Witness Name: Tom Abell
Statement No.: 1
Exhibits: 8
Dated: 28 May 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF TOM ABELL

I, Tom Abell, will say as follows: -

1. I have worked for the East of England Ambulance Service NHS Trust (EEAST) since 2021 and I am currently employed as the Chief Executive. I am writing this statement on behalf of EEAST in response to the Rule 9 request by the UK Covid-19 Inquiry (reference M3/EEAS/01).

Background

2. For the purposes of this statement, the "relevant period" is from 1 March 2020 to 28 June 2022.

3. EEAST covers a regional geographical footprint comprising of six counties (Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk) and serves approximately 6.5 million people, through a workforce of over 5,500 staff and volunteers. EEAST provides both urgent and emergency healthcare via 999 and non-emergency patient transport services (PTS), as well as Hazardous Area Response Team (HART) provision in line with the Civil Contingencies Act.

4. During the period in question, the core structure of EEAST did not change and the provision of 999, PTS and HART services remained core business. Additional roles were put in place to support pandemic response, mutual aid processes were

established and the governance structure was amended to enable delivery – all of which are addressed further in this statement.

5. EEAST did not provide any 111 services during the relevant period.

6. In terms of pandemic planning prior to March 2020, Business Continuity Plans were in place with pandemic as a cause identified. This was tested around 2018 and a further small exercise was conducted at the beginning of the pandemic. Mechanisms for mutual aid in emergency circumstances were in place between providers and other services, such as fire and military, as part of our business continuity plans. These were stepped up and expanded during Covid-19. Sub-contractor provision to increase ambulance provision was already in place prior to the pandemic through private ambulance provision, this was expanded during Covid-19 as part of our business continuity plans.

Governance arrangements and decision-making (internal)

7. The Trust Board and Executive Leadership Team remained as key decision makers for both 999 and PTS provision and the individuals appointed to the Trust Board are outlined below;

Name	Role	Dates
Dorothy Hosein	Chief Executive Officer	01.11.2018-07.01.2021
Tom Abell	Chief Executive Officer	02.08.2021-ongoing
Emma de Carteret	Director of Corporate Affairs and Performance	01.12.2021-31.03.2024
Hein Scheffer	Director of Strategy and Culture	01.04.2022-ongoing
Kate Vaughton	Director of Integration	14.02.2022- ongoing
Kevin Smith	Director of Finance	01.06.2014-ongoing
Marcus Bailey	Chief Operating Officer	01.03.2019-31.03.2024
Marika Stephenson	Director of People Services	01.12.2021-ongoing

Bob Champion	Interim Director of Workforce	08.04.2021-14.12.2021
John Syson	Director of Workforce	24.02.2020-30.09.2022
Melissa Dowdeswell	Director of Nursing	08.03.2022-ongoing
Simon Walsh	Medical Director	01.12.2021-ongoing
Tom Davis	Medical Director Interim Chief Executive	02.02.2018-30.09.2022 07.01.2021-01.08.2021
Nicola Scrivings	Trust Chair	18.11.2019-31.05.2023
Alison Wigg	Non-Executive Director	15.01.2019-14.01.2024
Carolan Davidge	Non-Executive Director	04.07.2019-03.12.2022
Julie Thallon	Non-Executive Director	04.01.2021-03.12.2025
Mrunal Sisodia	Non-Executive Director Chair	01.05.2020-31.05.2023 01.06.2023 - ongoing
Neville Hounsome	Non-Executive Director	10.07.2019-09.07.2023
Tom Spink	Non-Executive Director	15.01.2018-30.06.2022
Wendy Thomas	Non-Executive Director	04.07.2019-ongoing

8. Day-to-day decision making specifically related to responding to critical issues relating to the pandemic was undertaken by an Incident Management Group, chaired by the Director of Finance and included key managers across all EEAST departments. Decisions were logged via the Covid-19 Decision Log (Exhibit TA/1 INQ000421812). This approach enabled us to take rapid, risk-based decisions to ensure that our response to emerging risks or variables was timely, to maximise patient and staff safety.

9. The following documents are included which outline the structures and changes undertaken as a result of Covid:

- Covid Governance Framework (Exhibit TA/2 INQ000421813)
- On call structure and process (Exhibit TA/3 **INQ000480137)**

The Trust also established the Incident Management Group for discussion and escalation of specific issues relating to Covid-19, both in relation to frontline and support operations.

10. It should be noted that the Covid Governance Framework was a flexible document and was reviewed every few months, to ensure our approach was proportionate to the situation at that time. All versions can be provided as evidence if the Inquiry deems this to be necessary.

Escalation and decision-making (external)

11. A clear national and regional decision-making structure was in place throughout the pandemic, in line with the pre-existing requirements under the Civil Contingencies Act, which included the Local Resilience Forums. The Local Resilience Forums (LRF) are county-based (six across the East of England) and the membership comprised of EEAST, other emergency services, utilities, Acute Trusts within the county and local government representatives. They acted as a link at tactical and strategic level in each county to the wider healthcare system and community and were a route for escalation (from or to EEAST) for resolution of issues and coordination of any joint responses required. EEAST also engaged with A&E Delivery Boards (AEDB) / System Resilience Groups (SRG), and Local Alliance Forums.

