Witness Name: Anthony Marsh

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Exhibits: INQ000226598 - INQ000226623

Dated: 3rd August 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF ANTHONY MARSH

Introduction

I, Anthony Marsh, Chief Executive of the West Midlands Ambulance Service University NHS Foundation Trust (the Trust) based at Millennium Point, Waterfront Business Park, Waterfront Way, Brierley Hill, DY5 1LX, will say as follows: -

1. I am making this statement in my capacity as Chief Executive of the Trust. I have worked within the UK ambulance sector for over 36 years, and I have been a Chief Executive / Ambulance Officer since 2003. I began my ambulance service career in Essex Ambulance Service NHS Trust in 1987 within Patient Transport Services. My career has taken me to various ambulance services before I took up Director of Operations roles in Lancashire and Greater Manchester, where I led the ambulance service during the Commonwealth Games.

2. My first Chief Executive role was in Essex Ambulance Service NHS Trust before I moved to the West Midlands as Chief Executive when the Trust was formed in 2006. I am also the National Strategic Adviser of Ambulance Services to NHS England, a role that I have held since 2018. I have set out below any matters of relevance relating to this role. I was the Chairman of the Association of Ambulance Chief Executives (AACE) from 2014 until 2020. At the beginning of the pandemic, I set out three very clear strategic objectives for my senior managers and leadership teams which were 1) to do everything necessary to protect our staff; 2) to be able to help all of our patients by ensuring we were never overwhelmed (by demand) and to maintain the 999 critical national infrastructure; 3) to save as many lives as possible.

3. I will set out how the Trust organised in order to achieve these objectives and reduce the impact that COVID-19 had on our people, our patients and our organisation. In conclusion I aim to reflect on what we have learnt as a Trust from the most exceptional circumstances in the history of the NHS. The response to this unprecedented National Emergency and effect of the pandemic upon us all has been profound.

4. This statement is prepared to the best of my knowledge and belief. Insofar as matters in this statement are derived from my own personal knowledge, they are true. Where matters are not within my own personal knowledge, they are true to the best of my information and belief and derived from sources stated.

Overview of West Midlands Ambulance Service University NHS Foundation Trust Services

5. It may be helpful to the Inquiry if I start my statement by providing some key information regarding the Trust. The Trust serves a population of 5.6 million people covering an area of more than 5,000 square miles made up of Shropshire, Herefordshire, Worcestershire, Staffordshire, Warwickshire, Coventry, Birmingham and The Black Country conurbations.

6. The West Midlands is a Region full of contrasts and diversity, it includes the second largest urban area in the country (Birmingham, Solihull and the Black Country) yet over 80% of the region is rural.

7. As the region's emergency ambulance service, we receive around 4,000 '999' calls each day and dispatch emergency ambulances from 15 Ambulance hubs across the region. During the pandemic the number of staff employed peaked in February 2021 to just over 7,800.

8. The Trust is fortunate to have access to a number of organisations and charities which provide critical care services within the region. The two primary air ambulance services are Midlands Air Ambulance Charity and The Air Ambulance Service. In addition, the Trust maintains relationships with volunteers from the British Association for Immediate Care Services (BASICS) who operate in the region. Governance with the organisations is maintained through service level agreements and regular meetings occur to review performance and clinical standards. The Trust also works closely and co-ordinates Community First Responder (CFR) teams across the region. CFRs are volunteers who respond to emergency 999 calls within their local community. In the West Midlands, we are proud to be supported by more than 500 active CFRs who are generally lay people who have received medical first aid training from their local ambulance service. They respond when available, in their own time and without pay to emergency 999 calls in both urban and rural areas. CFRs are not a substitute for ambulance clinicians however they do provide life-saving skills to patients in their local community until an emergency ambulance arrives. As well as responding to emergency 999 calls, CFR teams promote health and wellbeing in their local community by raising awareness of the importance of bystander cardiopulmonary resuscitation (CPR) and the use of a defibrillator and bleed kits.

9. Although the Trust accesses clinical support to care for our patients from the charitable organisations listed above, our workforce is made up entirely of NHS employees, meaning that we do not employ front line bank or agency staff and we do not require support from the private or charitable ambulance sector.

10. We also provide non-emergency patient transport services (PTS) across some parts of the region for those patients who require non-emergency transport to and from hospital and who are unable to travel unaided because of their medical condition or clinical need. Our staff complete approximately 1,000,000 non-emergency patient journeys each year.

11. The Trust operated the NHS 111 service from 5 November 2019 until 1 March 2023. The 2021/22 planning guidance detailed the 111 service had a clear priority to support the urgent and emergency care system. Through a single Clinical Assessment Service (CAS), healthcare professionals working outside of a hospital setting, staff within care homes, paramedics and other community-based clinicians are able to make the best possible decision about how to support patients closer to home, potentially avoiding unnecessary trips to A&E and reducing the burden on emergency departments. The aim of NHS 111 is to support the Urgent and Emergency Care (UEC) system by:

- Ensuring patients with urgent needs get the right advice in the right place, first time.
- Using the CAS to simplify the process for GPs, ambulance services, community teams and social care to make referrals via a single point of access for urgent response from community health services.
- Supporting full implementation of the Urgent Treatment Centre (UTC) model so all localities have a consistent offer for out-of-hospital urgent care, with the option of appointments booked through NHS 111.
- Be the single universal point of access.

12. The Trust is commissioned by NHS England, to host the National Ambulance Resilience Unit (NARU) which is a specialist service responsible for supporting and providing a response to:

- Hazardous Area Response Teams (HART).
- Marauding Terrorist Attack (MTA).
- Chemical, Biological, Radiological, Nuclear, Explosives (CBRNE).
- Mass Casualties.
- Command and Control (C2) National Ambulance Coordination Centre.

- Mutual Aid.
- Support to NHS England and wider NHS.
- Provision of Subject Matter Expert (SME) to support National Policy Groups.
- Multi-Agency Interoperability.
- High Consequence Infectious Disease (HCID) case management.

Organisational Structures

13. As an organisation, we were formed in 2006 with the merger of three smaller ambulance services, adding a further ambulance service (Staffordshire) to our portfolio in 2007. In January 2013, we were authorised as a Foundation Trust and, in line with the provisions of the Health and Social Care Act 2012, licensed as a provider of NHS Services on 1 April 2013.

14. The Trust is a Foundation Trust which means that it has a governance and accountability structure with a Membership drawn from the local community and its employees, a Council of Governors elected by its membership and a Board of Directors.

15. The Trust is required to have a Chief Executive Officer, a Medical Director, a Nursing Director and a Finance Director within its executive management structure. These posts and other significant roles within the executive team were maintained throughout the pandemic meaning the organisational structure did not change during the relevant period, with the exception of some changes in post-holder. The boards' stability helped to provide strong leadership and excellent shared understanding of the Trust's and individuals objectives. The Executive Management structures are set out in detail within Exhibit AM1 - INQ000226598 and changes to post-holders are set out in Exhibit AM2 - INQ000226609. Senior Managers responsible for key operational functions such as providing 999 services, NHS 111, and Patient Transport Services (PTS) services are set out in AM3 - INQ000226617, with a brief description of their roles and responsibilities in Exhibit AM4 - INQ000226618.

Governance and Assurance

16. As a Foundation Trust we have some degree of independence from the Department of Health and Social Care. Our accountability is to the communities we serve through our Governors and Membership. We are part of the NHS and as an NHS Provider, we are subject to Care Quality Commission (CQC) regulation and must be compliant with our CQC registration. We also work in partnership with other NHS organisations and co-operate with local partners. Whilst foundation Trusts technically have greater freedom to determine their own future, with flexibility to adjust to the needs of their communities; the success of individual NHS Trusts and foundation Trusts will increasingly be judged against their contribution to the objectives of the Integrated Care System (ICS) to which they belong.

17. The Single Oversight Framework (SOF) was introduced by NHS England in 2016 as a model for overseeing and supporting healthcare providers in a consistent way. The objective was to help providers to attain and maintain CQC ratings of 'Good' or 'Outstanding', meet NHS constitution standards and manage their resources effectively, working alongside their local partners. This is done by collating information relating to achievement of the following key themes:

Theme	Aim
Quality of Care	To continuously improve care quality, helping to create the safest, highest quality health and care service
Finance and Use of Resources	For the provider sector to balance its finances and improve its productivity
Operational Performance	To maintain and improve performance against core standards
Strategic Change	To ensure every area has a clinically, operationally and financially sustainable pattern of care
Leadership and improvement capability (well-led)	To build provider leadership and improvement capability to deliver sustainable services

18. The Trust maintained its overall rating of Segmentation 1 since the SOF was introduced in 2016. In 2021-22 NHS England re-assessed all providers against the SOF and placed the Trust within segmentation 2, this was in recognition of the pressures resulting from and support required to address the significant deterioration in ambulance handover delays and the resulting lengthening response times. The Trust remains in segmentation level 2 and is working closely with our six ICS's and NHS England to jointly address these two key issues.

