Witness Name: Daren Mochrie

Statement No.: 1

Exhibits: **DM/1, DM/2, DM/3, DM/4, DM/5, DM/6, DM/7, DM/8**

Dated: 23 August 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DAREN MOCHRIE

I, Daren Mochrie, will say as follows: -

1. I am the Chief Executive Officer (CEO) of North West Ambulance Service NHS Trust (referred to hereafter as "NWAS" or "the Trust"), a role I have held since 2019. I have worked within the NHS for the past 35 years, 32 of which have been within the Ambulance Sector. I am a Registered Paramedic and hold a Master's Degree in Business Administration from Napier University, a Diploma in Immediate Medical Care from The Royal College of Surgeons and an Honorary Doctorate in Health Care. In addition to my role within NWAS, I am the Chair of the Association of Ambulance Chief Executives (AACE) and in 2013 was awarded the Queens Ambulance Medal for my distinguished service to the sector.

2. I produce this statement in response to a request received on behalf of the Rt. Hon Baroness Heather Hallet, Chair of the UK Covid-19 Public Inquiry, dated 30 March 2023 pursuant to Rule 9 of the Inquiry Rules 2006.

3. To assist me in producing this statement, I have sought advice and assistance from various departments within the Trust who have in turn provided information to me that has formed part of the contents contained herein.

4. Reference within this statement to the "Relevant Period", is reference to the period of time between 1 March 2020 and 28 June 2022. The matters contained within this statement will focus upon that which occurred within the Relevant Period, unless stated otherwise.

5. I firstly want to take the opportunity to offer my sympathies and condolences to those families who lost loved ones during the pandemic and to those who continue to be impacted by it.

A: STRUCTURES, ROLES, PEOPLE AND PROCESSES

Organisational Structure of NWAS

6. North West Ambulance Service NHS Trust was established on 1 July 2006 following the merger of the Cumbria, Greater Manchester, Lancashire and Mersey regional ambulance trusts. One of the largest ambulance trusts in England, NWAS provides services to a population of around 7.5 million people across a geographical area of approximately 5,400 square miles.

7. NWAS employs just over 6,300 staff who operate from over 100 sites across the region and provide services for patients in a combination of rural and urban communities, in coastal resorts, affluent areas and in some of the most deprived inner-city areas in the country. NWAS also provide services to a significant transient population of tourists, students and commuters.

8. NWAS' core services are delivered through four distinct service lines. These are:

   - Paramedic Emergency Service (PES) – Through solo responders, double crewed ambulance response and volunteer community responders we provide a pre-hospital care emergency response to 999 and urgent calls.
   - Patient Transport Service (PTS) – PTS provides essential transport for non-emergency patients in Cumbria, Lancashire, Merseyside and Greater Manchester who are unable to make their own way to or from hospitals, outpatient clinics and other treatment centres. PTS services for Cheshire are provided by West Midlands Ambulance Service NHS Trust.
   - Resilience – Services associated with NWAS' statutory responsibilities under the Civil Contingencies Act 2004.

- NHS 111 – NWAS delivers the NHS 111 and urgent integrated care service for the North West region operating from 4 call centres.

9. Core service delivery is supported by a number of support service functions, including but not limited to: Finance, Human Resources and Organisational Development, Quality Improvement and Innovation, Training and Development and Transformation.

10. NWAS' PES is organised around three geographical areas; Cheshire and Merseyside, Cumbria and Lancashire and Greater Manchester, thus ensuring that our services reflect local community needs. Strategic capacity and support services are provided centrally from the Trust's headquarters in Bolton with managers/teams based in each area to provide local support.

11. NWAS have 7 contact centres delivering our core services in 999, NHS 111 and PTS and has 2 Hazardous Area Response Teams (HART) trained to the national standard in specialist equipment and skills. These teams are used to safely access and treat patients in difficult and hazardous conditions and are linked to the National Ambulance Resilience Unit (NARU).

12. NWAS has one of the largest and longest established Community First Responder (CFR) schemes in England, with some 800 active CFRs operating across all areas of the North West, providing an effective, complementary service in their local communities. CFRs are volunteers who live and work in local communities, they are trained and activated by NWAS to attend certain calls, such as chest pain or cardiac arrest, where time to respond is critical and can make the difference between life and death. During the pandemic, CFRs gave more than 110,000 hours delivering much welcomed refreshments to busy staff at hospitals, distributing PPE to our stations and at our own vaccination centres.

13. Volunteer Car Drivers provide invaluable support to our Patient Transport Service regularly assisting us in taking patients to and from non-emergency outpatient appointments throughout the region. Prior to the Covid-19 pandemic, there were circa 300 operational volunteer car drivers. During the period March 2020 to November 2021, a large number decided not to continue volunteering for a variety of reasons with 200 operational volunteers remaining.

14. The North West region is one of the most culturally diverse areas in England, with over 50 different languages spoken by members of the community. Consequently, NWAS places

considerable emphasis on equality and diversity and public engagement activities to ensure that our services are accessible to all members of the community. All frontline staff and call handlers, as well as NWAS' corporate functions, have access to Language Line (audio) interpretation support.

15. In 2020/21 almost 90% of the NWAS workforce were white British (89.88%) with just under 9% (8.84%) Black and Minority Ethnic groups (BME) and 1.28% not stating.

16. The impact of the pandemic, alongside world events highlighting the ongoing disproportionate impact of racism and discrimination, caused many organisations to pause and reflect on the experiences that ethnic minority colleagues face on a daily basis. In turn this led NWAS to reflect on our own efforts to support and progress the diversity and inclusion agenda and to make a step change in the experience of staff and patients.

17. NWAS also focused on risk assessments and support for those groups most seriously affected by the pandemic. In particular we had a comprehensive risk assessment process focused on age, disability, ethnic background and pregnancy which aimed to support the physical and mental wellbeing of staff.

18. The risk assessment process **[DM/1- INQ000249078]** was prepared in collaboration with the NWAS Occupational Health services. The individual vulnerability risk assessment questionnaire was developed by the national body of Occupational Health doctors and was informed by current epidemiological evidence and national and international medical data on individual factors associated with higher risk of serious ill health from Covid. It sought to eliminate the risk to an individual once infected based on a "covid score" determined by the individuals age, health conditions/risks and other demographics

19. From the end of July 2020 all colleagues who had either been medically suspended or allocated alternative duties as an outcome of the initial risk assessment process were asked to participate in an individual vulnerability risk assessment questionnaire with their line manager to re-assess their individual vulnerability and support their return to the workplace where possible.

20. The questionnaire provided a more evidenced based assessment of individual risk than earlier 'risk discussions' and contrasted with both the available understanding of Covid risk at the onset of the pandemic and the limited risk assessment initially devised and applied to our staff. Following the re-assessment, the vulnerability level of some individuals

reduced although this may have also been supported by the changes in the work environment; for example, work locations became 'covid secure', accessibility of PPE increased, and staff behaviours changed. Conversely, some vulnerability levels increased given that epidemiological evidence also identified vulnerability traits that had not previously been given much emphasis, such as Body Mass Index (BMI), those over 60 years and males. Staff who had not previously been identified as being vulnerable were then invited to undertake the individual vulnerability risk assessment questionnaire.

21. The questionnaire identified an individual score of 'covid age' which corresponded with a vulnerability level namely; low, low moderate, high moderate, high and very high. At each vulnerability level workplace considerations were provided for both clinical and non-clinical staff. The considerations included suitable adjustments and PPE type proportionate to the risk level – restrictions recommended increase the higher the covid age. Occupational Health advice was sought for those staff whose covid score was associated with the very high and high levels and where immunosuppressant disease or medication was identified.

    - Individuals who fell into the very high level were deemed to be at high risk of death if infection occurred and significant restrictions were applied – in that they should work from home. Individuals who fell into the high vulnerability level were deemed to be at high risk of becoming hospitalised and seriously ill if infection occurred; individuals in this category were to avoid patient contact and lone and/or socially distanced working was to be facilitated.
    - Individuals who fell into the high moderate category were usually able to remain in the workplace and fulfil their substantive job role providing the adjustments identified could be facilitated.
    - Individuals associated with the low moderate and low vulnerability levels were able to continue without adjustments and in adherence to the covid safety measures.

22. In cases where it was deemed appropriate for staff to return to the workplace – with or without adjustments, the managers conducted a modified return to work / action plan document. It was recognised that staff returning to the workplace whilst the pandemic continued would most likely be apprehensive and concerned. The purpose of the action plan was to address individual concerns by identifying and talking about 'risk' factors in the workplace and agree what steps should be taken to minimise risk and provide reassurance. Additionally, the process sought to address psychological wellbeing, and action required to support mental wellbeing.

23. Around August 2020, individuals born as men and European individuals aged over 60 were included in the 'at risk' category. NWAS invited all staff in those categories to undertake an online self-assessment and where potential greater risk was identified, individuals were asked to complete an individual risk assessment document and submit to their line manager to ensure the appropriate action was taken based on risk level. The individual risk assessment document was modified for the purpose of self-assessment and the guidance also amended to support individuals completing the process. Subsequently, NWAS extended the self-assessment tool to all remaining staff in NWAS who had not previously participated in an assessment of risk.

24. The Risk Assessment process resulted in the medical suspension of 246 colleagues.

25. NWAS is part of the Northern Ambulance Alliance together with Yorkshire, North East and East Midlands Ambulance Services. We are governed by a Board of Executive Directors and Non-Executive Directors who meet on a monthly basis (the Board). Patient and staff stories are heard and discussed by the Board on a regular basis to inform organisational learning and place the patient voice at the heart of all that we do.

26. NWAS was rated 'good' by the Care Quality Commission following an inspection in 2020 and this remained unchanged following a focused inspection looking at emergency and urgent response and our 999 and 111 call centres in 2022 (not a ratings inspection).

<u>Key-Decision Makers within NWAS</u>

27. The table below outlines those individuals within NWAS who were key decision-makers during the Relevant Period. Each individual was in post for the entirety of the Relevant Period unless otherwise stated.

Name	**Job Title**	**Role & Responsibilities**	**Notes**
Daren Mochrie	Chief Executive Officer Chair of the Association of Ambulance Chief	Chair – Covid-19 Executive Oversight Coordination Group	

	Executives (AACE) (*replacing Professor A Marsh as Chair with effect from July 2020)*		
Ged Blezard	Director of Operations	Covid-19 Executive Oversight Coordination Group	Acted as Deputy Chief Officer from 1 January 2022 until 30 April 2022 Chair of Operational Response
Salman Desai	Director of Strategy and Planning *(1 March 2020 – 31 March 2021)* Director of Strategy, Partnerships & Transformation *(1 April 2021 – 31 May 2022)* Director of Strategy, Partnerships & Transformation/Deputy CEO *(From 1 June 2022)*	Covid-19 Executive Oversight Coordination Group	Acted as Deputy Chief Officer from 1 September 2021 until 31 December 2021 and then again on an ad hoc basis during May 2022. Chair of Communications & Engagement
Dr Chris Grant	Executive Medical Director	Covid-19 Executive Oversight Coordination Group	Chair of Patient Safety & Clinical
Lisa Ward	Director of People	Covid-19 Executive Oversight Coordination Group	Chair of Workforce & Wellbeing

Carolyn Wood	Director of Finance	Covid-19 Executive Oversight Coordination Group	Acted as Deputy Chief Officer from 1 May 2021 until 31 August 2021 Chair of Finance, Fleet & Logistics
Maxine Power	Director of Quality, Innovation and Improvement	Covid-19 Executive Oversight Coordination Group	Chair of Regulatory Compliance & Safety
Angela Wetton	Director of Corporate Affairs	Covid-19 Executive Oversight Coordination Group	Chair of Assurance & Reporting Sub Group
Michael Forrest	Deputy Chief Executive *(1 March 2020 – 31 March 2021)*	Covid-19 Executive Oversight Coordination Group	Michael Forrest left the Trust on 31 March 2021 Chair of Business Continuity Planning (BCP) & Restoration of Normality
Stephen Hynes	Deputy Director of Operations Assistant Director of Resilience	Strategic Commander – Covid-19	
David Kitchin	Head of Service *(1 March 2020 – 31 March 2022)*	Strategic Commander – Covid-19	

Roger Jones	Head of Service *(1 March 2020 – 31 March 2022)*	Strategic Commander – Covid-19	
Dan Smith	Head of Service *(1 March 2020 – 31 March 2022)*	Strategic Commander – Covid-19	
Joe Barrett	Head of Special Operations	Strategic Commander – Covid-19	
Peter Mulcahy	Head of Service *(30 March 2020 – 30 April 2020)*	Strategic Commander – Covid-19	Peter Mulcahy returned to support during Covid. His last day was 30 April 2020.
Ian Stringer	Head of Patient Transport Services (PTS) *(1 March 2020 – 31 March 2022)* Assistant Director of Business & Performance Assurance *(From 1 April 2022)*	Head of PTS	
Dan Ainsworth	Strategic Head of Emergency Operation Centre (EOC) *(1 March 2020 – 31 March 2022)* Integrated Contact Centre Director *(From 1 June 2022)*	Head of EOC	Dan was promoted to the Integrated Contact Centre Director on 1 June 2022

Jacqueline Bell	Head of Service, 111	Head of 111	
Strategic Commanders	n/a	Strategic Commanders	The Trust operates a 24/7 strategic commander structure that covers specific areas across the region – this consists of 18 Strategic Commanders in total, 6 per geographic area.
Senior Medical Advisors	n/a	Strategic Medical Advisors on call	The Trust operates regional Senior Medical Advisors 24/7 cover
111 & EOC On Call	n/a	111 & EOC on call	The Trust operates a 24/7 on call rota that provides cover for any issues escalated from EOC and/or 111
Regional Operations Coordination Centre Tactical Commanders	ROCC Tactical Commanders	ROCC Tactical Commanders 24/7	5 x ROCC Tactical Commanders operating 24/7

28. Following the outbreak of Covid-19 in Wuhan, China and the World Health Organisation (WHO) raising the risk from low to medium, an Executive Oversight Co-ordinating Group (EOCG) was formed within NWAS separate to the weekly Executive Leadership Committee (ELC). The EOCG was chaired by me as NWAS' Chief Executive.

29. The main purpose of the EOCG was to ensure continued, fast paced, cross directorate collaboration and to ensure all Executive Directors were up to date with NWAS' position

across all immediate priorities, and if required to make recommendations to improve performance.

