency stock for those staff unable to access test kits locally but there was a delay in receiving this.

Staff Support

68. In order to support our staff and provide a safe working environment we reviewed and revised our working practices and safety arrangements to ensure they were in accordance with the AACE – "Working Safely during COVID-19" guidance document. We also ensured that staff who were extremely clinically vulnerable did not attend work and where possible worked from home. We undertook individual risk assessments for staff categorised as vulnerable and agreed appropriate working arrangements to support their needs. Where it was possible to do so and still meet the organisation's needs we supported individual staff in developing flexible working arrangements to accommodate childcare arrangements and other commitments and pressures.

69. We made available a range of mental health and wellbeing support to staff during the pandemic. This support comprised:
    - Staff wellbeing support for NHS staff including wellbeing applications and services and a national telephone and text helpline;
    - Support made available through the AACE including guidance for managers on psychosocial support; signposting to services such as The Ambulance Staff Charity; national helplines; MIND resources; Samaritans support services; ambulance specific Common Room sessions to provide a safe and confidential space for staff to share experiences with a small group of peers; and wellbeing webinars.

70. We already provided a comprehensive suite of mental health and wellbeing support, which included Occupational Health Services; access to specialist talking therapies; an Employee Assistance Programme; Peer Support; and Chaplaincy and pastoral services. All of these services remained available to staff during the pandemic. In addition we introduced some additional mental health and wellbeing support services, including:
    - Development of a bespoke digital application to support staff mental health, wellbeing and resilience called the MIND CADDY to provide staff and volunteers with personalised wellbeing reports, access to information, learning materials, and wellbeing support resources.
    - A pro-active mental health check-in service which focused on pro-actively identifying those staff who may need support particularly as a result of the pandemic and who may be experiencing anxiety, stress and trauma. The Trust worked in partnership with Hospice UK to roll out the pro-active mental health check-in for all staff with patient contact. The aim of the initiative was to support staff who may benefit from emotional and mental health support but who may not readily seek out that support. The service was telephone-based and involved a trained practitioner contacting staff members to initiate an opportunity to discuss their mental health and wellbeing and access confidential support for bereavement, trauma and other psychological issues and to signpost staff to other specialist services.
    - Specific guidance on dealing with a range of matters impacting health during the Pandemic.

71. The Trust promoted the various staff support services that were available, extensively via its weekly staff and volunteer digital magazine.

72. Our Chief Executive and our Black, Asian and Minority Ethnic (BAME) network chair sent a joint letter to all of our staff from a BAME background on 6 May 2020 noting the national information that there was an indication that Covid-19 may be having a disproportionate impact on BAME members of the population. The letter set out support which the Trust was providing for these staff including a risk assessment for all BAME staff, prioritising Occupational Health Services

assessments where a need for this was identified through a risk assessment, support regarding obtaining a Covid-19 test and wellbeing support details.

73. In line with national guidance we carried out individual risk assessments for all clinically and extremely vulnerable staff groups, including providing guidance and standard templates to support managers in this process. This approach was phased with a primary focus on staff from groups identified by Public Health England as being at risk. We completed risk assessments for all staff in BAME groups by 30 July 2020 and for all at risk staff by 25 August 2020. By 15 September 2020 we had completed risk assessments for all of our workforce, regardless of whether they were in a high risk group. In the event that an individual risk assessment identified the staff member to be at medium or high risk, then further advice and support was available from our Occupational Health Service. We agreed with our external Occupational Health Service provider that any Covid-19 related management referrals would be considered as a priority. Where indicated by the risk assessment we made amendments to the individual's job role, identified an alternative role for them or placed them on paid medical stand-down.

74. Once Covid-19 vaccinations were available for healthcare staff we worked with our healthcare partners to obtain vaccination appointments for our frontline staff, ensuring that those who were clinically vulnerable were prioritised. In 2020/21, the Trust delivered a Covid-19 vaccination programme to its frontline healthcare and other eligible staff and subsequently implemented arrangements to publicise the availability of booster vaccinations from local NHS systems and encouraged staff to take up this opportunity.