Funding

19. NHS Commissioners are the bodies responsible for assessing the health needs of their local population and then purchasing required services from providers via a payment mechanism arrangement. Pre-pandemic, the payment mechanism in use was a National Tariff, which was a legal framework that ensured payments made to NHS providers were based on the level of services actually provided. This meant that each recorded piece of activity that was delivered was paid for at an agreed published rate and relied on data being captured, verified and agreed between commissioners and providers to inform payment levels. In March 2020, to allow NHS organisations to respond to the pandemic, NHS England paused this payment and contracting regime. This was intended to reduce the administrative burden on all NHS organisations and allow staff to be focused on responding to the pandemic. All organisations moved to a simplified basis of contracting services for the duration of the pandemic. An estimated amount, based on actual income received between April and December 2019 was paid to providers each month, this was a fixed amount, not dependant on activity levels and was referred to as a block contract payment. When block contract payment were not sufficient to cover a provider's underlying costs, additional central top up payments were made and in addition, further COVID-19 top up payments were made to cover the reasonable costs of responding to the pandemic.

20. The Trust did not independently request the nationally determined COVID-19 funding but did negotiate extra funding to support additional costs incurred within its Patient Transport Services (PTS). This additional top up funding was negotiated with those Clinical Commissioning Groups (CCGs) and providers with whom a contract was in place. An exercise was undertaken at a national level to determine the level of additional income support required by NHS providers to support cost pressures arising from the COVID-19 response. Funding for the national top-up and COVID-19 top-up allocations was passed to local CCGs for distribution to NHS Trust and Foundation Trust provider

bodies. The Trust engaged with its host commissioner Black Country CCG and with the other system provider organisations, to agree a suitable methodology whereby the nationally derived top-up funding allocated to the CCG, could be apportioned / distributed to individual provider Trusts within the system to enable each organisation to achieve their financial targets for the year.

21. Other additional funding was associated with the additional costs incurred in PTS due to the need to reduce vehicle passenger numbers to accommodate social distancing requirements plus the costs of additional single use vehicles such as Taxis. This funding was negotiated with those CCGs who contracted the Trust to deliver PTS.

22. An independent national review in May 2021 by Deloitte UK into COVID-19 cost reimbursement within our Trust was satisfied with the processes and financial arrangements in place.

23. As Chief Executive I am the Accounting Officer for the Trust (the specific duties are as detailed in the NHS Foundation Trust Accounting Officer Memorandum published by NHS England), however I work closely with the Director of Finance (DoF) and other key members of the Board to determine how resources should be used appropriately by the Trust. At the beginning of the reference period Linda Millinchamp was employed as the DoF. The role of DoF was filled in April 2021 by Claire Finn and then by Karen Rutter in February 2022. Throughout the period of the pandemic the Board received regular financial updates from the DoF and the Trust's governance structure continued to operate. Until the full implications of the pandemic were known the Board of Directors provided me with delegated authority to take appropriate action to protect patients and staff, in consultation with the Chairman. The Trust established a separate COVID-19 Budget code to ensure that there was correct oversight of public funds in managing this incident.

24. To support the DoF, some budgetary responsibilities were delegated to other key Directors to allocate in areas such as 999 staffing, support staffing, PTS Staffing and fleet costs; this is shown in detail in Exhibit AM5 - INQ000226619.

Decision Making Structures

25. COVID-19 presented significant challenges to the Trust and our staff which required additional support structures to be implemented to ensure that we were able to deal with issues as they arose. The Trust ensured that there was always a nominated COVID-19 Incident Director, to help oversee and respond to COVID-19 on behalf of the organisation.

26. A fundamental step taken to co-ordinate our response was the establishment a 'COVID Cell' in February 2020. The cell was a room at Trust headquarters where key members of the response team co-located and began to manage the Trusts response to the pandemic and act as a single point of communication. The COVID cell was enhanced on 14 March 2020 by increasing the size of the team as we recognised the significant increase in response required from the ambulance service and also due to the NHS announcing a level 4 national incident. At this point a COVID-19 director was appointed, and the COVID cell was staffed by tactical level officers, a national inter-agency liaison officer (NILO), a support officer and an incident loggist. The hours of operation were 0600-0200. The appointed COVID-19 incident directors were as follows; Steve Wheaton (Resilience and Specialist Operations Director) prior to 14 March 2020, Craig Cooke (Executive Director of Strategic Operations and Digital Integration from 14 March 2020 through to 13 July 2020. Andrew Proctor (EPRR & Quality Improvement Director) from 13 July 2020 to 30 April 2021 and then Vivek Khashu (Strategy & Engagement Director) from 30 April 2021 until the time of writing.

27. The COVID Cell was integrated within a newly established 'incident room' which was created on 10 October 2021, at this point the size of the team was again increased by doubling the Tactical Incident Commander roster from five staff to ten. This larger team oversaw the COVID cell functions and the creation of the incident command room commander role. Throughout the pandemic, the COVID cell and then the incident command room linked into the Trust's senior command team meetings, which were initially held daily.

28. The Trust's senior command team were already meeting in early 2020 on a daily basis prior to the start of the pandemic, to manage the Trusts response to severe flooding caused by the busting of the River Severn, River Terne and River Wye in Worcestershire, Herefordshire and Shropshire. The Trust's senior command team

meetings were comprised of senior operational managers within the organisation and assistant Chief Ambulance Officers. Pertinent information and decisions from this meeting were escalated to the Executive Management Board (EMB) and Board of Directors as appropriate and actioned at an operational level. These daily senior command team meetings continued long into the reference period.

29. The COVID cell and then incident command cell was a single point of contact for the regional NHS England Team led by NHS England Midlands Region Operations Centre (MIDSROC) and other key stakeholders. Providing a consistently responsive contact point ensured continued communication channels between the Trust and the region. Our communication allowed for appropriate decision making and implementation of guidance received regionally and nationally, a more detailed organisational chart of the roles within the COVID cell [Exhibit AM6 - INQ000226620], and the development to Incident Coordination Cell (ICC) [Exhibit AM7 - INQ000226621], have been provided to the Inquiry.

30. The COVID cell was open and staffed in line with the regional requirements at all times, following the inception of the Incident command room the cover was increased to 24 hours, seven days a week.

31. The Pandemic presented unique challenges not seen by the ambulance sector in recent history. This included genuine risk to patients, staff, and the infrastructure required to continue functioning. The structures and processes introduced; COVID-19 incident director, daily senior command team meeting, the COVID cell and incident command room, etc. The daily senior command team meetings included the operational leads for each area, including frontline operations, control rooms, emergency preparedness, patient transport services, etc. Due to this, the Trust was able to make informed and effective decisions about how to operationally respond to the pandemic. Many of these decisions were dynamic, reacting to changes in national guidance, levels of resourcing, staff welfare, PPE availability, etc. The overarching principles which shaped the decisions the Trust made were the three strategic objectives I set out at the beginning of the pandemic.

The Trusts involvement in the response of healthcare systems to pandemics/COVID-19 pandemic

32. Joint working and collaboration with neighbouring Trusts; acute, community, ambulance and other key partners is something I am proud of. Each Local Resilience Forum (LRF) was assigned an assistant chief ambulance officer. This group coordinated all issues within a region at a strategic level and communicated key information.

33. Prior to the pandemic, the Trust established a Strategic Capacity Cell (SCC) within the Emergency Operations Centre (EOC). The SCC role was pivotal, especially during the early stages of the pandemic, in working collaboratively with other NHS Trusts. The SCC is staffed 24/7 and is the link between the ambulance Trust and other NHS Trusts within its area, particularly acute hospitals. The SCC's primary responsibilities include maximising intelligent conveyance to acute sites within the region and attending daily meetings to ascertain bed status and patient flow at sites. They also acted as a central contact point for acute trusts within the region.

34. Through communication with the COVID-19 cell, and the incident command room, the Trust maintained regular contact with NHS MIDSROC. The Trust embedded a national interagency liaison officer within the incident command room to maximise working collaboratively between NHS Trusts, using the specific relationships and contacts that this role has. This role was embedded throughout the pandemic. The Trust maintained a running log of tasks completed for the region, which included daily counts of PPE across all sites in the Trust, staffing and sickness levels, any predicted operational issues, etc. In the early stages of the pandemic, the Trust regularly worked with regional NHS England to complete NHS stock disruption reports, where PPE was challenged. The region would work to rectify any issues and provide PPE.

35. The Trust was in regular contact with other local NHS Trusts regarding PPE stock levels through their incident command rooms, and informal relationships, built through the NILO network and business as usual networking. These relationships and collaborations ensured regular information sharing, oversight, and awareness of issues across the NHS. On a number of occasions, the Trust provided other NHS Trusts with PPE and arranged deliveries, to ensure the welfare of their staff and patients. These were all captured in the PPE mutual aid log [Exhibit AM8 - INQ000226622].

36. An example of engagement and collaboration within the Black Country area were daily meetings where the CEOs of several local NHS organisation met or were represented to discuss issues and aim to collectively solve pertinent issues or share examples of best practice. All organisations involved generally ensured suitable representation and this initiative was an informal arrangement but one which worked effectively from April 2020 until well into 2021.