30. Initially, teleconferences took place on a Monday, Tuesday, Thursday and Friday and an in-person meeting immediately prior to the weekly ELC meeting on a Wednesday.

31. The table below outlines the Executive Led Sub-Groups reporting to the ELC during the Relevant Period. All Sub-Group leads were often required to take actions outside of their usual Directorate and work across Directorates to find strategic solutions to support both 'business as usual' and the response to the pandemic.

Sub-Group	**Chair**	**Chair's Job Title**
Assurance & Reporting	Angela Wetton	Director of Corporate Affairs
BCP & Restoration of Normality	Michael Forrest	Former Deputy CEO
Communications & Engagement	Salman Desai	Director of Strategy, Partnerships & Transformation
Finance Fleet & Logistics	Carolyn Wood	Director of Finance
Operational Response	Ged Blezard	Director of Operations
Patient Safety & Clinical	Dr Chris Grant	Medical Director
Regulatory Compliance & Safety	Professor Maxine Power	Director of Quality, Innovation & Improvement
Workforce & Wellbeing	Lisa Ward	Director of People

Funding

32. During the whole of the Relevant Period the Executive Team and Board of Directors remained responsible for the overall financial position of the Trust.

33. A draft breakeven financial plan, which identified how the Trust's budgets for the period 1 April 2020 to 31 March 2021 would be spent was prepared, presented, and approved by the ELC and submitted to NHS England/Improvement (NHSE/I) on 5 March 2020. This was then presented to the Trust's Resources Committee (sub-committee of the Board of Directors) on the 20 March 2020.

34. On 17 March 2020 all NHS providers received notification from NHSE/I, which included guidance on amended emergency financial arrangements for the NHS for the period 1 April 2020 to 31 July 2020, with block funding to be paid based on historical expenditure levels.

35. Subsequently, on 6 May 2020, the ELC received an emergency financial budget plan for the period 1 April 2020 to 31 July 2020, this detailed the income the Trust would receive over that period (£122 million) and the baseline expenditure budgets/costs. This was presented and agreed by the Board of Directors on 27 May 2020.

36. By having the baseline budgets approved on historical levels of expenditure, and included within our financial ledger systems, this enabled the Trust to then accurately track reasonable additional costs incurred in responding to the coronavirus outbreak. On a monthly basis the Finance Team were able to capture and report the total costs across the Trust and submit a monthly monitoring return to NHSE/I demonstrating the additional costs incurred in preparing and responding to the pandemic, which was then reimbursed to the Trust by NHSE/I by way of a retrospective top-up payment.

37. The Finance and Procurement Team also put controls and systems in place to be able to capture the costs which specifically related to Covid-19 expenditure in order to maintain accurate reporting and monitoring for the 1 April 2020 to 31 July 2020 period.

38. The NHS emergency financial regime remained in place for August and September 2020, therefore papers to approve the continuation of the emergency budgets were presented and approved by the necessary Trust committees in July 2020.

39. Prior to Covid-19 allocations being included in the financial planning process, papers continued to be presented to the ELC and Board for specific high-cost items, outside of the emergency financial plans, for example PPE.

40. From the 1 October 2020 the responsibility and funding transferred to the Integrated Care Systems (ICSs). Even though NWAS covers multiple ICSs in the North West the funding allocations were all managed through Lancashire and South Cumbria Integrated Care System (L&SC ICS). The financial envelopes allocated to each system were based on phase 3 of the national planning to resource the additional costs of the Covid-19 response and recovery, and continuing readiness for winter and a potential increase in Covid-19 cases.

41. In addition, the Trust was experiencing additional activity in relation to the NHS 111 First Programme and NHSE/I asked that all NHS 111/Integrated Urgent Care (IUC) providers increase their call handling and clinical capacity to manage the additional workload which was being generated as patients were encouraged to call NHS 111 rather than attend Emergency Departments. NHSE/I calculated the additional revenue funding required for each NHS 111 contract area and this funding was passed through to the Blackpool Clinical Commissioning Group (CCG) and onto NWAS.

42. Decisions around maintaining and increasing staffing levels were managed through the Incident Command Governance Structure and then through the Workforce and Wellbeing Sub Group. Finance membership and liaison with the operational management team was maintained during the period and any resourcing / financing implications were identified and included in the financial Covid-19 monitoring templates. Examples include the cost of buying back annual leave which increased operational capacity; agency staff in the EOC; training student paramedics and military personnel.

43. Update papers were presented to the ELC from the Workforce and Wellbeing Sub-Group, clearly identifying the projected changes in staff numbers across clinicians, call handlers and all service lines.

44. Any decisions around managing, increasing or changing the operational focus of the Trust's fleet over the emergency period were identified through the Trust's Incident Command Governance Structure, but any fleet changes or requests was routed, co-ordinated, actioned and managed through the Finance, Fleet & Logistics Executive Sub-Group. From a governance point of view papers were presented to the ELC on the 13 May 2020 for approval.

Changes to funding within the Relevant Period

45. At the start of the relevant period (1 April 2020 to 30 September 2020) the Trust requested additional funding via retrospective monthly top-up payments. This process was established by NHSE/I and monthly monitoring templates were submitted, which demonstrated across a number of categories, the additional costs that had been incurred in preparing for and responding to the pandemic. All requests for retrospective top-up payments, over the first six-month period, were granted in full.

46. Subsequently, the additional funding was allocated to the ICSs. NWAS reports into L&SC ICS and any additional financial allocation made to the L&SC ICS was then allocated to the L&SC providers and NWAS. The additional funding requested was based on our financial plans which focused on continuing with the higher level of operational resources, social distancing requirements for PTS journeys and moving to single occupancy vehicles, higher sickness abstractions and Infection Prevention and Control (IPC) measures in place. This process was managed by the ICS Finance Team, details were submitted as part of operational planning, and included peer reviews. The financial allocation required to cover these additional costs was included within NWAS financial plans and was granted in full by the ICS.

47. In relation to NHS 111 the additional funding was calculated nationally by NHSE/I and allocated and apportioned across all the North West CCGs. NWAS received all the funding, in full, as per the NHSE/I allocations.

48. In relation to the first six month (period 1 April 2020 to 30 September 2020) the Trust received monthly retrospective top-up payments from NHSE/I based on the monitoring returns submitted. These monitoring returns detailed the additional costs expected with respect to planning for and responding to the pandemic across several mandated categories. In total £18.8 million additional funding was received from NHSE/I for this period.

49. The funding for 1 October 2020 to 31 March 2021 was provided by L&SC ICS. The specific additional funding provided to NWAS with respect to Covid-19 over this six-month period was agreed at £14.9 million.

50. In addition, as the Trust also provides the North West NHS 111 facility the Trust received a further allocation of £2.919 million for the period 1 October 2020 to 31 March 2021. The Trust was notified of this by NHSE/I but the sum was paid by Blackpool CCG.

51. The funding allocation for 1 April 2021 to 31 March 2022 continued to be provided by the L&SC ICS and was again managed by financial planning in 6-month periods referred to as H1 and H2. In line with agreed financial plans, NWAS received a £22.8 million funding allocation for H1 and £22.1 million allocation in H2. The monitoring of the actual costs incurred as against the financial plans continued to be done monthly and the final actual additional spend associated with the Covid-19 response for 2021/22 was £41.3 million, which was covered in full by the allocation received in that year from L&SC ICS.

52. In relation to NHS 111 for 1 April 2021 to 31 March 2022, funding transferred to national Service Development Funding (SDF). The additional allocations were set by NHSE/I and directly allocated to Blackpool CCG for the H1 period, totalling £3.227 million. In addition, during H1, regional NHS 111 funding was provided to NWAS from county lead CCGs in the North West totalling £1.822 million. In H2, national SDF allocation was spread across all the CCGs in the North West at £6.762 million. In total, during 2021-2022 national and regional NHS 111 funding was an additional £11.811 million.

53. Alongside the additional revenue funding support, from the outset of the pandemic there was also a capital bidding process for funding to support any capital investment needed as part of the NHS response.

54. In total NWAS incurred additional capital costs of £2.815 million in relation to Covid-19.

55. NWAS submitted bids for capital funding in line with the NHSE/I guidance. Only the LUCAS devices at £585,000 were not supporting by NHSE/I, and in total the Trust received additional funding via Public Dividend Capital (PDC) of £513,000.

B: THE TRUST'S INVOLVEMENT IN THE RESPONSE TO THE COVID-19 PANDEMIC

National Response to Ambulance-Related Services

56. On 17 March 2020, Sir Simon Stevens, NHS Chief Executive, wrote to all NHS Trusts and Foundation Trusts setting out the next steps with respect to the NHS response to the

pandemic and the actions to be taken to redirect staff and resources; a copy of that letter is attached as **[DM/2 - INQ000249079].**

57. In addition, Professor Anthony Marsh, as the National Strategic Advisor of Ambulance Services for NHSE/I, sent a letter to all Ambulance Service Chief Executives, Director of Operations and Medical Directors dated 29 March 2020 outlining the '*New national ambulance service governance arrangements for Covid-19*'; a copy of that letter is attached as [**DM/3 - INQ000249080**].

58. That letter set out the new national ambulance service governance arrangements for Covid-19 and the creation of a single Command & Control structure under the leadership of Professor Anthony Marsh in order to simplify decision making and the rapid implementation of response activities nationally.

59. The National Ambulance Co-ordination Centre (NACC) became the single point of oversight for assessing, determining and communicating the national level of ambulance services escalation. Mutual aid arrangements were also the responsibility of the NACC.

60. Feedback and consultation were delivered through a number of routes namely AACE, National Ambulance Service Medical Directors (NASMeD), The National Director of Operations Group (NDOG) and Quality Improvement, Governance and Risk Directors (QIGARD); please see further explanation below.

61. During the initial phases of the pandemic there was a period of instability whereby feedback was provided but the rapidly changing landscape meant that feedback was no longer relevant. After a short period, an effective process was in place and co-ordinated through the network.

Collaboration with other NHS Trusts and Ambulance Services

62. In addition to our own internal incident command structure, NHSE/I (both nationally and regionally) supported by Public Health England (PHE), stood up their own Incident Command Teams. I, as NWAS CEO, and/or the NWAS Medical Director were core members and attendees of the twice weekly NHSE/I North West Incident Management Team meetings in order to ensure system leadership and co-ordination. I remain the sole

NWAS representative at the Incident Management Team Meeting and the North West Regional Leadership Group Meetings (deputised to Salman Desai, as required).

63. I have listed below the different multi-agency meetings attended by NWAS during the Relevant Period (and continuing in some cases) which ensured collaborative working with other NHS Trusts/agencies. The nature of the multi agency meetings varied across each local area/Local Resilience fora but would focus on key topics such as the latest Public Health England guidance, the levels of PPE, referral pathways, testing, vaccination levels, access to vaccinations for staff, infection rates, mutual aid for services under pressure etc

- North West Incident Management Team Meetings
  Attendees: NHSE/I Northwest Region, PHE, Health Education England (HEE), North West Employers, Local Government, Integrated Care Community (ICC) Northwest.

- North West Regional Leadership Group Meetings
  Attendees: NHSE/I Northwest Region, PHE, Cheshire & Merseyside (C&M) Health & Care Partnership, North West Acute Trusts, Blackpool CCG.

- NHS 111 Oversight Group
  Attendees: NHSE/I Northwest Region, Northwest Acute Trusts, Blackpool CCG.

- Stockport Improvement Board
  Attendees: NHSE/I Northwest Region, various Great Manchester (GM) Acute Trusts, Blackpool CCG, CQC.

- GM Resilience - Strategic Co-ordinating Group
  Attendees: GM Combined Authority, GM Police, GM Fire.

- Northwest Systems Leaders
  Attendees: NHSE/I Northwest Region, Northwest Chief Executives, Accountable Officers, ICS Leads.

- Hospital Cells
  Attendees: NHSE/I Northwest Region, Northwest Acute Trusts.

- Other meetings
  - Local Health Resilience Forums

- NACC
- NARU
- Gold, Silver and Bronze incident command structure
- Regular updates with the Commissioners
- Regular meetings with regional Police and Fire Chiefs
- Regular updates meetings with the CQC

64. Across the Ambulance sector there were two specific groups external to the Trust which helped to facilitate the ambulance sector response to the Covid-19 pandemic.

65. AACE is chaired by me and throughout the pandemic I chaired meetings to discuss and make decisions to support a sector response across England, but also with the presence of devolved Ambulance Trusts covering Northern Ireland, Wales and Scotland.

66. As previously advised, Professor Anthony Marsh, CEO of West Midlands Ambulance Service and member of AACE was, and still is, the National Strategic Advisor of Ambulance Services for NHSE/I. Professor Marsh was empowered to act as a single point of escalation for agreeing mutual aid arrangements, including liaison at the national level with other emergency services and the coordination of Military Aid to Civil Authorities (MACA) requests to the National Head of Emergency Preparedness, Resilience and Response (EPRR).

67. The NACC became a single point of oversight for assessing, determining, and communicating the national level of ambulance service escalation to the services in relation to Covid-19.

68. AACE, with the direction of Professor Anthony Marsh in his role as National Strategic Advisor of Ambulance Services, disseminated information and decisions taken across the sector using, where required, NDOG.

69. NDOG contains membership of all Ambulance Trusts across England, and the devolved nations Northern Ireland, Scotland and Wales. Membership is via the Director of Operations from each Trust or their nominated deputy.

70. This group worked together throughout the pandemic, receiving decisions, making decisions and working together as a sector to respond to the pandemic. The group also escalated issues through to AACE, or other national groups e.g. NASMeD.

71. Mutual Aid, whether that be for staff within the EOC, of frontline staff would be discussed through NDOG, but as defined by Professor Anthony Marsh coordinated through the NACC.

Overview of NWAS' Operational Response to Covid-19

72. During the pandemic NWAS was placed under extreme operational pressure. This presented itself in several ways. Firstly, we had a reduced workforce due to staff absence with staff suffering from Covid-19, at times 20% of the workforce were unavailable. Incident cycle times became extremely extended, by an average of 14 minutes, due to staff having to don and doff appropriate PPE on arrival at incident addresses and completing increased clinical assessments to ensure that patients who were reluctant to attend hospital were safely left at home. Hospital handover times became extended as Acute Trusts had to separate Covid-19 patients from non-Covid-19 patients which created capacity issues within the hospital system. The average handover times increased from pre pandemic levels of 21minutes to 22.5minutes. Extended handover times reduce the availability of operational resources to respond to other emergencies. Although an average increase of approximately 90seconds does not sound significant in isolation, the cumulative effect of that in itself across 41,000 hospital attendances each month equates to more than 1000 lost ambulance hours or eighty two twelve hour shifts.