75. A number of our staff members have experienced Long Covid, a term used to describe the symptoms and effects of coronavirus that last longer than four weeks beyond the initial diagnosis. We provide a range of support while a member of staff is absent from work due to Long Covid, including regular welfare calls; referrals to Occupational Health Services; extension of full pay where under normal arrangements pay would be reduced; and signposting to wellbeing and psychological services or their GP for referral to a Long Covid Clinic.

76. When staff with Long Covid return to work we offer a phased return or an alternative role on a temporary basis, where appropriate. A risk assessment, occupational health support and ongoing welfare support are also provided.

77. To support these staff, we established a Long Covid Peer Support Group which meets virtually every month and is facilitated by the Head of Wellbeing and Inclusion. The purpose of the group is to give staff an opportunity to discuss their experience of Covid-19, to receive support from other colleagues and provide support through sharing their experiences. The first Long Covid Peer Support Group meeting was held on 30 June 2021 and we currently have 38 members.

Available Resources

78. Demand for our services fluctuated during the pandemic and at times was lower than prior to the pandemic. Resourcing was however challenging at times due to staff absence where individuals tested positive for Covid-19 or had been in contact with someone who had.

79. As at 1 March 2020 we had 402 Double Crewed Ambulances and 120 Fast Response Vehicles used by our accident and emergency teams and 117 ambulances used by our NEPTS. In addition we were using third party providers for additional support. As at 1 March 2020 we were using 25 ambulances and crews from Private Ambulance Services as additional resource to support our Accident and Emergency Services.

80. While we did not change our frontline operational fleet numbers of vehicles over the period the level of Private Ambulance Service Support which we used did vary. We increased our expenditure on Private Ambulance Services to aid our response to the pandemic. At exhibits INQ000216643 and INQ000216644 I have provided details of the Private Ambulance Service resources used each month between March 2020 and June 2022 to support both our Accident and Emergency Services and our NEPTS. Our Private Ambulance Service providers experienced similar staff absence issues due to Covid-19 and therefore at times were not able to provide the total amount of resource requested, hence the variation in their

resourcing levels during the period. At exbibit INQ000216644 I have also included details of the resources we obtained from taxi services to support our NEPTS in transporting patients. NHS England tendered for additional third party ambulance resource which was made available to ambulance trusts to supplement their own Private Ambulance Service resources. We used this resource at times during the pandemic when it was available but the amounts were small compared to our own resource.

81. At an early stage in the pandemic we reallocated staff from non-operational areas of the Trust to assist with tasks to support the response, for example in packing and distributing PPE and administering the booking and reporting of staff testing and vaccination. The complex and fast-moving nature of the situation required multi-disciplinary working of staff from different parts of the organisation, including clinical functions, frontline operations, infection prevention and control, human resources and finance.

82. The additional Private Ambulance Service and support taxi services for our NEPTS teams also made it possible for us to respond to the request from NHS England to become the regional discharge coordination centre in the East Midlands, including the counties where we were not the NEPTS provider (Lincolnshire, Northamptonshire and Nottinghamshire). We were also able to provide some assistance for patient discharges in areas within the region not covered by our NEPTS services.

83. We created further additional capacity through offering to purchase some annual leave from staff, use of bank workers and overtime, including making incentive payments to encourage take-up of overtime at certain times. During the period of the pandemic we placed no restrictions on overtime or additional shift working (providing the staff member remained safe and compliant with legal requirements). These measures were less successful as the pandemic progressed as staff became fatigued, were absent due to Covid-19 or were unable to be so flexible as previously due to external pressures such as childcare while schools were closed. We also postponed training which provided some additional capacity.

84. In our Emergency Operations Centres we created capacity by increasing resource levels and through reducing risk of transmission of Covid-19, therefore reducing absence and protecting our staff.