12. The Incident Management Group (IMG) provided the next level of escalation from an internal perspective. From IMG, escalation was then made to the Executive Team for internal issues or through NHS England/Improvement (NHSE/I) for external issues.

13. Regular calls took place with NHSE/I in relation to outbreak management and ranged from daily to every couple of days, these were part of the NHSE/I Covid-19 system call. These calls were an opportunity to escalate concerns and raise/share situational awareness. An example would be to discuss the IIMARCH forms that were used to report outbreaks to the local Health Protection Teams. These would be discussed with NHSE/I and Public Health England so information could be relayed by EEAST in

relation to the details of the outbreak and NHSE/I could explore what actions we had taken and what processes we had in place (e.g. hand hygiene, social distancing).

14. The procurement team escalated supply issues through the Regional Command Centres. Any national guidance or decisions were circulated to organisations via the Chief Executive, our 24/7 central point of contact within the control rooms, or through the above-mentioned joint forum routes.

Impact on provision of service and targets

15. Significant planning was undertaken at pace, and modelling assumptions were taken from analysis of the impact upon London based on the known spread of Coronavirus into the UK. Early decisions were taken to maximise the number of staff able to respond to both 999 calls and face to face patients.

16. Extensive collaboration with other providers including fire and military services (see 16 below) to increase capacity was undertaken. This included the implementation of rapid volunteer recruitment and Memorandums of Understanding with a number of services, to enable this enhanced support to occur safely.

17. The impact of the pandemic during the full course of the pandemic on provision included:

- Initial reduction in 999 activity and reduction of PTS activity due to elective cancellations. PTS redeployed to 999 responses
- Increased staff sickness and isolation due to contact tracing or positive testing
- Alternative crew skill mix to attend to patients, in order to expand our frontline resources so we could respond to greater numbers of patients as the need arose
- Reduced workforce availability due to shielding requirements
- Increased handover delays at hospital due to capacity issues which impacted the flow of patients through the hospitals to discharge.

- Access changes to patients in care homes – this became dependent on covid testing of our staff which meant a variation in our processes
- Increased PPE need
- 999 triage resulting in lower acuity patients receiving telephone advice rather than a face to face response, in order to safeguard frontline resources to be able to attend our highest acuity patients in a timely manner.

18. Contacts to EEAST for the relevant period for both A&E provision and PTS are outlined below:

	PTS	A&E (999 calls)
Mar-20	24,143	80,409
Apr-20	11,668	60,867
May-20	12,955	59,214
Jun-20	16,058	59,319
Jul-20	19,780	64,029
Aug-20	20,504	69,415
Sep-20	22,818	66,509
Oct-20	23,809	72,037
Nov-20	22,460	63,234
Dec-20	20,237	73,894
Jan-21	17,881	77,350
Feb-21	17,902	57,393
Mar-21	23,071	63,854
Apr-21	24,718	66,700
May-21	25,594	77,838
Jun-21	28,648	86,077
Jul-21	29,038	95,941
Aug-21	27,561	93,145
Sep-21	28,444	97,418
Oct-21	27,642	101,371

Nov-21	30,731	83,376
Dec-21	24,741	87,237
Jan-22	26,639	79,793
Feb-22	27,487	76,100
Mar-22	35,598	95,417
Apr-22	22,849	86,614
May-22	24,776	84,567
Jun-22	24,107	87,297

19. For A&E provision, the targets remained the same as pre-pandemic and EEAST's compliance with targets did deteriorate as seen below.

Hh:mm:ss	**Target**	**Actual 20/21**	**Actual 21/22**
C1	00:07:00	00:07:01	00:09:50
C2	00:18:00	00:21:33	00:45:42
C3	02:00:00	02:10:35	02:19:00
C4	03:00:00	02:27:22	02:49:00

The key reasons for targets not being met include:

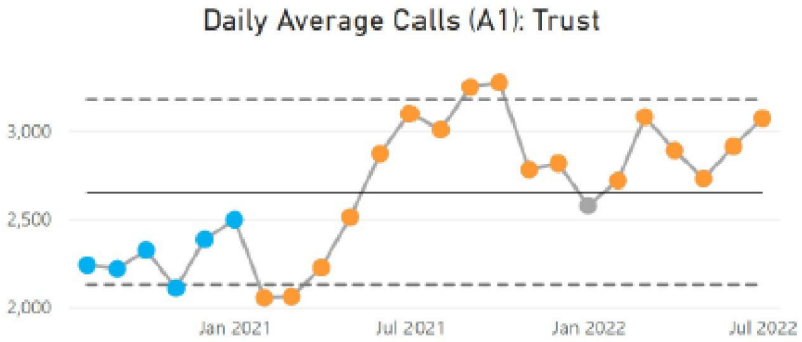
- Residual capacity gap: before COVID-19, EEAST had a staffing gap which contributed to reduced response times.
- Staff sickness absence, predominantly with COVID-19 symptoms, or isolating due to contact with positive individual.
- Extensive handover delays at the Acute Trusts in the region. The table below demonstrate the level of handover delays pre and post-pandemic:

Time lost in HH:MM:SS where arrival to handover is > 15 mins (EE-AS67)							
2019/2020		2020/2021		2021/2022		2022/2023	
Apr-19	5722:08:29	Apr-20	3311:31:24	Apr-21	4624:42:12	Apr-22	14592:33:21
May-19	4892:14:40	May-20	3543:00:12	May-21	5929:38:31	May-22	13531:58:14
Jun-19	4615:23:18	Jun-20	3383:56:23	Jun-21	7545:31:56	Jun-22	14685:13:44
Jul-19	5346:16:36	Jul-20	3585:11:19	Jul-21	9790:07:01	Jul-22	18776:40:04
Aug-19	5389:05:11	Aug-20	4549:06:50	Aug-21	10575:58:49	Aug-22	16580:35:15
Sep-19	5537:07:29	Sep-20	4877:52:55	Sep-21	11316:02:57	Sep-22	18010:55:55
Oct-19	7066:33:11	Oct-20	5893:01:34	Oct-21	12854:20:22	Oct-22	24489:04:58
Nov-19	7770:56:39	Nov-20	5697:24:43	Nov-21	12786:15:01	Nov-22	22155:04:36
Dec-19	9546:40:45	Dec-20	10395:36:18	Dec-21	12439:34:06	Dec-22	29382:01:24
Jan-20	8799:24:32	Jan-21	8787:47:02	Jan-22	12715:31:14	Jan-23	17780:38:33
Feb-20	6081:38:51	Feb-21	4524:04:33	Feb-22	12743:56:46	Feb-23	15373:59:08
Mar-20	5520:21:26	Mar-21	4744:56:55	Mar-22	16617:14:20	Mar-23	24247:18:10
Total	76287:51:07	Total	63293:30:08	Total	129938:53:15	Total	229606:03:22

20. In relation to PTS, the decision to stop formal contract negotiations and contract management (which included reporting) was a national decision. This was designed to enable organisations to focus on service delivery rather than performance management. Each PTS contract has individual KPIs rather than national targets, which are managed locally.

21. In terms of the 'stay at home, protect the NHS' message, 999 calls significantly reduced over the first 12 months of the pandemic suggesting that patients did not seek care. It is not possible for us to determine the reasons for this although is likely to be multi-factoral, and include social isolation limiting spread of other illnesses and viruses beyond coronavirus.

22. Activity increased from February 2021. Communications via social media sought to encourage patients to call in an emergency situation.



Resourcing and funding

23. During the course of the pandemic we increased our overall frontline staffing levels (those roles that directly provide a response (telephone or face to face) to patients. This was through the recruitment of non-clinical drivers and the use of volunteers, including collaboration with the fire service. EEAST also implemented an annual leave buy-back scheme to increase frontline staffing levels. A more detailed breakdown by regional sector can be provided if the Inquiry require this level of detail.

Staff Numbers - **Excluding** Bank Staff

Staff Type	**Headcount as at 1/3/2020**	**Headcount as at 28/6/2022**	**Variance**
Frontline A&E	3173	3531	358
Frontline HART & Air Ops	121	125	4
Frontline PTS	449	399	-50*
Call handling, Dispatch Staff & ECAT	506	517	11

* this relates to a change in contract arrangements in South Essex

Staff Numbers - **Including** Bank Staff

Staff Type	Headcount as at 1/3/2020	Headcount as at 28/6/2022	Variance
Frontline A&E	3411	4007	596
Frontline HART & Air Ops	127	133	6
Frontline PTS	474	480	6
Call handling, Dispatch Staff & ECAT	556	583	27

24. Staff numbers were further bolstered by the use of Private Ambulance Service providers from the independent sector.

	A&E Shifts				PAS Shifts		A&E Vehicles				PAS Vehicle	
Month	DSA	HCRT	ITV	ACA	DSA	ITV	DSA	HCRT	ITV	ACA	DSA	ITV
Aug-20	25581	167	4108	16	1514	397	12791	84	2054	8	757	199
Sep-20	24776	151	3230	25	2365	597	12388	76	1615	13	1183	299
Oct-20	26137	179	2706	55	2511	528	13069	90	1353	28	1256	264
Nov-20	26556	127	2964	266	2351	409	13278	64	1482	133	1176	205
Dec-20	27946	100	3169	150	2256	528	13973	50	1585	75	1128	264
Jan-21	26964	117	3109	164	2332	290	13482	59	1555	82	1166	145
Feb-21	26021	99	2953	209	2089	472	13011	50	1477	105	1045	236
Mar-21	28050	137	2999	150	2395	422	14025	69	1500	75	1198	211
Apr-21	26383	122	2861	173	2402	392	13192	61	1431	87	1201	196
May-21	26340	116	2714	223	2134	254	13170	58	1357	112	1067	127
Jun-21	25079	111	2496	186	1874	276	12540	56	1248	93	937	138
Jul-21	26433	107	2491	237	1545	403	13217	54	1246	119	773	202
Aug-21	26670	120	2460	249	1339	324	13335	60	1230	125	670	162
Sep-21	25947	134	2510	217	1193	310	12974	67	1255	109	597	155
Oct-21	26330	103	2481	195	1414	268	13165	52	1241	98	707	134
Nov-21	26032	96	2428	203	1315	240	13016	48	1214	102	658	120
Dec-21	27112	108	2458	206	1243	250	13556	54	1229	103	622	125
Jan-22	27122	128	2496	223	1338	274	13561	64	1248	112	669	137
Feb-22	24328	106	2245	149	1140	273	12164	53	1123	75	570	137
Mar-22	25876	121	2422	145	1215	279	12938	61	1211	73	608	140
Apr-22	24623	99	2314	98	1680	242	12312	50	1157	49	840	121
May-22	25659	100	2275	120	1764	123	12830	50	1138	60	882	62
Jun-22	24582	28	787	35	1775	132	12291	14	394	18	888	66