73. The combination of the factors outlined above severely reduced NWAS' operational resource availability and therefore impacted on ambulance response times.

74. The focus of the response and mitigation to the impact of Covid-19 for NWAS was to maximise its conveying resources – that is resources that had the capacity to transport patients to a healthcare facility. A notional target of 600 vehicles per day was set. At the peak of our response, we came very close to achieving this target with 590 vehicles operational on a daily basis.

75. The Trust developed 'Covid-19 Response Strategic Intentions', which set out clear strategic objectives for the Trust in terms of their response to the pandemic including how staff would be allocated to areas of most need/priority. The strategic intentions evolved with the pandemic and Trust response to the same but the overarching objective was to ensure that the Trust was able to continue to provide an emergency response to the North West general public. The strategic intentions were reviewed and updated at regular

intervals and as necessary but remained focussed on effective capacity management. For example, decisions were made to repurpose the non emergency PTS in order to increase the emergency response capacity. The decisions that were taken were documented by Trust Commanders in their respective logbooks.

76. Regional strategic meetings were held on a regular basis during the course of each and every day. These meetings included representatives from all service lines across the Trust region as well as support services. Updates were provided by each service line and decisions were taken to ensure any risks were identified including the movement of resources (staff) where gaps in resource were identified and additional resources were required to meet demand.

77. Any operational decisions taken were frequently reviewed and action taken as required should initial decisions require revision. Policies and procedures were factored into any decision taken.

78. The NWAS Covid-19 Response Plan outlined the contingencies and actions to be taken by Trust Commanders during an outbreak of a communicable disease. All decisions taken by Commanders followed the principles of the Joint Decision Model.

79. The Trust's Regional Operational Coordination Centre (ROCC) were making decisions on a daily basis relating to how resources would be allocated to meet areas of most need; this is part of their core function.

80. It was integral that the Trust maintained existing fleet capacity for operational use throughout the pandemic. This was managed by re-deploying staff usually based within a corporate role to support within the fleet maintenance workshops such that the trained mechanics could prioritise maintenance and repairs in order to maximise fleet availability.

81. A key operational priority was also to increase capacity to respond to as many emergency and non-emergency calls as possible. In order to achieve this, the Trust retained 15 PES vehicles which were due to be decommissioned and converted 80 PTS stretcher vehicles for use in the response to emergency 999 calls. Again, corporate and support staff were utilised to transport these vehicles down to the Trust's convertors in Cheshire and transfer them back to relevant ambulance stations once the work was complete. 60 of the vehicles were then directly transferred to PES with the remaining 20 staying in the PTS fleet available for use in PES should further flexibility be required.

82. Private providers have been an integral part of the NWAS resources prior to and post the Covid-19 pandemic. Private providers were in general used for lower acuity emergency, urgent, and general work. However, decisions would be taken through the command structure, and in line with policies (Demand Management Plan) in terms of how best to utilise them based on demand.

83. The pandemic demonstrated the need for the Trust to develop services and pathways for people ringing 999 with a mental health need and/or in mental health crisis. As a result the Trust developed a number of roles to support the operational response to these patients. This team function at a strategic level liaising with Integrated Care Boards (ICBs), mental health partners and other system partners to improve our pre-hospital response to mental health patients.

Advice, guidance or policies relating to ambulance response during the pandemic

84. The following paragraphs provide a date-stamped narrative of clinical advice, guidance and policies reviewed and implemented during the Covid-19 pandemic. As part of the Trust's pandemic response a 'Strategic Clinical Cell' ("the Cell") was established under the Chair of the Executive Medical Director. The Cell met weekly with additional 'extraordinary' meetings convened to maintain maximal responsiveness. The Cell consisted of Associate Medical Directors, Consultant Paramedics, Clinical Leads and where necessary senior members of other Directorates who joined to support individual decisions. All decisions and changes to clinical practice as detailed below were implemented following review by the Cell.

85. In recognition of the limited evidence base associated with the rapidly evolving pandemic, the Trust made an overarching strategic decision not to make any individual Trust based policy changes and no decisions were made to alter any clinical practice outside of national guidance.

86. There was no NWAS originating, specific clinical guidance provided to ambulance staff about the care of and treatment for Covid or non-Covid patients, rather national guidance was incorporated where applicable into existing Trust guidelines, communicated to and made available to all clinicians.

87. The Trust did not differentiate any clinical guidance for any patient group to ensure equality of access to pre-hospital care. Where national guidelines, based upon the best evidence at the time, existed and referred to clinically vulnerable patients these were reviewed and considered for implementation within the Trust in accordance with the process outlined in paragraph 77.

88. Any new policy or procedure introduced within the Trust must have an Equality Diversity and Inclusion (EDI) risk assessment carried out on it. During the pandemic there was a National Vulnerable Persons EDI Assessment checklist produced by AACE and shared with all Ambulance Trusts; this revised EDI checklist/assessment tool took into consideration all protected characteristics in relation to the main risks the pandemic presented **[DM/4 - INQ000249081]**. The checklist/assessment tool was designed to ensure that recommendations which were likely to disproportionately affect the health of vulnerable groups were identified so that risks could be mitigated where possible. Policies and procedures for all patients and staff were thereafter adapted accordingly. One example of this was with respect to the availability of Respiratory Protective Equipment (RPE) hoods for staff that could not be fitted with a standard FFP3 mask, which included those that had smaller faces (females for example) and staff who have beards for religious reasons etc.

89. It was integral to the Trust to maximise the availability of PES resource, which was heightened markedly given the pressures on the Trust following the outbreak of Covid-19 within the United Kingdom. It was vital that NWAS made full use of all its ambulance resources, the demand for which had increased due to the pandemic.

90. An option discussed at an early stage of the pandemic (March 2020) was the use of 'no send' scripts, whereby ambulances would not be sent to some patients in order to maximise availability. However, recognising the impact such scripts might have i.e., they may result in high self-presentations to healthcare facilities and therefore an increased risk of spread of the disease, the Trust agreed that suspected Covid-19 patients would not be advised to make their own way to the Emergency Department under normal business. However, suspected Covid-19 patients were permitted to be read the 'no send' script during periods of increased demand on the service, acknowledging that there is potential for an increased number of those patients to self-convey to a healthcare facility. This decision remained under review both internally and in accordance with national guidance.

91. The Trust continued their normal processes for auto-allocation of operational vehicles for early identified and coded Category 1 incidents within the NWAS footprint. NWAS uses auto allocation to dispatch to certain Category 1 incidents which meet auto allocation criteria, ensuring either the allocation of an available vehicle or diversion of a vehicle from a lower category call. This process allowed for the allocation of NWAS resources to occur faster than through the traditional manual allocation process. There was initial concern that due to the increased risk to responders regarding contraction of Covid-19, that this auto-allocation may have put them at undue risk. However, the Trust recognised the need for the provision of high quality and timely clinical care even within the pressures on the Trust following the outbreak of Covid-19, together with the mitigations provided via PPE guidance, and therefore agreed to make no alteration to the auto-allocation processes. This remained under regular review although no additional changes were made.

92. Recognising the importance of the safety and welfare of our staff together with the provision of high quality and timely clinical care following the outbreak of Covid-19 within the United Kingdom, the Trust agreed that all pre-hospital cardiac arrests should be treated as Covid-19 positive until robust information indicated otherwise. Guidance was issued to all staff on 13 April 2020 following updated guidance from PHE confirming that Level 3 PPE should be donned for all cardiac arrest incidents when an AGP was being performed.

93. NWAS operates a specific Pre-determined Attendance (PDA) for Category 1 incidents. This includes both a Rapid Response Vehicle (RRV) and Double Crewed Ambulance (DCA). Further to this, in an effort to improve the quality of care to patients who have suffered a cardiac arrest and where full Advanced Life Support is required, the Trust operates a procedure dictating that four responders attend these incidents, wherever possible including a senior clinician.

94. The Trust agreed to make no change to the cardiac arrest PDA (4 responders should be dispatched to any active cardiac arrest in which Cardio Pulmonary Resuscitation (CPR) is taking place). Concerns were raised regarding whether the dispatch of this many resources is an efficient model of response in times of high demand. Further to this, there was a growing concern that NWAS staff could be exposed to potential Covid-19 patients unnecessarily. It was evident that reducing the PDA response to cardiac arrest incidents may significantly degrade the quality of care given, hence the decision was made to make no change.

95. NWAS utilises the GoodSAM application to notify volunteers of pre-hospital cardiac arrests in their vicinity. The Trust identified at the beginning of the pandemic, that ensuring high standards of IPC was an absolute key requirement in the pandemic response and management. As the Trust was not able to provide PPE to these screened GoodSAM volunteers and owing to the national guidance relating to the use of PPE, the decision was taken to cease GoodSAM activations in March 2020 to ensure the safety of volunteer responders.

96. There was a national concern that due to the increased risk of Covid-19 contamination and exposure to our clinicians, that the allocation of multiple resources and clinicians to futile resuscitation attempts may put them at undue risk. In addition, the guidance around the use of PPE at cardiac arrests would have only exacerbated the tensions surrounding PPE supply by sending multiple vehicles to cardiac arrest cases where resuscitation would be thought futile. As a result, London Ambulance Service (LAS) sought to demonstrate through analysis of their response to particular incidents, that in February 2020 a total of 286 ambulances were saved as a result of early recognition of futile resuscitation. Furthermore, there were no serious incidents reported as a result.

97. In recognising and acknowledging the work of LAS and the critical need to ensure the most appropriate resource allocation to patients in cardiac arrest at a time of unprecedented demand, the Trust therefore approved the introduction of a procedure to enable the early identification of futile resuscitation attempts and support the modified dispatch of resources to these incidents within the EOC at the end of March 2020.

98. NASMeD and the Royal College of Emergency Medicine (RCEM) jointly issued guidance in June 2020 around cardiac arrest management and decision making on arrival at emergency departments. The Trust implemented these guidelines and worked with system partners to ensure their introduction across the region.

99. Mechanical CPR chest compression devices are a reasonable alternative to high quality manual chest compressions where manual compressions are impractical or compromise provider safety (Resus Council UK, 2015). Covid-19 resulted in unprecedented operational demand and available resources became limited, hence the Trust purchased the mechanical cardiopulmonary chest compression device LUCAS. This device had previously been trialled and tested within the organisation prior to Covid-19 and deemed fit for use. The decision to purchase 60 LUCAS devices was approved by the Board on 3

April 2020 with Trust wide roll out commenced on 21 April 2020 as soon as the procurement process was completed.

100. Within NWAS, clinical staff of the grade Emergency Medical Technician 1 (EMT1) utilise a clinical decision support tool named Pathfinder to support clinical decisions. Where the Pathfinder tool identifies patients who may be suitable not to be conveyed and therefore to stay at home with self-care advice, EMT1s are required to call a senior clinician to ensure that decision is safe. In response to the anticipated markedly increased demand on both ambulances and remote clinical advice because of Covid-19, the decision was made to allow EMT1s to undertake discharges on scene in strict accordance with the Pathfinder tool without the need for a call to a senior clinician at the end of March 2020.

101. As the Covid-19 pandemic created exceptional demand for ambulance services, one of the first steps taken by the National Incident Response Board (NIRB) led by Professor Anthony Marsh, as detailed in paragraph 50 above, was the approval, introduction and implementation of Emergency Triage System Pandemic Protocols. During the Relevant Period NWAS used the Medical Priority Dispatch System (MPDS), owned by the International Academies of Emergency Dispatch ("The Academy") as the platform for triaging 999 calls. As a consequence of the decision taken by the NIRB the Trust introduced Protocol 36 into the MPDS Triage System on 30th March 2020.

102. Protocol 36, also known as Card 36, is the 'Pandemic Flu Triage Protocol' designed to provide alternative triage for when demand exceeds resource during a disease outbreak. The revised triage process sought to mitigate the effect of demand outstripping available resources by preserving an ambulance response for the most seriously sick and injured patients. All patients who presented with breathing problems, chest pain or flu like illness were assessed under this Protocol. Some patients with flu type symptoms who would otherwise have received an ambulance were re-directed to alternative care pathways or advised of appropriate self-care.

103. In addition to the specific triage protocol there were four differing levels of triage and as the level of triage within the protocol increased, the response to certain call categories would be impacted. Level 1 triage was surveillance only with no degradation of response or 'no send'. Level 4 would have resulted in a 'no send' to 429 triage outcomes and presented a significant degradation of response. The move to escalate/de-escalate through the triage levels was the responsibility of the NACC under Professor Marsh's command.

104. Following the approval and introduction of Protocol 36, the Trust reviewed its guidance pertaining to 'no sends' as detailed in paragraph 83 above. The implementation of Protocol 36 required any locally agreed 'no send' arrangements to be superseded by the national guidance which encouraged self-conveyance as part of routine business. As a result, the Trust began asking patients to self-convey to a healthcare facility as part of the call taking response from the beginning of April 2020, except for those patients categorised as Category 1, those with chest pain and or those who have suffered a stroke.

105. Throughout the pandemic The Academy published guidance to support the use of its triage system and authorised changes to its protocols. One of those changes was that in April 2020 the Academy agreed that chest compression only CPR was to be advised by EMDs whilst crews were being mobilised. This guidance was implemented in full under both the licencing arrangements for the use of MPDS and to ensure the Trust was compliant with best practice guidelines. In the case of paediatric arrest (for a child under the age of 8) NWAS added an additional process and asked EMDs to instruct ventilation, unless refused, to ensure optimal bystander care was provided to this cohort.

106. Following the introduction of Protocol 36, NWAS conducted an internal clinical review into its application. This review highlighted nine cases within two MPDS subprotocols in which patients had suffered an ST elevation myocardial infarction and where patients had received a reduced priority response (category 3 response rather than a category 2 response) following the Protocol 36 triage. NWAS highlighted its findings with NASMed and the NHSE Clinical Advisor. The NHSE Clinical Advisor, having completed their own review, produced a draft report which included several recommendations. As it was, prior to the draft report being received, NWAS had already applied an automatic upgrade to incidents in this MPDS subcategory such that they automatically received a category 2 response.