85. To ensure safer working in the Emergency Control Centres we removed all other staff from the building to work from home and changed the layout of the building to ensure more space was available. We implemented national safer working guidance, including implementing social distancing, separating groups of staff in different rooms, requiring staff to wear face masks when moving between work areas, placing Perspex screens between workstations, increasing the frequency of deep cleans, undertaking regular touch point cleaning, undertaking workplace inspections and ensuring we reviewed and learnt from each Covid-19 outbreak. These actions reduced transmission of Covid-19 and associated absence and therefore created capacity but also provided assurance to Emergency Operations Centre staff that their workplace was as safe as possible.

86. We sourced additional capacity for our Emergency Operations Centres through employing agency staff for both call-taking and as radio operators and dispatchers. We also sourced clinical agency staff to support our clinical team, including mental health clinicians to assist us in prioritising our response to patients in the greatest need. Staff who were clinically vulnerable and unable to work in patient facing roles were employed in remote roles supporting our Emergency Operations Centres, primarily in our clinical hub. These members of staff provided remote telephony clinical assessment support to ensure patients received the appropriate response.

87. Non-registered operational staff including Technicians and Emergency Care Assistants, who were unable to be patient-facing during the pandemic, supported our Emergency Operations Centres by ringing patients whose calls had been transferred to us by the 111 provider. They advised callers of the latest response times and supported their decision-making regarding the best way to seek the treatment they required.

88. In April 2020 we introduced a Coordinated Clinical Support Desk within our Emergency Operations Centres, staffed by a registered doctor to provide guidance and support for patients waiting for a response and to provide senior advice to frontline clinicians. The function has been successful and remains in place.

89. From September 2020 our Specialist Practitioners spent some of their time in our Emergency Operations Centres to increase the clinical support capacity by providing senior clinical advice on complex cases. Both the Coordinated Clinical Support Desk and the Senior Practitioners enable us to evaluate and clinically assess a number of our patients by telephone, determine the best response for individual patients and reduce the need to dispatch an ambulance where this would be inappropriate for that individual.

90. In September 2020, to support the use of alternative conveyance to treatment centres rather than an Emergency Department, where appropriate, we implemented the use of taxis where a clinical assessment had occurred. We focused mainly on disadvantaged patients who had no alternative means of transport. We used a taxi provider who was already supporting our NEPTS to ensure appropriate governance checks were in place.

91. In May 2020 we introduced remote working for clinical staff and other support roles in the Emergency Operations Centres, which reduced the number of staff in the building and consequently reducing the Covid-19 transmission risk and associated staff absence. This also gave us an opportunity for additional support from our staff for short periods of the day when call volumes were particularly high as they were working from home and able to be flexible.

92. We further increased capacity within our Emergency Operations Centres by ensuring staff had the skills and knowledge to perform in more than one role so they could move between roles to cover shortfalls in staff resource. We also introduced plans setting out how we would operate during periods of reduced staffing to ensure the Emergency Operations Centre function continued.

93. In September 2020 we removed the requirement for clinicians in our Emergency Operations Centres to use the clinical triage platform for all clinical assessments,

empowering them to use it as required. This reduced the time required for the clinical assessment of each patient from between 15 and 20 minutes to between 5 and 10 minutes. This reduction in time underpinned our decision to remove the requirement to use the tool, along with feedback from our clinicians that this would support them in being able to assess more patients in a clinically safe way in order to find the most appropriate care for them.

94. Rather than follow a defined algorithm we allowed the clinicians to use their clinical experience to ask supplementary questions to ascertain the best outcome for that particular patient, with a specific focus on lower acuity patients. Removing the requirement did not remove the clinical triage platform but empowered clinicians to use it for complex cases, allowing a shorter clinical triage time for non- complex cases.

95. During the summer of 2021, as call volume increased significantly, we recruited additional staff in the Emergency Operations Centres from a baseline establishment of 140 whole time equivalents to 180 whole time equivalents. These arrangements ensured we maintained a strong emergency call pick-up performance. Prior to quarter 3 of 2021/22 we increased our target and associated budget further to 210 whole time equivalents but were unable to successfully recruit to that level.