37. The Trust was able to work collaboratively with a number of adjacent Ambulance Trusts through existing National and Regional committees and Structures. Examples of these include the Association of Ambulance Chief Executives (AACE) subcommittees, such as National Director Operations Group (NDOG) and Human Resources Director group (HRDs). The Trust ensured that each meeting was attended by a nominated individual, or a deputy in their absence. By attending, engaging and supporting these meetings and committees, the Trust was able to be fully abreast of National dynamically changing situations, and communicate and work collaboratively with other ambulance Trusts, sharing best practice to ensure that the three main strategic objectives were prioritised at all times.

38. The National Ambulance Coordination Centre (NACC) was used throughout the pandemic. The NACC is hosted and staffed by the Trust within our Headquarters. The NACC disseminated guidance changes, urgent issues, completed audits and collected other important data from Ambulance Trusts. The oversight of The NACC falls within the scope of my role as National Strategic Adviser of Ambulance Services. One of the primary functions of the NACC is to coordinate mutual aid across the ambulance sector, and this capability was maintained throughout the pandemic and was used on a number of occasions. This is detailed in the NARU NACC plan. This plan details exactly how the NACC would respond to a mutual aid request.

Caring for our Staff

39. The welfare of our staff was a huge priority for me and my entire leadership team, we all had responsibilities to do everything possible to protect the health and wellbeing of staff so that we could continue to maintain a safe and effective 999 service. This priority extended to all staff and not just to those who were working face to face with patients suspected of having or diagnosed with COVID-19.

40. Providing staff with high levels of support is something that the Trust has always strived to attain and the welfare that we provide to our people is something that I am immensely proud of. The COVID-19 pandemic was an exceptionally worrying time for our staff and their families so providing the maximum support to our staff so that they could continue to provide emergency care to our patients was essential and this was achieved in a number of ways.

41. Mental Wellbeing: Colleagues were encouraged to access support from the Trusts in-house psychotherapists called 'mental wellbeing practitioners' (MWPs). Support could be arranged by self-referral through the Trusts Intranet, telephone, email or from a manager's referral (with consent). Following an initial MWP assessment, an advice appointment was usually conducted within 7 business days. Following this initial assessment there was open invitation (access) for future advice and psychological interventions by direct contact with MWPs. There are circumstances when colleagues may require structured and more intense support, and this can be provided through the MWPs to our employee assistance provider (EAP) The Listening Centre in the form of counselling sessions when this would be beneficial. In addition to support through EAP the Trust established an arrangement between MWPs and Dudley NHS Talking Therapy improving access to psychological therapies (IAPT) service for expedited NHS psychological support for the Trust's workforce where their occupational functionality has become impaired. Dudley IAPT covered concentrated workforce areas at Millennium Point (HQ and EOC), Navigation Point (NHS 111) and the Trusts Training Academy. MWPs were introduced by the Trust in August 2019 and were only in operation for a few months prior to the pandemic therefore it is difficult to quantify if the impact of COVID-19 created a greater demand for this service, however during the reference period 1,058 episodes of care were provided by the MWP team to our staff.

42. The Trust has found that having MWPs as an integral part of the workforce who are available to staff has brought many benefits, including where appropriate a link with secondary care services to strengthen safety for staff. The Trust recognises that some staff may find on-line resources more beneficial than talking therapy and therefore the Health and Wellbeing intranet page provided a 24 hour a day Mental Wellbeing and suicide prevention information with signposting to a range of wellbeing resources. A hugely valuable pool of support within the Trust is our peer-to-peer Trust-wide network of staff advice and liaison service (SALS) volunteers who provide accessible face-to-face support at many Trust locations or via the dedicated intranet page along with a twenty-four-hour phoneline and an active social media group. Although I feel we have

described excellent welfare services we understood that COVID-19 would place greater demands on staff that would require us to provide stronger communication and better support for our people.

43. Providing better access to support services was achieved by the introduction of an Employee Assistance Device called 'Qwell' in June 2020. Qwell provided 24-hour a day access to an online moderated therapeutic community along with scheduled access to online asynchronous text-based counselling sessions with a qualified counsellor. The Qwell device was accessed 4,680 times from June 2020 to September 2022 and during this period 2,170 direct messages were exchanged between staff and clinicians. We also extensively promoted welfare services on as many media channels as possible including email, Trust Weekly Briefing, intranet landing pages, Health & Wellbeing and COVID-19 guidance intranet pages, the SALS network and staff social media groups to regularly disseminate mental wellbeing signposting, guidance and promotion of digital mental health products that were accessible to the NHS workforce. The Trust also liaised with local NHS organisations to expedite workforce access to psychological treatments when distress was reactive to the COVID-19 pandemic.

44. Physical Wellbeing: The early stages of the pandemic saw challenges for close contact wellbeing services including the Trust's musculoskeletal and massage therapy services which were temporarily stopped due to the close contact required. In response to this, an interim change in service delivery was required so that staff could continue to be supported and an open access musculoskeletal telephone triage service was introduced. To support staff further, promotional self-help material was produced on themes such as "managing recurrent musculoskeletal problems" and "management of new joint pain or stiffness." A refresher of the referral process and a referral template was sent to all managers however musculoskeletal services developed further by carrying out consultations on platforms such as WhatsApp and Zoom (prior to Microsoft Teams) plus the trialling of "exercise on prescription programmes" via web platforms. Educational videos were produced on topics including respiratory advice and breathing exercises for staff at home with COVID-19 or long COVID, how to work safely from home and keeping mobile with stretch and mobility exercises.

45. The launch of the COVID-19 vaccination programme for staff was hugely welcomed and the Trust immediately implemented an internal booking service and call centre which was initially available to our staff 24 hours a day. The first vaccine appointments were offered to Black and Minority Ethnic (BAME) colleagues followed by those who were

extremely clinically vulnerable or who had previously shielded. Within the initial 24 hours of operation, the majority of BAME colleagues were offered vaccination appointment as we understood this group experienced disadvantaged outcome if COVID-19 was contracted. Once priority staff had been contacted, all other staff were contacted and were able to book a vaccine appointment at a suitable time and location in the region. COVID-19 Vaccination was something that the Trust promoted and there were several initiatives to provide advice and guidance on the benefits of the vaccine; this included a webinar which was recorded and later distributed, 1:1 conversation with those not vaccinated and their line manager and mobile vaccination clinics at Trust working locations with lower vaccination rates. The Trust understood that vaccination was important to reducing the severity of COVID-19 infections and continued to support staff closely when vaccination was mandated nationally which in the first instance was for patient transport services staff who were entering nursing homes in order to transport patients for routine medical appointments.

46. Vulnerable Staff: Any staff who were required to isolate or shield due to being at higher risk were recorded in both the global rostering system (GRS) and the HR Electronic Staff Record (ESR) system for identification purposes. Regular contact and welfare checks were undertaken by local line managers to staff who were shielding, and support was provided to try and prevent any disengagement from the Trust. Access to the Trusts Weekly Brief and associated clinical and operational notices was made available to all staff whether in work or at home. Weekly operational sickness meetings with managers and HR teams were scheduled to discuss any staff concerns or issues and to ensure that appropriate support was in place including Occupational Health. Advice and support remained available for both managers and staff, in partnership with our occupational health provider (Team Prevent) a designated occupational health advice line for COVID-19 enquiries was established. A personal letter was issued by myself to all BAME colleagues identified through HR records offering support routes, priority COVID-19 Polymerase Chain Reaction (PCR) testing and also inviting participation in completion of individual risk assessments to highlight options of reducing their risk of exposure through hybrid working or changing the type of work performed.

47. We learnt over time that COVID-19 appeared to affect some groups more than others for example BAME groups were more susceptible to infections and some experienced less favourable outcomes, in June 2020 in response to a letter containing recommendations from NHS England, BAME staff were offered increased support and participated in individual risk assessment in order to identify way of reducing potential

exposure and this process acknowledged the higher risks associated with COVID-19 infections.

48. Most of our staff were considered essential NHS workers and those who had school aged children within their family unit may have been able to continue to send their children to school, particularly when the majority of children were required to remain at home. The Trust supported staff as much as was practical by providing letters to staff which confirmed their essential NHS worker status and assisting with flexibility when there was a need to care for children or family members.

49. Pay and Conditions were protected for all NHS staff who were required to stay at home due to a COVID-19 infection or had to isolate due to close contact with an infected person. NHS Employers produced guidance for organisations to follow in relation to sickness absence due to COVID-19 and the Trust immediately aligned to these standards. Staff who were required to shield, due to being identified as being clinically vulnerable and those who were off work due to suffering from symptoms of long COVID were provided with greater assurance that these episodes of absence would not be considered and this protection continued until July 2022. Our payroll teams were asked to give additional consideration to staff who may have been required to make salary repayments and any overtime payments due to staff continued to be dealt with and paid quickly and efficiently.

50. The long-term effects of COVID-19 are many and complex and the Trust continues to work hard to support all colleagues in many different ways whether this is providing access to a fast and reliable occupational health service, excellent health and wellbeing support and sensitive managers who understand that adjustments may be required for staff affected by COVID-19. The Trust was keen to understand the impact of COVID and participated in several studies. Notably we were the biggest contributor to the University of Birmingham COPE-WM study. The aim of the COPE study was to examine the relative contribution of occupational, socio-demographic, and clinical risk factors for COVID-19 infections among healthcare workers in NHS Trusts and how to minimise these risks.

