Witness Name:
Statement No.:
Exhibits:
Dated:

UK COVID-19 INQUIRY

WITNESS STATEMENT OF HELEN RAY

I, Helen Ray, will say as follows: -

1.0 I am the Chief Executive of the North East Ambulance Service NHS Foundation Trust. I commenced my role in 2019 having previously been Chief Operating Officer for Northumbria Healthcare NHS Foundation Trust; Joint Managing Executive Director (Operations) for North Cumbria Acute and Community Services; Deputy Chief Executive for North Cumbria University Hospitals NHS Trust and Chief Operating Officer for South Tyneside NHS Foundation Trust. I trained as a nurse and have held a professional registration for 30 years.

2.0 An overview of the organisational structure of the North East Ambulance Service NHS Foundation Trust

2.1 The North East Ambulance Service NHS Foundation Trust (the Trust) operates across Northumberland, Tyne and Wear, County Durham, Darlington and Teesside. We provide an Unscheduled Care service to respond to emergency calls, and a Scheduled Care service which provides pre-planned non-emergency transport for patients in the region.

Since 2013, we have delivered the NHS 111 service for the region to provide urgent medical help and advice, and we have been able to demonstrate how this service can run alongside the 999 service to provide a seamless access point for patients. We became a Foundation Trust in November 2011 and are one of ten ambulance services in England, covering an area of around 3,230 square miles. We serve a population of

more than 2.71 million people and employ more than 3182 (Permanent and fixed term and temporary staff as of 16th May 2023) staff including our valued volunteers and bank staff (116).

2.2 The overall Executive and Directorate structure did not alter from March 2020 until June 2022, although there were some personnel changes during this period. The Trust was led by the Executive Team, who were answerable to the Board, and delivered by the senior management team in each Directorate. The Trusts operational delivery was divided into Unscheduled Care (frontline emergency response), Scheduled Care (patient transport services) and Emergency Operations Centre (EOC) (Dispatch, 999 and 111 call taking, Clinical Assessment Service). From 13 March 2020, the Trust instigated a direct Command and Control method of service management in response to the developing pandemic [HR/01- INQ000221470]. This centralised much of the day-to-day decision making to the Incident Co-ordination Cell led by the on-call Strategic Commander, with daily briefings to the Executive Team. From May 2022, the service undertook a restructure of our Unscheduled Care management, in response to a variety of service requirements outside the pandemic. Overall service structures are illustrated as part of the evidence accompanying this statement [HR/02- INQ000221471].

2.3 The Executive Team lead by me, were responsible for the oversight of the Trusts response to the pandemic, liaising with the Board and setting the overall Trust corporate strategy. The Heads of Service took responsibility for establishing the Covid 19 strategic plan through the Strategic Co-ordinating Group (SCG, or 'Strategic Cell') and ensuring it was delivered by the Tactical Co-ordinating Group (TCG, 'Tactical Cell'), comprising the operational middle management structures. Heads of service not usually party to the strategic on-call command structure, such as the Deputy Chief Operating Officer (DCOO), Heads of Operations EOC, the Head of Integrated Urgent Care Clinical Assessment Service (IUC CAS), supplemented the established Strategic Commanders (Heads of Operations, Consultant Paramedic, Head of Emergency Preparedness Resilience and Response (EPRR)) to ensure a business as usual command response capability as well as a Covid 19 command response capability. The SCG also contained subject matter experts from across the Trust, including:

- Clinical Operations Manager (As per Tactical On-Call Rota)
- Scheduled Care representative
- Chief Executive
- Chief Operating Officer / Deputy Chief Executive
- Quality & Safety Directorate Representative to cover:
  - Infection, Prevention and Control (IPC)
  - Patient Experience
- Information Technology Representative
- Head of Strategy and Transformation
- Finance Representative
- Communications & Engagement
- Medical Directorate Duty Officer
- Training Representative
- EOC Representative to cover:
  - Call taking
  - CAS
  - Dispatch
- Occupational Health Manager
- HR Representative
- Procurement Representative
- EPRR Representative
- Health and Safety/Risk Representative

2.4 Daily executive briefings took place late each day to ensure that all executives were sighted on key decisions/issues. Some executives also joined the 09:30h Strategic Cell calls with the Deputy COO acting as the link between the Strategic Cell and the Executive Team. The strategic and tactical plans are included in the accompanying evidence outlining the key priorities of each group [HR/03-INQ000221472] [HR/04- INQ000221473] The Head of Operations with responsibility for Scheduled Care (later Head of Scheduled Care) led separate coordinating meetings for the Patient Transport Service (PTS) through the pandemic with a management team comprising the PTS Business Manager, Lead Demand Planner, Demand Planner; Contracts manager, Call Taking Manager, EOC PTS team, and the

Third Party Providers Team (who looked after the private sub-contractors). They were responsible for interpreting the national IPC / NHS England (NHSE) operational guidance in relation to patient transport services.

2.5 National direction was for 'governance lite' or 'governance necessary' which the Board of the Trust implemented promptly. The Board remained supportive and 'hands off,' allowing Executives and the Strategic Cell to focus on the Trust's response to the pandemic. At the same time the Board continued to meet, albeit with a reduced agenda and where appropriate offer encouragement and scrutiny. By March 2020, the Board had agreed to interim COVID-19 Board governance arrangements, continuing to meet monthly but with a reduced agenda that focused on business-critical items only, i.e. COVID-19, quality and performance, finance and risk. From mid-March 2020, both the Board and the Council of Governors received twice a week regular briefing which provided a timely update of the current situation and appropriate management actions.

3.0 Command and Control

3.1 Regional Command and Control arrangements were put in place from Tuesday 3rd March 2020, 7 days per week and 12 hours per day, to aid the management of the increasing need for coordination in response to the impact of the virus. This was known as the COVID-19 co-ordination service. As mentioned above, the Trust established a Command-and-Control structure from 13th March 2020. This included the establishment of a Strategic cell 7 days per week, a tactical cell 0700 – 22:00 7 days per week, and a 24/7 COVID-19 desk in EOC staffed with a Dispatch Manager, dispatcher, and an operational commander (Clinical Operations Manager or Clinical Care Manager).

3.2 Professor Keith Willet's weekly webinars provided a national oversight of on-going work, any identified issues and forecasted workstreams for the NHS and upcoming requirements for the Trust. Professor Keith Willett is the Director for Acute Care to NHS England and had a leading role in the health service response to Covid.

3.3 As a national level 4 incident was declared which involved NHS England taking over the overall coordination of the health service's response to the pandemic this

introduced additional multi-agency elements and brought about prolonged system step up working. Command and control discussions within the region and at 'place' (sub-region) were established. A weekly call was held with the following partners:

- Public Health England (UK Health Security Agency (UKHSA), from 1 April 2021)
- Critical Care Network
- Acute Trusts
- Infection Prevention and Control (IPC) agency representatives
- Local Authorities
- Ambulance Services
- Primary Care
- Mental Health
- Clinical Commissioning Groups (Integrated Care Boards (ICB's), from 1 July 2022)
- Communications representatives
- NHS England

3.4 This call updated on infection rates, staff absence, vaccination status/availability, testing status/availability, critical care capacity and communication messaging. Locally, these meetings were supported by the North East Commissioning Support Unit (NECSU).

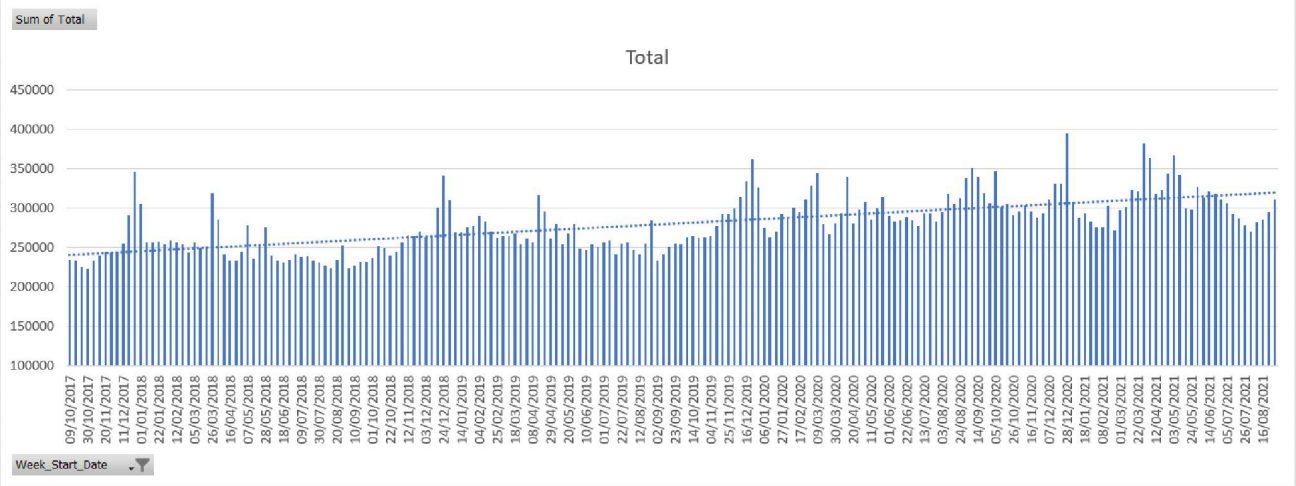
3.5 National Co-ordination was also facilitated by NHS England EPRR regional teams and the National Ambulance Co-ordinating Centre (NACC), which interfaced with the Trust structures in that the Trust fed in situation reports and requests or items for escalation, and national co-ordination fed down advice, guidance and other relevant information. Further local groups were established, such as to enable co-ordination of testing and vaccinating capacity, as well as Local Resilience Forum Structures (LRF) at a Strategic Co-ordinating Group and Tactical Co-ordinating Group level across the three LRF's in the Trust region (Northumbria, Durham, Cleveland). Additionally, there were weekly meetings with the recognised unions in the Trust, Unison and GMB.

3.6 The DCOO attended a weekly North East and North Cumbria (NENC) Health Co-ordinating Group meeting and the Director of People and Development attended

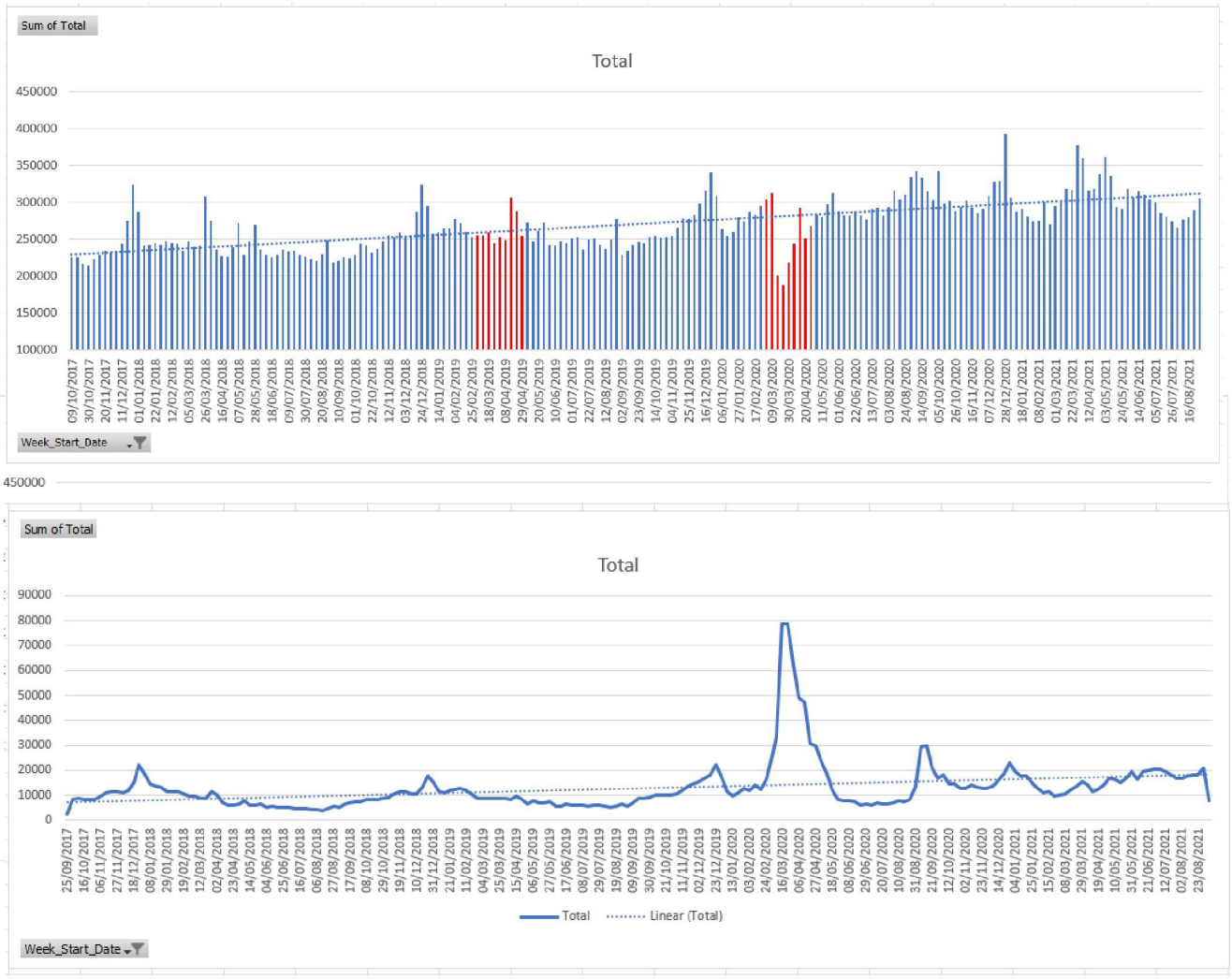
weekly Association of Ambulance Chief Executives (AACE) led Human Resource Directors meeting specifically about Covid, and a NENC HR Director weekly meeting. She also attended a regular meeting with the National Ambulance Social Partnership Forum (trade union colleagues).