Shifts	The planned shifts recorded on the workforce planning system (GRS).
Vehicles	These vehicle are staff by two members of staff, so this figure takes the planned shifts and divides by 2 to calcualte the planned.
DSA	Paramendic Lead vehicle
ITV	EMT lead vehicle
HCRT	Non Qualified Crew
ACA	Non Qualified Crew

These figures are based on the pre planned situation of the day but the skill mix on a vehicle may have changed on the day or during the day and these changes may not have been recorded on GRS.

25. In terms of resourcing and funding, the responsible individuals are outlined below:

Area of responsibility	Responsible director
Budget	Director of Finance
Number of ambulance clinicians	Chief Operating Officer 01.03.2019 - ongoing Director of Workforce 24.02.20 - 30.09.22 Director of People Services 01.12.21 - ongoing
Number of support staff, such as call handlers	Chief Operating Officer 01.03.2019 - ongoing Director of Workforce 24.02.20 - 30.09.22 Director of People Services 01.12.21 - ongoing
Number of ambulance vehicles	Chief Operating Officer
Response time targets	Chief Operating Officer

26. EEAST received the following funding throughout the pandemic:

    2019-2020 EEAST received an allocation for the year of £1.3m (£1,288).
    2020-2021 EEAST received an allocation for the year of £4.5m (£4,478).
    2021-2022 EEAST received an allocation for the year of £34.5m (£34,451).
    2022-2023 EEAST received an allocation for the year of £14.6m so around £3.6m from April – June 2022.

    EEAST received an adjustment for 'pushed stock' so did not receive the money itself, however NHSE automatically sent EEAST various stock. At the end of the year, EEAST would mark this as an expense and include it in the nominal income to cover it.

27. No additional funding was requested. The additional funding for the pandemic response was sufficient to meet the needs of the organisation during the period.

Collaboration with others

28. In early 2020, EEAST established a Mutual-Aid agreement to enable us to expand our work with partner NHS providers, and other agencies such as Private Ambulance Services, Fire and Rescue Services, Voluntary Sector and the Military. The intention behind the Mutual-Aid agreement was to ensure clear identification of roles and responsibilities for all parties involved, in an expedited way which negated formal contract negotiations and enabled a swifter preparedness and response to the Covid-19 pandemic. The Mutual-Aid arrangements allowed EEAST to clearly identify the financial support required that was solely attributable to spend against the Covid-19 response, and therefore funded via the Covid-19 monies made available to NHS organisations (as opposed to core contractual funding to deliver business as usual (BAU) services). EEAST BAU services as commissioned were:

- Our core 999 Emergency Service provision
- Non-Emergency Patient Transport Services (where we had contracts awarded to EEAST)
- CallEEAST commercial call handling contracts
- TrainEEAST commercial training contracts (i.e. first-aid / Basic Life Support training)

The Mutual Aid agreement was used extensively in support of both EEAST's 999 and PTS Service Delivery, to keep both services operating at an acceptable level whilst maintaining patient and staff safety.

29. In terms of PTS, NHS Ambulance Services were tasked by the national NHS England team to become regional central coordinating providers, effectively undertaking the role of coordinating the services of all commissioned PTS providers within that region. The PTS Case Transport Response Service (CTRS) was stood up at pace during the early part of 2020 and remained in place for the first 2 lockdowns, in order to ensure that patients that had no other means of transport could get to their vital clinic appointments. Where patients were able to attend via their own transport they were asked to do so, in order to minimise infection, prevention and control risk through spread within NHS transport vehicles, and to minimise vehicle off road time due to the need for deep cleaning of these vehicles.

30. EEAST engaged with Commissioners, private PTS providers and acute hospital colleagues to mobilise this service, and was commended by all CCGs and our regional NHS England team for how successfully EEAST coordinated a large number of external providers under EEAST's governance, and the positive impact this had on keeping patients as safe as possible in light of the mandated Covid-19 restrictions. There was significant system engagement and collaboration during the pandemic, and in many senses the pressures and impact of Covid-19 broke down a great many traditional barriers and silo working between NHS Trusts and/or with Commissioners. For example, previous issues that had created tension and escalating conversations still existed however the different systems quickly moved towards a more collaborative approach, including discussions in relation to how we could integrate our respective resources to find solutions. In addition, NHS providers were moved away from 'cost and volume' contracts whereby we could be financially penalised for non-delivery of performance, and on to 'block' contracts where we all received a guaranteed income to deliver services which provided further assurance that we could all collectively focus on the must-dos to get through the pandemic.