96. We used staff in non core roles such as call audit and training to take calls when our dynamic forecasting indicated they were needed. This proved effective at peak times and over meal break periods. We also reviewed call taking processes and identified ways in which the process could be streamlined to support a shorter call length.

97. A business continuity incident was declared in Derbyshire and Northamptonshire from 31 March 2020 which coincided with NHS Trusts starting to cancel their non urgent and elective appointments. This impacted on the way in which we delivered NEPTS and created additional capacity. As a result we focused our NEPTS services on continuing to provide a service for renal dialysis patients, oncology patients, and patient transfers and discharges (including both suspected and

confirmed Covid-19 cases). A rapid assessment process for outpatients requiring transport under exceptional circumstances was implemented and bookings for exceptions had to be authorised.

Operational Performance

98. In the week ending 1 March 2020 we received 20,779 calls to our Accident and Emergency Service. Of those calls, 4,360 were calls taken by the independent 111 service provider in our region and passed to us for a response. Some of the calls we received were duplicate calls relating to the same incident. In that week we recorded 16,854 separate incidents. The mean call pick-up time that week was seven seconds. There is no national target for call pick-up times.

99. In the week ending 1 March 2020 we received 4,443 calls to our NEPTS. I have provided details of the NEPTS contractual call pick-up targets and details of the number of calls received by our NEPTS between March 2020 and June 2022 in exhibit INQ000216645.

100. Exhibit INQ000216646 provides details of performance against national response time targets for our Accident and Emergency Services in the week ending 1 March 2020.

101. At exhibit INQ000216634 I have provided details of the number of 999 calls received during the period 1 March 2020 to 28 June 2022 including the number of calls forwarded to us for response from the 111 providers in our region. Call volumes varied throughout the period but we did see a reduction in the number of calls we received during times of national lockdown.

102. At exhibits INQ000216646 and INQ000216635 I have provided details of our call pick-up performance and performance against national response time targets between 1 March 2020 and 30 June 2022 for our Accident and Emergency Services. I have provided monthly performance data for our NEPTS and contractual targets for the period 1 March 2020 to 28 June 2022 at exhibit INQ000216636.

103. While our call pick-up times were good, our performance against national response targets for Accident and Emergency Services varied during the period 1 March 2020 and 28 June 2022 and on a number of occasions we did meet the required targets. Achieving national response standards for Accident and Emergency services had been an issue prior to March 2020, mainly due to pressures within the local health system and the impact of increased demand and delays in our ability to handover patients at hospital which restricted the availability of our resources to respond to patients who were waiting for an ambulance.

104. Response time targets for NEPTS vary between different services and are set by the commissioners in the relevant county. I have included these in exhibit INQ000216636. Prior to the pandemic, the Derbyshire NEPTS service performance was monitored against a set of KPIs which were challenging to deliver, mainly due to the high volume of differing patient appointment times. The Integrated Care Board (ICB) had started to develop a revised set of KPIs but during the pandemic put in place temporary measures known as service delivery principles to maintain an effective and safe service whilst dealing with the increased focus and pressure for patient discharge and social distancing. The Service Delivery Principles are designed to ensure patient and stakeholder experience was maximised by allowing the provider greater flexibility to manage resources across the whole system, within the existing budget and better align with the change in system priorities.

105. In October 2019 we were approached by the Northamptonshire Clinical Commissioning Group (now Northamptonshire ICB) to take on the NEPTS in Northamptonshire at short notice. Agreement was reached between EMAS and the ICB that the contract would not be performance managed using the Key Performance Indicators (KPIs) while alternative performance monitoring arrangements were developed, however we monitored our performance internally against the contractual KPIs and the service delivery principles.