3.7 The Trust was subject to a number of national directives and guidance which influenced the provision and operation of its services, including those about how to manage staff welfare, patient welfare, and equipment. Local Social Care and Acute and Community Healthcare providers also introduced IPC measures which directly and indirectly influenced ambulance operations, including requirements for ambulance staff entering their premises. Government measures and patient behaviors, particularly during the first wave, also appear to have led to an increase in utilisation of 111 and 111 online.

The data below demonstrates that overall demand on 111 service increased throughout the first wave (March/April 2020). This is driven by a significant increase in calls pertaining to 'Breathing Problems', 'Covid19' and 'Cold/Flu' symptom group. The data below has been taken from IUC Demand and Resource Update provided by the NHSE and NHSI Provider Planning Forum,



National NHS111 Call data.



3.8 As information from national leads was shared to the Trust IPC, Clinical colleagues, and EOC colleagues it was reviewed interpreted and operationalised through the meeting structures described above, enabling the Trust to respond to patients following the latest guidance. For example, National Ambulance IPC meetings were attended by internal IPC leads, with information then reported back through the Trust via the specific meeting structures for the matters discussed – Isolation guidance, Testing, PPE, Social Distancing in the workplace/ within ambulance vehicles. Initial information would be provided via the SCG daily

conference calls, with meetings then established to operationalise the detail as required. To this extent the Trust were able to make decisions about how to operationalise national guidance and as detailed below, made representation at national forums during the drafting of IPC guidance.

3.9 In the early stages of the pandemic public behaviour changed and there was a reduction in ambulance incidents (although there was a significant increase in call volume this did not translate into ambulance dispositions). [HR/05- INQ000221474] We did have a loss of operational staffing due to Covid illness and those who were advised to shield due to clinical vulnerability. The Trust were able to instigate early implementation of swabbing for staff. The Procurement team were able to keep a flow of PPE to the frontline crews and the Clinical Care Managers co-ordinated the PPE locally, ensuring crews had appropriate levels/ support guidance throughout. A Business Continuity plan was in situ for the reduction in operational staffing, should it fall below 20%, however we did not reach this figure. Additional resource was provided by NHS volunteers and third-party providers to assist in maintaining business as usual. Support services undertook some redeployment into roles to support critical services/functions, thus all key dependencies within operations to deliver critical services/functions remained deliverable. Central Stores moving to 7 day working and ensured appropriate PPE was available for operational staff. Removal of Essential Annual Training abstraction and external training from 23rd March 2020 (for a period of 6 weeks and thereafter delivered online) afforded key resource availability. Compliance figures for statutory/mandatory training and appraisal compliance reduced.

3.10 National guidance released in September 2020 [HR/68-INQ000237269], and then subsequently updated in December 2020 [HR/69-INQ000237270], requested normal, routine non-emergency transport services to change and for the Trust (as the main NHS Health Care provider and the main contractor of these services in the region) to be the main coordinating Hub for all non-emergency transport in the Northeast region. The guidance also stipulated that only essential transport would be provided to patients who are attending hospital for treatments such as dialysis, chemotherapy and other cancer related services. In addition, the Trust were tasked to maintain hospital discharges across the region - moving our contracted response from 4hrs to 2hrs.

3.11 Changes were implemented via NHS Pathways for our 111 and 999 call taking and triage service There was a recruitment of staff into EOC through an expedited recruitment process, and a utilisation of agency workers and General Practitioners to assist in the CAS stack. Clinicians were trained in the Manchester Triage System (MTS), a clinical risk management tool, rather than NHS Pathways, as it is a much shorter course than NHS Pathways, and which does not have such strict licensing as Pathways so enabled more rotational working and support during periods of surge, whilst delivering a safe and efficacious triage model. MTS is used universally by clinicians to enable them to safely manage patient assessment. The main differences between NHS Pathways and MTS are that MTS is used solely by clinicians, and it is the responsibility of the of the clinician to probe and ask appropriate questions to rule out conditions. Patient conditions must be ruled out in MTS before triage continues. MTS will guide clinicians to appropriate outcomes and the clinician must decide the actual outcome or disposition. NHS Pathways looks for positive answers to direct questions and gives a definitive outcome that cannot be deviated from. The training in the use of MTS is much shorter due to the fact that MTS clinicians are trained to use a triage tool that is independent of the Computer Aided Dispatch (CAD) system, and they are not taught clinical skills or techniques in probing or questioning.

3.12 In the initial phases there seemed to be a lag between information and guidance for acute services being translated into applicable models for ambulance services and sometimes contradicting advice around Aerosol Generating Procedures (AGP's) and resuscitation. There was a large focus on intelligence gathering from national team (NACC) and as all ambulance services do not have the same data set, it was sometimes difficult to interpret what was required and how this information was used. The data requests are received via the EOC from the NACC. The variation in requests is linked to Advanced Medical Priority Dispatch System (AMPDS) / Pathways sites. There was also an obvious variation in how organisations capture absence or fleet data, for example.

3.13 The national and regional guidance regarding PPE & social distancing requirements was also initially very slow. Once information did flow from national and regional teams it was often subsequently changed multiple times and at

pace, which led to challenges operationalising the information and communicating this to frontline clinical workforce. This is predominantly (though not exclusively) linked to the IPC advice and guidance being issued in the early stages of the pandemic. To support our implementation of this, we had the strategic cell coordinating meetings and workstreams with IPC (and other relevant) colleagues, as well as daily conference calls and briefings with Trade Union colleagues. The support for staff testing within the Northeast was very good, however, the process and standardisation of this took some time. The availability of PPE was intermittent, with no national stance on what constituted appropriate ambulance Level 3 masks (respirators, FFP3 variation) supported by an agreed product/supplier.

3.14 As mentioned previously, Acute Trusts and the Care sector were implementing measures that impacted on the ambulance service with no consultation or communication. There was no obvious mechanism to give feed-back to national decision makers.

3.15 Within the Trust during the period 1st March 2020 and 28 June 2022 each budget holder retained responsibility for their own budget, however the Strategic Cell also made decisions about procurement and redistribution of Trust resources, in particular decisions regarding the use of any additional finance made available under the guise of COVID monies. Below are details of key budget holders and periods of employment where they are no longer with the Trust or commenced in post during the reference period:

a. the budget and deciding how that budget is spent	Kev Scollay (03/06/2019-30/10/2022) Mark Redhead Full list of budget holders [HR/06-I NQ000221475]
b. the number of ambulance clinicians	Paul Liversidge (01/02/2013- 31/03/2022), Stephen Segasby (31/03/2023-present), Vicky Court
c. the number of support staff, such as call handlers	Paul Liversidge (01/02/2013- 31/03/2022), Stephen Segasby (31/03/2023-present), Vicky Court, Lynn Huldie

d. the number of ambulance vehicles	Paul Liversidge (01/02/2013- 31/03/2022), Stephen Segasby (31/03/2023-present), Vicky Court

3.16 Responsibility for what would be understood in the Trust as Operational and Call Handling resources, and the targets attached to these activities, sits with the COO, who is accountable to the Chief Executive and Board. Supporting the COO was the Deputy COO and heads of EOC (dispatch and call handling for 111/999, including the CAS) and frontline operations for both unscheduled care and scheduled care. Below are details of key decision makers and periods of employment.

3.17 During out-of-hours periods (OOH) and as part of the Command-and-Control structure established, the Strategic Commander daily also held some responsibility in consultation with the Covid SCG for decisions regarding the utilisation of finance and resources. These decisions tended to be on a proactive and reactive basis in response to organisational pressures due to the pandemic or national policy changes. Below are details of Strategic Commanders who led the cell during the period under consideration:

Strategic Commander	**Role**
Claire Jobling	Clinical Service Manager/Head of Operations North
Darren Green	Clinical Service Manager/ Head of Operations South
Barry Dews	Head of Operations North/Head of Scheduled Care
Douglas McDougall	Head of Operations South
Simon Swallow	Strategic Head of EPRR
Paul Aitken Fell	Consultant Paramedic

Below were not on the Strategic Commander on-call rota however supported in the Strategic Command Cell.

Staff	**Role**

Lynn Huldie	Acting Head of EOC/Head of EOC
Clare Bannister	Head of CAS IUC
Vicky Court	Deputy Chief Operating Officer

4.0 Finance

4.1 At the end of 2019-20 the Trust submitted a bid for funding of £0.845m - mainly in relation to PPE, Information Management &Telephony (IM&T) equipment and third-party front line additional resources. This was paid retrospectively following review by NHSE in Quarter 2 2020/21. (Guidance was issued by NHSE for this claim process on 6th April 2020). We also received £8,471 per week additional funding for 111 response to Covid for the last week in February 2020 through to the end of March 2020. (Letter included within evidence). [HR/07- INQ000221476]

4.2 For 2020/21, months 1 – 4 (April to July), NHSE issued a guidance letter on 17th March 2020 outlining funding arrangements for this period [HR/08- **INQ000087317**]. As a result, the Trust received a 'top-up' payment to its normal contracting arrangement at a value of £0.547m per month (£2.188m in total) for the period – based upon the funding mechanism outlined in the NHSEI letter. For this period all contracting reverted to block contract arrangements and the value paid by commissioners was calculated based on NHSEI formulae of 19/20 payments at Month 9 plus an inflation uplift of 2.8%.

4.3 Phase 3 of the Covid response was enacted from Aug 2020. For financial funding purposes, the regime was amended by NHSE such that from Months 7-12 an allocation was made to healthcare systems – giving them a fixed budget for the remainder of the year and allocations within systems were negotiated and agreed by providers and commissioners. From this, in 2020/21 overall the Trust received £13.780m to cover Covid expenditure, over and above its fixed system allocation. In 2021/22 we recorded spend on Covid related schemes of £7.264m (including £0.271m reimbursement for the costs of supporting vaccination delivery).

4.4 From 2021/22 funding has been through a fixed system allocation budget within local ICB systems, with value determined according to agreements arrived at between system partners following negotiation. We applied for and received capital funding of £64k for equipment purchase relating to 2019/20 and a further £378k for Equipment and IM&T assets in 2020/21. Bids were submitted in accordance with NHSE guidance and timescales.

4.5 As illustrated above the Trust did request additional funding throughout the pandemic period from the end of February 2020 through to March 2022. At a national level, NHSE set up a number of processes that allowed the Trust to retrospectively seek funding for Covid-related expenditure. At the close of financial year 2019/20, NHSE requested all organisations to submit retrospective claims for Covid related expenditure. Two claims were submitted – an initial claim for spend up to 15 March 2020, followed by a request to estimate spend from 16-31 March 2020 as part of annual accounts closure.

Thereafter funding in 2020/21 was provided as a top-up – based on 2019/20 contract rates plus top up for additional expense – rather than there being a request for funding. Although we had to submit monthly returns to NHSE outlining our spend on pre-specified Covid related categories.

4.6 NHSE guidance for phase 2 of the pandemic response (Months 1 – 4) outlined that Covid spend could be claimed retrospectively to bring organisations back to break-even, but scrutiny was maintained through submission of normal financial monitoring returns where separate tabs were included to record Covid spend.