31. In terms of collaboration with other ambulance Trusts, the National Ambulance Resilience Unit (NARU) was responsible for communicating any mutual aid requests by ambulance services, in line with the approach already in place prior to the pandemic. Mutual Aid provision was then co-ordinated by the National Ambulance Co-ordination Centre (which was hosted by West Midlands Ambulance Service). EEAST did not utilise mutual aid from any other ambulance services.

32. The National Directors of Operations Group (NDOG) met regularly during the pandemic and EEAST's Chief Operating Officer was a member of this group. Any formal/informal mutual aid discussions were also recorded here. Close liaison through this group as well as contact between different Trust's control rooms were undertaken on an ongoing basis to ensure a nationally coordinated approach which maximised patient safety.

33. During the height of the pandemic, EEAST requested and utilised Military Mutual Aid to Civil Authorities (MACA) support on multiple occasions, with military personnel and vehicles / equipment moved into Wattisham Airfield in Suffolk, to provide on-going support and to aid urgent mobilisation of these resources should this be required.

34. EEAST also sought support from some Fire and Rescue Services across the East of England in order to not only assist us in relation to driving our vehicles so that our clinicians could focus on patient care and treatment, but also mobilising their own response models for C1 Incident Response, Bariatric / Complex Patient Rescue / Extrication, and lower acuity Falls Response. EEAST worked with Bedford Fire and Rescue Service most proactively who, post-Covid, are now leading the FRS regionally on a longer-term sustainable model in support of EEAST, given the significant success following their support during the pandemic.

Policies and guidance

35. In terms of call prioritisation, the only significant change was the use of "Card 36 Pandemic flu" within Medical Priority Dispatch System (MPDS) in line with national guidance. Emergency Operations Centre Standard Operation Procedure (ESOP) 69 was produced at the start of Covid and updated regularly as the situation/pandemic/guidance changed (Exhibit TA/4 INQ000421814). The key changes were the introduction of the Emergency Infection Disease Surveillance toolkit, which was used to ask Covid-19 related questions approved by NHS England; addition of a Decision Support Tool appendix for non-pregnant adult patients with confirmed/suspected Covid-19; inclusion of information pertaining to Quarantine Hotel residents; and changing the use of Protocol 36 to only be used for patients with confirmed Covid-19 with an SPO2 reading.

36. In essence patients with certain symptoms/presenting complaint were triaged using Card 36 and Emergency Call Prioritisation Advisory Group (ECPAG) provided guidance on the subsequent call category. At times we would also ask certain questions once the call was coded as a surveillance tool (have they travelled to a certain country, do they have a temp of fever etc) but this did not affect the coding.

37. Clinical guidelines were updated as required throughout the pandemic, the key documents relating to Covid-19 are identified below:

Guidance Reference	Guidance Date	Guidance Title
EAST0004	01.02.2021	Delayed Handover
EAST2300	01.02.2021	Covid-19 Guidance for Amb
EAST2300	01.03.2020	Covid-19 Guidance for Amb
EAST3060	20.04.2021	Decision Support Tool
G0065	24.08.2021	End of Life Care
G0065	25.05.2021	End of Life Care
G0065	01.03.2020	End of Life Care
G0240	20.04.2021	Mental Health Presentation
G0240	01.02.2021	Mental Health Presentation
G0240	01.03.2020	Mental Health Presentation
G0360	01.03.2020	Acute Coronary Syndrome

The 'Delayed Handover' document from AACE provided guidance to clinicians to ensure that any incidents whilst waiting to handover at hospital were reported following the usual procedures; concerns were appropriately escalated to hospital clinicians; and advice on repeating observations and appropriately recording these.

The 'Decision Support Tool' provides clinical advice and guidance to staff in relation to decision-making on conveyance and non-conveyance of patients displaying Covid-19 symptoms.

38. EEAST policies and guidance were disseminated via the following routes however, since the pandemic, staff have been provided with a personal-issue iPad for rapid access to updates which has improved the accessibility of information for staff, particularly frontline. The dedicated Covid intranet page was beneficial for staff to access the relevant information in one location and improved the dissemination of information in relation to this:

- Email
- Need to Know bulletin
- Dedicated Covid intranet page

- Station wallboards and manager dissemination
- Emergency changes in real time via text message and MDT screen alerts in the vehicles
- Clinical Instruction cascade in line with our usual policies and processes

39. Consideration to the impact of EEAST policies/guidance on at-risk groups was given throughout the dissemination. The Covid decision making process incorporated identification of risks to patients, staff and the organisation and mitigations were always considered prior to a decision being agreed, in line with the Covid Governance Framework. As more information relating to the Covid impact on at-risk and vulnerable groups was received from the national teams, specific risk assessments and processes were put in place to mitigate and this information was shared on the Covid-19 homepage on the intranet. This included shielding vulnerable and BME staff at home, or moving them to temporary alternative duties, following a risk assessment and line manager discussion.