51. The Trust's test and trace team supported all staff and their family members by arranging rapid Polymerase Chain Reaction (PCR) testing, providing test results, contact tracing

and acting as a single point of contact for COVID-19 infection related queries. The test and trace team in conjunction with the Incident Command Cell ensured that the senior command team were appraised daily of the number of staff who had contracted COVID-19, their working location, any trends in infections at particular locations, the total number of staff who were in various forms of isolation and importantly if any staff had become so unwell that they were admitted to hospital. We appreciated but were saddened that many patients who were receiving hospital care were unable to receive visits from loved ones, friends and family members and so we tried to reach out to staff in other ways, through get well cards, flowers when discharged home and personal phone calls.

52. During the early stages of the pandemic before testing was widely available, diagnosis of COVID-19 was based on the presence of clinical features, many of which were common with other types of illnesses. The Trust could see staff sickness increasing but could not access suitable diagnostic testing for staff. At the beginning of April 2020, 200 PCR tests were purchased from an authorised and approved private laboratory. These tests cost £50,000.00 however the early access to PCR testing meant that we were able to safely return staff to work prior to the establishment of a CCG led healthcare worker drive through service and before Government Testing Services were established. Becoming an early adopter of PCR testing meant the Trusts testing service became first choice for the majority of our staff with over 80% of all PCR testing being completed through a Trust provided PCR. The Trust service invariably produced a faster result, meaning a quicker return to work for those staff who were negative for COVID-19 or more rapid contact tracing and isolation for those who were positive.

53. We understood the importance of reliable and consistent access to PCR testing, and this was achieved in a number of ways:

- The Trust was a member of the Midlands Pathology Network, who met weekly, the aim of the network was to assess at laboratory capacity and ensure that demand was met.
- PCR Consumables were obtained by the Trust and were quickly accessible to staff.
- The Trust obtained an emergency supply of tier 2 government postal PCR kits, which could be used in the event of a laboratory outage.
- The Trust received an undertaking from our tier 1 laboratory which provided assurance of a continuous testing service.
- The Trust had an agreement with a second laboratory which could be used if the primary laboratory faced outages.

54. Offering staff and their family members a reliable PCR testing service helped maintain our ability to respond to patients by safely returning negative staff to work and reducing the spread of infections through identifying positive staff. Over 30,000 PCR tests were completed however, to reduce the pressure on the laboratory system, we also ensured that any changes in testing methodology endorsed by NHS England were immediately introduced by the Trust. Examples of changes to COVID-19 testing was the move from PCRs to Lateral Flow Devices (LFDs), initially for close contacts and then for use in diagnosis. Exhibit AM9 - INQ000226623 is a copy of an internal audit report completed in relation to the test and trace team, which confirms optimal process and arrangements in place.

55. Although at the beginning of the pandemic there were no plans that specifically related to COVID-19 PCR Testing, these were quickly developed and resulted in the Trust's Test and Trace Procedure.

56. COVID-19 PCR Testing became available for both symptomatic and asymptomatic staff, and symptomatic members of household including children through place of work, drive through and home testing services. The Trust's test and trace team delivered a reliable and efficient testing and contact tracing service which usually provided staff with test results in 24 hours, this service helped to ensure that sickness absence was lower than any other English ambulance Trust. The success of the testing team saw other tests being offered to staff including more than 5,000 colleagues voluntarily receiving antibody serology tests, NHS England asymptomatic testing schemes, lateral flow devices testing and Loop-mediated isothermal amplification (LAMP) testing. The testing team helped to support colleagues who we understood were disadvantaged in terms of outcomes, this included priority testing and support to BAME colleagues, colleagues who were shielding or identified as vulnerable and also by providing support to our staff and their immediate family members. The demand for advice and support from the testing team was significant and the team operated up to 16 hour each day, 7 days a week at the peak.

Communicating with our staff

57. In order to provide our people with the most up to date COVID-19 information the Trust ensured that there was a regular flow of information to all staff through the established Weekly Brief. Each week, articles would be published highlighting issues such as the

latest developments, advice on how to stay safe, the roll out of new equipment and data that would help understand the level of risk to themselves and the public.

58. Trust Staff are aware that Clinical Notices contain important information that will affect their clinical practice. We tried to make the development of clinical information easy to follow and maintained one evolving Clinical Notice throughout the pandemic for the latest updates so that staff always knew where to look for the most up to date information. Please see further at paragraph 62 below. The weekly brief also contained Clinical Notice updates, and these were disseminated by email to all staff and could also be issued to a personal email address. The weekly brief was also available on the Trust intranet, which all staff have access to at both at work and at home via the Trust's website. If there was an important change in process such as PPE or testing and the weekly brief was not due be issued for several days, detail of the important change would be sent to all Trust staff by email and posters would be placed in all work locations which would be affected by the change. Urgent emails relating to changes would always be followed with an article in the proceeding issue of the weekly brief and this helped to ensure that staff were as up to date as possible.

59. Staff were able to access the most up to date clinical information in digital format from a dedicated area within the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) digital application. This area provided an additional source of important information in a location that all staff could access in a digital format.

60. The Trust rapidly rolled out the use of Microsoft TEAMS not only for the leadership team to communicate regionally but also for local teams, departments and individuals working from home. The IT systems operated within the Trust allowed all staff to access Teams either online using Trust or personal devices (phones, tablets, laptops, desktops) or via a national rate telephone number with access code.

61. Ensuring that staff were fully appraised of the most up to date information relating to COVID-19 was an essential part of reducing the risk of transmission. The Trust obtained 6,000 personal issue ipads at the end of March 2021. These were distributed and issued to staff between October 2021 and November 2021 following a period of application development, security testing, user testing and staff training. We may have been able to improve communication if the Trust had been in possession of personal issue ipads sooner however it was only indicated by NHS England that capital funding may be available in February 2021. In addition to this we have been running all staff briefings on

the Microsoft TEAMS platform, if these had been available to all staff, we could have completed these engagement events sooner, particularly as large face to face meetings were no longer an option. A weekly summary was produced by the COVID cell / ICC which provided the Communications Director with useful material and information for the weekly briefings, introducing this sooner would have been beneficial.

Caring for our patients

62. In order to save as many lives as possible we needed to demonstrate precision in the communication and application of the latest clinical advice from NHS England and respond immediately when there were changes to this advice. The Trust produced Clinical Notice 403 on 23 January 2020 which provided our staff with all of the information that they would need pertinent to COVID-19 as either a health care worker or employee. This Notice was updated many times over the pandemic as advice developed and changed. A copy of the Clinical Notice 403 which was in place at the beginning of the reference period 01/03/2020 can be seen in Exhibit AM10 - INQ000226599 and a copy of Clinical Notice 403 at the end of the relevant period 28/06/2022 has also been provided to the Inquiry in Exhibit AM11 - INQ000226600.

63. There are systems in place which contribute to the patient response and the advice provided. NHS Pathways is triage software utilised by most NHS telephone providers which is supported and maintained by NHS England to triage public telephone calls for medical care and emergency medical services – such as 999 and 111 calls. This system which is managed by NHS Digital helped to determine if patients required a front-line ambulance or if they were well enough to access alternative care pathways such as COVID-19 clinics. Similarly, this system also helped clinical advisors to provide patients who called the 111 service with advice if they were concerned that they had contracted COVID-19. This system ensure that all patients were treated in a consistent way and that patients were provided with the most up to date information available at the time. The Trust did not move away from the information and advice provided by the NHS pathways system in its determination of who should receive a 999 ambulance, or the clinical information provided by NHS 111.

64. Decision making by clinicians surrounding which patients should and should not be conveyed to hospital was based on the clinical need of the individual patient and the Trusts messaging was clear that patients who required further treatment and

assessment should be conveyed or referred to an appropriate treatment centre. We supported staff with information and decision-making tools which were provided by NHS England, UKHSA and AACE, an example of which can be found in Exhibit AM12 - INQ000226601. There were also some initiatives that did help to support patients remaining at home when they were safe to do so, such as the use of Salbutamol metered dose inhaler and spacer - this prevented known respiratory patients having to go out during lockdown reducing the chances of transmission (Clinical Notice 412) and COVID Virtual Ward Clinical Notice - keeping people at home where safe to do so to reduce risk of transmission (Clinical Notice 450)

65. Accident and Emergency Departments separated their clinical areas into zones; red and blue, hot or cold, COVID-19 and non-COVID-19, this information was provided to ambulance crews. COVID-19 was probably the illness that the majority of the Country was thinking about, however it should be remembered that patients were still suffering from many other acute, chronic conditions, traumatic and emotional conditions that required assistance.

Response Time Targets

66. Ambulance Trusts are directed to achieve response time targets in a range of areas such as how quickly we are able to answer calls to how quickly we are able to respond in person to emergency and non-emergency calls. Details of response time targets across all directorates are set out below:

The following table shows 999 ambulance response time targets set by NHS England which were in place between 1 March 2020 – 28 June 2022:

	Mean Response Target	90th Centile Response Target
Category 1 Call	00:07:00	00:15:00
Category 2 Call	00:18:00	00:40:00
Category 3 Call	01:00:00	02:00:00
Category 4 Call		03:00:00

There was no formal target set relating to 999 call answering response times however further details about call answering performance is covered in paragraph 70.