106. Achievement of our targets for NEPTS services was particularly challenged during the pandemic due to requirements introduced at county and national level with regard to physically distancing which restricted the number of patients we

could transport at the same time. Also achieving call pick-up targets for NEPTS was challenging because each individual patient had to be triaged using additional questions before a booking was taken.

107. In both counties, Service Delivery Principle 2.1 has been the most challenging to achieve, however not all patients arrived significantly outside of the measured target, with patients arriving either earlier or within 30 minutes of their agreed arrival time.

Infection Prevention and Control

108. National documentation on infection prevention and control for NHS bodies was issued but in the main the information provided by NHS England and other national bodies was in the form of guidance rather than mandated requirements, however there were examples where it was mandated. The requirement for staff to undertake lateral flow testing before returning to work after contact with Covid-19 is an example of where NHS England mandated infection prevention and control practices. Another example was the requirement for risk assessments to be undertaken when relaxing mask wearing in certain settings. A further example related to management of clinical waste. Initially all Covid-19 waste was determined to be Category A waste because it was a high consequence infectious disease. This dictated the way in which the Trust dealt with its waste. Covid-19 related waste was subsequently downgraded at a national level.

109. In a small number of instances EMAS took a stricter interpretation of the guidance where local risk assessments determined this to be appropriate. For example at the end of March 2020 our Executive Team agreed to implement a requirement for surgical masks to be worn in all clinical settings slightly before it became national guidance. This followed a number of local incidents where our staff had raised concerns that 999 callers were not declaring Covid-19 symptoms and staff were arriving at the location unprepared. Also when national guidance indicated that mask wearing could be relaxed we were more cautious and deferred this decision for a few days to ensure there was sufficient time to communicate fully to staff.

110. National infection prevention and control guidance was initially not specific to the ambulance sector and was therefore interpreted nationally by the ambulance sector and then applied by EMAS. The ambulance services recognised the importance of having an interpretation from an ambulance sector perspective and the AACE agreed to establish a national adviser role on infection prevention and control to do this. A full-time post of National Adviser for Infection Prevention and Control, advising AACE was established in November 2020. This became a part-time role in October 2022 and is still in place. The ambulance trusts share the cost of the post.

111. During the pandemic the national adviser for infection prevention and control interpreted the national guidance for ambulance services and presented it to the Quality Improvement, Governance and Risk Directors group for agreement before it was applied in EMAS and other ambulance services. The post holder worked closely with NHS England and the UK Health Security Agency (formerly Public Health England) to advise on national policy for the sector. Prior to the formal establishment of the national advisor role, the chair of the National Ambulance Service Infection Prevention and Control Group coordinated the review and interpretation of national guidance and the group agreed by consensus on the application in the ambulance sector. The AACE national advisor was able to advise the national Infection Prevention and Control cell on ambulance specific issues to inform national guidance for the sector as the pandemic progressed.

112. NHS England issued information in March 2020 relating to Covid-19 and NEPTS including infection prevention and control requirements to minimise the risk of transmission. The documentation set out requirements to fit temporary bulkheads to vehicles, additional cleaning requirements, instructions regarding separation of symptomatic patients and details of when patients could be accompanied. Further documents were issued by NHS England during 2020 which included details on use of PPE and social distancing within vehicles, including guidance on transporting patients who were clinically extremely vulnerable and those who were shielding.

113. The EMAS process for agreeing and implementing any changes to Infection Prevention and Control measures during the pandemic was informed by national guidance changes and the subsequent recommendations arising from the National Ambulance Service Infection Prevention Control Group, at which EMAS was represented by the Head of Infection Prevention and Control or Deputy Director of Safety and Patient Experience (who is also the Deputy Director of Infection Prevention and Control). Where appropriate, recommendations were implemented following approval by the appropriate group or committee in accordance with our agreed arrangements for managing the pandemic and the Trust's Scheme of Delegation. Where required, urgent decisions were made using appropriate delegated authority to ensure timeliness of implementation. Where the national guidance encouraged local variation, risk assessments were undertaken to support the Trust's approach.