107. All ambulance trusts later received a letter from Professor Marsh dated 7 May 2020 **[DM/5 - INQ000249082]** advising of an error in MPDS and sought confirmation that corrective action had been taken and instructed Trusts to complete a review to identify any cases that may require investigation under existing governance processes, for example the Serious Incident Framework. Having completed the requested review, NWAS did not identify any occurrences of harm having been caused to a patient.

108. To further support our emergency response, during April 2020 a decision was taken to train Newly Qualified Paramedic (NQP) staff to perform telephone triage. NQP staff were previously excluded from this as part of a preceptorship process to support them during their early career, however it was felt that in order to support increased demand that as long as they were registered clinicians then there should be no concern in allowing telephone triage to take place supported with a bespoke training package. As it was, NWAS did not ultimately deploy NQPs to perform telephone triage on account of the national NQP scope of practice.

109. On 27th March 2020, Covid-19 related call filtering was introduced across England in an effort to reduce the increasing demand on ambulance services and to ensure that Covid-19 related callers were appropriately signposted to the correct service for their needs. Call filtering was initially introduced within LAS, then filtered out across the country. This filter introduced an extra triage at the point a 999 call is connected to the BT Operator before being put through to the relevant ambulance service. The questions posed by the BT Operator at the initial phases of the call as part of this filter were:

- *"Is this call for Coronavirus?"* – This would be asked by the BT Operator on every 999 call received when the request made by the caller was for an ambulance. If the answer was no, the call would thereafter be connected to the relevant ambulance service.
- "*Is the situation life threatening or do you require advice or a test?"* – This question would be asked if the caller has indicated in response to the question above that the call relates to coronavirus. If the caller indicated that the situation is life threatening, they would be connected to the relevant ambulance service. If the caller indicated at this stage that they were calling for a test, they would be directed by the BT Operator to call 119 to book a Covid-19 test.
- *"Is the patient aged under 16 or over 70?"* – This question would be asked if the caller indicated in response to the question above that they were calling for advice. If the caller indicated that they were between the ages of 16 and 70 they would thereafter be referred to NHS 111 Online for advice. If under 16 or over 70, the caller would be connected to the relevant ambulance service.

110. Call filtering was stopped on 9th June 2020 and reintroduced on the 10th November 2020 when the second wave of the pandemic struck; it remained in place until 4th December 2020.

111. In order to support the Trust response to Covid-19 there was a dedicated critical care transfer service established in partnership with North West Air Ambulance (NWAA). There was lower than anticipated demand for this service and it was therefore stepped down in June 2020.

112. CPR is the default treatment for cardiac arrest unless a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form is in place and in certain defined circumstances such as whether conditions unequivocally associated with death are identified or where a Paramedic assesses that death is imminent because of terminal illness; as per Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance.

113. NWAS clinicians do not initiate or conduct conversations or decision making in relation to DNACPR. This is not in the scope of an ambulance clinicians practice and this remained so throughout the pandemic period. NWAS clinicians would access pre-existing DNACPR forms either physically present at the patient's side or via shared patient records as part of their routine clinical practice. No changes to NWAS' clinical practice in relation to DNACPR occurred throughout the pandemic period.

114. Central Government guidance was issued in relation to deaths in the community in April 2020. NWAS reviewed and clarified that this guidance pertained to community and primary care services and continued their internal diagnosis of death procedures, as the guidance did not divert from current practice.

115. NWAS had an established team and protocols for the management of service users who make frequent and repeated calls for our emergency service. Recognising that this is a potentially vulnerable group of patients, during the Covid-19 response and from April 2020 additional scheduled review meetings were established to ensure close and continued review of the plans for patients meeting these criteria.

116. Based upon a nationally agreed template, NWAS implemented a bespoke Covid-19 assessment tool **[DM/6 - INQ000249083]**. It included information regarding red flag symptoms in potentially vulnerable patients. The tool was uploaded onto the JRCALC + application allowing access by all clinicians.

117. The guidance tool was introduced to support patient safety and to ensure the appropriate safe disposition of patients suspected of having Covid-19. It supported the existing triage tools (specifically Manchester Triage System and Pathfinder) used by

NWAS clinicians and supported clinicians in their assessment, history taking, examination and decision making in relation to patients presenting with Covid-19 symptoms.

118. The Trust continued to receive and review national clinical guidance from NASMeD including those around Covid-19 symptom management, choking and end of life care. Following review by our senior clinical team any pertinent new, or amending guidance was incorporated into Trust guidance and uploaded to the JRCALC Plus application.

How were policies and practices disseminated to Trust staff during the relevant period?

119. With the pandemic being at the forefront of the Trust's activities the front page of the Trust's intranet was structured to present Covid-19 headlines and current messages, along with a link to a dedicated page with current information for all employees to access. As CEO, I delivered a video message to the workforce specific to Covid-19 pandemic.

120. Changes to clinical practice were made known to staff via specific 'Covid Bulletins' that were issued separately to all other communications. Due to the number and frequency of clinical updates which needed to be communicated to staff in a way that they could easily identify, access and implement, a Covid specific bulletin was introduced. This was separate to other Trust information and sent out via email on a daily basis. Covid specific clinical information was also uploaded onto the staff app and onto the JRCALC+ app.

121. All Trust communications are housed on the Trust's intranet, known as the Green Room and to improve accessibility to essential Covid specific bulletins, a "home page takeover" was put in place. This was a large prominent and instantly visible section of the homepage which linked a new Covid information hub which contained all of the latest Covid specific information including clinical bulletins, operational bulletins, wellbeing initiatives or HR related guidance. All bulletins were dated and numbered.

122. Videos were used to explain new guidance and processes for example how to remove patients via stretcher into a Nightingale hospital, how to take a Covid test and quarantine requirements. Podcasts and Facebook Live sessions were also used to help colleagues manage their health and wellbeing as well as providing an opportunity for colleagues to ask questions of the senior management team on all aspects of our Covid response.

123. Specific targeted campaigns were used to help staff better understand how to keep themselves and others safe for example, "Beard off/Reach for the Razor" to encourage staff to remove facial hair to help with mask fitting.

124. The measures outlined in paragraphs 119 and 123 above were developed with colleagues and communicated internally, externally, on social media channels and via posters. They were intended to compliment the Trust's daily clinical bulletin and connect with colleagues on a more emotional/personal level.

125. Whilst NWAS had the ability to gather data and information as to the number of times a bulletin has been viewed, either in the Green Room or via the JRCALC+ app, the data was not available at granular individual level. Qualitative feedback confirmed that the daily Covid bulletins and other methods of communication were well received and worked well. Additionally, clinical contact shifts and specifically the "must have conversations" between senior clinicians and clinicians provided an opportunity to ensure the pertinent and key messages were conveyed understood and implemented.

126. The Trust upgraded their subscription to JRCALC+ during the pandemic to allow for monitoring and reporting of clinical bulletins. Clinical practice changes were uploaded to this JRCALC Plus platform, which is available to all clinicians and notifies them when changes have been made for them to review.

127. E-Learning platforms were used to also disseminate training on donning and doffing PPE and how to undertake lateral flow testing.

128. In addition, a team of NWAS staff made up of Estates and Facilities, Health and Safety and IPC members went around all sites to undertake site risk assessments for Covid-19 measures and mitigations. As part of the site visits Covid-19 precautions were installed including 'Covid-19 tables' that had information for staff, access to face masks and alcohol gel and temperature 'stations' were introduced. Covid-19 prevention posters and IPC guidance was put on display and regularly checked to ensure that things were kept up to date and in-stock.

129. Staff posters were developed to promote social distancing, using face masks, how to keep your colleagues safe etc. The posters were displayed across all NWAS workplaces.

130. Communication packages were also implemented including regular posters and communication for staff engagement including 'buddy brews' and support for staff.

C: STAFFING

131. The table below outlines the baseline staffing position for the Trust throughout the Relevant Period.

	PES	PTS	Frontline NHS 111	Frontline Control Room	NWAS Frontline total
March 2020	3558	693	664	357	**5272**
April 2020	3541	690	653	365	**5249**
May 2020	3532	689	652	385	**5258**
June 2020	3534	691	650	428	**5303**
July 2020	3542	687	644	488	**5361**
August 2020	3525	685	639	502	**5351**
September 2020	3545	683	638	552	**5418**
October 2020	3533	668	637	581	**5419**
November 2020	3546	650	642	604	**5442**
December 2020	3534	650	630	588	**5402**
January 2021	3522	648	657	590	**5417**
February 2021	3515	640	657	616	**5428**
March 2021	3519	637	662	621	**5439**
April 2021	3519	632	671	605	**5427**
May 2021	3522	629	675	576	**5402**
June 2021	3511	627	721	557	**5416**
July 2021	3517	640	707	527	**5391**

August 2021	3516	652	695	551	**5414**
September 2021	3526	651	693	517	**5387**
October 2021	3529	671	687	513	**5400**
November 2021	3600	676	680	490	**5446**
December 2021	3583	677	672	474	**5406**
January 2022	3627	685	665	467	**5444**
February 2022	3627	682	653	469	**5431**
March 2022	3610	682	645	479	**5416**
April 2022	3601	682	646	466	**5395**
May 2022	3576	683	648	454	**5361**
June 2022	3567	679	658	470	**5374**

132. Throughout the pandemic, staffing levels were considered and appropriate action was taken to support the required resources levels.

133. Staffing levels changed during the Relevant Period due to sickness absence level and an increase in the number of staff the Trust required.

134. Given the need for a rapid increase in resource levels at the start of the pandemic, temporary staffing options were utilised through both bank and agency routes. There were also a small number of ex-staff who returned to work, including some senior managers to support the Trust's strategic response to the pandemic.

135. After the first eight weeks of its response to the pandemic, the Trust continued to review its staffing levels. Emergency Medical Technician 1 and Paramedic courses were run during the Relevant Period with adaptations made for classroom sizes in line with national social distancing requirements.

136. For 2021/22, the normal operational planning approach was paused and this meant that there was no further growth added to the establishment. Instead the Trust utilised non-recurrent winter planning monies to support resource levels. Recruitment and training plans were based on meeting the existing establishment levels. Agency staffing was mainly used in EOC, with plans in place to move agency staff, not substantive positions.

137. Moving into 2022/23, the Trust saw a return to the operating plan model and recruitment plans were made in accordance with confirmed growth to the baseline, with a commitment to reduce previously utilised levels of agency staff.

How was increased staffing achieved?

PES

138. Increase to PES resources was achieved through three main routes:

- The Trust approached recent retirees to enquire as to their availability to return to work. The Trust was therefore able to re-engage a number of clinical and managerial staff to support the command structures and direct response to the pandemic. This was supplemented by a small number of staff who came via the National Returner Schemes. Following an initial request in March 2020, in November 2020 a further request went out to ex-employees for support.
- The Trust upskilled 155 PTS staff and 12 Urgent Care Staff (UCS) such that they were able to then undertake a PES Assistant role. This role had a specific scope of practice, developed by the Medical Directorate and agreed with the Trade Unions. It was designed to enable them to work alongside an attending Technician or Paramedic to provide general assistance with equipment and direct support for certain procedures such as resuscitation. This role did not include emergency driving initially. Initial training was delivered to upskill these staff to work safely and effectively; this training was 4 days in duration. In December 2021 an additional emergency driving course was introduced for those PES Assistants who had completed the clinical upskill and had already completed the PTS driver training and

were willing to undertake it. The Trust also upskilled a small number of enhanced CFRs to undertake the PES Assistant Role; this included 3 days clinical training with driving familiarisation and assessment.

- The Trust made the decision to cease student placements on 27th March 2020 and worked with HEE and Higher Education Partners to deploy our students to support the Covid-19 response; 194 second year paramedic students were trained to undertake a UCS/PES Assistant role.

111

139. The primary resource increase in NHS 111 was delivered through the training and deployment of 87 year first year paramedic students into Service Advisor and Covid-19 specific roles and with a small number of corporate staff being redeployed.

140. In addition, ELC approved the over recruitment of 111 Health Advisors by an additional 78.59 Whole Time Equivalent (WTE) over the current establishment of 193.86 WTE positions. Recruitment was managed through telephone and virtual means.

EOC

141. Increases in EOC staff were met through student deployment, corporate staff redeployment and agency staff. A truncated training course was developed which was three weeks in length supported by one week of mentoring. This provided the minimum training to be able to initially take 999 calls and operate MPDS effectively and to then hand calls over to fully trained EMDs as required. Overall 139 additional call taking staff were deployed as at the end of May 2020. Against a normal call taking establishment of 272 WTE at that time; this represented around a 50% increase in staff. The use of agency staff provided a rapid option for increasing staffing and provided the option for the Trust to consider offering these individuals NWAS contracts with no additional fee after a 12 week period.

Corporate

142. All corporate teams reviewed their plans and resources at the start of the pandemic in order to identify whether resources could be released to support the effort. Overall, over 40 staff (some full time and some part time) were redirected on a temporary basis to direct frontline duties or to support frontline activities. In other cases staff were redirected within corporate teams to new activities, for example, the improvement team were responsible for leading the staff testing initiative and Organisational Development (OD) staff were redirected to support welfare and wellbeing efforts or from work based training to support direct upskilling delivery.

Staff redeployed to NWAS under the North West Memorandum of Understanding (MoU)

143. Under the North West MOU, the Trust has been offered staff from other North West Trusts, predominantly CCGs. A small number of staff have been successfully redeployed into the Trust in areas such as 111, PES administration and the Communications Team through this initiative.

Changes to Student Paramedic Programmes

144. As noted above, paramedic programmes at four North West universities were amended to mitigate Covid-19 risks and maximise resourcing opportunities. Agreement was reached with the university partners that education programmes be redesigned in order to provide concentrated practice placements.

Mutual Aid (Military Aid to Civil Authorities [MACA])

145. In February 2021 the Trust commenced a plan to train 120 military personnel. The training programme was to run over four days, broken down into 1 day driver training and vehicle familiarisation and 3 days clinical/operational skills training. The aim was that

military staff would be able to drive vehicles safely (non-blue light) but also provide safe and effective support to the clinician in the management of patients.

146. This training was delivered simultaneously at three area specific venues. All personnel completed the clinical training with a small proportion who were unsuccessful with their driving assessments but for whom the military leadership deployed to alternative supportive roles.

147. In January 2022 the Trust commenced the second phase of training for military personnel. There were three simultaneous groups who received clinical and driving training. 161 staff completed this training.