The following table shows NHS 111 call answering targets set by NHS England which were in place between 1 March 2020 – 28 June 2022:

Metric until March 2021	**Target**
111 Calls Answered in 60 seconds	95%
Metric from April 2021	**Target**
Average speed to answer 111 calls	20 Seconds
95th Centile time to 111 call answer	120 seconds

It should be noted that the calls answered in 60 seconds continues to be reported within NHSE IUC ADS, although not the KPI standard now.

The extent to which response time targets were achieved through the reference period was varied and based on some external factors which I will describe.

67. PTS achieved nearly all KPI's across all contracts during the reference period. Throughout the pandemic there had been a reduction in outpatient activity, non-emergency patient transport services prioritised discharges within 2 hours to maintain patient flow within hospitals. There was a significant reduction in our capacity due to new social distancing requirements which largely meant individual patients were required to travel in a smaller vehicles such as cars and mini vans and a maximum of two patients could travel in larger sized vehicles such as traditionally sized ambulances. There were challenges with our renal patient groups who regularly travelled to life saving dialysis appointments as these individuals were now required to travel alone. Additional dialysis clinics were set up within the existing network to be able to provide treatments to those who tested positive for COVID-19, however individual journeys and longer travel times did have an impact and it is clear that planners and non-emergency control rooms worked tirelessly to keep these patients safe. PTS Contract Performance Tables for whole of reference period (2020 – 2023) as Exhibited AM13 - INQ000226602, AM14 - INQ000226603 and AM15 - INQ000226604.

68. The Trust did achieve all 999 operational ambulance response performance targets in the year 2020-21. Hospital handover delays began to increase significantly in July 2021. Hospital handover delays occur when a hospital is unable to accept an ambulance

patient in their premises within the 15-minute target time which was set out by NHS England. When ambulances are waiting to handover patients and are delayed at hospital it obviously prevents our resources attending to other patients requiring emergency care in the community and increases the time taken to respond. Unfortunately, handover delays at hospital still remains a serious issue and consequently performance has been challenged since July 2021.

69. Despite resourcing being strong, hospital handover delays continued to increase during 2021-22 with some months showing over 36,000 ambulance crew lost hours in excess of the target 15-minute hospital handover time. The increase in hospital handover times can be seen in Exhibit AM16 - INQ000226605 which plots these lost hours. Hospital delays caused poor performance and meant that our patients waited for ambulances for extended periods. The Trust used the Resource Escalation Allocation Plan (REAP) and instigated Level 4 measures to try and improve capacity however the issues described continued, and a similar pattern of increased hospital delays and decreased response time performance continued throughout 2022/23. The Trust 999 response times can be seen in Exhibit AM 17 - INQ000226606 which demonstrates challenges from July 2021.

70. The 999-call answering performance of our Trust has always been excellent and although there is no formal target in place, there is an expectation that emergency calls should be answered quickly, the average being less than 10 seconds. Call answering performance data is collected by British Telecom and shared with ambulance Trusts, this highlights any 999-calls not answered within 2 minutes [AM18 - INQ000226607]. I am proud of the achievements of our emergency control rooms in managing the levels of calls during difficult circumstances.

71. It is acknowledged that 111 response times (call answering) were challenged during the reference period and there are a number of contributory factors which should be understood. The NHS 111 contract began in November 2019, shortly before COVID-19 began to emerge and spread. The 111-service was commissioned to answer on average 100,000 calls per month and was staffed accordingly, in contrast to contracted and forecasted calls, actual calls received was well in excess of these amounts and the service was unable to cope with the demand. In addition, contract tracing and COVID-19 infections had an impact on abstraction levels and public health messaging signposted many types of non-emergency queries to NHS 111. The number of calls offered and the % answered can be seen in Exhibit AM19 - INQ000226608, this graph

shows both 111 calls received, and the corresponding 111 call answering performance and demonstrates that when call demand increases in excess of contracted levels, call answering performance decreases.

Education and Training

72. Providing excellent care requires staff to be clinically and professionally up to date and prepared. Mandatory training and safeguarding delivery rates have always been consistently high within our Trust and despite COVID-19 I felt that it was important to the care of our patients that we continued to deliver training and education as much as possible. I expand on this in the section headed 'Staffing' at paragraph 74 onwards.

Stay at Home, Protect the NHS, Save Lives

73. I understand that many people stayed at home during the pandemic and this was evident within some of the operational information provided as there was a correlation to lockdowns and reduced demand for ambulances. There also appeared to be a passion for the NHS, and I feel that our workers felt supported and respected by the public at critical times during the pandemic, for example we saw how large sections of the community clapped for carers. Understanding the public health messaging and its effectiveness is a complex issue, but there is no doubt that we witnessed a behavioural change during the period of time that “Stay at Home, Protect the NHS, Save Lives” was a well-publicised campaign. I personally think that people remained at home for a range of reasons; they were following national guidance or legal restrictions, they were protecting themselves from contracting COVID-19, they were protecting vulnerable loved ones, for example some may have felt concerned that they had a greater chance of contracting COVID-19 from a healthcare setting or from a heath care worker. I have heard many stories from our staff about how patients were more resistant to attending hospital in order to protect the NHS, themselves and loved ones. I believe that the instructions given as a public heath campaign were successful, it was promulgated frequently, and people understood clearly what action they needed to take and who would benefit from the steps and sacrifices that each and every one of us made.

Staffing

74. The Trust must ensure that sufficient staff are available to respond to patients with the correct level of skill and this is fundamental principle to providing a safe service for our patients and can only be achieved through recruiting the best candidates to work in our Trust and educating staff to the highest possible level.

75. The Trust works closely with several universities within the region: supporting paramedic education, work-based placements, research in emergency medicine and professional development. In recognition of these relationships the Trust was the first Ambulance Service to become an Ambulance Service University Trust 2018 and remains the only University Ambulance Service in the country.

76. The Trust's Academy (The Academy) which incorporates our training and education teams, plays a vital role in ensuring we maintain a skilled workforce; the Academy's notable achievements is the establishment of a long and successful student paramedic education programme and the delivery of all statutory and mandatory education and emergency blue light response driving courses.

77. The Academy has developed a full Level 6 Degree/apprenticeships (BSc equivalent) Student Paramedic programme in partnership with our local Higher Education Institutions, which requires learners to attend University to complete the final stages of their academic qualifications.

78. The Academy alongside the University of Derby have worked hard to develop a innovative new education model that builds upon current education delivery but also provides level 5 and level 6 education that is delivered entirely within the Trust. This forward-thinking approach will be the first of its kind in ambulance education with the premise being to immerse students directly into workplace-based education programmes and place the learner at the forefront of their education programme and role.

79. The Trust participated in the Government Kickstart Scheme which was aimed at 16–24-year-old individuals who were not in employment or education. The Trust created placements lasting 6 months during COVID-19 as vehicle preparation assistants throughout the region. The Kickstart scheme not only provided vital support to the Trust to enhance the capacity of vehicle cleaning but has also provided successful candidates

with relevant experience and suitable training to improve their prospects of gaining future employment. Of the 22 Vehicle Preparation Assistants who embarked on a placement with the Trust a total of 13 subsequently commenced a permanent role within the Trust.

80. The Trust made significant efforts to increase staffing in all areas, including 999, PTS, EOCs and 111. The strategic objectives that were set by me required our Trust to increase our available capacity both in terms of staff and vehicles given the significant uncertainly and future demands such as supporting the wider health response for example Nightingale Hospitals. Regular senior command team meetings ensured that we maintained command and control at all times and we agreed which areas required additional capacity. It should be noted that our workforce increased by nearly 25% in the first year, 1 March 2020 – 1 March 2021 as follows:

    Increase to Staff Across the Trust from 01/03/2020 – 01/03/2022 (Data taken from Electronic Staff Records System – ESR)

	1 March 2020	1 March 2021	1 March 2022
Emergency Control (EOC)	497	568	697
Emergency Services	3,709	4,290	4,207
NHS 111	666	832	921
Non-Emergency Control	134	142	124
Patient Transport Services	917	1,537	1,361
Total	**5,923**	**7,369**	**7,310**

81. The actions that the Trust took to increase staffing levels are summarised below:

- Deployment of University student paramedics to support operations.
- Staff from corporate departments redeployed to assist in a variety of support roles.
- Additional 111 call handlers employed for surge capacity.
- Additional 111 clinical staff employed at all levels.
- Maintaining 15 additional winter hospital ambulance liaison officers (HALO) in their HALO roles.
- Robust and effective test and trace procedures and swabbing services to maximise availability within guidance.
- Increased use of overtime to maximise resourcing.
- Significant recruitment plans in all operational areas.
- Utilising home working where appropriate to maximise capacity, including vulnerable staff who were shielding.

- Use of 4x4 volunteer drivers to deliver PPE.
- Upskilling and maximising the use of CFRs to work in operations.
- Use of Government Kickstart Scheme.
- Accepting support of redeployed staff from the local Clinical Commissioning Group (CCG).