4.7 Phase 3 of the Covid response was enacted from August 2020. For financial funding purposes, revised financial arrangements were put in place by NHSE (see Annex 2 of letter dated 31 July 2020) [HR/09- INQ000221478] - with Months 1-4 arrangements retained to September 2020 but then replaced from Month 7 (October 2020) by funding envelopes at ICB system level to cover NHS provider block income, top-ups and a system share of a COVID funding envelope.

4.8 Effectively from Month 7 2020/21 funding allocations were reset by NHSE such that a negotiation with other providers and commissioners within our healthcare systems around gaining a share of allocated funds from NHSE through a 'fixed system budget' was required. Covid allocations were shared on top of this.

4.9 For 2021/22 - guidance on financial arrangements for the first 6 months of the year (a period referred to as H1) was issued by NHSE with financial envelopes on 26 March 2021 [HR10/INQ000221479]. These envelopes encompassed normal system funding allocations but also included specific 'top-up' payments and system Covid allocations. Again, providers within systems were expected to negotiate and agree shares of the system allocation to deliver their services and manage Covid costs. Funding for this half of the year was generally based on extrapolation of spend run rate in Quarter 3/ Quarter 4 2020/22. (See H1 Plan paper in additional documents) [HR11/ INQ000221480].

4.10 From H2 (second half of the financial year) – System allocations continued to include top-up to block contracts which incorporated COVID spend. For the Trust, there was and remains significant spend going into third party resource coverage to manage absence rate spikes and ensure delivery of response performance.

4.11 Allocations in 2022/23 continued similarly, based on NHSE baselines uplifted for inflation and agreements as to funding within systems reached between partners. In 2022/23 minimal Covid funding was included in system allocations with an expectation that costs were to return to pre-pandemic levels – although some exceptions were made for the Elective Recovery Fund (ERF - which was an NHSE funding stream to support discharge from hospital) and specific development schemes that were directly funded, though much of this funding was defined as non-recurrent.

4.12 Internally, as national guidance was received in Q4 2020, the new financial arrangements / emergency budgets were notified the Trust issued guidance to managers to ensure governance was maintained in relation to requests to spend against Covid related schemes and to ensure compliance with requests. This

guidance was issued alongside wider guidance from the Trust Covid cell at the time [HR/12- INQ000221481].

5.0 Preparedness

5.1 As of 1 March 2020, the Trust had a Strategic Planning Framework for Pandemic Influenza [HR13/ INQ000221482]. This plan was based upon guidance from the Government, last updated 24 November 2017 [HR14/ INQ000221483], the PHE Pandemic Flu: public health response, published 7 February 2013) [HR15/ INQ000221484], and NHSE publication 'Operating Framework for Managing the Response to Pandemic Influenza' published 15 December 2017 [HR16/ **INQ000113189**]. The Trust framework did not cover novel Coronavirus or other High Consequence Infectious Diseases (HCID's), however the principles within the framework were applicable to the Trust response in the case of Covid. The plan foresaw the importance of infection control processes, requirement for increases in PPE stock levels, fit testing of FFP3 masks, likely requirement to modify business processes and demands on the ambulance service. The basis of the framework in relation to resourcing across emergency care, PTS and EOC was the reliance on business-as-usual triggers and contingencies contained in the Resource Escalation Action Plan (REAP) [HR17/ INQ000221486]., as well as the local demand management plans [HR18/ INQ000221487] [HR19/ INQ000221488] [HR20/ INQ000221489] and business continuity plans. The overarching framework for response to any emergency or resilience challenge, Emergency Preparedness, Resilience and Response Framework (NHS England) 2015 [HR21/ **INQ000113172**] was also applicable to the Coronavirus scenario regarding the core principles of response.

6.0 Resource Utilisation

6.1 The Trust Demand Management Plan (changed to the Clinical Escalation Plan 31.08.21) [HR22/ INQ000221491] [HR23/ INQ000221492] [HR24/ INQ000221493] [HR25/ INQ000221494] [HR26/ INQ000221495] [HR27/ INQ000221496] utilised a variety of triggers, based upon demand and capacity across frontline emergency ambulance resource, 111 and 999 call taking, and the CAS, to identify areas of pressure and instigate mitigation to increase

capacity, reduce demand and reduce clinical risk. This plan gave the ability to move up and down in escalation on a shift by shift and sometimes hour by hour basis. In addition, REAP was calculated upon similar triggers including staff absence, and affords some longer-term considerations for service modification, command and control, and mutual aid. REAP was generally calculated on a bi-weekly and prospective basis, enabling trends and horizon scanning to inform proactive measures. Alongside both processes sit the Business Continuity Management System, which identifies a wide variety of triggers and service risks to the Trusts ability to continue BAU across emergency care, EOC, PTS and support services such as stores and I.T.

6.2 Resource Scheduling Department (RSD) and Work Force Management (WFM) teams would monitor and plan resources. Sickness absence rates would be closely monitored, and Third-Party Providers/Agency resources provided to areas most in need, with EOC, Frontline Ambulance resources priortised.

6.3 During 2020 and into 2021, we redeployed a number of corporate support staff into a variety of roles to support operational functions, this took place on both a planned basis with agreed duration and ad-hoc as need arose. We were looking to fulfil roles where there were shortages, due to Covid or long-term staffing challenges, or to enable clinical staff to be released from roles to become operational.
The roles that were covered were as follows, including numbers trained or who volunteered:

- Manchester Triage System (MTS) training – for EOC. Approximately 60 clinical staff trained to provide support. Some of these were already operational, others were in other roles.
- Tactical/Covid desk cover – provided support for staff with queries. Based in EOC. Around 20 staff trained.
- Low acuity calls* – 15 staff trained (only 2-3 were used eventually due to availability)
- 11 staff undertook C1 driver familiarisation.
- 18 staff provided support to stores to help with restocking vehicles.
- 31 staff were trained in CAS administration support.

- Covid vaccine clinic (January/April 2021) – 15 staff involved with additional support from the training team.
- Covid marshals in HQ – up to 20 staff provided support at certain points.
- Swabbing – clinical staff – 6 staff
- PTS call backs – 13 staff
- Communications Support Officer (CSO) dispatch role – 16

* The NEAS Interactive Voice Response (IVR), since superseded by the National IVR, presented callers with the following options to choose from when they called 111;
1) Calls from a HCP
2) Calls for Emergency Medication/Prescription
3) Calls for a Dental Problem
4) Calls where the patient had Symptoms.
Where the caller selected options 1 - 3, these were routed to that specific skillset. These are classed as Low Acuity calls. Low Acuity Health Advisors would only have these skillsets assigned.

6.4 The numbers above include some staff who volunteered for more than one role. Additional training was provided for the CSO dispatch, low acuity call taking, MTS and driver training. Other roles either didn't require training or this was delivered on the job.
Periods of redeployment varied. The Covid desk cover was spread over several months and into 2021. Staff did a shift as part of a roster and volunteered for what they could cover. The restocking was also spread over 2020 and well into 2021. This was in place for several months overall with a core of 6-8 people who covered a large number of shifts. There was some cover also provided in 2022 due to staffing shortages. Most other roles were ad hoc.

6.5 Staff were communicated with on a daily basis through internal communication methods (Siren intranet/Workplace social media/Staff Bulletins), ensuring up to date information was provided at the earliest opportunity. Operational line management structures provided welfare support within the confines of social distancing/PPE requirements. Signposting to Occupational Health resources and adherence to the latest IPC and shielding guidance also supported staff

wellbeing, as did the ability to identify outbreak sites and mitigate the spread of Covid 19, together with the testing of staff and their relatives.

6.6 Demand forecasting continued to support allocation of resources, as did service configurations (such as changes in elective and day case models impacting PTS demand). These forecasting models were constantly under review as IPC requirements for vehicles (i.e., social distancing on PTS vehicles, downtime for emergency care vehicles to undertake cleaning), and staff (cardiac arrest protocols) by way of example, changed. RSD and WFM as well as EOC dispatch staff reconfigured demand and resource allocation.

6.7 Third Party Providers (TPP) were and still are utilised to supplement frontline operational resources within Scheduled & Unscheduled Care as well as EOC. They were contracted based on demand forecast against anticipated planned hours of delivery and service shortfall; with some shorter notice requests dependent upon unanticipated pressures. Each provider worked to the Trust standards of service delivery including PPE and IPC requirements.

7.0 Testing

7.1 Testing was provided internally and via regional Acute Trust providers. Continuous communication between the Trust Emergency Preparedness Resilience and Response (EPRR) department and the regional teams ensured maintenance of provision. Agreements were in place to pool capacity if required and test each other's staff. The Hazardous Area Response Team (HART) was utilised to provide in-house testing capability and capacity through available testing kits and lab capacity was agreed with local labs. Covid testing was coordinated through the Tactical cell, with testing available through antibody testing (over 2000 staff), with results provided to the Trust for dissemination. Testing later became available through the national booking systems, LFT testing kits were distributed by the Trust and later also through the national booking system. There was no perceived detriment to the provision of the Trust services attributed to a lack of testing capacity.

8.0 Guidance

8.1 There was a plethora of advice, guidance and policies during the period under review, in addition to system changes in NHS Pathways. A chronological list is included below and, in the evidence, supporting this statement [HR28/ INQ000221497].

8.2 The Trust utilises NHS Pathways across 111 and 999 call taking. Pathways will lead the patients through a series of algorithms to identify possible illness or injury and then suggest a suitable disposition, including self-care, assessment by a healthcare professional (face-to-face or remote) and an ambulance disposition. There were several Pathways updates in response to the pandemic, as well as the establishment of the Covid-19 Response Service (CRS) in March 2020 to undertake Covid specific assessments, leaving 111 for patients with co-morbidities and/or non-Covid presentations. Identifying COVID calls and placing them on the clinical stack of the CLERIC operating system utilised in the Trust to enable computer aided dispatch, helped to stream those patients to our clinical teams. They were asked questions relating to illness and injury and this identified those patients with COVID confirmed and/or symptoms and this information was used to inform responding ambulance crews to enable them to decide about care and a plan for onward transport to the Emergency Department or other appropriate services.

8.3 Guidance on clinical management of Covid patients for ambulance crews was released via Patient Care Updates, including assessment tools. The JRCALC guidelines application for ambulance crews was also revised to display the latest guidance (Joint Royal Colleges Ambulance Liaison Committee) [HR29/ INQ000221498] [HR30/ INQ000221499] [HR31/ INQ000221500] [HR32/ INQ000221501] [HR33/ INQ000221502] [HR34/ INQ000221503]. Guidance on Covid management by hospital was similarly distributed to the clinicians in the CAS and frontline PTS and Emergency Care crews.

8.4 PTS management team worked collaboratively with our 3 dialysis sites across the region. We worked together to help interpret and operationalise national guidance. This involved social distancing on vehicles and IPC / PPE requirements.

9.0 System Working

9.1 Emergency care operational managers worked with Acute Trusts to understand routes for patients into the hospitals as each hospital had a different footprint or set up of how they received Covid patients into the hospital. [HR/35-INQ000221504]. In addition, business as usual arrangements regarding capacity and demand (or surge) response, such as system meetings, resulted in Strategic, Tactical, Operational command teams having frequent contact with regional NHS Trusts. As discussed above, conversations were undertaken regarding swabbing capacity and sharing masks and PPE, whilst further into the pandemic resources worked across ambulance, acute and community providers to roll out the vaccination programme.

9.2 The National Directors of Operations Group (NDOG) and AACE met throughout the response which resulted in shared learning/ process refinement. This supplemented National Ambulance Clinical (NASMED), IPC & EPRR collaborative work. The National Directors of Operations held weekly calls to share knowledge, experience, challenges and best practice.

9.3 The Northern Ambulance Alliance Directors (The Trust, North West Ambulance Service, Yorkshire Ambulance Service, East Midlands Ambulance Service) and Deputy Directors of Operations held weekly conference calls. These were to highlight challenges, share best practice, offer mutual aid, share resources, sense check decisions and actions and provide support. These arrangements were on an informal basis.

9.4 Mutual aid remained available via the BAU escalation process and the National Ambulance Resilience Unit, though not utilised. During the initial emergence of

Covid-19 in January 2020, the Trust HART undertook the transport of the first Covid patient from Hull to Newcastle Royal Victoria Infirmary infectious disease unit.

10.0 Vulnerable Staff Groups

10.1 The Trust prepared and assessed the impact of Covid 19 through an Equality Analysis Assessment on the Human Resource policies and practices of the diverse workforce to ensure a range of support, assistance and protection was in place for our staff and those providing services on our behalf [HR/36-INQ000221505].