Changes to annual leave

148. To support the capacity during the pandemic the Trust allowed staff to carry over annual leave and also introduced an option that the Trust could buy back leave from staff. The objective of this was to support staffing levels.

149. The total hours sold back to the Trust was 24,383 hours.

150. In January 2022 the Trust recognised that the ongoing pressures of the pandemic required ongoing staffing levels to be maximised. The Trust's annual leave year runs from April to March each year. As such the option to sell remaining leave in January was seen as an opportunity to allow staff to sell leave and ensure that resource levels were maximised.

151. Overview of the hours sold for the January 2022 scheme was: Prebooked leave: 6839.5 hours and carry forward leave: 1863.91 hours.

Staff Sickness and Abstractions

152. From April 2020 onwards the Trust was required to report specifically on Covid-19 sickness absence.

153. To ensure the Trust captured Covid-19 related absence and the different variations of it alongside "non-Covid sickness", we centralised the sickness reporting arrangements. All staff were required to contact the Trust's Support Centre to book absence, report fit and confirm the nature of their absence. A flow chart and script were developed for the Support Centre to ensure absence reasons were recorded and coded correctly and appropriate advice given in relation to the absence in accordance with national guidance e.g. length of time an individual was required to 'isolate', how absence would be recorded if continued beyond isolation.

154. Managers were notified of staff absence. Given their understanding of the reason for absence, they were able to provide staff with appropriate support, plan backfill/cover arrangements, understand likely return to work timescales and the support that would be needed on return to work.

155. Sickness reporting arrangements were subject to constant review in response to the changing national position and HR Guidance was updated accordingly to ensure staff were kept updated on how their absence should be recorded and what was required of them depending on the nature of their absence.

156. The impact of Covid-19 in all areas was reasonably consistent across the timeline in relation to peak times such as the first national lockdown, periods of increased restrictions and the emergence of new variants. That being said there, were hotspots of infection in various locations which impacted on staffing levels.

157. Most of the Trust's frontline Operational PES were significantly affected between November 2020 and February 2021 which was a period of renewed government restriction and high infection rates. Similar impact could be seen in this area again in December 2021 to April 2022 following the emergence of the Omicron variant and heightened isolation requirements.

158. Sickness absence within our EOCs followed a similar trajectory and timeline as PES but at slightly lower levels, as did Finance and PTS.

159. One of our highest impacted areas was our NHS 111 Call Centre who reported the highest Covid-19 absence percentages during the aforementioned peaks at 6.53% and 8.25% respectively; this is likely to be associated with the type of working environment and proximity of staff, despite PPE, leading to breakouts.

160. Unsurprisingly, corporate services was the least affected area, mainly attributed to the greater ability to isolate and work from home.

161. As expected, the Trust saw a subsequent overall increase in non-Covid related absence which can be seen further in the data below. A lot of our staff members have reported issues with their mental health, the data supporting that shows a significant increase in Stress/Anxiety/Depression related absence from 2020/21 at 1.98% into 2021/22 at 2.98%. However, the measures detailed from paragraph 148 onwards have helped to bring these levels back down to 2.48% for 2022/23.

162. As of today, daily Covid-19 levels are at an all-time low with only a handful of staff remaining off with Long Covid. The Trust continues to support this recovery with our internal services and investment in mental health support. Policies on phased return/adjusted duties and redeployment have been utilised where it was considered that this would aid in supporting staff with Long Covid to return to work in some capacity whilst still recovering, reducing financial pressure and easing them back into working life.

D: STAFF WELFARE

Identification and support for 'at risk' staff

163. At the onset of the pandemic, the Government identified those with a chronic health condition, those aged 70 years or above and pregnant women to be at greater risk of serious ill health if they contracted Covid-19. The Government announced a period of shielding to protect those most vulnerable by minimising interaction with others. Those identified as extremely clinically vulnerable received a letter advising them to shield, i.e. to

remain at home, leaving only to exercise and shop and avoiding social interaction with anyone not in their household, including family and friends. The shielding period commenced mid-March and was initially for a three-month period, this was subsequently extended to the end of July 2020.

164. As a result, the Trust asked staff who received a shielding letter to refrain from work immediately and to undertake a risk discussion with their line manager. Additionally, any staff member who had a serious health condition as listed by the Government, were aged 70 or above or pregnant were asked to engage in a one-to-one discussion with their manager and participate in a risk discussion assessment. The risk discussion sought to understand an individual's health condition/circumstances better and assess the appropriateness of them being exposed to risk and, with assistance from internal clinical support and Occupational Health, identify the most appropriate safeguarding option. Staff that lived with a clinical vulnerable person, whilst not necessarily deemed high risk themselves, were also risk assessed.

165. As further medical evidence emerged about Covid-19 vulnerability, the risk discussion process was extended to BME staff and included an exploration of individual concerns to enable management teams to provide appropriate welfare support.

166. In or about May 2020, a national inquiry was launched to review the evidence and causation in relation to the emerging evidence of a differential impact of COVID-19 on BME communities and healthcare workers which was not previously identified. The evidence indicated that individuals from the BME community may have been three times more likely to be hospitalised and have a higher likelihood of dying from the virus than their white colleagues.

167. NHS Trusts were asked to take action prior to the findings of the inquiry to ensure steps were taken to support their BME workforce. In response to this, NWAS agreed it would risk assess all BME staff in the service, prioritising those who were already known to have high risk conditions to ensure that measures put in place remained adequate.

168. In collaboration with Occupational Health NWAS devised a risk discussion pro forma for managers to conduct with all BME staff and updated the Risk Stratification document that informed managers of health conditions and individual factors that may pose increase

of severe ill health if infected with covid. Staff who had already participated in a risk discussion pro forma due to another factor, e.g., chronic health condition, were asked to participate in a further risk discussion to ensure the additional questions specifically relating to ethnicity were discussed. Staff identified as requiring a clinical review were referred to Occupational Health and advice obtained regarding any adjustments required. HR monitored risk discussions to ensure they were undertaken with all identified staff.

169. Additionally, managers were also asked to ensure priority was given to those staff who had not passed the face fit test. For PES staff who failed the fit test or had not been tested, alternatives to attending incidents involving aerosol generating procedures were to be actively considered e.g. deployment into the Clinical Hub, deployment on repurposed PTS vehicles which focused on lower acuity category 3 & 4 responses. Staff who were in this situation were prioritised for respirator hoods.

170. In May 2020, I wrote to all BME staff **[DM/7 – INQ000249084]** to highlight the support available to them and encouraged participation in a risk discussion with their manager.

171. Subsequently, in July 2020 with the improved medical understanding of covid risk factors the risk discussion pro forma evolved further and a risk assessment questionnaire was devised and utilised across the workforce. The assessment incorporated consideration for those of a BME background and the heightened risk presented to those individuals by Covid-19.

172. During the shielding period a monthly average of 282.5 staff were recorded as medically suspended.

173. As the shielding arrangements came to an end, a new risk assessment process was prepared in collaboration with Occupational Health. Informed by current epidemiological evidence and greater medical data collated nationally and internationally on individual factors associated with higher risk of serious ill health from Covid-19, the individual vulnerability risk assessment questionnaire was developed by the national body for Occupational Health Doctors in conjunction with medical physicians and various academics and seeks to estimate the risk to an individual once infected based on a 'Covid' score that is determined by the individual's age plus other demographics and health conditions / risks.

174. From end of July 2020, all staff who had been medically suspended or allocated alternative duties as an outcome of the initial risk assessment process were asked to participate in an individual vulnerability risk assessment questionnaire with their line manager to re-assess their individual vulnerability and support their return to the workplace where possible.

175. The questionnaire provided a more evidenced based assessment of individual risk and contrasted with both the available understanding of Covid-19 risk at the onset of the pandemic and the limited risk assessment initially devised and applied to our staff. The outcome of the re-assessment of some individuals was that their level of vulnerability reduced, although this may have also been supported by the change in the work environment that was also factored in, for example, work locations became 'Covid secure', accessibility of PPE increased and staff behaviours changed.

176. Conversely, the epidemiological evidence also identified vulnerability traits that had not previously been given much emphasis, such as Body Mass Index (BMI), those over 60 years and those who were born male. Staff who had not previously been identified as being vulnerable were then invited to undertake the individual vulnerability risk assessment questionnaire.

177. The questionnaire identified an individual 'Covid age' score which then corresponds with a vulnerability level, of which there were five, namely: low, low moderate, high moderate, high and very high. At each vulnerability level workplace considerations were provided for both clinical and non-clinical staff. The considerations included suitable adjustments and PPE type proportionate to the risk level. The restrictions recommended increases the higher the Covid age that was identified.

178. Occupational Health advice was sought for those staff whose Covid-19 score was associated with the very high and high levels and where immunosuppressant disease or medication was identified. Individuals who fell into the very high level were deemed to be at high risk of death if infection occurred and significant restrictions were applied, in that they should work from home. Individuals who fell into the high vulnerability level were deemed to be at high risk of becoming hospitalised and seriously ill if infection occurred; individuals in that category were to avoid patient contact and lone working or working socially distanced from others was to be facilitated. Individuals who fell into the high moderate category were usually able to remain in the workplace and fulfil their substantive job role providing the adjustments identified could be facilitated, whilst individuals

associated with the low moderate and low vulnerability levels were able to continue without adjustments and in adherence to the Covid-19 safety measures.

179. In cases where it was deemed appropriate for staff to return to the workplace, with or without adjustments, their managers conducted a modified return to work action plan document. It was recognised that staff returning to the workplace whilst the pandemic continued would most likely be apprehensive and concerned. The purpose of the action plan was to address individual concerns by identifying and talking about 'risk' factors in the workplace and agree what steps should be taken to minimise risk and provide reassurance. Additionally, the process sought to address psychological wellbeing and action required to support mental wellbeing.

180. In around August 2020, individuals born male and European individuals aged over 60 were included in the 'at risk' category. We invited all staff in those categories to undertake a self-assessment and where potential greater risk was identified, the respective individuals were asked to complete an individual risk assessment document and submit to their line manager to ensure the right actions were taken for those individuals, based on risk level. The individual risk assessment document was modified for the purpose of self-assessment and the guidance also amended to support individuals completing the process.

181. Subsequently, we extended the self-assessment tool to all remaining staff in NWAS who had not previously participated in an assessment of risk.

182. Where the on-line assessment identified lower risk and therefore no further action was required over and above correct use of PPE and social distancing, individuals were advised of this and asked to contact their manager should their circumstances change.

183. In accordance with NHS Employer's Guidance, we supported staff financially throughout the shielding period by recognising them as 'stood down' from duty as opposed to recording absence as sickness. Full pay continued to be paid plus any pay enhancements such as unsocial hours pay and Recruitment and Retention (R&R) pay, and an average monthly overtime payment made to compensate for the overtime they were unable to do. When the shielding arrangements came to an end, staff who were unable to return to the workplace, continued to be managed as during the shielding period and pay was in effect "protected".

184. Due to increased staff absence and significant pressures, the HR team developed a Welfare Hub and conducted weekly contact calls with staff who were 'shielding' or absent long term due to Covid-19 sickness to ensure contact was maintained.

185. In relation to pregnant members of staff, medical advice was sought from our Occupational Health provider at regular intervals as and when guidance changed. This allowed us to apply suitable restrictions from front line working and redeploy or medically suspend where appropriate. This ensured risk mitigation with no financial detriment. This was also taken a step further when vaccinations became available and the trepidation some pregnant employees had around the unknown effects of vaccination on both them and their unborn babies.

186. In January 2021, during the early stages of the vaccination programme, the Occupational Health Department reviewed their guidance on Covid-19 and the risk to pregnancy, which stated that pregnant women of any gestation were at no more risk of contracting the virus than any other non-pregnant person who is in similar health. For those women who were 28 weeks pregnant and beyond, there was an increased risk of becoming severely ill should they contract Covid-19, as is the case with any viral illness.

187. As the pandemic progressed, the Trust continued to liaise with the Occupational Health Department to obtain medical advice to share with staff and keep them appraised of the latest medical information so that they could make informed decisions. An initial staff bulletin was published on 18 March 2021 sharing a leaflet produced by experts in maternity care that provided balanced arguments of the potential benefits and potential risks in advance of there being any trial data to refer to. Subsequently further advice received from the Joint Committee on Vaccination and Immunisation (JCVI) was shared in a subsequent staff bulletin on 21 April 2021. In summary the JCVI advice was that '*...it's preferable for pregnant women in the UK to be offered the Pfizer- 2 BioNTech or Moderna vaccines where available. There is no evidence to suggest that other vaccines are unsafe for pregnant women, but more research is needed.*'

188. As a Trust, we monitored all staff vaccinations and encouraged managers to discuss the vaccine with their staff if they were apprehensive. The risk assessment tool and vulnerability level and work considerations document continued to be the primary means of assessing individual risks in the workplace and identifying appropriate adjustments / actions.

Measures introduced to support staff through the pandemic

189. The Trust has followed all of the necessary national and regional guidance and updates throughout the pandemic in relation to PPE (detailed further from paragraph 222 onwards), shielding/isolation and risk assessment to protect vulnerable patients and staff whilst also trying to reduce chances of infection for those less vulnerable. The Trust also worked hard on availability of a vaccination/booster programme along with our usual flu vaccine investment to give those that wanted it the opportunity to be protected.

190. There has been access to a wide range of support at different stages of the pandemic to try and proactively mitigate the effects/risk. Corporate HR wanted to build upon the various support and wellbeing offerings already in place and ensure that there was accessible information, guidance and help if needed. The intention was to provide a suite of options that would cater for varying groups of staff in terms of inclusivity, job role and personal preference.

Agile Working

191. On 23 March 2020, the Government announcement was made that where possible, people should work from home.

192. An all NWAS bulletin was issued on 24 March 2020 from the CEO advising staff that where possible arrangements should be made to work from home in roles where this was possible.

193. In response to this a Temporary Home Working Policy was issued dated 30 April 2020. Further to that, a Working Group was then established to review the Trust position regarding Home Working and to ensure that all the necessary Health & Safety and HR requirements were in place to enable this working arrangement to be further embedded into flexible working opportunities where roles permit. The Working Group was Chaired by the Deputy Director of People and comprised of relevant Managers from Corporate

Departments. Following a series of meetings and discussions at ELC, an Agile Working Policy was developed by the Working Group and was signed off by the Trust Policy Group

Alternative Duties

194. The Trust recognise that protracted absence from the workplace is widely documented to be linked to the development of poor mental health and, at this particular period in time, poor mental health was likely to be further compounded by the psychological impact of the pandemic. There are significant psychological benefits to individuals when they feel a continued connection and involvement in the workplace; being able to make a valued contribution, support colleagues and retain structure to the day provides a sense of worth and reduces feelings of isolation and helplessness. The Trust also recognised the significant benefits gained by utilising the skills of our workforce, maintaining staff engagement with the organisation and reducing the cost of staff absence.