Capacity Available to the Trust 1 March 2020

82. In order to protect the 999 infrastructure, it was essential that we had enough people and assets to perform the various essential roles required throughout the Trust, a breakdown of general capacity has been collated from Trust information held on 1 March 2020 is set out below:

The following table collated from internal fleet records shows the number of vehicles available to the Trust which were able to respond to patients on 1 March 2020:

Fleet Availability 1 March 2020	
Emergency Ambulances	471
RRVs (all types)	29
Officer Response Cars	57
HART Vehicles	14
PTS Ambulances and Cars (all types)	390
Total	**961**

The following table collated from internal records held by our human resources department show the number of staff employed in key departments on 1 March 2020:

Staffing Levels 1 March 2020	
Emergency Control (EOC)	497
Emergency Services	3,709
NHS 111	666
Non-Emergency Control	134
Patient Transport Services	917
Total	**5,923**

The following table collated from internal records held by our human resources department show the number of clinical employed within NHS 111 on 1 March 2020:

111 Clinical Capacity 1 March 2020	
Advanced Practitioner	6
Call Operator	436
General Practitioner (GP)	17
Nurse Manager	13
Paramedic Specialist Practitioner	28
Pharmacist	27
Specialist Nurse Practitioner	12
Staff Nurse	50
Technician	11
Total	**600**

Calls Received to the Trust in the week prior to the reference period 24 February 2020 – 1 March 2020

The following tables collated from internal records from our telephony systems show the number of emergency 999 and NHS 111 calls received between 24 February 2020 – 1 March 2020:

999 Calls 24/02/2020 – 01/03/2020	
Total 999 Calls	19,332
Mean Call Answer	00:00:05
95th Centile Call Answer	00:00:27

111 Calls 24/02/2020 – 01/03/2020	
Calls Offered	31,701
Calls Answered	29,064
Calls Answered in 60s	22,784
Calls Answered %	91.7%
Calls answered in 60s %	78.4%

The following table collated from internal records within our telephony systems show the number of non-emergency patient transport services calls received between 24 February 2020 – 1 March 2020. It also documents the % of calls that should be answered with a set time period and the degree to which the Trust met these targets.

PTS Calls 01/02/2020 - 29/02/2020			
Contract	**Target set by Commissioner**	**Total Calls**	**Answer %**
Coventry	95% calls before 60 seconds	3,851	97.40%
Cheshire	75% calls before 20 seconds	7,787	92.15%
Dudley	95% calls before 60 seconds	1,351	96.60%
Worcester	95% calls before 120 seconds	3,325	99.31%

83. The impact that additional staff had on patient care was successful, the increased capacity meant that for the first year of the pandemic (March 2020 - March 2021) the Trust was able to meet all operational targets across frontline emergency services, control rooms and patient transport services.

84. Although initially successful the level of staffing could not prepare the Trust for the hospital delays that were experienced from July 2021 onwards.

Increasing Capacity

85. We were advised of and deeply concerned about the prospect of becoming overwhelmed and as such we needed to respond by increasing our capacity, this was achieved in a number of ways; fleet (vehicles) and staffing.

86. At the beginning of the pandemic (01/03/2020) there were 961 vehicles in operation within the Trust which had the capacity of either responding to or transporting patients. It should be noted that some vehicles* were modified to enable response to patients and these have been listed below:

	1 March 2020	1 October 2020
Emergency Ambulances	471	526
RRVs (all types)	29	29
Officer Response Cars	57	57
HART Vehicles	14	14
PTS Ambulances and Cars (all types)	390	390
*Driver Training Ambulance	-	16
*High Dependency (HDU) / Urgent Tier	-	50
*Specialist Vehicles (ISU)	-	26
Total	**961**	**1,108**

87. The arrangements for the maintenance and servicing of all vehicles apart from PTS is through the Trust's in-house workshop facilities. PTS vehicles are maintained by third-party commercial providers. At the point that COVID-19 became prevalent and started to create pressure on the Service (prior to the Level 4 declaration), options and decisions related to the fleet were taken by the Head of Fleet and the relevant Director to maximise fleet availability and increase the fleet where possible.

88. Where possible, leases on vehicles were extended and owned vehicles which were scheduled for disposal were retained to increase the total fleet available for operations. Every blue light equipped vehicle, including major incident assets and driver training units were equipment with medical response equipment to significantly increase the 999-response capability of the Service. A new High Dependency and Urgent Tier was introduced by utilising a combination of older Emergency ambulances and PTS stretcher vehicles. This additional fleet provided the Trust with the capability to deploy University student Paramedics working with registered paramedics and other qualified ambulance staff to increase the total resources available.

89. Additional fleet workshop support was obtained from the private sector to provide an increased number of trained mechanics to support our larger fleet, this helped to avoid pinch points should significant sickness in mechanics occur.

90. The carpark and vehicle deployment area at Bromsgrove A&E Hub was expanded to enable the Trust to manage and deploy the increasing number of ambulances. The second reason this additional capacity was created at Bromsgrove Hub was to create a feeder hub to the Nightingale Hospital at the National Exhibition Centre (NEC).

91. Fleet workshops were staffed seven days-a-week to ensure the fleet was maintained at maximum capacity at all times, decisions were taken to repair vehicles outside of dealership warranty and bulk parts were pre-purchased to ensure continued availability of mechanical parts and tyres. Suitable vehicles were made available for the movement of stores and PPE and the Trust's fleet was also enhanced by providing additional vans and lorries from external companies to ensure the Trust Stores and Distribution department had the required assets to move increased bulk of stores and PPE items to operational hubs and other sites.

92. The Trust's fleet availability was reported twice daily seven days a-week to maximise the command and control of operational capabilities. The impact of the hard work completed by the fleet teams can be seen in the numbers set out above at paragraph 87.

93. At no point during the period did the Trust use any voluntary ambulance services, private ambulance services, fire and rescue services or police services to support ambulance operations. We deem this to be a significant achievement as it shows that the Trust was

able to manage and prioritise its resources to maximise its ability to respond to patients. This also allowed the fire and rescue services and police to continue undertaking their own statutory responsibilities. Furthermore, by not utilising voluntary ambulance services such as St John Ambulance these resources were able to be allocated to other ambulance services who required further support. In addition to this, the decision not to use any private ambulance services meant that these assets were available to be used by other ambulance Trusts.

Personal Protective Equipment

94. My initial priority in protecting our staff was to ensure that Personal Protective Equipment (PPE) was available, fit for purpose and staff were competent and confident in its application, usage, storage and safe disposal.

95. The management of PPE within the Trust during the early stages of the pandemic posed a challenge, as the traditional schedule of consumable deliveries by our distribution and logistics team could not provide individual ambulance hubs with sufficient supplies. We took early action to increase the size of this important internal team who were responsible for the stock management, procurement and distribution and in addition we also increased the frequency of deliveries and delivery days to include weekends.

96. A significant focus was placed on ensuring that each staff member had access to the appropriate, high-quality PPE to provide maximum protection while responding to patients. Daily PPE stock checks within our central warehouse were immediately introduced and stock levels were shared with NHS England and following an internal review the methodology was amended to include stock levels on ambulance hubs. The inventory count was strengthened further from 16 April 2020 following the publication of a letter from NHS England. The counting and reporting of PPE stock ensured clear oversight at a senior level regarding the PPE levels that were available. Key decisions were taken by the senior team to maximise the availability of PPE suitable for Ambulance operations and in line with national guidance. The Trust worked with numerous suppliers to obtain and maximise relevant PPE product lines to mitigate the initial limitations of the national NHS supply chain and 'push stock' arrangements. Despite challenges, the Trust had sufficient levels of PPE during the pandemic and Exhibit AM20 - INQ000226610 shows information from our stock holding system on PPE and key IPC items that were available within our central stores on 1 March 2020.

97. The Trust obtained supplies of PPE and respiratory protective equipment (RPE) through standardised procurement processes, in line with Trust Policy. During the early phase of the pandemic response, some PPE/RPE product lines migrated to the Department of Health and Social Care (DHSC) parallel supply chain, branded as 'push stock'. Some issues were identified with specific elements of push stock, relating to the quality, integrity, and assurance of products. For example, the Trust received some items that had expired or were labelled incorrectly, some presented with integrity issues such as disintegrating facemasks and masks with mould spores. All issues relating to PPE quality were escalated via the Trusts COVID cell and Incident Command Room who provided feedback to NHS England. Despite daily stock checks and robust assurance processes in place, it was highlighted that Type IIR surgical masks posed a stock issue with limited receipt of goods from push stock systems, this remained a challenge for several weeks. It is important to note that at no point were the Trust depleted of any PPE/RPE product line and all front-line staff had continued access to all PPE/RPE stock relevant to their duties.