10.2 There was evidence that staff who are of a BAME background may be disproportionally affected by Covid. This was evidenced during the early stages of COVID through several reports as referenced below;

10.2.1 HR/70-INQ000237271 sighted the following risks:

- Overrepresentation of BAME populations in lower socio-economic groups.
- Multi-family and multi-generational household leading to increased risk of transmission due to the lockdown.
- Disproportionate employment in lower band key worker roles who either work in high exposure care environments or are unable to implement safe social distancing due to their roles.
- Co-morbidity exposure risks especially for CVD, diabetes, renal conditions and complex multi-morbidities in ICU.
- Increased health and care setting COVID-19 exposure risks.

10.2.2 HR/71-**INQ000250215**

- Within previous national vaccination programmes in the UK, reported vaccine uptake has been lower in areas with a higher proportion of minority ethnic group populations. There was a significant risk that vaccine uptake for COVID-19 would also be lower among minority ethnic groups.

10.2.3 HR/72-INQ000237273 :

- From early on in the crisis, warning signs emerged of a disproportionate impact on black and minority ethnic (BME) communities, prompting questions over what accounted for the disparity and what measures could be put in place to mitigate risks and protect lives.
- This report detailed the findings of a research study into the underlying factors. It is based on interviews with BME NHS leaders, clinicians, community organisations and service users, and a survey of over 100 members of the NHS Confederation's BME Leadership Network.

10.2.4 HR/73-INQ000237274:

- People from Black ethnic groups were most likely to be diagnosed. Death rates from COVID-19 were highest among people of Black and Asian ethnic groups. This is the opposite of what is seen in previous years, when the mortality rates were lower in Asian and Black ethnic groups than White ethnic groups. Therefore, the disparity in COVID-19 mortality between ethnic groups is the opposite of that seen in previous years.
- An analysis of survival among confirmed COVID-19 cases and using more detailed ethnic groups, showed that after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British.
- These analyses did not account for the effect of occupation, comorbidities or obesity. These are important factors because they are associated with the risk of acquiring COVID-19, the risk of dying, or both. Other evidence has shown that when comorbidities are included, the difference in risk of death among hospitalised patients is greatly reduced.

10.3 This above data was considered when completing our Equality Analysis Assessment for ethnic minority staff and our response to provide:

- A letter to all staff highlighting the challenges.
- Calls to all ethnic minority staff highlight potential challenges and checking in.

- Risk assessments for each ethnic minority staff member based on their job role [HR/37- INQ000221506] [HR/38- INQ000221507].
- Reasonable adjustments to current practices based on the risk assessments.
- Priority access to FIT testing for people wearing beards and the provision of hoods.
- Increased vulnerability status for ethnic minority staff.
- Shielding options.
- Consider vitamin D supplements.
- Guidance on what to do when returning home to reduce risks.
- Case studies and videos from local leaders about vaccine uptake and their experience to dispel the myths around vaccine uptake.

10.3.1 A letter was issued to staff of known ethnicity and letter to staff with no disclosed details of ethnicity; corporate risk assessment and individual risk assessments were put in place; individual risk assessments were completed with line managers to consider risk factors and adjustments [HR/37- INQ000221506] [HR/38- INQ000221507]. Support networks were in place for staff to for mutual support. BAME staff received a welfare call from an Equality, Diversity and Inclusion advisor to offer ongoing support.

10.4 For pregnant staff, the Trust followed guidance from the Royal College of Obstetricians and Gynecologists; to undertake non-patient facing duties after 28 weeks, or with an underlying condition to self-isolate and work from home where possible. [HR/39- INQ000221508].

10.5 As mentioned above, risk assessment was in place for staff in 'at risk' groups (BAME, aged over 55 years, white aged over sixty, underlying health conditions, pregnant staff, male staff compared to female). Shielding was utilised to mitigate risk of transmission/serious illness/death, including full pay. There was regular contact with managers and home working facilitated where possible. The risk assessment and associated documentation was used to support a return to work where appropriate. Compassionate discussions to support mental health were

commonplace, as were early vaccination offers, and alternative duty arrangements. [HR/40- INQ000221509].

11.0 Communication

11.1 We wanted our corporate communication channels to be easy to use, accessible on any device; meet NHS guidelines on security and governance; and be flexible that employees could switch off while away from work.

11.2 Before the pandemic:

- Our staff weekly update had become too lengthy and often missed key updates which were then circulated by email.
- Ownership of departmental information on our intranet, called Siren, was nascent and developing, having only launched six months earlier with author training just rolled out to departments before the first lockdown.
- Employees were not able to be involved in conversation or decisions.

11.3 The technology was just a means to support significant changes we made to the processes and distribution of messages. As a result of the pandemic, we introduced:

- A daily e-bulletin. This was particularly important in the early days of the pandemic when guidance and health advice was updated, often daily [HR/41-INQ000221510]
- A monthly LIVE broadcast on Microsoft Teams to give everyone the opportunity to ask questions of executive directors and hear the latest developments.
- Workplace from Facebook – a private space owned by the Trust that all staff could access easily to connect with peers; bridging the boundaries of geography, time and department.

11.4 We needed to build a new framework for internal communications to meet the demands of the pandemic that gave employees a safe space to share stories, ask questions, challenge each other and build a stronger team.

11.5 We had to move quickly to react to the changing work environment created by the pandemic, collaborating in a highly regulated sector with teams from information governance, information technology, organisational development, operations and our senior leaders.

11.6 Our approach was focused around:

1. Strong personal leadership from our executive and senior team
2. Creating a team of 70 champions from mixed staff groups across the organisation to identify how we overcome barriers to communication flow, information ownership and team collaboration.
3. The communication team set up processes to support a new internal communications framework, providing strategic advice, training on new systems, generating engaging content and facilitating discussions and campaigns; as well as critical COVID-19 updates.
4. Learning from the data and developing a continuous cycle of testing and improvement of ideas, content and campaigns.

11.7 Our innovation and creativity were drawn from a bold approach to allow employees to shape the structure of 'Workplace' themselves (Workplace is an online collaborative software tool) - to create communities of interest and customise their own environment. The result was the creation of 204 groups during the pandemic, of which 76% are work related; 13% are discussion groups and 7% are set up for social purposes.

11.8 Key to our success has been the integration of these diverse channels. Our Siren intranet is a "*single point of truth*" while discussions on all topics are active on 'Workplace'; supported with regular updates through a daily bulletin and frequent opportunities to hold senior leaders to account on live Q&A broadcasts. It is from this breadth of engagement and information that we gave employees a voice, changing organisational culture and building trust. The timeline of the above steps is detailed below:

- January 2020 onwards

Intranet (Siren) development throughout 2020 building key portals of information for employee support, wellbeing and recognition, operational developments and leadership – including 'Thank-you Thursdays' and a Help Hub to support mental health and an "alerts library" of clinical developments mandated for patient care.

- March 2020

Daily update launched with key updates on business activity, clinical alerts, Government announcements, infection prevention guidance.

- April 2020

First monthly LIVE Q&A broadcast with executive directors

- June 2020

Workplace launched to 2700 staff.

- August 2020

Weekly summary of the daily e-bulletins was added in response to shift workers who had been away for several days.

- Oct 2020

'T Awards' – moving annual employee recognition awards into a 12-hour 'Thank you' event on Workplace featuring live video, video messages and thousands of appreciations sent between colleagues.

11.9 Our 'Daily Update' readership rose from an average of 1,775 views per week in January 2020 to an average of 4,948 views per week 12 months later. The Intranet page views per month rose by 58% on average. Live Q&A broadcasts were seen by up to 100 employees per month. Almost half of all employees claimed their 'Workplace' account in the first three weeks of launch in June. Adoption rates are now at 81% against a target of 80% within 12 months and there were 1,500+ active users every month on Workplace with 280 Workplace groups ranging from clinical interest, staff safety, LGBT staff network.

11.10 Our virtual award ceremony on Workplace became the largest employee participation event ever held, with 133 scheduled posts over 12 hours, generating 981 comments and 4,681 reactions from employees. The communications team were recognised with several awards for its disseminating information to frontline clinicians and staff during the pandemic.

12.0 Staffing

12.1 As of 1st March 2020 Frontline Ambulance Staffing (Emergency Care and PTS) numbered 1697 staff, 111 328 staff and Dispatch 139 staff.

12.2 Due to Covid absence and shielding there was a reduction in our overall daily staffing levels at various points during the reference period. A business continuity card was developed if staffing fell by 20% within Emergency Care, with contingencies to support, however this threshold was not reached. Staff who were shielding if able went to work in other areas such as stores to support PPE deliveries.

12.3 Sickness absence/vacancy rates were monitored by the RSD and WFM teams, with exceptions reported through the command structure [HR/42-INQ000221511]. Uncovered shifts were offered to overtime and there was an uplift in third party provision, use of NHS volunteers and clinical staff identified to return to front line. Agency staffing was utilised for 111 call taking and CAS. The Health and Care Professions Council (HCPC) allowed third year student paramedics to register early and become Newly Qualified Paramedics (NQP's), which had both advantages and disadvantages for NEAS. The allowance of early pre-registration was helpful to allow them to progress to the pre reg NQP induction course and therefore commence employment sooner.

This allowed NEAS to have this group operational as registrants earlier than usual as they had, at that point, already completed training and education. The disadvantage to this was that they were not fully independently registered and therefore could not work as a registered clinician until full registration was received some 4 months later.

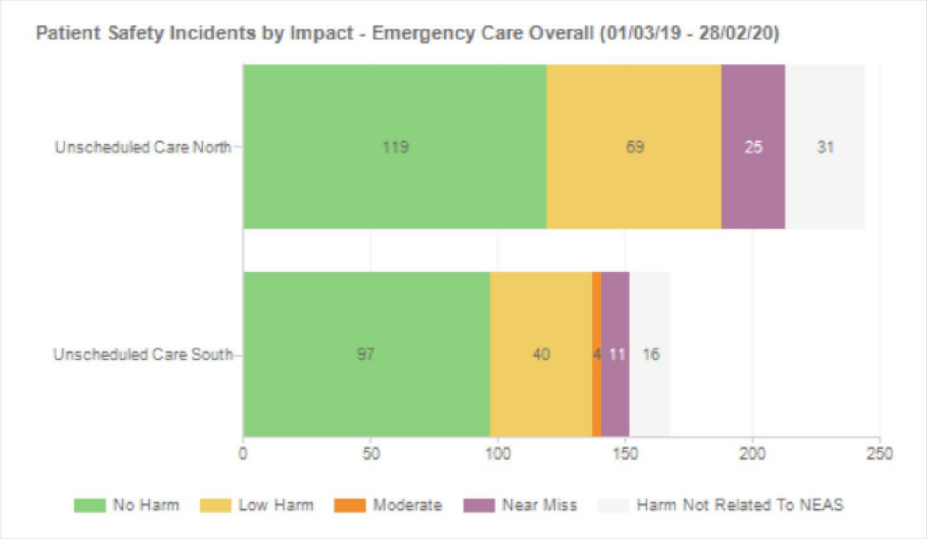
There were risks as their qualification had not been ratified at that point and should they have required re-sit or failed then this would have further delayed full registrant working.