195. The Trust therefore developed an alternative duties register and invited managers across NWAS to identify any meaningful tasks, projects, duties etc., that could be logged centrally on the register and offered to staff who were stood down from their substantive role.

196. Additionally, approved vacancies were assessed to determine whether they would be suitable to be offered initially for alternative work purposes on a temporary basis and therefore added to the register. The HR Business Partner Team, who had oversight on all Covid-19 vulnerable cases, managed the register and liaised with managers to identify the allocation of alternative work.

197. Individuals allocated to alternative duties retained their contractual terms and conditions, i.e. maintained the same salary (unless undertaking a job role evaluated at a higher pay band), hours of work, unsociable hours pay etc.

Staff training

198. The rules governing social distancing impacted the way education in a classroom setting was carried out. This meant that the room configurations and infection control measures were implemented, as well as all venues undergoing a risk assessment to

enable staff training to continue where safe to do so. Some of the key measures implemented in this regard are outlined below:

- Classroom numbers were reduced to create space to maintain 2m between learners.
- Where learners had to work less than 2 metres apart FFP3 face masks were worn.
- During driving courses, all learners and driving instructors wore FFP3 face masks in the vehicles where it is not possible to be 2 metres apart.
- Cleaning supplies in each vehicle and all controls wiped down when changing drivers.
- Individual desks were purchased for all learners.
- Health check questions and temperatures taken for all people entering the buildings.
- Each learning venue was subject to regular risk assessments.
- More vulnerable staff members had individual risk assessments completed and action put in place (shielding and working from home for example).
- Additional equipment was purchased for staff working from home (chairs, laptop, monitors etc).

Welfare support measures and communications with staff

199. At the start of the pandemic the Trust implemented a 24/7 Employee Assistance Programme (EAP) contact line for staff to access around the clock in case they need emotional support. This complemented the existing counselling provisions the Trust offers through occupational health. and the NHS mental health hotline. We also worked with a charitable organisation on a programme called "Just Be" which held anonymised independent health conversations with staff in order to identify themes and actions required in any particular area.

200. The Trust has a comprehensive wellbeing offering covering Occupational Health, Physiotherapy and Counselling. All have been utilised where required in the diagnosis and ongoing treatment of Long Covid as well as advising on those with a less direct and obvious impact. Physiotherapy has helped some people regain strength and mobility and our counselling service has often dealt with the mental health effect of Long Covid. Occupational Health Physicians and Specialists have supported us with regular case updates as well as referrals and signposting into Long Covid support groups. All these

support groups seem to provide a slightly different service depending on location but have been beneficial for many individuals.

201. Our spend on our Occupational Health services has significantly increased over the last 2 years indicating the investment in Occupational Health referrals and internal mental/physical health to support the wellbeing of staff throughout. During lockdowns our Occupational Health provider adjusted the delivery method of Occupational Health/Physiotherapy and counselling appointments to ensure that staff could retain access to the support they required.

202. During this time the Trust launched the Mental Health Toolkit and the Suicide Prevention Toolkit aimed at supporting both staff and managers by providing proactive and reactive support with respect to mental health and suicide prevention. In addition, the Trust refreshed and reviewed resources on financial wellbeing.

203. Long Covid support was provided through a partnership with the Welsh Ambulance Service. Staff could access a network of peers and provide mutual support. The group operated virtually via MS Teams with the input of clinicians to better understand the symptoms and effects of Long Covid.

204. In November 2021 the Trust invested in an Attendance Improvement Team which has helped support and coach managers with complex long Covid-19 cases, subsequent Occupational Health advice and up to date guidance on supporting/managing Long Covid cases as well as day to day Covid-19 isolation managers. This ensured managers felt comfortable and equipped to provide appropriate care and support to their staff suffering long term effects of Covid-19.

205. A significant proportion of those diagnosed with Long Covid remained absent from work based on either physical or mental symptoms so were supported through our sickness management process and in particular long term sickness process which is set up to support individuals with any condition with weekly welfare/wellbeing conversations, facilitate access into services such as occupational health, physiotherapy, counselling, employee assistance programs.

206. As guided by NHS employers, pay protection applied through the course of Covid related absences up September 2022 following a 3 month transition period announced in

July 2022. At this point those that remained off work moved over to their full entitlement of standard sick pay. This ensured there were no unwanted financial pressures and focus could be solely on recovery.

207. Care and support was, and continues to be, provided via a range of means including access to specialist Long Covid clinics, specialist long term recovery services, adjustments to the way in which welfare/wellbeing meetings are delivered, exploring reasonable adjustments to duties, extensions to long term sickness timescales which allow for extended recovery timeframes. Where advice has been received through Occupational Health – which is often agreed – that recovery is unlikely, all avenues to support ill health retirement applications have been explored to provide financial support into early retirement.

208. Health & Wellbeing Leads worked with local Resilience Hubs and signposting targeted support for staff within Greater Manchester, Cheshire & Merseyside and Lancashire & South Cumbria. Staff were able to access mental health support via the hubs as well as take part in group activities and events local to them.

209. Throughout the pandemic members of the People Directorate and line managers actively called members of staff that were shielding to ensure they felt connected and any concerns were addressed, these were called welfare checks. To converse with those who may feel particularly vulnerable was important for the Trust, in order to ensure staff felt included and supported. The teams were then able to signpost to various support options where necessary.

210. At the start of the pandemic, the Trust did not have a multi-faith provision. However, in order to provide a holistic 'listening ear' service for those members of staff who did not want to speak to peers, we recruited a Chaplaincy Volunteer. Their role was to be accessible for staff who wanted to speak to someone who may not want to go down the counselling route or speak to a peer through the Blue Light Champions Network or Peer Support Network.

211. The Trust partnered with the Manchester Stress Institute (MSI) to create and design bespoke digital online wellbeing support using experts on mind and mood transformation specifically to help during the Covid-19 crisis. After obtaining feedback from staff, the podcast content has been designed to focus on helping with, exhaustion, anxiety and stress. The information was designed to be succinct to accommodate the needs for a

busy workforce. The podcasts focus on an array of topics to try and accommodate varying individual needs. The team also asked chefs and nutritionists to design healthy, low fat, high protein satisfying recipes for our staff which can be prepared before or after shift.

212. It was also fed back from staff that exercise is important to relieve stress and tension. Podcasts were designed to introduce staff to physiotherapy exercises to help with neck, shoulder and back pain, repetitive strain, as well as relaxation exercise for headaches, migraines and tension.

213. To ensure that staff had easy access to a variety of wellbeing information and guidance, a suite of leaflets were produced to go onto response vehicles covering topics such as staff support networks, multi faith provisions and gambling support along with a general health and wellbeing support directory.

214. During the first 12 months of the pandemic, a series of support calls were made to managers and these themes were collated and used to drive the wellbeing offer.

215. A new wellbeing conversation template was launched to allow staff to be open and honest about the status or their mental and physical health. Those dealing with ongoing anxiety/depression and trauma have been able to access counselling, alongside more complex therapies such as Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR). In 2021-2022, 2427 counselling sessions were attended and Covid-19 was specified as the specific driver for 52 of those. Many of those citing anxiety, trauma, depression and stress will also indirectly have related to Covid-19. In 2022-2023, 2486 counselling sessions were attended with Covid-19 specified as the driver in 14 of those cases.

216. Social media played a big part in communication with staff and the Trust created a closed Facebook page whereby senior managers conducted live Facebook chats and staff were able to post messages regarding concerns or share positive news. The staff mobile phone app was also used as a communications tool and there has been a considerable increase in staff downloads.

217. Through our 'Invest in Yourself' wellbeing intranet site, guidance sheets were developed to share support regarding subjects of notable importance during the pandemic, such as domestic violence awareness, suicide prevention awareness, sleep tips, fatigue and burnout and useful tips about staying connected when working from home.

218. As well as informative bulletins illustrating operational and procedural requirements the Trust felt that they needed to acknowledge and highlight positive messaging. This was done through 'Wellbeing Wednesday Bulletins' which round up wellbeing news for the week and 'Feel Good Friday' Bulletins which celebrated good news and acts of kindness both internally and from the public.

219. In order to support staff wellbeing and in recognition of the additional toll on staff and their efforts during the height of the pandemic, the Trust provided all staff with an additional days annual leave, titled 'Wellbeing Day', in 2021.

220. The Leadership Team also sent a gratitude card to every member of staff and volunteer through the post to thank them for their hard work and commitment.

221. Following the first 12 months of the pandemic where there was a clear initial response to the emerging picture the welling offer then evolved. The focus was based on providing an ongoing wellbeing offer to support staff, but also with the recognition that staff were burnt out and experiencing some longer-term impacts of the pandemic, both in their physical and their mental health. As a result, the Trust engaged MSI to run a manager's health and resilience programme called 'Beat the Burnout'. The Trust continues to engage MSI to run this programme.

222. Since January 2022 the Trust has been part of the National Ambulance Service Attendance Management Meeting. A large working group which has helped share best practice to ensure Trusts have provided a consistent and supportive offering with regards to Covid-19 recovery and reintegrating people safely back into the workplace.

Covid-19 Vaccination Programme

223. A vaccination governance structure was put into place to manage the Trust's Covid-19 vaccination programme. Executive leadership was managed by the Director of People in the capacity as Chair of the Covid-19 Workforce Cell. The Trust developed a Covid-19 Vaccination Cell and this has overseen the Covid-19 immunisation plan for NWAS staff, volunteers, students and third party providers.

224. The Covid-19 Vaccination Cell focused on the development and delivery of our in house vaccination offering, along with engaging with ICS leads in the region on the

vaccination programme. Whilst staff have had the opportunity to have the vaccination at the Broughton Vaccination Hub, staff have also been provided with details of hospitals and vaccination hubs throughout the North West where they have been able to access the vaccine.

225. The Broughton Vaccination Hub was set up via a specific multi-functional sub cell focussing on the set up and operation of the hub covering aspects such as IPC, estates, procurement and IT.

226. The Hub opened on 18th January 2021 for the first dose phase of the vaccination programme, operating on specific dates up to the end of February 2021. Overall 2,023 first dose vaccinations were administered to staff, volunteers, third party providers and the supporting military personnel. The operation of the hub was then paused until second dose vaccinations of staff were due.

227. On 29th March 2021 the hub reopened to commence the second dose vaccination phase. All individuals who were provided with the first dose at the hub were invited back for their second dose. Take up of the second dose was carefully managed and the hub closed for second vaccinations in early May 2021.

228. At the point that the Covid-19 vaccine was made available, the Trust undertook a lot of work to encourage staff to take it up. A full communications plan to encourage staff to take up the offer of the vaccine was undertaken.

229. On a Trust wide level, the communications also focused on encouraging staff from ethnic minority backgrounds to take up the vaccine and also included a personal letter from me to staff who were from a BME background [**DM/7 - INQ000249084**]. The letter summarised the measures that the Trust was taking to support staff with the intention of providing reassurance that all possible steps were being taken. Measures highlighted in the letter included how colleagues could access testing, financial support during any Covid related absence, information in relation to risk assessments and PPE and specifically the additional wellbeing support available via the Race Equality Network. The Race Equality Network (REN) Chairs also took a significant role in encouraging their members to review

the available information about the vaccine and to consider the benefits of having the vaccination.

230. Whilst the Trust had their internal vaccination clinics, the Trust also made links with local clinics and hospital Trusts to ensure staff had easy access to the vaccine.

231. In addition, there was also focussed communication to staff who were pregnant and undergoing fertility treatment with respect to vaccination.

E: RESOURCES, INFRASTRUCTURE AND EQUIPMENT

Operational Response Standards

PES

232. With effect from 7 August 2017, NWAS adopted the Department of Health Ambulance Response Programme (ARP) standards and emergency calls are now prioritised as one of the following response categories:

- Category 1 – immediately life threatening – mean response of 7 minutes and 90th percentile of 15 minutes
- Category 2 – emergency – mean response of 18 minutes and 90th percentile of 40 minutes
- Category 3 – urgent – 90th percentile of 120 minutes
- Category 4 – less urgent – further telephone assessment within 90 minutes to identify the most appropriate care plus a 90th percentile of 180 minutes.

233. These response standards were in place for the duration of the Relevant Period.

NHS 111

234. The NHS 111 service specification defines the NHS 111 standards. With respect to NHS 111 calls & performance, the target is to answer calls within 60 seconds 95% of the time. Additionally, there is a target that abandoned calls should only account for 5% of the total calls received.

PTS

235. At theonset of the Covid-19 pandemic, the NHS suspended PTS eligibility criteria and KPIs to enable PTS providers to support the increase in the provision of urgent and emergency ambulance capacity, and to ensure maintenance of services to essential patient groups (those travelling for dialysis, cancer treatment and discharges/ transfer).

Operational Resources & Response

236. In March 2020 NWAS had the following numbers of operational resources:

- NWAS Emergency Ambulances: 323 Peak
- NWAS Non-Emergency Ambulances:
  - 33 Peak (Urgent Care Service)
  - 338 Peak (Patient Transport Service)
- Non NWAS Emergency Ambulances: Zero
- Non NWAS Non-Emergency Ambulances: Approximately 24 (Private Ambulance Service)

237. In the week commencing 24 February 2020 up to the 1 March 2020, the Trust received 30,154 emergency 999 calls.

238. The following data outlines how swiftly (on average) the Trust provided a response to the different category of 999 PES calls received in the week commencing 24 February 2020 up to the 1 March 2020:

- Category 1 Mean Response - 07:20 minutes.
- Category 1 90th Percentile Response - 12:17 minutes.
- Category 2 Mean Response - 25:35 minutes.
- Category 2 90th Percentile Response - 54:35 minutes.
- Category 3 Mean Response - 01:46:08 hours/minutes.
- Category 3 90th Percentile Response - 04:03:23 hours/minutes.
- Category 4 90th Percentile Response - 03:26:32 hours/minutes.