40. EEAST established an Clinical Ethics Advisory Panel (CEAP) to consider any ethical or moral decisions to be taken based on level of risk. The aim was to establish a forum for discussion of ethical concerns related to patient care, which can reflect and consider specific situations against agreed values and criteria. The outcome of which was to deliver concluding ethical advice and recommendations to support robust organisational decision-making at Trust Board and within strategic command structures. An example of an issue discussed at the Ethics Advisory Panel is "*The Trust provides PPE to Level 3 protection. The Trus'ts current policy advises clinical staff to don Level 3 PPE when AGPs (aerosol generating procedures) are to be undertaken. Does the Trust's position on PPE remain correct when other healthcare organisations are advocating donning the highest level of PPE for all COVID patient contact?".* In May 2021, a one-year review of the (CEAP) was taken to EEAST's Quality Governance Committee meeting for assurance.

Impact on staff

41. Support was provided to staff through the wellbeing team and our Occupational Health contract, with Covid Leads within each area for advice and guidance in relation to the policies in place at any given time during the pandemic. Vulnerable or high-risk staff members were stood down in line with national guidance and office staff were supported to work from home and provided with equipment to do this. Line managers provided regular check-ins to support staff at home and Microsoft Teams was used to facilitate this.

42. All staff were required to undertake a risk assessment to establish the level of risk to them. BME staff and other more vulnerable staff were supported to work from home or alternative duties if appropriate.

43. During the pandemic, EEAST supported staff to utilise Trauma Risk Management (TRiM) and Occupational Health and both services referral numbers increased significantly. Additional mental health support was available through central hubs with Integrated Care Boards and NHS England. Due to a national lack of understanding of the impact of coronavirus on long term health and residual health issues, we elected to not apply the sickness management policy in relation to evidenced C-19 infections, so as to not penalise individual staff members with performance management for contracting the virus. This approach helped to minimise spread within our workforce. Following national review and consideration of the research and understanding of long Covid and the likely impact on long term health, the sickness policy has since been reinstated in order to support individuals with long term symptoms to return to work or find alternative employment options should they be unable to continue in their role. This change took place in July 2022 in line with the NHS Employers guidance.

44. Staff were also offered alternative accommodation in order to help protect families from Covid-19 and food packages were offered where required.

Covid testing

45. Covid testing and the impact upon service delivery has evolved over the course of the pandemic as greater understanding has been developed nationally. Initially, (April 2020) every staff member "stood down" due to either being symptomatic for Covid or

due to potential contact, had to be stood down for a period of 14 days, which reduced our available level of resourcing for an extended period. At that point, NHSE requested that swabbing of key NHS workers (including critical care, emergency departments and ambulance staff) was undertaken to support a swifter return of these staff groups to work, if the index case within the household is Covid free (negative). A daily submission from the local management team (Covid sector lead) was undertaken on a case-by-case basis to enable our CallEEAST Coordination Centre to book swabbing at the local facilities across the region. The first regional Covid testing site opened on 10th April 2020 and more followed. Initially there was no ability to swab minors (under 18s).

46. In late 2020 a clinical evaluation from Public Health England (PHE) and the University of Oxford showed that lateral flow tests were accurate and sensitive enough to be used in the community, including for asymptomatic people. It was hoped that using the tests in mass testing could reduce COVID-19 transmissions by up to 90%. EEAST, via supply from NHSE/I, provided lateral flow kits to staff from November 2020. If we ran low on kits thereafter, NHSE/I signposted us to other NHS Trusts and we received mutual aid, and vice-versa. From 2020 to 2023 EEAST distributed 16,613 kits, 554 of which were provided to other Trusts, and 16,059 to EEAST staff (over 400, 000 tests, as kits contained multiple tests). During this period 101,744 results were submitted by staff via the QR code or link, with 1,110 positive results logged. EEAST are no longer able to obtain lateral flow kits although they are available to staff from the .gov website, for staff to utilise if they work with extremely clinically vulnerable patients. This is in line with national guidance.

47. EEAST also offered LAMP (loop-medicated isothermal amplification – commonly known as "spit tests") testing as a supplementary asymptomatic testing method in Norfolk & Waveney (as a trial in conjunction with NNUH) from 14/6/21 to 01/04/22.

48. A positive lateral flow test had to be confirmed by a PCR test until January 2022, when a positive lateral flow test (LFT) no longer required a confirmation PCR. Regional PCR testing sites all closed on 31/03/2022 and LFT became the only test required, so from 1st April 2022 to date EEAST are no longer able to provide PCR tests but could provide LFT.

Infection prevention control and Personal Protective Equipment (PPE)

49. EEAST followed the appropriate national guidance throughout the Covid-19 pandemic. There were incremental versions of the guidance, it began as the response to 'Wuhan Novel Coronavirus'. This developed and became the Covid-19 Guidance for Ambulance Trusts. This guidance was based predominantly on the guidance put together by the UK Health Security Agency (Formerly Public Health England), however the guidance was also reviewed and approved by national groups including NHS England, National Ambulance Service IPC Group, Association of Ambulance Chief Executives (AACE) and QGARD. At all times, the guidance document produced by EEAST for internal use aligned to the nationally produced documents.