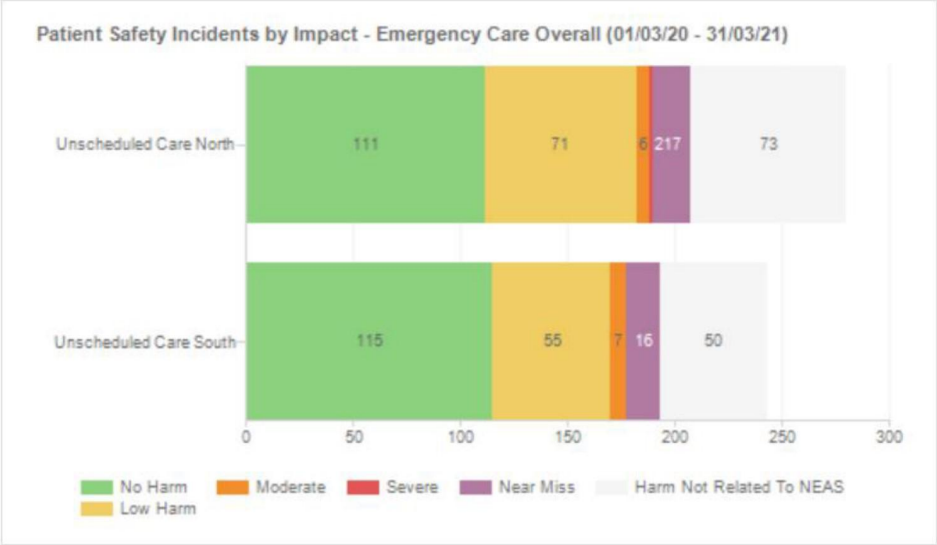
As already covered, there was a redeployment of corporate staff to support operations, and an increase in private ambulance cover. The Trust explored Fire and Rescue Service support but ultimately this was not possible due to their own staffing challenges during the height of the pandemic. A Military Aid to The Civil Authorities (MACA) request was similarly explored but this resulted in no

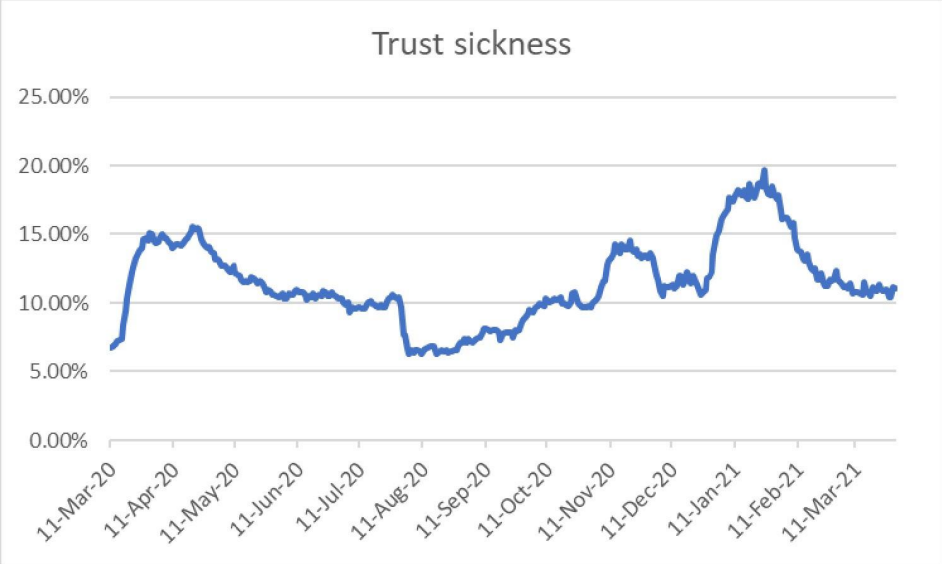
deployment in support of frontline services. Non-essential training was suspended to release further capacity from the workforce. All clinical trained staff not performing critical functions outlined within business continuity plans were requested to undertake clinical duties either on ambulances or within EOC. Remote working was put into place across the CAS to increase staffing and support staff at home who were isolating.

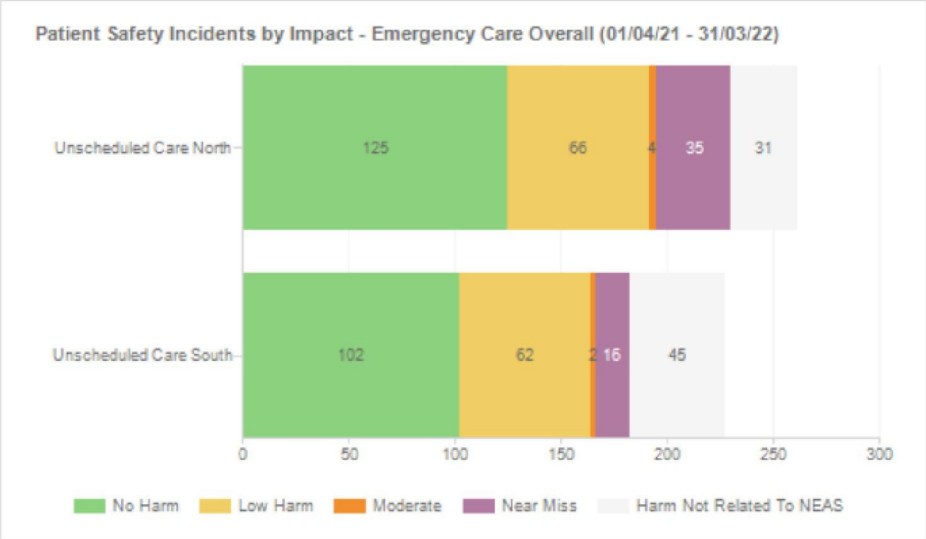
12.4 As of 28 June 2022, the headcount for Frontline Ambulance Staffing (Emergency Care and PTS) numbered 1850 staff, 111 395 staff and Dispatch 138 staff. In part this reflects contractual uplift for emergency care and 111 and variations in employment status (flexible working patterns).

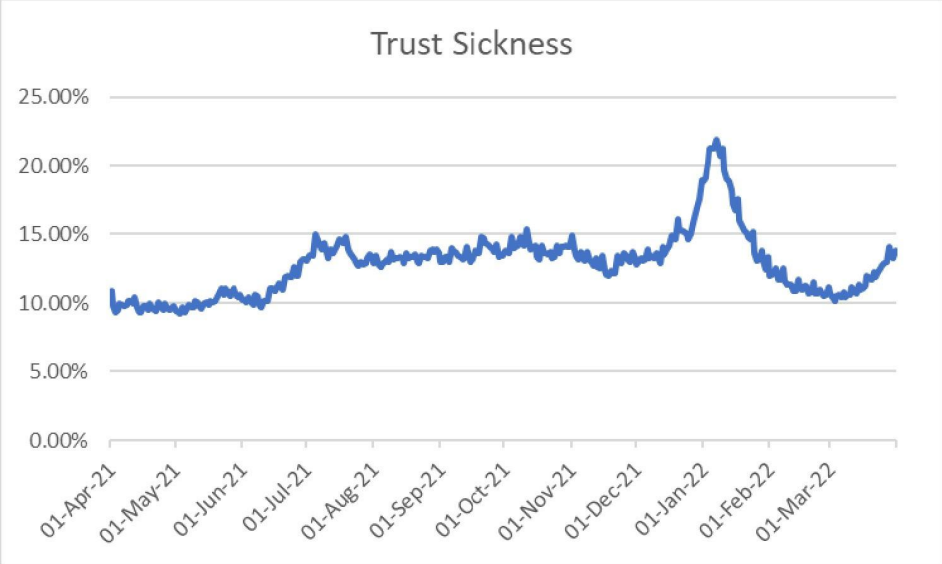
12.5 If we look at one measure of the potential adverse impact on patients from variations in staffing or performance, that of Patient Safety Incidents reported, we find the below:

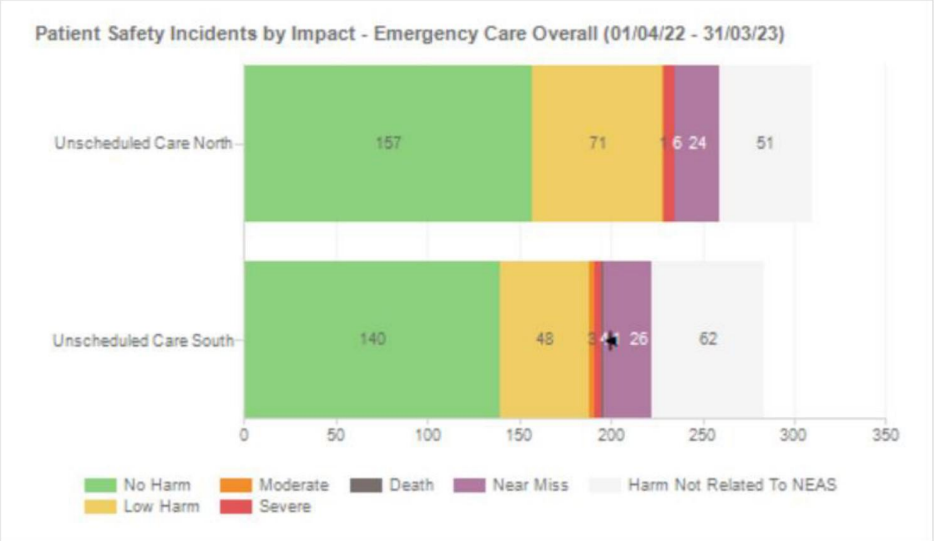



Patient Safety Incidents by Impact - Emergency Care Overall (01/03/20 - 31/03/21)
Unscheduled Care North
111
71
6
217
73
Unscheduled Care South
115
55
7
16
50
0
50
100
150
200
250
300
No Harm
Low Harm
Moderate
Severe
Near Miss
Harm Not Related To NEAS


Trust sickness
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
11-Mar-20
11-Apr-20
11-May-20
11-Jun-20
11-Jul-20
11-Aug-20
11-Sep-20
11-Oct-20
11-Nov-20
11-Dec-20
11-Jan-21
11-Feb-21
11-Mar-21


Patient Safety Incidents by Impact - Emergency Care Overall (01/04/21 - 31/03/22)
Unscheduled Care North
125
66
4
35
31
Unscheduled Care South
102
62
2
16
45
0
50
100
150
200
250
300
No Harm
Low Harm
Moderate
Near Miss
Harm Not Related To NEAS


Trust Sickness
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
01-Apr-21
01-May-21
01-Jun-21
01-Jul-21
01-Aug-21
01-Sep-21
01-Oct-21
01-Nov-21
01-Dec-21
01-Jan-22
01-Feb-22
01-Mar-22



12.6 Given the above figures it is difficult to attribute causality between the impacts of Covid on the Trust emergency operations and adverse impact upon patient care, during the reference period as compared to the past 12 months in which demand and hospital handover delays have significantly impacted ambulance operations regionally and nationally.

13.0 Staff Welfare

13.1 As I have previously detailed, information to staff was available through the Trusts intranet site on the Covid-19 'Help Hub', providing ongoing advice on support groups, self-help, mental health and wellbeing, occupational health and counselling services. Managers remained in regular contact with staff through welfare calls and Microsoft Teams meetings. Staff were able to request a letter from the Trust stating they were a 'key worker' to access childcare through schools [HR/43- INQ000221512], and a Parental Leave Policy was in place, encompassing flexibility of shifts/working hours, emergency leave, carers leave, use of annual leave and unpaid leave (or a combination of different types of leave). Childcare provision information was also available on the intranet site - 'Siren'. For staff who were required to work from home (agile) a Display Screen Equipment and home worker assessment was revised, and equipment made available (IT and chairs) [HR/44- INQ000221513]. A task and finish group was

set up to look at a long-term plan for staff groups and agile working. Agile workers were able to work more flexibly. As discussed previously, some staff were asked to undertake alternative duties, either because they were shielding or as a result of service requirements.

13.2 Post-pandemic we have implemented proactive wellbeing calls offered to all staff, Occupational Health referrals with counselling and appointment of a psychological wellbeing adviser, development of mental health maintenance programme including a suicide toolkit and suicide awareness. We also offered referral to Occupational Health Physiotherapist and/or Occupational Health Consultant. Reasonable adjustments including extended phase return to work and alternative duties are available. Some ill health retirement and redeployment has been necessary. The long-term effects from both a physical and psychological perspective may not be known for some time, and we are continuing to assist staff to manage their symptomology as they approach Occupational Health or networks within the Trust, i.e., Able@NEAS the Trusts network for disabled employees and their allies.

13.3 NEAS also responded to the introduction of the vaccination programme, working with regional partners in the delivery of vaccinations to staff through priority access and in-house provision.

14.0 Performance

14.1 The Ambulance Response Programme (ARP) targets were implemented in 2017 for 999 responses. For Category 1 calls the target is an average response time of 7 minutes. For Category 2 calls the target is an average response time of 18 minutes, and for Category 3 calls the target is for a response of 120 minutes 90% of the time (90th Centile). Similarly, Category 4 calls have a target for response of 180 minutes 90% of the time (90th Centile).

14.2 For 111, performance is measured against the Integrated urgent care: key performance indicators. There are five primary key performance indicators for the NHS 111 service:

- Calls abandoned – less than 5% of all calls to be abandoned by the caller.
- Calls answered – 95% of all calls to be answered within 10 minutes.
- Calls warm transferred* – 75% of clinical calls to be warm transferred.
- Call backs – 75% of call backs to be made within 10 minutes.
- Clinical intervention – 30% of all calls to require clinical intervention.

* 111 and 999 calls are triaged initially by a Health Advisor. It may be necessary for calls to be transferred to a NEAS in-house clinician for further management or assessment. This can be for several different reasons including; a complex call, multiple unrelated symptoms, a refused ambulance response or a disposition ending in a the requirement for a clinician assessment. There are two ways in which these calls can be transferred to a clinician. A warm transfer involves transferring the patient's call directly to a clinician and handing this over. Alternatively, the call can be placed on the 'Clinical Stack' and a clinician will call the patient back. I would note that from 13/09/21, the Warm Transfer function was removed and all calls requiring a NEAS clinician were passed to the Clinical stack.