98. The Trust was in a strong position in March 2020, having previously recognised in 2019 that there was an assurance gap relating to the adequacy and continuous cycle of fit testing required for all staff in the safe use of FFP3 masks. This gap was identified as a result of a 2017 CQC report at another ambulance Trust which identified difficulties in ensuring all staff were trained and fitted in the use of filtered masks and went onto advise that they "must ensure all staff are fitted for and trained in the use of a filtered face piece mask to protect them from air borne infections." In addition to this testing regime, we needed to ensure that staff for whom FFP3 was not suitable were provided with a safe alternative. In order to address the inequalities of FFP3 mask suitability, the Trust took a decision to invest and migrate to Powered Air Purifying Respirators (PAPR) in April 2019 and as such staff within the Trust did not utilise FFP3 masks throughout the pandemic, the Trust did not experience the logistical burdens associated with fit testing products, or utilising fit testing equipment. The organisation took the decision to provide our staff in the emergency and urgent care workforce with personal issue hoods. This involved procuring hoods and purposefully designed protective cases to store the product within. This step-change from vehicle-based 'shared' hoods to personal issue significantly reduced the burn rate of this product line and provided staff with assurance and a greater degree of protection.

99. Initially, and in compliance with national guidance, COVID-19 infection was managed in line with high consequence infectious disease (HCID) principles and therefore, required

the organisation to bolster its existing respiratory protective equipment arrangements whereby the Trust procured Centurion PAPR to accompany its pre-existing 3M PAPR product. This action was undertaken due to a worldwide shortage of the 3M product, the Trust escalated the risks directly to 3M and worked tirelessly to access further 3M kits and once stocks became available the interim Centurion style kits were withdrawn and held for resilience purposes. Additionally, throughout the HCID response, RPE filters were discarded following each patient contact and as a direct result, this posed a potential supply threat if the burn rate should continue at such an unprecedented pace. This issue was escalated to Public Health England for technical advice in addition to 3M, the manufacturer for guidance relating to biological settings. Following a national review the status of the virus was downgraded from a HCID to a category 3 pathogen and therefore, negated the requirement to discard filters after each use and permitted the Trust to revert to locally agreed IPC principles for RPE filter management which was replacement every three months. No further issues with filter supply were identified and remained the case throughout the pandemic response.

100. Despite the positive PPE arrangements in place, there were a small number of staff who were unable to wear standard issue PPE, it was important that we recognised these issues and supported staff by finding suitable alternatives. Some staff experienced PPE fatigue and for others prolonged use of PPE such as gloves and masks caused reactions such as contact dermatitis and eczema. The Trust introduced a process to deal with the problem of staff being unable to wear PPE and this involved assessing their individual role and the associated PPE requirements, referral to occupational health for ongoing support, procurement and use of sensitive approved alternative PPE products and monitoring any changes that these had on reported conditions.

101. Through feedback, engagement, and concerns raised by staff through the Trusts incident reporting system, it was identified that the low-grade 16-20-micron aprons provided through push stock caused aprons to tear and blow up into the face of our staff, thus posing a significant IPC risk to staff members undertaking clinical duties. I have no doubt that this PPE would have been suitable for use in controlled environment or clinical settings such as hospitals however they posed difficulties for staff in out of hospital settings as they were tearing when donning/doffing and became easily damaged. The Trust took steps in mitigating these risks by designing and procuring a purposeful, longer, wider and thicker (100-micron) apron, which gave staff a greater level of protection. The new aprons were designed, sampled, tested and procured in April 2020,

the initial procurement cost was £186,260.00. The Trust received a supply of 400,000 aprons on 16 May 2020, which were then distributed immediately to staff. Again through staff engagement, the thickness of the apron was subsequently reduced in November 2020 to a 60-micron apron, and this has now become the standard across the pre-hospital sector.

102. The Trust communicated regular guidance and updates with clear instructions to staff regarding minimum levels of mandatory PPE and RPE and what conditions and clinical procedures required an increased level of PPE and RPE through dedicated clinical, operational and safety notices. These communications were also disseminated via the Trust's global email address to ensure messages were received Trust wide, whether staff were clinical or non-clinical. Further to this, all updates to national guidance were collated and disseminated via the Trusts Weekly Briefing document, which is emailed to all staff and volunteers on a weekly basis.

103. All clinical guidance obtained within the Trusts Clinical Notice template was uploaded to the JRCALC application for frontline operational staff to observe in practice. Guidance shared with staff included written information, pictorial diagrams, and a stepwise approach to donning and doffing PPE. The Trust did not publish guidance to ambulance staff from other organisations, such as the UK Resuscitation Council or the College of Paramedics and remained aligned to national government guidance for ambulance Trusts throughout the pandemic response.

104. The Trust observed national guidance closely, and mandated PPE/RPE measures accordingly. This included the mandatory requirement for enhanced levels of PPE when the UK experienced peaks in prevalence and where universal face masks were mandated in clinical and non-clinical settings. Additionally, droplet-precautions (level 2 PPE) were adopted for all patient contacts and airborne-precautions (level 3 PPE) for all aerosol generating procedures (AGPs) and/or if an individual staff members own dynamic risk assessment dictates a higher level of protection was required i.e., where the application of the hierarchy of controls had been implemented but the risk remains. A full chronology of guidance issued by both UKHSA and AACE can be found in Exhibit AM21 - INQ000226611 and Exhibit AM22 - INQ000226612 respectively, importantly our Trust maintained strict adherence to the national guidance.

105. The Trust maintained at all times a mutual aid plan, which detailed how it would receive, or provide support to or from other services. There were also many informal arrangements between neighbouring acute, community, ambulance trusts and specialist services. In total the Trust provided PPE on 147 occasions with over 700,000 units of PPE to NHS colleagues.

106. The Trust received push stock that was surplus to our requirements for example FFP3 masks. To ensure that no stock was unused or wasted, the Trust led and hosted an event, where some ambulance Trusts brought all of their FFP3 masks into one location, then sorted by type and batch numbers, and redistributed, which saw Trusts significantly reduce their fit re-testing, and maximise the use of available PPE via the push stock process.

Infection Prevention and Control

107. To protect our staff we understood that there was a requirement to increase symptom surveillance and also help to reduce the risk of contact spread. Reducing contact spread can be achieved by improvements in cleaning regimes and focusing on common touch points. All Trust premises transitioned to a deep cleaning schedule following a retendering process of our contract cleaner in September 2019 with focus on reducing infection spread by using chlorine-based cleaning solutions in all buildings twice a day paying particular attention to touch points. In addition to these enhanced cleaning arrangements in place the Trust invested in a misting chlorine dispersal device in December 2020 which helped to kill bacteria in difficult to reach areas or on surfaces which are more complex to clean using traditional methods. To support cleaning antibacterial and antimicrobial wipes were available to staff in all locations. Every desk in the Trust had disinfectant wipes, alcohol hand rub and tissues, all main doors had disinfectant wipes next to them so that staff could use these before touching handles and personal issue hand sanitising tottles were available and issued to all staff for use between hand washing.

108. In order to assist with surveillance of staff who may have a temperature the Trust invested in thermal imaging cameras which were placed at the main entrances or main thoroughfares of all premises. In the first instance 55 thermal cameras were purchased and the presence of these removed the requirement for staff to use more traditional methods of checking temperature such as the use of tympanic thermometer which

posed an additional risk of contact spread. The benefit of this technology is that they could detect when staff were not wearing a mask and they were verbally reminded to put one on and not to enter if they had a high temperature.

109. From 23 January 2020, the Trust communicated all mandated infection prevention and control measures that were published by Public Health England to the operational workforce. This involved the introduction of mandatory airborne transmission-based precautions, in line with the Trusts Infection Prevention and Control Personal Protective Equipment Procedure and High Consequence Infectious Diseases Procedure, when responding to patients who met the epidemiological or clinical criteria for coronavirus.

110. By February 2020, Public Health England released national guidance which was published on the Government website. The formation of this guidance involved ambulance sector representation in the form of the Chair of the National Ambulance Service Infection Prevention and Control Group (NASIPCG), a subcommittee of AACE, who sat at the National IPC Cell, chaired by NHS England. Subsequently, with national guidance changes, droplet transmission-based precautions were mandated for all patient contacts and airborne transmission-based precautions were mandated for all aerosol generating procedures or where the application of the hierarchy of controls were considered ineffective.

111. The publication of all national ambulance service guidance was disseminated through the National Ambulance Service Infection Prevention and Control Group, which during the early response to the pandemic was held daily, with representation from ambulance providers from all four nations, independent Islands and devolved administrations, working together to provide a consensus in approach for adopting and implementing national IPC measures across the sector.

112. Consideration was also given to those staff who undertook duties in non-clinical areas, such as control rooms and offices. AACE released the guidance document 'COVID Secure in the Workplace and Non-Clinical Areas', which saw prevention and control measures mandated in areas such as ambulance hubs, cabs of ambulance vehicles, emergency operations centres, logistics and support services and education and training facilities. In addition to complying with all national guidance, the Trust further bolstered local arrangements and took steps to implement the following measures:

- Powered Respiratory Protective Hoods – implemented April 2019 and withdrew FFP3 masks which were associated with a high fit test fail rate.
- Amended the specification of aprons to ensure correct micron procured that were fit for the environment staff were operating.
- Implemented thermal digital cameras to detect mask use compliance and temperature monitoring on entry to Trust sites.
- Implemented Clorox 360, hydrogen peroxide vapour sanitisation to bolster cleaning/decontamination arrangements.
- Implemented hand sanitising wipes for all frontline staff who do not always have immediate access to soap and water.
- Implemented Perspex screens across all office areas and Emergency Operations Centres
- Wall mounted combined disinfectant/detergent wipes installed across the Trust and near to frequently used touch points.
- All staff (clinical/non-clinical) were issued with alcohol gel tottles to be worn on their belt line.