50. The other guidance document followed internally on station was the Covid-19 Working Safely Guidance for Non-Clinical Areas. This was also agreed by the above groups and was derived from Health and Safety Executive (HSE) guidance.

51. The guidance outlined above covers this. We reviewed our position in relation to Infection, Prevention and Control via the nationally mandated IPC Board Assurance Framework document, to ensure all aspects were considered and managed.

52. The IPC guidance in place and provided by AACE is documented in Exhibit TA/5 INQ000421815.

53. The levels of PPE and other vital products available at 1 March 2020 is set out in the table below. However, there were a number of other clinical and non-clinical items that Ambulance Services required during the pandemic period that were also in short supply but were vitally important to the safe and effective delivery of patient care. This was identified as an area of learning.

A	B	C	D	E	F
Pr	Item T	Description	Un ls:	QTY	Trust 7 day Usage or amou required
C305	PPE Coverall	Tyvek Suit or Equivalent - Small	each	0	152
C040	PPE Coverall	COVERALL TYPE 6B SIZE MEDIUM	each	0	1,850
C045	PPE Coverall	COVERALL TYPE 6B SIZE LARGE	each	0	1,850
C046	PPE Coverall	COVERALL TYPE 6B SIZE XL	each	0	1,850
C220	PPE Coverall	Tyvek Suit or Equivalent - XX Large	each	0	1,206
C302	PPE Coverall	Tyvek Suit or Equivalent - XXXL	each	0	328
C310	PPE Coverall	Tyvek Suit or Equivalent - XXXXL	each	0	20
C036	PPE- Oversho	Overshoes - Disposable - Single	each	0	972
C042	PPE- Sleeve P	Sleeve Protectors - Disposable - Single	each	0	3,800
U004	PPE- Eyewear	Safety Glasses or Equivalent	each	1528	5,200
U006	PPE-Eyewear	Safety Goggles or Equivalent	each	82	5,200
M712	PPE-Eyewear	Face Shield / Visor or Equivalent	each	656	1000
M120	PPE-Apron	Aprons Disposable - **Single**	roll of 100	41	95662
M710	PPE-Mask	Surgical mask with visor (Individual mask)	Box of 50	0	
M122	PPE-Mask	Surgical mask (Elastic Loops)	Box of 50	67	87920
M145	PPE-Mask	Surgical mask (Tie Backs) (Individual mask)	Box of 50	0	
U790	PPE-Mask	**FFP2** 3M 9320+ Mask	Box of 50	0	5000
U793	PPE- FFP3 Ma	FFP3 MASK 3M 1873V	each	0	
U001	PPE- FFP3 Ma	FFP3 3M 1883v (Individual Mask)	each	230	
U008	PPE- FFP3 Ma	FFP3 MASK IND WRAPPED	each	454	
U796	PPE- FFP3 Ma	FFP3 MASK HONEYWELL 3207	each	0	
U791	PPE- FFP3 Ma	FFP3 MASK CARDINAL	each	0	
U792	PPE- FFP3 Ma	FFP3 MASK 3M 8833	each	0	4500
U794	PPE- FFP3 Ma	FFP3 MASK 3M 1863	each	0	
U795	PPE- FFP3 Ma	FFP3 MASK 3M 9330+	each	0	
U798	PPE- FFP3 Ma	FFP3 MASK HANDANHY HY9632	each	0	
U799	PPE- FFP3 Ma	FFP3 MASK MEIXIN	each	0	
U820	PPE- FFP3 Ma	FFP3 MASK MEDICOM KOLM	each	0	
M368	PPE-Glove	Surgical gloves XS	Box of 200	308	127
M369	PPE-Glove	Surgical gloves S	Box of 200	400	305
M370	PPE-Glove	Surgical gloves M	Box of 200	602	305
M371	PPE-Glove	Surgical gloves L	Box of 200	441	305
M372	PPE-Glove	Surgical gloves XL	Box of 200	228	127
U805	PPE_-RPE par	3M Sensitivity Solution - Sweet FT-11 (55ml per bottle)	each	0	5
U803	PPE_-RPE par	3M Fit Test Solution - Sweet FT-12 (55ml per	each	0	5
U804	PPE_-RPE par	3M Sensitivity Solution - Bitter FT-31 (55ml per bottle)	each	0	5
U802	PPE_-RPE par	3M Fit Test Solution - Bitter FT-32 (55ml per	each	0	5
U808	PPE_-RPE par	Bitrex Fit Test Solution (100ml per bottle)	each	0	5
U810	PPE_-RPE par	Bitrex Sensitivity Solution (100ml per bottle)	each	0	5
non sto	PPE-RPE	HOODS	each	0	600
non sto	PPE-RPE	RESPIRATORS	each	0	600
U800	PPE_-RPE par	3M Versaflo Filter TR-3712E	Pack of 5	0	50

54. In early March 2020 EEAST had challenges in the provision of PPE, including surgical gloves, Type 2 surgical masks, coveralls, eye protection, Fit Test solution, overshoes, and aprons. It also had challenges in items required to ensure vehicles remained clean environments - for instance mop heads, sterile wipes, cleaning cloths and cleaning tablets. There was also a shortage of general items such as small clinical waste bags, tuff cut shears to enable the safe removal of coveralls and thermometers. The supply

of FFP3 PPE was heavily restricted due to worldwide demand and hooded respirators were also in very short supply.