14.3 Core PTS targets are:

- Arrival for appointment on time 80% of the time
- Time on vehicle within 60 minutes 90% of the time
- Collection after appointment within 60 minutes 85% of the time
- Aborted journeys 15%

14.4 The Trust reviewed the use of PTS and how we could support patients and hospitals in our region. With our workforce potentially limited due to the spread of the virus, we identified three key ways PTS could continue to support our patients. These three ways were:

1. **Transport to essential clinics.** We identified twenty essential clinics across the region which must continue to run to ensure patients receive crucial treatment. This included renal dialysis clinics, chemotherapy clinics and other cancer treatments. These twenty clinics made up approximately 500-600 journeys a day.

This was approximately a quarter of our usual daily activity (approximately. 2500 daily journeys).

2. **Hospital discharges.** We redirected a number of resources to supporting planned and same day discharges across the region. This supported hospital flow across the region, and ensured patients who were well enough to go home, made it home safely.

3. **Supporting low acuity urgent transport.** We also looked to support our emergency and urgent services where possible, by safely transporting patients to hospitals who must urgently attend.

Total journeys dropped from around 2,800 per day to 1,500 from March 2020.

14.5 With regard to the Trust operational fleet on 1st March 2020, the nearest recording period for which we have a contemporaneous record is 20 March 2020, when we had 128 Dual Crewed Ambulances, 28 Rapid Response Vehicles and 214 Patient Transport Vehicles operating from a total fleet of 165 emergency ambulances and 221 PTS vehicles. On Sunday 1st March 2020 we had 3 PTS vehicles supplied by TPP's and 23 Emergency Care vehicles supplied by TPP.

14.6 The 999 calls and 111 calls made to the Trust in the full week up to 1 March 2020 are detailed below

Week Commencing 24th February 2020

999 Calls Offered*	8,022
111 Calls Offered	26,836

Cat 1 Mean	00:06:16
Cat 1 90th centile	00:10:40
Cat 2 Mean	00:22:07
Cat 2 90th centile	00:44:07
Cat 3 Mean	01:02:15
Cat 3 90th centile	02:27:41
Cat 4 Mean	00:52:34
Cat 4 90th centile	02:08:39

*Includes Emergency and Urgent calls

14.7 The 111 Integrated Urgent Care performance reporting period encompasses the month of February 2020 as detailed below:

KPI No.	Key Performance Indicator	Target	Feb-20	YTD
1	Calls abandoned	<5%	8.10%	5.61%
2	Calls answered in 60 seconds	95%	81.40%	83.63%
3	Clinician call backs in 10 minutes	50%	25.69%	23.61%
4	IUC Treatment Centre bookings	95%	73.25%	70.62%
5	UTC bookings	50%	75.90%	76.87%
6	Cat 3 and 4 revalidations	50%	29.89%	25.82%
7	ED revalidations	50%	11.07%	12.67%
8	Health Advisor self-care	15%	2.06%	0.87%
9	Clinician self-care	40%	18.71%	16.58%
10	Prescription issued	80%	90.30%	84.32%
11	DoS catch-all	<3%	0.06%	0.07%
15	Clinical Input	50%	34.74%	34.46%

The Trust operates an integrated EOC, where Health Advisors answer both 999 and 111 calls. It is not possible to separate 111 call takers only. As of 1 March 2020, our Health Advisor Gross Live Staffing across 111 and 999 was 208.6 FTE.

Our non-emergency/patient transport calls made to the Trust in the full week up to 1 March 2020 are detailed below:

Week Commencing 24th February 2020

PTS Calls Offered	7,218

On Time Arrival %	75.1%
Collection within 60 mins %	85.1%
Time on vehicle <60 mins %	91.7%

14.8 The Trust implemented a strategy to recruit volunteers to facilitate a number of roles across the organisation, engaging 168 people in some capacity. The education team developed and delivered an education package that was role specific to support their integration. Volunteers filled roles such as PTS, stores and deliveries. All volunteers had the same availability for Lateral Flow Test's and FFP3 Fit testing as required as well as all IPC training and education.

14.9 We trained additional Support services and NECSU staff in taking low acuity calls. The uptake of those staff for additional shifts was minimal as they could not always be available for shifts, and some had a change of mind once they had been in for a shift as the role was difficult.

14.10 We also trained some staff (support) to work on the logistics desk to manage our safeguarding process and vulnerable patients and referral to social services teams for assessment. This did work well when we got the support as it allowed us to remove our dispatch trained staff back to the desk to allocate ambulances. This was effective especially when the staffing was low due to infected staff unable to attend work.

14.11 ARP response times initially reported improvements through Q1 2020/21, because of reduced demand and an increase in both Hear & Treat and See & Treat, with patients showing a desire not to put additional pressure on hospitals as well as fear at admission and potential nosocomial spread. Capacity

increased with statutory and mandatory training stood down, low levels of abstractions for leave and sickness and additional third-party vehicles in place. All response time standards were achieved April 2020 – July 2020, with the exception of C2 mean.

14.12 Response time performance from July 2020 began to deteriorate, with staff sickness rising particularly in the winter months with the second wave, increased downtime from enhanced vehicle cleaning and increased job cycle time from reductions in See & Treat rates and longer on scene times. C1 mean continued to be achieved until June 2021 and C1 90th centile was achieved throughout March 2020 – June 2022, however from July/August 2020 all other categories became increasingly challenged.

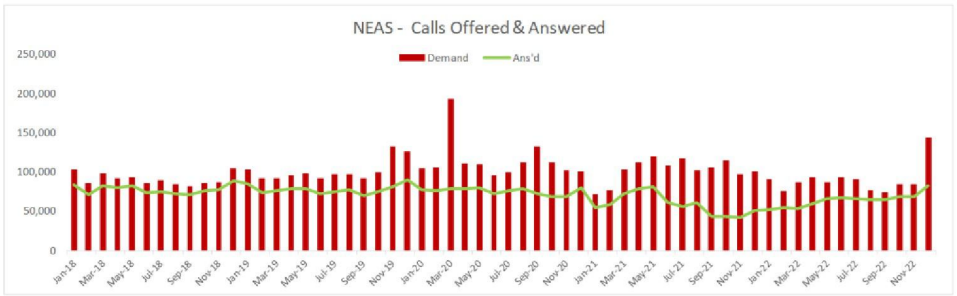
14.13 Response time performance from July 2021 onwards became increasingly challenged, despite maintaining higher levels of capacity through additional third-party provision. While overall face to face demand was controlled through demand management policies, the acuity of demand increased with both C2 and particularly C1 volumes increasing putting pressure on response times. Further pressure came from hospital handovers which increased significantly from July 2021 and remained high.

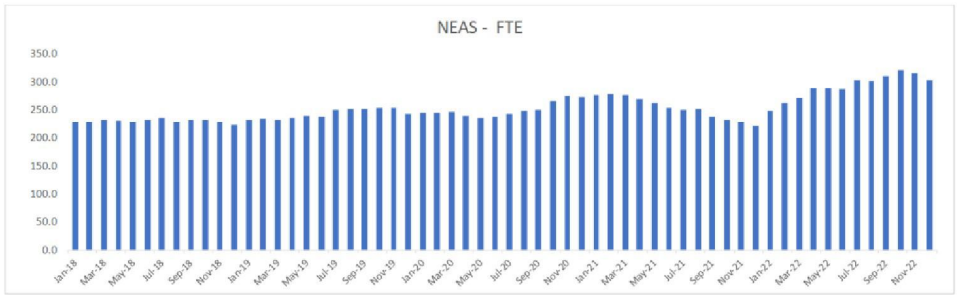
14.14 Call demand for 111 significantly increased in March 2020 leading to deterioration in call answer and call abandonment rate. Following a slight recovery through Q1 and Q2 111 call performance began to further deteriorate, linked to increasing sickness absence and Covid outbreaks in EOC in January 2021.

14.15 Call demand for both 999 and 111 increased through 2021, impacted by out of area calls and additional support provided to other Ambulance Trusts and 111 providers. Due to our integrated EOC model, the increase in pressure from 999 also impacted deteriorating call performance for 111. Reductions in staffing through Q3 2021/22 further increased pressure on the service.

14.16 Reductions in 111 demand from the end of 2021 and throughout 2022, along with increased Health Advisor staffing levels has supported improvements in call answer performance for both 999 and 111.

Demand		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2018	Calls	102,932	85,467	97,997	91,630	93,670	84,924	88,938	83,866	82,105	86,045	87,142	104,447	1091181
	FTE	229.1	229.3	232.6	229.8	229.1	231.9	235.5	228.5	232.3	231.7	228.1	222.8	
2019	Calls	103,600	91,802	92,147	95,067	98,134	92,359	97,095	97,262	91,624	99,803	132,800	126,617	1220329
	FTE	231.4	234.6	232.2	236.5	238.4	237.4	249.1	250.8	251.6	252.6	253.3	242.8	
2020	Calls	104,303	105,151	192,475	111,201	109,204	96,028	100,030	111,863	132,439	112,654	101,774	100,646	1379788
	FTE	244.6	244.0	246.1	239.4	235.9	237.0	242.2	248.0	250.7	265.2	275.3	272.3	
2021	Calls	71,774	76,508	103,371	112,379	119,270	107,871	117,227	101,811	105,723	114,090	96,736	100,580	1229361
	FTE	276.8	278.4	276.9	269.5	261.4	253.0	250.1	251.5	237.7	232.9	229.3	221.2	
2022	Calls	90,498	75,115	87,394	93,720	86,696	92,800	90,107	76,560	73,539	84,884	84,056	143,998	1081389
	FTE	247.6	261.4	270.8	288.2	288.9	287.2	302.7	300.9	310.5	320.2	314.7	303.7	





14.17 As hospital appointments and clinics were cancelled March/April 2020, PTS Key Performance Indicators saw an immediate improvement linked to the reduction in demand. As demand has increased through 2020 and 2021 with the easing of restrictions, PTS performance has reduced.

Same day journey rate increased in 2020, impacted by reductions in planned appointments, this has now returned to pre-pandemic levels. Patient mobilities for PTS were also impacted by the pandemic, with journey case-mix becoming more complex with increased low mobility patients.

14.18 The "Stay home, save the NHS, protect lives" campaign launched 23 March 2020, and this was replaced on 10 May 2020 by a new campaign, "stay alert, control the virus, save lives" as lockdown restrictions were eased. On 4 January 2021, "Stay home, save the NHS, protect lives" messaging was re-introduced as part of the third national lockdown (following a tier of restrictions applied locally and varying between regions) and then from 8 March 2021 lockdown measures started to ease, through to autumn of 2021.

14.19 Reviewing the data available to the Trust, it would appear that the reduction in demand for ambulance response and improvement in ARP coincide with the initial 'stay home' campaign. However, call demand in 111 increased during this period, suggesting some patients still sought health advice through this route. The Trust collected no data regarding patient attitude to the campaign or the health effects of changing patient behaviors. Clinical Incidents during these periods have been detailed above.

15.0 Infection Prevention and Control

15.1 During the Pandemic IPC Guidance was issued in the form of Patient Care Updates (PCU's) electronically and Alerts via Ulysses (Incident and risk management system). Further communication with the Trust staff was via Siren including the daily bulletin. All PCU's and Alerts were formulated by the IPC Team (Manager) from information received from the Government, NHS England, UKHSA or the National Ambulance Service Infection Prevention and Control Group (NASIPCG). As information or direction from the Government/NHSE/UKHSA was received the IPC Manager would inform the Strategic Cell and present a draft PCU/Alert for consideration by the Trust. PCU's and Alerts were signed off by the Director of Infection Prevention & Control or the Deputy Director of Infection Prevention & Control.

15.2 The Trust IPC Manger was a member of the National Ambulance Service IPC Group. This group met via Microsoft TEAMS meetings twice weekly and discussed published guidance from the Government/NHSE and UKHSA. The NASIPCG has IPC Lead representation from all ambulance services in England, Scotland, Wales and Northern Ireland and the sharing of local experience of the evolving situation with Covid was supportive when formulating the Trust IPC guidance and consensus with the group was sought to ensure all ambulance services were applying national guidance. The chair of the group represented the NASIPCG at a national NHS level and provided feedback and insight into NHS decision making when ambulance service sector guidance was included in NHSE IPC Guidance; the group had consideration and input through draft copies being shared.