114. In January 2021 AACE issued guidance to minimise the risk to staff arising from delayed handover at hospital where staff were spending prolonged periods of time in the back of ambulances. We undertook ventilation checks on our ambulances and minimised the risk through opening ambulance doors while waiting and requiring one member of the crew to sit in the vehicle cab. Guidance was also issued on cleaning touchpoints and in-between cleans for vehicles.

115. At exhibit INQ000216637 I have included a chronology of changes to infection prevention and control measures in ambulance healthcare settings.

Personal Protective Equipment

116. In March 2020 we did not have an electronic stock system and therefore do not have a record of our PPE stock levels held at a particular point in time. The staff in our warehouse conducted a visual check to assess whether stocks of particular pieces of equipment were low and ordered additional items as necessary. Only small amounts of stock were held centrally or on ambulance stations. This was because many types of PPE including surgical masks, eye protection and coveralls were used only infrequently. We had a larger supply of latex gloves prior to the pandemic because these were the main item of PPE that we used regularly.

117. Stock levels held centrally by our Logistics Team would have been relatively low at the start of the pandemic. An estimate of the level of stock held centrally at 1 March 2020 is at exhibit INQ000216638. In addition to this PPE stock would have been available at each of our ambulance stations for staff to replenish items on our ambulances as needed.

118. We had a Personal Protective Equipment Policy in place prior to the pandemic. Version 6.0 was in place on 1 March 2020. We also had a Respiratory Protective Equipment Standard Operating Procedure and version 3.0 was in place on 1 March 2020.

119. Particularly in the early stages of the pandemic changes to PPE requirements were relatively frequent in response to increasing knowledge of the epidemiology of the virus and modes of transmission. It was neither practical nor appropriate to make constant changes to our overarching policy and standard operating procedures during this time and our approach was to adhere to national guidance (interpreted for the sector by AACE National Ambulance Service Infection Prevention and Control Group). Appropriate communications methods were used to ensure that staff were kept updated with changes and the rationale for these and that they were given opportunities to raise queries or concerns. The Covid Bulletin was used to ensure timely sharing of updates including infection prevention and control and PPE guidance changes.

120. We undertook risk assessments at various points in the pandemic when making changes to use of PPE and to support our decision-making and shared these with staff.

121. Our Logistics Team introduced our PPE to Vehicles Initiative early in the pandemic to manage levels of PPE supplied to our ambulance stations and other locations. We used a WhatsApp group within the Fleet and Logistics teams to assist in recording stock levels and distributing PPE to ambulance stations with low levels of stock. The team attended the stations, restocked them with relevant items of PPE and then recorded stock levels on the WhatsApp group, which enabled a central record to be maintained in timely manner. We redeployed staff

from non frontline areas of the organisation to create packs of PPE so that they could be issued as self-contained bundles to stations. Each bundle contained the PPE needed for one job, making it easier for frontline crews when they arrived with a patient.

122. There was a requirement to report levels of stock every day to the regional NHS England team and we are still required to do so on a weekly basis. The regional NHS England team used this information to send us additional items as required, although amounts were limited and we did not know what would be delivered until it arrived. To address the situation our Fleet and Logistics teams were proactive in obtaining PPE from other sources.

123. Managers within the Fleet and Logistics teams used their contacts in other organisations, such as the motor industry, fire and rescue services, the police, prison service, and power stations, to obtain additional PPE, especially coveralls. We checked these items to ensure they were of the correct standard for safety and suitability for use by our staff. This was not a national direction but was initiated by managers within the Fleet and Logistics teams to ensure adequate levels of PPE were maintained. We also made contact with other ambulance trusts and NHS Trusts to obtain PPE through mutual aid.

124. We used our existing routes for testing PPE and RPE. Any items donated were assessed by the Infection Prevention and Control Team for suitability prior to use. This included checking that the relevant standards were met.