55. Very early in the pandemic EEAST drew up a list of items that could be restricted and started to source stock, as well as implementation of a manual count daily dashboard of available stock across our 18 main Hub sites (that feed our 125 stations) and main stores. This provided us with a daily stock position of around 60 of the critical items required to maintain staff safety.

56. Using the live-stock position, we were able to predict the projection weekly demand requirements, which enabled us to take a range of different actions to source requirements. These included;

- Use of Multi-Quote tender portal to conduct quick quotes from external suppliers (a dynamic real-time market place with over twenty thousand suppliers).
- Mobilised our existing supplier base to support during gaps in supply e.g., our stationary supplier provided small waste bins, gloves, and masks.
- Reviewed and explored external offers of support e.g., provision of eye protection. Suppliers and the public came to EEAST with direct offers of support.
- Direct engagement with suppliers by Procurement and Supplies staff to support our needs e.g., provision of thicker aprons from a manufacturer normally producing waste bags.
- Ongoing discussions with NHS Supply Chain regarding stock availability.
- Escalation to Regional Command Centres set up to support during the pandemic regarding shortages or supplies issues. The Regional Centre supplied some type 2 masks and supported stock availability.
- Use of Clipper through the new Foundry stock system for some critical items. During the pandemic the supply of usual consumables that are normally supplied through NHS SupplyChain and PPE was differentiated into two separate supply chains. NHS SupplyChain supplied normal consumables (e.g bandages) and Foundry orders were delivered through Clipper- a dedicated supply route for PPE.

- Collaborative sharing of stock with other NHS Trusts.

57. The Supplies team expanded deliveries into main hub sites/AOC sites/HART/PTS to twice per week- one delivery of clinical goods and a further delivery of available PPE and increased opening hours to manage demand. Supplies staff worked 6 days per week to ensure maintenance of supply, including Saturday and Sunday deliveries based on the available supply into stores. The supplies team delivered approximately an additional 4.8m PPE related items during the pandemic period.

58. Through the systems and processes established to respond to the procurement and supplies challenge, EEAST staff were provided with suitable PPE during the pandemic period. However, there were several shortages and challenges in maintaining the stock required which required active management throughout, in particular the initial period. An example of this would be that initially the EEAST procurement team used MultiQuote (a compliant online marketplace with over 20,000 suppliers) to seek alternative supplies but this produced few meaningful results as demand was high across the country. The procurement team contacted all known suppliers to secure any deliveries of alcohol gel that was available within the market. EEAST also made contact with a number of distillers who had converted production as a result of government intervention and purchased alcohol gel direct from the distillers. A Distillers in Norwich supported EEAST with a large delivery that was decanted into bottles for use in stations and AOCs.

59. Various PPE was available to staff in EEAST to cover the range of items required to protect against the key transmission modes of pathogens (contact/droplet/airborne). The PPE was sourced primarily through NHS supplies and had to meet a technical specification and approved items list, including CE markings (for safety standards certification) and the set of EN standards (European technical standards). New items or items sourced outside of the standard supply chain were checked to conform to specifications outlined in national guidance. Any items that were not certified were not used.

60. PPE instructions within EEAST conformed to the National IPC manual and were aligned to the nationally published COVID guidance for ambulance Trusts. If staff did

not pass fit testing for face fitted respiratory equipment, then they were provided with a powered hood device, as per HSE guidance. This included individuals who had facial hair. Where long sleeves or bangles were required for religious reasons, a risk assessment was conducted and the individual could either use sleeve protectors or other mitigation was explored.

61. If a staff member was unable to conform to PPE requirements for any reason, then alternatives were explored. In the absence of any alternative options or additional mitigation/controls, the staff member could be removed from duties that posed an infection transmission risk. PPE was not solely supplied to frontline operational staff, all offices needed masks, alcohol gel and thermometers.

Lessons learned

62. An initial review (Exhibit TA/6 INQ000421816) was undertaken and shared within EEAST in relation to lessons learnt from the pandemic in May 2020 in a document entitled "Organisational learnings from EEAST's response to COVID". Following this on 13 May 2021, the Yorkshire Ambulance Service NHS Trust Business Continuity Manager did a structured strategic debrief (Exhibit TA/7 INQ000421817) for all department heads.

63. An internal debrief report (Exhibit TA/8 INQ000421818) and action log was completed and reported to EEAST's Transformation Committee and the Business Continuity and Steering and Assurance Group. EEAST also attended the Association of Ambulance Chief Executive's debrief.

64. EEAST had no involvement in issuing Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) notices for patients and is not aware of any concerns raised around these types of patient or lessons learnt in relation to this.

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: 29th May 2024