15.3 At the inception of the pandemic Covid was classified as a HCID and the Trust published a PCU 0169 [HR/45- INQ000221514] Wuhan novel coronavirus on 22/01/20 based on UKHSA (formally PHE) guidance and the National Ambulance Service Infection Control Group. PCU 0173 issued 07/02/2020 [HR/46-INQ000221515] provided information instructing staff that IPC full level 3 PPE precautions and decontaminating equipment and vehicles including floors and with chlorine was required after transport of every case/suspected case. As Covid cases increased the government updated their guidance frequently including case definitions Government/UKHSA updates were received into the trust including to the IPC Manager who informed the Trust Strategic cell of all Government/UKHSA updates, and the Trust guidance was updated accordingly. The Trust updated the IPC PCU's in line with the evolving situation and as directed by the Government and NHSE. PCU 0176 [HR/47- INQ000221516] states -

This guidance has been provided by the National Ambulance Service IPC Group, in consultation with NHS England/ Improvement, Public Health England, Scotland, Wales & Ireland and the National Ambulance Resilience Unit (NARU). This guidance is for suspected cases of COVID-19 where an emergency ambulance response is required. If the patient is a confirmed case, then refer to

the relevant HCID guidance for confirmed cases, confirmed cases will be transferred by HART.

15.4 Covid was declassified as a HCID on 19th March 2020, but was still considered by the World Health Organisation as a Public Emergency and the UK government on 26th March 2020 locked down the whole of the UK. On 3rd April the Government / NHSE / UKHSA published IPC Guidance for NHS Acute trusts which identified Covid as having sustained transmission in the community. The trust acknowledged this progression and updated the Covid PCU 0186 for all service lines Unscheduled Care and Scheduled Care accordingly. As Covid case definitions changed the Trust responded by publishing this information in updated PCU's for example 18/05/2020 PHE advised loss or change of normal sense of taste or smell should be included in the case definition (PCU 0194 for Scheduled Care [HR/48- INQ000221517] and PCU 0197 for Unscheduled Care) [HR/49-INQ000221518].

15.5 Agile working commenced in March 2020 with all non-essential workers working from home this protected the workforce by allowing them to isolate during lockdown and also protected essential call handlers in EOC having more space and less personnel in buildings.

15.6 AACE issued guidance for working safely during Covid 19 for non-clinical areas, version 1 published 10th June 2020 and updated throughout 2020, including version 4 published December 2020. THE TRUST response was led by the Health and Safety Group to implement safe working practices in EOC, ambulance sites (education facilities) and ambulance stations. Initially a task and finish group was formed with an implementation plan. The IPC Manager supported this work by supporting the Health and Safety Team with inspections of EOC areas, identifying risks, measuring desk spaces to ensure they were two metres apart and by advocating screens were put in place. COVID checkpoints including non-touch thermometers were installed at the entrance of all large sites. All other sites had Covid checkpoint information at entrances without a thermometer. All ambulance stations were to have a Covid secure assessment to denote the footprint and walkways of the building; rooms were assessed as to

how many people they could accommodate safely, and signage provided, as well as information posters, including advice to increase hand hygiene and wearing of face masks.

15.7 During the Summer months of 2020 although the UK came out of lockdown, the North East of England had restrictions during this time – the IPC Guidance at the Trust did not change as it was thought there was considerable community transmission based on local Covid Prevalence rates.

15.8 As Covid rates began to rise again (second wave) universal face mask wearing was being advised by NHSE and Department of Health and Social Care; the Trust issued PCU 0207 [HR/50- INQ000221519] on 20 /11/2020 stating:

The use of facemasks (for staff) and face coverings (if tolerated by the patient/individual) is recommended in England and Scotland, in addition to social distancing and hand hygiene for staff, patients/individuals and visitors in both clinical and non-clinical areas to further reduce transmission risk.

15.9 The Trust IPC Guidance remained the same during the following waves until January 2022 when PCU 0218 [HR/51- INQ000221520] was issued allowing for distancing to be reduced from 2 metres to 1 metre as advised by NHSE/UKHSA/NASIPCG on 25/11/2021.

15.10 On 14th April 2022, AACE, NASIPCG - reporting to ambulance Quality Improvement, Governance and Risk Directors (QIGUARD) and approved by the UK National Infection Prevention & Control Cell led by NHSEI - published direction relating to post pandemic phase and stated:

There is no longer a requirement to undertake physical distancing in any setting.

15.11 The Trust published PCU 0220 [HR/52- INQ000221521] and PCU 0221 [HR/53- INQ000221522] in May 2022 considering the AACE direction and advised completing risk assessments for all patients to maintain distancing for confirmed or suspected cases and advised risk assessments to determine the transport of

vulnerable patients immunosuppressed/immunocompromised should continue. Universal face masking for staff and patients was still being advised.

15.12 As part of the step-down approach the Trust was undertaking due to low Covid prevalence rates throughout the whole of the North East of England PCU 0224 [HR/54- INQ000221523] was issued in June 2022 which stepped down:

- Level 2 PPE for all patient contacts
- Universal FRSM wearing in cabs, the Trust sites and with non- infectious patients.
- Daily cleaning regime has been stepped down to exclude ceilings, walls, and cab area.

15.13 At the inception of the pandemic the Trust along with all other ambulance services did not take microbiology swabs or had systems in place to order, record and report results. Initially a system was set up working with local acute NHS Trusts laboratories for the HART Team to take PCR swabs for the Trust staff and the COVID Cell to book test appointments and record results on an excel document. This developed into a digital database which could generate daily reports for PCR and LFT testing.

15.14 Government Guidance published by NHSE was fluid with changing rules for isolation of positive staff and contacts and tracking and tracing of positive staff and patients. The Trust only managed staff as an ambulance service and did not undertake patient testing. The legal responsibility for reporting tests lay with the clinician/service provider ordering the test. Standard Operating Procedures/Alerts for staff who were a contact of a positive case were agreed by the Strategic Cell to manage staff with Covid symptoms and when they were asymptomatic (but had a temperature). The IPC manager worked closely with NASIPCG, NENCIPC Group, Strategic Command and HR leads to ensure national guidance for NHS workers was implemented in a timely manner.

15.15 In the second wave October 2020 the first staff Covid outbreaks were identified at the Trust. Pallion Ambulance Station 02.10.2020 and Gateshead Ambulance

Station 04.10.2020. Outbreak management followed the new 'Communicable disease Outbreak Policy' and there is good evidence from Outbreak meeting minutes that the Trust Operational Leads were involved, and outbreak management included Estates, Occupational Health, Communication Team, Health & Safety as well as IPC. Initial lessons learnt included staff transmission in rest rooms and cab areas when crew had worked together. Annual Reports document all the outbreaks at the Trust during the pandemic [HR/55-INQ000221524], [HR/56-INQ000221525].

15.16 In January 2020, whilst Covid was classified as a HCID, response was via HART who decontaminated vehicles on HART site at Russell House following the Trust IPC and NARU guidance for Wuhan/Covid. As cases increased and emergency vehicles were being utilised to transfer suspected/confirmed cases NASIPCG /NHSE guidance was implemented which detailed cleaning requirements for suspected and confirmed cases and for cases where AGP's had been carried out on the vehicle. This advice was issued by the Trust in PCU's. The Trust initially followed all UKHSA and NARU/ NASIPCG guidance regarding decontamination of equipment and vehicles using chlorine-based products and decontamination of floors after every confirmed or suspected case as documented in PCU 0173 [HR/46- INQ000221515], PCU 0175 [HR/57- INQ000221526], PCU 0176 [HR/47-INQ000221516] and PCU 0178 [HR/58- INQ000221527] to facilitate decontamination of vehicles. When it was identified, emergency crews were also responding to suspect COVID cases, PCU 0175 [HR/57- INQ000221526], issued 28/02/2020 documented which hub stations could be used to decontaminate vehicles.

15.17 As the first wave gained momentum and Covid cases increased delayed response times were noted, in part due to vehicles being delayed at hub stations to facilitate cleaning after every suspected or positive case. The Covid Strategic Cell decided to introduce a daily enhanced vehicle cleaning including floors. Between patients' decontamination of vehicles floors was no longer required, unless AGPs had been performed or the floor was soiled. PCU 0181 25/03/2020 [HR/59- INQ000221528] and PCU 0186 [HR/60- INQ000221529] issued 04/04/2020 document a daily enhanced clean of vehicles. It was noted

that this was not in line with NASIPCG Guidance which still stipulated a floor clean after every suspect or confirmed case. When this guidance was first introduced vehicles were going to hub stations where Chlor-clean was available to clean their vehicles, but this was found to be having a serious effect on response times. A decision was taken by the Strategic Cell, after discussion with the IPC Manager, to reduce the cleaning of vehicle floors to daily and have Chlor-clean at all stations. Operational Alerts were published to provide information to support crew with vehicle decontamination. An investigation into the use of chlorine was commenced led by the Health and Safety Team due to adverse events including three staff members having serious reactions to chlorclean which was being used to clean vehicles and sites, as advised by national guidance NASIPCG and NHSE. In September 2020, chlorclean was withdrawn from THE TRUST sites and a disinfectant Steri 7 X was introduced which was risk assessed and deemed the equivalent to chlorine. The Trust IPC and Health and Safety Team had collaborated with Yorkshire Ambulance Service who were using Steri 7 X to decontaminate vehicles and sites without any adverse events reported.

15.18 Specific instructions and modification of some vehicles for Schedule Care (PTS) to transport suspect and positive patients being discharged from hospital was issued in April 2020, including instruction that crew and patients should wear face masks and ventilation increased by opening windows. Specific measures to allow for 2 metre distancing on vehicles were undertaken for all vehicles that may transport more than one patient during Scheduled Care journeys (PTS Services which included 3rd Party and Volunteers). The IPC Manager worked with Scheduled Care Operational Leads and the Risk team to risk assess and measure vehicles to ensure 2 metres distancing was in place on vehicles that transported more than one patient. PCU's 0193 [HR/61- INQ000221530], PCU 0194 [**HR/48 - INQ000221517**] were published that included IPC measures to be taken including: screening of patients, face mask wearing for patients and crew, distancing, decontamination including after patient cleans and daily cleans. Operational Alerts were published to support Scheduled Care staff and clarify changing information, for example Operational Alert 109 Transporting of positive Covid patient [HR/63- INQ000221532]. Bulkheads were fitted on all the Trust

vehicles which required them to separate drivers from patients. Temporary bulkheads were fitted on all the Trust, third party and volunteer cars.

16.0 Personal Protective Equipment/Respiratory Protective Equipment (PPE/RPE)

16.1 Existing health and safety guidance/legislation issued by the Government and other national organisations such as Health and Safety Executive and NHSE underpinned the standards of PPE/RPE [HR/64- **INQ000269542**]. The Trust issued guidance in line with the relevant guidance/legislation and continued to monitor/develop PPE/RPE and information/instruction/training/supervision to staff.

16.2 Internally, the Trust changed Standard Operating Procedures (SOP's) and information guidance documents rapidly because of continuous changes in information provided by the government. This meant staff had to acknowledge and filter new information more frequently than should have happened, this frustrated managers and staff both on the front; line and supporting services who interpreted said guidance into local documents.

16.3 On 22nd May 2020, a Microsoft teams meeting was held to consider the Trusts strategic response to PPE shortages The meeting was specifically arranged to consider potential shortages of PPE and possible contingencies/mitigation if demand outstripped supply of key items of stock. At that time the Trust had sufficient stocks of all PPE, with a minimum supply of 3 months' stock for all items.

16.4 During the discussion it was identified that should there be supply issues with FFP3 face masks for the Trust then the national guidance would be to use FFP2 face masks. We are unable to source FFP2 masks as they are part of the national stock of push items and therefore controlled centrally. It was also identified that health and safety (H&S) legislation requires fit testing of FFP2 masks when used in these circumstances (i.e., for AGP's).

16.5 It was identified on the Strategic Covid-19 call on 6th June 2020 that we had been notified that we would not be receiving further supplies of 3M 1873V FFP3

masks and 3M were no longer producing this model. Prior to this, we had seen a reduction in the 1873V masks received on push pallets but had no prior indication from NHS Supply Chain that this mask was about to run out. We had approximately 70% of frontline staff fit tested and supplied with this type of mask. As of June 6th, we had a 3-week supply (based on usage) of these in stores, with procurement attempting to source any remaining stock from other Trusts (via mutual aid) to extend this period if possible.