239. With respect to NHS 111 calls & performance, the target is to answer calls within 60 seconds 95% of the time. For the week commencing 24 February 2020 up to the 1 March 2020 the Trust's achievement figure was 54.8%. Additionally, there is a target that abandoned calls should only account for 5% of the total calls received. The Trust's

achievement figure for this was 22.4% for the week commencing 24 February 2020 up to the 1 March 2020

240. The table below shows the staffing position for the NWAS NHS 111 service for the week commencing the 24 February 2020:

Call Takers (Non-Clinical)

	Monday 24/02/2020	Tuesday 25/02/2020	Wednesday 26/02/2020	Thursday 27/02/2020	Friday 28/02/2020	Saturday 29/02/2020	Sunday 01/03/2020	Total
Required Hours	896	866	898	838	1055	1801	1560	**7915**
Available Hours	725	689	684	690	693	1168	1015	**5665**
Variance	-171	-177	-213	-147	-362	-633	-546	**-2249**
FTE Variance	-22.8	023.6	-28.5	-19.6	-48.3	-84.4	-72.8	**-60.0**

Clinical Advisors

	Monday 24/02/2020	Tuesday 25/02/2020	Wednesday 26/02/2020	Thursday 27/02/2020	Friday 28/02/2020	Saturday 29/02/2020	Sunday 01/03/2020	Total
Required Hours	282	261	262	261	282	401	372	**2121**
Total Available Hours	221	276	255	230	239	327	377	**1923**
Available Online Hours	174	229	212	180	202	274	331	**1601**
Variance	-108	-32	-50	-81	-80	-127	-41	**-520**
FTE Variance	-14.4	-4.3	-6.7	-10.8	-10.7	-16.9	-5.5	**-13.9**

241. The following data relates to PTS calls received during the week commencing 24 February 2020 up to the 1 March 2020:

	Total

24-February	2938
25-February	3064
26-February	2984
27-February	3043
28-February	2719
29-February	931
01-March	54
Grand Total	**15733**

242. The following table outlines the PTS performance during the week commencing 24 February 2020 up to the 1 March 2020:

		Cumbria	**Greater Manchester**	**Lancashire**	**Merseyside**
Metric	Target	(Achieved)	(Achieved)	(Achieved)	(Achieved)
Call Answering	75%	**81%**	**81%**	**81%**	**81%**
Call Handling Average Waiting Time	1 minute	**15 seconds**	**20 seconds**	**18 seconds**	**16 seconds**

243. Demand on emergency ambulance services decreased as a result of lockdown and also as a consequence of NHS messaging that was designed to specifically ease the pressure and enable ambulance services to respond to the sickest patients.

244. We know that when this messaging eased, coupled with lockdown measures removed, the ambulance service quickly became overwhelmed with the number of calls and patients seeking help.

245. Emergency incident levels stabilised throughout the summer and early autumn of 2020. Additional restrictions were introduced in mid-September 2020 including a return to the Rule of 6, working from home, a 10:00pm curfew in the hospitality sector, and the introduction of a second lockdown on the 31 October 2020. A second full lockdown was

announced on 31 October 2021, and legally enforced from 5 November 2021. The impact of these measures did not follow the trends seen after lockdown one. Indeed, a stepped increase in emergency activity was noticed from 23 November 2020, and continued, other than activity variation through the festive period, until the middle of lockdown 3.

246. England entered a third National lockdown on 6 January 2021 including primary and secondary school closures. Whilst lockdown 3 was followed by a period of reduced activity, a relaxation of lockdown restrictions (announced on the 22 February) introduced through March 2021 was followed by a steady increase in incidents, peaking in late May (at which time Delta was acknowledged as the dominant variant).

247. The Trust did not undertake any formal research as to how Government messaging impacting their patient cohort and specifically a patients' willingness to call for an emergency ambulance. Subjectively however, some patients did confirm that during the pandemic they were worried that the ambulance services would be overwhelmed and there was concern around how safe it was to use our services. This worry was reflected across the wider NHS, namely a fear that patients would add to the pressure the NHS was under and whether they would be safe to use the NHS services. This attitude was mainly propagated by what patients had seen and heard on television and in the media.

248. Working with national charities the NHS did remind the public that the NHS was 'open' for anybody who needed us in an emergency, and messaging aimed to encourage those with chest pain or having a stroke for example to not hesitate in calling 999 swiftly.

Personal Protective Equipment (PPE) and Respiratory Protective Equipment (RPE)

249. On 1 March 2020 NWAS were operating a "pull" model at their 40 key ambulance stations. This meant that PPE/RPE was ordered from the Trust's preferred (and nationally mandated) supplier, NHS Supply Chain (NHSSC), via the online ordering portal. Stock would then be delivered directly to the key stations for operational colleagues to distribute onwards to satellite ambulance stations, as required. This method ensured that all vehicles were adequately stocked in a "just in time" approach.

250. Prior to the pandemic all staff followed general IPC policy and procedures based on standard precautions and transmission-based precautions and used PPE accordingly.

PPE was provided and available on each vehicle for staff to use including gloves, aprons, eye protection, sleeve protectors and an Infectious Disease Pack that contained Tyvek suits, overshoes and FFP3 masks. These kits were to be used when a crew deemed it necessary in relation to specific IPC diseases and where risk assessment deemed it appropriate in accordance with the Trusts Communicable Diseases Policy.

251. Pre pandemic, annual consumption of PPE/RPE products was very low. In the preceding 12 months to the commencement of the Relevant Period, NWAS procured circa 23,500 items (excluding single use nitrile gloves). In contrast, between the period 21st March 2020 and the 8th April 2020 NWAS received circa 560,400 pieces of PPE/ RPE (excluding gloves) from the push process and mutual aid.

252. At the end of March 2020 NWAS introduced a centralised JOT reporting tool (an internal stock management tool that provided visibility on each individual PPE item by areas within NWAS) which allowed the 3 PPE/ RPE Hubs (Bury/Blackpool/Wallasey) to report PPE/RPE stock levels. However, it was not until 9th April 2020 before this reporting process was refined to match demand with stock availability. The PPE stock levels on the 9 April 2020 were:

Items	**Units**
Aprons (Various)	132,00
Fluid Repellent Coveralls (Various)	4,587
Surgical Masks (Various)	95,600
FFP3 (Various)	26,193
Eye Protection (Various)	5,455
Total	**263,835**

How the Trust obtained supplies of PPE and RPE during the Relevant Period

253. In the early stages of the pandemic, as PPE stock availability via NHSSC became significantly reduced, it became apparent that a more structured and transparent process would be required to manage the whole internal supply chain and respond to the regional and national requirements to provide daily PPE stock levels on shared portals (initially

Adviceinc for Greater Manchester and then the Foundry portal to comply with the national requirement).

254. The national delivery model for PPE also moved from the standard customer "pull" model to a national "push" model which tried to match PPE/ RPE Trust stock levels as against Trust forecasted demand taking into account national stock availability.

255. Consequently, NWAS implemented a number of activities to control its internal stock, provide the required visibility and react to the fast-changing national distribution processes, including:

- Establishing a 24/7 central PPE/RPE receipt and distribution hub with bulk storage capacity, based at Fulwood, Lancashire.
- NWAS PPE/RPE procurement moved to a 7-day response and NWAS joined frequent (daily weekly) strategic and operational calls.
- Set up 3 area operational facilities (one in each region of the Trust – Bury, Blackpool, Wallasey) to produce level 2 packs for none Aerosol Generated Procedures (AGP), and level 3 packs for AGP procedures. These facilities were mainly staffed by volunteers and retired staff. The packs were then distributed to all operational areas of the Trust. Appropriate PPE was also distributed to all the Trusts non clinical facilities (e.g. surgical masks and infection control products such as disinfection wipes).
- Established a 3 times a week tactical call with representation from the 3 area PPE leads, central PPE distribution hub & procurement.
- Electronic stock control systems were established to improve visibility and monitor stock levels and locations (JOT form).
- A model was also created to forecast daily consumption rates.

256. During the relevant period there were several national changes to the PPE/RPE supply chain including:

- NHSSC, via Purchase Order (computer generated order that is emailed to suppliers) to 40 locations – this is known as the Pull Model (i.e. raise a purchase order to suppliers to replenish stock)
- NHSSC, via Purchase Order, to 3 locations (Bury, Blackpool, Wallasey) - Pull model
- NHSSC to 1 location, via Purchase Order to central store (Fulwood) – Pull model
- NHSSC via MOD (Ministry of Defence) to one location, via Purchase Order - Pull model

- Push stock via Moviato (logistic organisation) for national stockpile deliveries, stock uploaded to the Advice INC portal (stock reporting system) (Greater Manchester model) and eventually the national Foundry portal (stock reporting system). This is known as the Push model (i.e. each Trust is required to submit daily burn rates of each PPE item used into a stock reporting portal to calculate the volume of stock which would be sent to each Trust, daily, to maintain a 14 day stock level)
- Push stock via Clipper (logistic organisation), stock upload to Foundry (stock reporting system) - Push model
- Mutual Aid (Ambulance/Regional) – sharing system developed between local NHS Trust
- National Supply Disruption Response (NSDR) to facilitate requests for urgent stock requirements outside of the pull and push models as described above.

257. During the relevant period there were a number of PPE related issues.

258. In the early stages of the pandemic general stock availability of all products was limited and deliveries were unreliable. The Trust did not always know what PPE coming or when and in some instances PPE deliveries often did not match the published manifests, although this became less of a problem as additional stocks became available in the system.

259. Stock levels of eye protection, fluid repellent coveralls and NWAS Trust agreed FFP3 masks were low in the early phases of the pandemic. Where possible NWAS looked to source from alternative suppliers or mutual aid and between February and November 2020, forty eight purchase orders were raised with alternative suppliers.

260. Regarding RPE items (FFP3) the Trusts preferred products were not always available resulting in the Trust trying to secure a stock of a limited number of products so that fit testing could be undertaken of staff.

261. A mutual aid system was established to "swap" FFP3 products with other Trusts to secure stocks of NWAS' preferred products and build up some resilience of specific RPE product lines.

262. There were also low stocks of the "fit testing" solutions and kits. NWAS invested in 10 x Portacount fit test machines to support fit testing. In addition, the Trust also procured 1,470 Sundstrom respirator systems and 3,550 hoods, which we ordered and delivered

between April 2020 and September 2020. The elongated delivery period was purely down to the manufacturing process and the pandemic related disruption to the international supply chain.

263. Frequent changes to national guidance were at time problematic, although this was more pertinent to the acute setting rather than the ambulance operations.

264. The original bib aprons supplied from the national resilience stockpile were a light weight 16-micron gauge plastic. Operational colleagues, in the ambulance sector, found this to be too light and would "flap around" when used in windy weather conditions. NWAS locally sourced a heavier gauge bib apron until a nationally sourced 35-micron gauge bib apron became available, via collaboration with Ambulance Trusts and NHSSC.

265. There were also a number of quality concerns regarding both the initial national stockpile and later nationally sourced PPE. These included:

- Short expiry dates.
- Latex products – NWAS has a latex free policy to protect both patients and staff who have an allergy to latex.
- Inappropriate specifications - For example there were cases of deliveries of non-fluid repellent surgical masks, however Trusts needed the fluid repellent surgical masks.
- Recalls and quarantine instructions - There were various requirements to isolate deliveries which obviously reduced availability of stock but also reduced staff confidence.

266. NWAS set up a basic Quality Control (QC) process at its receipt and distribution hub, Fulwood, to check the above before releasing stock for operational use. All PPE introduction was led by the procurement team and as such the quality of the PPE was also assessed by them, if on occasion they were concerned or had questions regarding a particular product then they would involve the IPC team for their opinion. This was also discussed at the IPC cell as procurement were part of that group and kept the group updated on any changes to PPE provision.

267. In regard to FFP3/ RPE these were tested on staff to assess suitability including male/ female/ bearded staff, glasses wearers etc.

268. Many local services and suppliers donated items into NWAS for use as PPE when stocks were getting low however not all of these were introduced into the service as they

were not fit for purpose. If they were deemed to be ok for non-clinical areas (for example FFP2 masks) these were used in non-operational areas such as in offices, contact centres etc. Alcohol gel was also donated and this was shared out to staff across the Trust for personal use.

269. There were at least three product recalls that occurred during this period in relation to PPE, one in relation to a specific FFP3 mask, one in relation to wipes and one in relation to safety eye goggles. These recalls were circulated and the corresponding products were removed from service.

PPE Guidance during the Relevant Period

270. During the pandemic NWAS followed national guidance on the type of PPE that should be worn by crews attending Covid-19 positive patients. This was taken directly from NHSE and AACE guidance and highlighted the level of PPE to be worn for query cases of Covid-19, positive cases of Covid-19 and where AGPs were to be performed. Guidance was discussed at local IPC level with the IPC cell and all relevant parties including Trade Unions prior to any changes taking place. The Trust did not follow UK Resuscitation Council Guidance as this was out of 'sync' with NHSE and Government guidance.

271. National guidance changed several times over the Relevant Period and additional information bulletins and Trust wide correspondence was issued to frontline staff. Changes included moving away from full level 3 PPE for all cases to level 2 PPE for suspected cases and level 3 PPE for positive cases and where AGPs were to be performed.

272. Towards the end of the pandemic this also changed again to de-list some of the AGPs that the Trust had been wearing level 3 PPE for to only having to wear level 2 in accordance with the latest AGP research which was published by NHSE.

F: TESTING AND INFECTION PREVENTION & CONTROL

Establishing Gram Probe Real Time Polymerase Chain Reaction (PCR) Symptomatic Testing

273. As part of the response to the Covid-19 pandemic, the Trust established processes to ensure that staff who were self-isolating were able to gain access to a swab test to ascertain if they were positive for the virus. The testing was also offered to members of their household where appropriate. The home testing service was set up on the 30 March

2020 before national testing was available and 274 staff and household members accessed the home testing service between the 30 March and 30 June 2020. This service was stood down as access to testing services matured across the UK.

274. In preparation for the Covid-19 pandemic a number of staff were trained to undertake PCR swabbing. These staff included members of the IPC team and Community Specialist Paramedics (CSP). When the staff testing started, CSPs were redeployed to undertake the testing role in the community. They worked 7 days a week and covered the Northwest footprint. Regional level agreements were made around laboratory capacity and which laboratories would provide testing kits and process results.