113. Furthermore, the Trust understands the importance of the need to collaborate, engage and be involved in the formulation of national infection prevention and control measures within ambulance vehicles and work environments. The Trusts Head of Infection Prevention and Control supported AACE National Specialist Advisor for Infection Prevention and Control and held the position of Vice Chair to the National Ambulance Service Infection Prevention and Control Group. The process whereby infection prevention and control guidance documents were formulated involved the National Ambulance Service Infection Prevention and Control Group in order to provide a consensus in approach for adopting and implementing national IPC measures across the United Kingdom. In addition to the national guidance released by the government, both consensus statements and position papers were formulated through the National Ambulance Service IPC Group and approved by the AACE prior to publication and adoption by the Trust.

114. Throughout the pandemic, the Trust remained aligned to national guidance published through the government website by Public Health England (PHE) and United Kingdom Health and Security Agency (UKHSA). All guidance released by the AACE, a national body, such as COVID Secure in Non-Clinical Areas', was adopted on a national basis as best practice.

115. All guidance changes were communicated to the workforce by clinical, operational and safety notices, approved by the Director of Infection Prevention and Control (DIPC).

116. The Trust followed pandemic national guidance both clinically and for other aspects of patient response and care. Over the same period JRCALC was also developing new clinical guidance to assist clinicians in "recognising cyanosis and anaemia in darker skin tones".

117. Alongside this from the start of the pandemic the national ambulance service medical directors' group (NASMeD) started pandemic specific guidelines in line with national NHSE guidance but specific to the ambulance services operational and clinical practice led by the Trusts Medical Director. These guidelines were applicable to all patient groups. NASMeD and JRCALC chaired by the Trusts Medical Director also linked with the NHSE leads for sepsis and oximetry to review oximetry in people with darker skin tones in ambulance practice and provided updated guidance in line with the national reviews.

118. The Trust also understands the importance of considering infection prevention and control measures within ambulances. Many measures were explored to ensure staff were kept safe whilst undertaking their duties within operational ambulance vehicles. This includes a robust risk assessment of COVID Secure arrangements, the need to undertake individual dynamic risk assessments and to apply the application of the hierarchy of controls for each patient. The following areas were given specific IPC considerations in relation to ambulance vehicles:

- PPE – mandated levels of PPE for specific deployment i.e., level 2 (apron, gloves, mask, eye protection) for all patient contacts and level 3 (coverall, powered respirator, gloves) for aerosol generating procedures or where a staff members own dynamic risk assessment indicates (March 2020).
- Cleaning and decontamination: in-between patient cleans, equipment cleans, daily make ready cleans, deep cleans (March 2020).
- Ventilation system advice i.e., set to extract, not recirculate. Promoted manual ventilation i.e., window opening (March 2020).

- Ventilation systems – achieving 50+ air changes per hour, in comparison to an average of 10-12 in the equivalent hospital cubicle (March 2020).
- Clinical waste management in ambulance vehicles (March 2020).
- Linen and laundry management in ambulance vehicles (March 2020).
- Occupancy limits, including limitations/restrictions on non-essential persons travelling within a confined space (March 2020).
- Mask use – mask use for staff and patients and other travelling. Patients exempt unless unable to tolerate (March 2020).
- Cleaning and decontamination following specific scenarios i.e., cardiac arrests or where aerosol generating procedures had been undertaken (April 2020).
- PTS – occupancy limits set, including spacing requirements and maximum levels (May 2020). Working safely guidance in non-clinical areas – i.e., cab of the ambulance vehicle, this saw the release of an operational notice 'COVID Secure in Cabs of Vehicles' (June 2020).
- Introduction of Hydrogen Peroxide Vapour for sanitisation and greater assurance (June 2020).
- Cleaning/decontamination: reinforce the requirement to undertake regular wipe downs of touch points i.e., grab handles, keys, steering wheels, radios, control buttons (October 2020).
- Implementation of the national guidance for Hospital Handover Delays, produced by AACE (January 2021).
- Guidance to reduce viral load, swap duties in the saloon compartment of vehicle (January 2021).
- Hand Hygiene – introduced antimicrobial hand wipes (November 2021).

DNACPR

119. I understand that there may have been concerns during COVID-19 regarding do not attempt cardiopulmonary resuscitation (DNACPR) notices. I would like to stress that the Trust did not issue any such notices at any time. Clinicians within our Trust continued to follow existing protocols detailing when CPR should and should not be commenced and there was no change to this advice.

120. A small number of concerns were raised by Trust clinicians during the reference period relating to the appropriateness of DNACPR and the inappropriateness of documentation within the community. When concerns were received, they were immediately passed to social services as a safeguarding concern for further investigation by the relevant local

authority, it should be noted that it is unclear if COVID-19 played any part in these concerns.

Collaboration and Feedback

121. Joint working and collaboration with neighbouring Trusts; acute, community, ambulance and other key partners is something I am proud of. Each Local Resilience Forum (LRF) was assigned an assistant chief ambulance officer. This group coordinated all issues within a region at a strategic level and communicated key information.

122. Through the COVID cell, and the incident command room, the Trust maintained regular contact with the NHS MIDSROC. The Trust embedded a national interagency liaison officer within the incident command room to maximise working collaboratively between NHS Trusts, using the specific relationships and contacts that this role has. This role was embedded throughout the pandemic. The Trust maintained a running log of tasks completed for the region, which included daily counts of PPE across all sites in the Trust, staffing and sickness levels, any predicted operational issues, etc. In the early stages of the pandemic, the Trust regularly worked with the region to complete NHS stock disruption reports, where PPE was challenged. The region would work to rectify any issues and provide PPE.

123. The Trust was able to work collaboratively with a number of adjacent Ambulance Trusts through existing National and Regional committees and Structures. Examples of these include the AACE subcommittees, such as National Director Operations Group (NDOG), Human Resources Director group (HRDs). The Trust ensured that each meeting was attended by a nominated individual, or a deputy in their absence. By attending, engaging and supporting these meetings and committees, the Trust was able to be fully abreast of the dynamically changing situations, and communicate and work collaboratively with other ambulance Trusts, sharing best practice to ensure that the three main strategic priorities were achieved at all times.

124. The Association of Ambulance Chief Executives and their committees played an important role in responding to changes during the pandemic. These committees were established groups which were used to provide feedback both locally and nationally as they linked into National bodies. The Trust was also formally engaged with LRFs and regional CEO meetings. The Midlands Regional Operations Centre (MIDSROC),

National Operations Centre, Public Health England (PHE) who transferred its functions to UK Health Protection Agency (UKHSA) and local health protection teams also collated feedback from our Trust. Throughout the pandemic, the Trust ensured that it has representation at each meeting, wherever appropriate and possible. Exhibit AM24 - INQ000226614 shows the AACE committee structure from June 2022. The NACC regularly disseminated information and guidance, collected feedback and undertook audits and reviews nationally on issues relating to the response to the pandemic.

125. Attendance at the various AACE committees and the open communications between MIDSROC and the incident room with the addition of individual channels to NHS England infection prevention and control (IPC) teams, ensured that there was continual feedback formally into NHS England.

The Trusts future risks, reviews, reports and lessons learned exercises

126. The AACE group commissioned a national review of "Ambulance Services and the pandemic, a review of 2020-2021" and the Trust supported this work by providing detailed staff feedback. A range of views were collated from different areas within our sector, for example workforce and workforce representative groups [Exhibit AM23 - INQ000226613].

127. The Trust completed its own action plans of what could be improved, and these were documented and shared. These plans provided the Trust and our board with prioritised actions from July 2020 and July 2021 where learning was identified. The plans are listed in Exhibit AM25 - INQ000226615 and AM26 - INQ000226616.

128. Some learnings from COVID-19 have been embedded within policy and examples of this are the inclusion of contact tracing principles within the Trust's Test and Trace Policy. COVID-19 made contact tracing a common occurrence and our application of these principle can be related to all communicable diseases. This was particularly useful when we began dealing with MPOX cases in 2022. Learning from the pandemic has also been imbedded within The High Consequence Infectious Disease Proceedure and the Pandemic Plan which were consolidated and updated in June 2021. The Pandemic Plan now includes COVID pandemic lessons identified internally as well as Nationally and provides examples of reporting standards and processes adopted during the pandemic should these need to be replicated in the future.

129. There were many areas of learning and reflection, particularly relating to the speed in which we were able to achieve certain actions, for example procuring enough IT equipment for all appropriate staff to work from home and procuring enough Perspex screens to be able to ensure that all desks were COVID secure. I accept and agree on the whole with suggestions that some actions could have happened sooner, however there were many NHS Trusts and other types of organisations who were all trying to achieve similar objectives and therefore obtaining the right products in the right quantity could often be difficult.

130. I would like to place on record my praise, appreciation and thanks to my staff and colleagues for all the hard work and commitment they demonstrated during what has been an incredibly challenging period of time since the New Year in 2020 with the Floods during the Winter moving on to the COVID-19 global pandemic; and I would like to express my appreciation of their commitment, determination and professionalism.

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: 4th August 2023