16.6 We did have approximately 10,000 of 1863 FFP3 masks, however these masks tended to have a higher fit test failure rate as they are un-valved and require more effort to breathe. Staff would have needed to be fit tested to these masks if the decision was made to use these. Feedback from staff during fit testing was that they do not fit comfortably, with some experiencing difficulty in breathing when using them. These masks were used by other Trusts as the predominant mask sent on push pallets, but it was apparent that other organisations have experienced similar problems. The Covid pandemic triggered immediate and widespread demand for PPE; ranging from FFP3 masks, to sanitising hand gel, Type IIR surgical masks and beyond. All of these products were previously available via NHS Supply Chain or direct from suppliers. Due to the pandemic, demand for these products was understandably raised to global level, and as such the Government enacted national contingency to take control of supply and sourcing activity on behalf of the public sector. Via the Dept of Health/NHSE, it was decided that the supply and delivery of this PPE was to be separated from day-to-day consumables supply, and all PPE products were withdrawn from NHS Supply Chain. This established a secondary supply route into Trusts, predominantly provided by a private logistics contractor (Clipper Logistics) and was labelled as a 'push pallet' service.

This push pallet service was ultimately charged with the distribution across the UK of the large quantities of PPE sourced via Government led contracts, and to relieve pressure from NHS Supply Chain to ensure the supply of business-as-usual products could continue as far as possible. Use of the term 'push pallet' is apt in this scenario as quite literally PPE stock was pushed out to Trusts and into regions as quickly as possible in the first 6+ months of the pandemic, whether the product or quantity reflected actual need or if delivered to the right location or not.

For example, Trusts at the time may have been short of type IIR surgical masks, but a delivery of clinical waste bags or surgical gloves would appear instead. It was also evident in the first six months of the push pallet service that Clipper Logistics did not have the same prior knowledge of the extensive NHS delivery network or delivery locations, nor understanding of the operating hours or storage limitations of Trusts. This proved difficult to ensure appropriate integration into Trust supply networks in the short term, and there were widespread missed deliveries, drivers becoming lost and unfamiliar with geography and Trusts receiving deliveries meant for others. On several occasions deliveries were so delayed as to arrive days later, for example at 2-3am at weekends, with on call staff having to attend unmanned sites to take in deliveries.This disconnect was eventually resolved by weekly stock submissions by Trusts to NHSE to confirm current stock holding and required products/volumes. This provided much needed data to allow effective planning by Clipper Logistics, and improvements to the push pallet service were achived month by month.

Note - although the rationale to separate the PPE supply was understood, this discounted the existing and well-established supply lines used by NHS Supply Chain which could (and perhaps should) have been supplimented with additional resource to take on PPE deliveries. Without this, Clipper Logistics appear to have entered the NHS support network without prior knowledge or preparation and short to medium disruption may have been avoided.

16.7 It was suggested by Trust H&S staff that we should consider sourcing/procuring re-usable FFP3 rated half masks. Re-usable half masks also provide benefits such as:

- Personal issue to staff – more care taken, improve moral due to perception of better equipment.
- Less waste therefore positive environmental impact.
- Medium to long term cost improvement – re-usable last longer even though slightly more expensive on initial purchase (£25 per mask, filters are £6 each).

- Reduces costs for waste disposal.
- Avoids future supply issues for disposable FFP3 or FFP2 face masks.
- Future proof for use out with pandemic i.e., use at road traffic collisions, other environments whereby staff need respiratory protection.
- The Scott Aviva half masks were available in small, medium, large sizes therefore fit testing likely to be achieved.

16.8 The look of the Scott Aviva half mask was akin to use in industry, rather than healthcare and could be seen as frightening to patients and carers, however it was acknowledged that the use of the masks would be for AGP's and as such the patient would be critically ill in most cases and as such the impact of this is likely to be superseded by the priority to have clinical staff on scene providing assessment and treatment for the patient. It was also felt that the public were now familiar with the use of PPE by healthcare professionals and a positive communication plan could be produced to inform the public of the provision of this type of half mask.

16.9 Extensive work was undertaken to ensure there was a SOP [HR/65-INQ000221534] in place and that decontamination of the equipment could be undertaken safely. This required additional works carried out in the following stations:

· Pallion
· Blucher
· Ashington
· Chester-le-Street
· Newton Aycliffe
· Coulby Newham

16.10 Only those staff who had failed FFP3 mask fit testing were provided with a respirator hood. Key leads from IPC, H&S and Operations identified that the use of powered respirator hoods provide FFP3 level protection, however there were inherent risks associated with using this type of equipment, rather than FFP3 masks (disposable / reusable). These were:

- Delay in treating patients whilst donning the equipment, when time is critical.
- Increased risk of transmission to staff member / others when doffing.
- Increased risk of transmission to staff member when disinfecting these.
- Increased time to use & maintain the equipment – equipment checking / battery maintenance / time to don equipment.

16.11 To avoid potential supply challenges for FFP3 protection, it was proposed that we procure 2000 re-usable half masks (Scott Aviva). These would be mostly medium size 1700, 150 small and 150 large. This is due to the different face shapes/sizes of staff which is reflected in the current fit testing results. In addition, we procured replacement filters to maintain good stock levels to mitigate any supply challenges.

16.12 Prior to the Covid pandemic, the Trust had undertaken fit testing and issued PPE and RPE to operational staff in line with legal requirements. The PPE/RPE was compliant with the relevant International/European standards and procured via approved suppliers. As the pandemic developed, the Trust expanded the range of FFP3 masks to ensure resilience of supplies, this was in line with existing practice. As time progressed a risk-based decision was made to transition into re-usable FFP3 masks to mitigate the supply and demand risks. This move included the expansion into using Power Air Fed Purifying Equipment (hoods) for those who failed fit testing of FFP3 disposable and reusable masks. This included consultation with staff groups, leadership teams and other partners such as suppliers and other safety practitioners. Operational staff have been issued with personal issue PPE/RPE which continues for new starters as part of the 'fit testing' regime. The education team took over the FIT testing of staff and developed a section in ESR (Electronic Staff Record) to record all Fit tests for staff which meant the Trust were able to confidently produce reports on the exact date the FIT test was completed, to what mask types and when it was due for retesting. In addition to this the Trust purchased two PortaCount machines to allow us to fit test to the highest standards. Compulsory shaving was introduced.

16.13 The Trusts health and safety team worked in partnership with colleagues in the procurement team, education and training team, operational teams and various

other key stakeholders. The co-design process included groups of individuals by reference to age, sex, race, disability, pregnancy and other relevant physical characteristics such as wearing glasses or beards. Generic and individual risk assessments were undertaken as necessary and/or when any potential risks emerged.

16.14 Overall, the Trust reacted dynamically to changes in local/regional and national developments. Due to the partnership approach adopted the Trust took a proactive approach to PPE/RPE which included the transition to re-usable RPE with a view to the potential longer-term impact of supplies. This provided multiple benefits such as legal/financial/moral as well as the sustainability/environmental benefits.

17.0 DNACPR

17.1 As an Ambulance Trust we did not get involved in issuing DNACPR's, this being predominantly an activity for Primary Care, Community and Acute Trusts. If an ambulance crew responded to a patient in cardiac arrest, they would follow the guidance and protocols detailed within the JRCALC based upon the Resuscitation Council UK Guidance, for End-of-Life Care and Resuscitation. Clinicians are aware that the presence or absence of a DNACPR order must not direct treatment options or discussion in a patient who is actively dying, and that a DNACPR is not a legally binding document, but it is a decision support tool to help guide clinicians as to whether CPR is appropriate. There have been no concerns raised with the Trust about increase in numbers or characteristics of DNACPR notices.

18.0 Learning

18.1 The Covid-19 pandemic has had a significant impact upon the NHS locally and nationally. Ambulance services played a vital role in supporting the public and the health system during this period, by the continuation of good levels of response to those most in need and working flexibly with partners in areas such as hospital discharge, maintenance of essential clinics, staff testing and then the vaccination programme. The 111 service saw unprecedented demand at times and had to

cope with changing advice and guidance for the public. The rate of guidance disseminated centrally was often challenging to interpret, assimilate and disseminate to staff, but as a Trust and as an ambulance sector, I feel this was handled well.

18.2 Following the first year of the pandemic response NEAS commissioned AuditOne to undertake a review of the Trusts response [HR/66- INQ000221535]. The auditors found that pre-pandemic the Trust was well positioned in terms of its experienced operational senior leadership team, its Business Continuity and EPRR processes and the support from the Executive team and Trust Board. They did however identify a culture of non-compliance in relation to aspects of the Trusts preparedness, including non-compliance of EPRR national standards, attendance at EPRR training events and long overdue actions on the EPRR action log. The Trust has made efforts to address each of these issues through new governance processes for monitoring national standard compliance, Commander training and exercising, and scrutiny of action logs. The Trust has also included a section in its Major Incident Plan covering 'enduring' incidents, such as experienced with Covid, including explicit responsibility for standing up command and control for such incidents.

18.3 NEAS moved the first UK COVID-19 patients in January 2020. Operational managers reviewed the learning and sought to amend Business Continuity plans to help ensure that the Trust was best placed to respond to the expected wave of COVID activity.

18.4 The pandemic accelerated remote working practices, which has brought challenges on a technical level as well as adapting how support is offered to colleagues, but which has brought advantages for many of our non-frontline staff who have found a greater flexibility introduced to their work/life balance. The degree to which staff at all levels were prepared to adapt to new working practices, at times being displaced in areas of the Trust to which they had not previously worked, was also admirable.

18.5 Early implementation of Command and Control and the establishment of the SCG and TCG enable a coordinated response to the challenges of the pandemic, and a responsivity in decision making which was vital to the continuation of both the core services offered by the Trust but also the safety of our staff. The initial learning highlighted the need for a separate roster to cover on-call command requirements and those of the SCG, and the inclusion of appropriate subject matter experts when required.

18.6 Plans for the response to any future pandemic revolve around the Trusts Strategic Planning Framework: Pandemic Influenza & High Consequence Infectious Disease (HCID), which details the Trust response to future pandemics, and the assumptions they are based upon. The NENC Integrated Care Board Emergency Planning Resilience and Response function would co-ordinate health response, in conjunction with the Local Health Resilience Partnership. The Local Resilience Forum would stand-up SCG and TCG's to co-ordinate multi-agency support. NHS England EPRR Regional Team would then be the point of co-ordination to the wider health system in region and country. Pandemic and EPRR Training will be delivered to the on-call managers on their twice yearly CPD Sessions. This will start in 2021/22.

18.7 Internally there has also been a plan drafted to enable the co-ordination of staff redeployment to alternative functions in support of operational delivery, based upon the learning of the pandemic [HR/67- INQ000221536]

18.8 The half-mask FFP3 will continue to be used in trust and the fit testing process continued. Daily cleans of vehicles continues, as does adherence to changing RPE guidelines as they relate to Covid.

18.9 We continue to learn about how to best support our staff members identified with Long-Covid and promote vaccine uptake to all staff groups.

List of Acronyms

Advanced Medical Priority Dispatch System	AMPDS
Aerosol Generating Procedures	AGP
Ambulance Response Programme	ARP
Association of Ambulance Chief Executives	AACE
Black, Asian and Minority Ethnic	BAME
Category 1	C1
Category 2	C2
Category 3	C3
Category 4	C4
Clinical Assessment Service	CAS
Clinical Care Manager	CCM
Clinical Operations Manager	COM
Clinical Safety Plan	CSP
Command and Control	C2
Communications Support Officer	CSO
Chief Operating Officer	COO
Dual Crewed Ambulance	DCA
Demand Management Plan	DMP
Emergency Department	ED
Emergency Operations Centre	EOC
Equality Analysis Assessment	EAA
Hazardous Area Response Team	HART
Health and Care Professions Council	HCPC
High Consequence Infectious Diseases	HCID
Incident Coordination Cell	ICC
Infection Prevention and Control	IPC
Integrated Care Board	ICB
Integrated Urgent Care	IUC
Interactive Voice Response	IVR
Joint Royal Colleges Ambulance Liaison Committee	JRCALC
Local Resilience Forum	LRF
Manchester Triage System	MTS
National Ambulance Coordination Centre	NACC
National Ambulance Resilience Unit	NARU
Newly Qualified Paramedic	NQP
North East Commissioning Support Unit	NESCU
Patient Transport Service	PTS
Patient Care Update	PCU
Resource Escalation Action Plan	REAP

Rapid Response Vehicle	RRV
Resource Scheduling Department	RSD
Strategic Co-Ordinating Group	SCG
Tactical Co-Ordinating Group	TCG
Third Party Providers	TPP
Work Force Management	WFM

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

18.08.2023

Dated: _____