125. Messages were placed on our social media channels and website for the public and in staff newsletters, advising of the required standards and requesting that any donations come via the communications or Infection Prevention and Control Team so that suitability could be assessed. We had some donations of PPE which we were unable to use as they did not meet the standards.

126. Prior to the pandemic we had already made the decision to move to using respirator hoods rather than Filtering Facepiece 3 (FFP3) masks and had supplied two to each vehicle. After the onset of the pandemic, we provided all members of staff with personal issue hoods to use with the respirators to reduce

the risk of spreading the virus. We had a small number of NEPTS staff working on the transfer of high dependency patients who needed to use FFP3 masks but as the number of staff was small we did not have significant issues in sourcing the required masks. During the early stages of the pandemic we changed from respirator hoods being available on all vehicles to each member of staff having a personal issue hood to reduce the risk of transmission. This decision was communicated to staff on 24 March 2020 and the hoods began to arrive from June 2020 onwards.

Do not Attempt Cardiopulmonary Resuscitation Notices

127. Ambulance services do not issue Do not Attempt Cardiopulmonary Resuscitation (DNACPR) notices for patients. We have reviewed our incident reporting system to identify any cases where our staff reported concerns regarding DNACPR notices between 1 March 2020 and 28 June 2022. Four cases were identified where the patient had queried the existence of a DNACPR, which was not an unexpected number of cases over that time period. These cases were reviewed as part of our normal incident investigations.

Reflections on the Response to the Pandemic

128. EMAS worked closely with healthcare systems across the East Midlands region throughout the pandemic and built on existing working relationships with other trusts, including other ambulance trusts. This closer working generated a better understanding of the respective roles of each organisation, which has also proved beneficial post pandemic, particularly in the context of the working arrangements for the new Integrated Care Systems. Examples of where there was good integration with other trusts included obtaining access to Covid-19 testing and vaccinations for EMAS staff before these facilities were available to the general public. The way in which the ambulance services worked together through AACE in interpretating guidance and sharing experience and resolution of issues was very productive and successful.

129. We experienced a number of challenges in responding to the pandemic including responding to a rapidly changing situation and associated guidance which was continuously being revised and regular requests for data and information.

130. Supporting our staff throughout was very important to us particularly in the beginning of the pandemic when there was much uncertainty regarding the nature and impact of the virus and staff were anxious for their own safety and that of their families. Supporting our staff was also important as the pandemic progressed and staff became fatigued from working under pressure for a sustained period and from the necessity to wear PPE throughout their shift. A large number of our staff contracted Covid-19, some becoming seriously ill and being hospitalised. This had a significant impact on colleagues across the organisation, particularly when tragically one of our frontline paramedics passed away due to the Covid-19. Our staff continued to work hard to provide compassionate, good quality care to patients throughout the pandemic despite the extreme pressures both at work and in their home life.

131. Other challenges included arrangements for the provision of PPE from national supplies as we did not know what we would receive until the delivery arrived. We established good arrangements in the Trust to be able to supplement this through donations from various organisations and mutual aid from other NHS bodies.

132. As soon as national recommendations were made for staff to work from home wherever possible, we fast-tracked existing plans for implementing information technology to enable remote working and video conferencing. By moving support services staff out of our headquarters building this allowed us to make changes to our office layout and facilitate appropriate physical distancing in our Emergency Operations Centres. We were keen to take the learning from this and subsequently made these arrangements permanent, through embedding new ways of working facilitated by information technology, alongside changes to our estate.

133. Temporary revised financial arrangements for NHS Trusts was a positive action and ensured that funding was not a barrier in our response to the pandemic.

134. We successfully established the Trust as a vaccination hub, training our staff as vaccinators and providing vaccinations in-house, which enabled our frontline staff to obtain faster access to Covid-19 vaccinations than had been possible previously.

135. The pandemic provided us with an opportunity to test our emergency planning and business continuity arrangements. We have not made any significant changes to our existing arrangements but we do now have improved arrangements in place for obtaining PPE and have made the divisional tactical cells established in response to the pandemic a permanent feature.

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