275. For NWAS staff and household members the PCR swabs were processed at Royal Oldham Laboratory, following which the tested individuals were contacted with their result by either an Advanced Paramedic, Senior Paramedic Team Leader or a member of the Education Team. It was important for these calls to be led by clinical practitioners. Any staff who were on light duties due to pregnancy, were shielding due to having low immune systems through illness or previous organ transplants, were shielding due to high-risk family members or those staff unable to undertake frontline 999/NHS 111 work as they were recovering from Long Covid were also redeployed to the staff testing cell from March to July 2020.

276. Results were made available to staff in most cases within 24 hours; and no-longer than 3 days. In the early stages of the pandemic some Covid-19 sickness reporting was managed locally so processes were put in place for all NWAS sickness to be reported by the Carlisle Support Centre (CSC). Staff were asked to contact the CSC to confirm they had their test result and the outcome of the result. If the result was negative the staff members would return to work. If a result was positive the affected staff member received a welfare call from either their operational team or HR and isolated for the recommended time period.

277. The responsibilities of the Staff Testing Cell included:

- Understanding and accessing swab testing capacity at Royal Oldham Laboratory.
- Capturing and recording details of the staff and family members requiring a swab test, crucially including NHS number.

- Booking slots for the swab testing i.e., community, Dukinfield, national testing 'drive thru'.
- Providing a community swab service.
- All governance and assurance processes including:
  - Information governance (IG) i.e. Data Protection Impact Assessment, incident reporting.
  - Risks management.
  - Lessons learned.
- Reporting on tests undertaken, results received and staff abstraction.
- Offering an expert resource to NWAS staff by keeping up to date with the latest clinical research and guidance relating to Covid-19 i.e. when the loss of taste and smell was introduced as a symptom.
- Monitoring the positive results obtained in order to identify possible hot spots which became known as outbreaks or clusters.
- Delivering briefing sessions to operational managers.
- Developing Trust wide communications.

278. 3 weeks after the Trust established its staff testing process, a series of national 'drive thru' testing facilities were established. Initially the Trust fully utilised the national service at Manchester Airport and subsequently Haydock Racecourse. However, following a change in national process and associated poor service from the national testing, the Trust decided to develop a NWAS 'drive thru' based at Dukinfield. The set up for this service was based on initial learning gathered at the NWAS Penrith 'drive thru' which was set up initially due to limited testing in Cumbria.

279. The Trust also had local arrangements with Acute Trusts to swab test staff. The majority of these testing arrangements were set up via local hospital relationships and then promoted to all staff. These services were provided at:

- Royal Blackburn Hospital
- Royal Preston Hospital
- Blackpool Victoria Hospital
- Furness General Hospital
- Royal Lancaster Infirmary
- Wirral University Hospital Trust
- Salford Rugby Stadium 'Drive Thru' which was managed by the Northern Care Alliance
- Cumberland Infirmary

- West Cumberland Infirmary

280. The Staff Testing Cell was stood down at the end of June 2020 and redeployed staff returned to their pre Covid-19 roles. Staff were advised to book Covid-19 testing via the national Government website which offered testing at regional community locations.

281. Covid-19 positive cases amongst staff were reviewed on a daily basis via strategic command cells and operational cells such as the Staff Testing Cell in order to influence daily decision making. At the start of the pandemic this data was used to understand what testing opportunities were available across the North West regional footprint and if any staff members where disadvantaged with respect to accessing testing solutions. In the early part of April 2020 rural areas in Cumbria were struggling to access testing hence NWAS set up a local testing site at Penrith, as referenced above. We also offered community testing for staff and family members who were too unwell or unable to travel to regional testing facilities. When testing was limited in early March/April 2020 NWAS had the foresight to offer testing to staff families to alleviate the stress and anxiety of not knowing if they were positive with Covid-19. If results came back negative staff who were self-isolating could return to work.

282. The issue for many ambulance services was that they did not have access to their own laboratory to process PCR test results. NWAS was very fortunate for the mutual aid provided to us from Oldham Laboratory which enabled us to process our community PCR tests. We were also supported by local Acute Trusts who allowed NWAS staff to access their local testing.

Test, Track and Trace Service

283. NWAS established a new Test, Track and Trace (TTT) service at the end of July 2020 to protect staff, partners and patients, in response to a mandated national request from NHS England/NHS Improvement. The NWAS TTT service is a supplemental service to the National Test Track and Trace system, which does not trace NHS staff at work.

284. NWAS TTT was designed using national guidance provided by AACE requiring the Trust to complete a risk assessment where a positive Covid-19 PCR test had been reported by an individual to NWAS. Financial resources were made available to recruit a Test, Track and Trace Manager and project support officer to manage the team. Staff who were shielding or recovering from Long Covid were also offered alternative duties and

worked as tracers. Over 10 Standard Operating Procedures and internal processes were developed to ensure the TTT service could be established.

285. The service was offered 7 days a week 8am-7pm weekdays and 8am-5pm weekends. The staff work a rota and have a duty manager on weekdays. The service was also supported by the ROCC out of hours and operational managers.

286. The duties performed by the team include:

- Understanding the demand for the TTT services and escalating any capacity issues
- Checking the welfare of Covid-19 positive staff members and understanding whether there are any further workplace risks
- Tracing close contacts and recording accurate information about these cases
- All governance and assurance processes including:
- Information governance (IG) i.e. DPIA, incident reporting
- Risks management
- Lessons learned
- Auditing the data to understand if there are any potential outbreaks or clusters for clinical review
- Implementing changes to Government policy i.e., isolation dates
- Holding drop-in sessions for managers
- Developing trust wide communications
- Point of contact for operational managers
- Developing and updating managers guidance
- Escalating issues of concern to senior leads

SafeCheck

287. SafeCheck is an internal compliance database. During Covid-19 SafeCheck was modified to collect staff Covid-19 positive results and also LFT results. SafeCheck was also used to develop QR codes to use for training and large communal areas to understand if staff had been near each other before a staff member presented as Covid-19 positive.

Reporting Covid test results

288. At the start of the Covid pandemic there was no standardised way of reporting Covid-19 sickness within NWAS. We recognised this as an area that required urgent improvement and we were able to commission the support of the Mersey Internal Audit

(MIAA) Team who started reporting cases for us in a more effective manner. The following data was collated with respect to positive cases during the relevant period:

- July 2020 - March 2021 - 1707 positive cases of Covid-19 were identified within the Trust workforce.
- April 2021 to March 2022 - 4632 positive cases of Covid-19 were identified within the Trust workforce.
- April 2022 to June 22, 2022 - 1091 positive cases of Covid-19 were identified within the Trust workforce.

289. A small number of Trust staff were subject to inpatient stays as a result of the virus and we sadly lost 3 colleagues to Covid-19.

290. The change in sickness reporting helped to more accurately capture daily Covid-19 positive cases, the number of people shielding, the number isolating due to close contacts or having been traced by the national Test, Track and Trace (TTT) team. This data was reviewed daily by the Executive Gold Cell and Regulatory and Compliance Cell to understand the impact of Covid-19 on the workforce and service delivery.

Other Testing Solutions

Asymptomatic testing

291. Following a request from NHS England the Trust participated in a national piece of research looking at the prevalence of the Covid-19 staff in asymptomatic staff. At very short notice, the Trust established swab-testing facilities across the North West at 10 locations. Each location was resourced with swab-testing teams, comprised of a clinician swab tester, swab assistant and administration support. Booking staff provided support mainly focused on searching for and assigning the NHS Number for the staff member that was to be tested. Approximately 100 staff were involved in this work, testing over 400 staff members in one day.

292. As this was a national initiative, the laboratories at Royal Oldham Hospital provided additional swabbing equipment and testing capacity for this specific period which was due to cover Friday 8 May 2020 until Sunday 10 May 2020. Despite significant staff interest in this initiative, an NHSE representative confirmed that they only required a maximum of 500 tests. Of the 412 swabs submitted by the Trust, 3 tested positive.

Antibody Testing

293. Antibody testing arrived just as the Trust approved the shift from providing swab testing internally to recommending staff utilised the national testing sites or used a home testing kit. This allowed the Staff Testing Cell to focus its attention on providing the opportunity for all our staff to access an antibody test within a specific six-week window. The national antibody testing programme comprised of several phases with the ambulance service required to offer antibody testing to all staff from the beginning of June 2020 until 12 July 2020. The Trust was required to report the number of tests taken daily to the NACC via the ROCC.

294. The Trust does not have permanent phlebotomy staff, neither does it have laboratories required to test the blood samples for the antibody. Therefore, a process had to be developed to enable access to these resources in order to achieve the testing aim.

295. The test was offered to over 6500 staff dispersed across the North West. The Acute Trusts were geared up to provide antibody testing to their staff and some patients naturally, resulting in the processes being aligned to their workforce model. Most of these Acute Trusts employed digital solutions to provide the laboratory testing and results reports; unfortunately, these IT systems were not consistent across the North West. The different oversight processes within each of the areas (Cheshire & Merseyside, Greater Manchester, and Cumbria and Lancashire) further compounded this complexity. Cheshire and Merseyside had representatives from MIAA co-ordinating the processes, within Greater Manchester this was an item for the Strategic Command meetings and within Cumbria there was less overarching oversight with processes managed at an individual organisation level. Support and oversight was also provided by NHSE/I.

296. 5876 trust staff took the opportunity to have the antibody test during the six week period. This equated to approximately 89% of the workforce. The breakdown of antibody tests by area is shown below:

- Greater Manchester - 2079
- Cumbria and Lancashire - 991
- Cheshire and Merseyside -1744

297. The Trust was not informed of the results of the antibody tests and staff were not obliged to inform the Trust of the outcome. However, the Cheshire and Merseyside reporting process included the levels of positive results. Within Cheshire and Merseyside positivity amongst staff was approximately 21.8% versus 16.7% across all the Cheshire and Merseyside tests (staff and patients).

Lateral Flow Testing

298. On 9 November 2020, the Health Secretary, Matt Hancock, announced a plan to begin offering asymptomatic testing to all NHS staff twice a week to minimise the spread of Covid-19 and keep NHS staff and patients safe. A national pilot for asymptomatic testing went live at this time and included 34 Trusts across the country; three of these Trusts were within the North West footprint at Oldham, Blackburn and Warrington.

299. In response to a national requirement for all Trusts to start piloting periodic asymptomatic staff testing by 20 November 2020, a short life asymptomatic testing cell was established to lead the pilot and roll out asymptomatic lateral flow testing to staff across NWAS as part of the wider test and trace element of the regulatory cell.

300. The purpose of asymptomatic lateral flow testing was to reduce the nosocomial infection and spread of Covid-19 between staff and from staff to patients. Asymptomatic lateral flow testing formed a key part of NWAS's Covid-19 IPC strategy, thereby helping to prevent larger Covid-19 outbreaks occurring on our sites.

301. Lateral flow antigen testing detects the presence of the Covid-19 viral antigen from a swab sample. The test is administered by handheld devices producing results in 20-30 mins and can be self-administered. Lateral flow antigen testing has a lower sensitivity when compared to both PCR and LAMP technology. However, studies to date suggest that, similar to LAMP, these tests are better at returning positive results for individuals who are infectious rather than individuals who may have had Covid-19 recently and are no longer infectious (PCR will detect both).

302. The specificity of the test is 99%+. There is the possibility of some false positive results, therefore a confirmatory standard PCR swab test is required if a positive result is returned from an asymptomatic lateral flow test. Nationally it was expected that there would be a 2% positivity rate from the asymptomatic lateral flow tests. The sensitivity of the asymptomatic lateral flow test is lower than the standard Covid-19 PCR swab test;

therefore, there was a requirement for staff to carry our 2 tests per week to compensate for this; this is because carrying out 2 tests per week will result in a similar sensitivity rate as a standard Covid-19 PCR swab test.

303. Flu vaccine data was used to calculate how many asymptomatic lateral flow tests were needed for the Trust. The test kits were delivered to Trusts across England during the week commencing 16th November 2020. In total, 6,750 tests were delivered to NWAS and distributed across sites. The tests came in pre-packed boxes, comprising 25 individual tests and staff members were to be issued with one box each.

304. A pilot commenced at Estuary Point on 20 November 2020, in order to test the change to key processes (e.g. training, kit distribution and result recording etc.). Estuary Point was chosen as a pilot for the start of the rollout due its staff numbers and ease of distribution of the kits. Middlebrook NHS 111, HART Liverpool, Carlisle and Wigan were then identified as the next sites within the roll out for the week commencing 22nd November.

305. Reporting compliance for lateral flow testing was lower than expected. However, steps were put in place to increase lateral flow testing and included:

- Daily prompts when staff log on the NWAS IT systems to remind staff to undertake testing.
- Weekly staff bulletins about testing compliance and open outbreaks at sites.
- Training videos on how to undertake the Lateral Flow test and input the results.
- Regular refresh of staff 'Frequently Asked Questions' bulletins.
- Local manager engagement.
- Promotion of testing via NWAS's 3 geographic area outbreak leads.
- Promotion via social media i.e. Twitter and Facebook posts and videos.
- Introduction of an IPC Quality Improvement programme and coaching.
- Daily IPC checks.
- Escalation process for sites who require more intensive IPC support.
- Working closely with the regional IPC leads.
- Increased specialist IPC personnel.

306. Staff reported all lateral flow test results via SafeCheck and reported a positive test result via Carlisle. A second roll out of test kits commenced in February 2021. A total of 7163 kits were issued between November 2020 and March 2021.

307. Systems were also established to ensure lateral flow positivity data could be reviewed by the Test, Track and Trace team to ensure all positive staff members were traced swiftly.

LAMP testing

308. On 26 February 2021, in partnership with Lancashire and South Cumbria LAMP testing programme, Loop-mediated Isothermal AMPlification (LAMP) testing was introduced at some of the NWAS Critical Infrastructure Sites. Sites were identified based on their high prevalence of positive Covid-19 cases. LAMP testing is a way to deploy asymptomatic testing in an easy non-invasive approach. This process involves staff providing saliva samples which are sent to the laboratory for analysis and results are normally received within 24 hours. The saliva sample is highly accurate and more tolerable to weekly testing than undertaking lateral flow device testing.

309. Initially work started at the Middlebrook NHS 111 site and was then rolled out to Broughton EOC. Once learning from the initial test sites was understood LAMP testing was rolled out to the NWAS Critical Infrastructure Sites. Operationally, Lancashire and parts of North Cumbria were able to participate in the LAMP testing programme with those NWAS teams able to drop off their sample at local hospitals. LAMP was also deployed to two other operational sectors in GM and C&M which were identified as being areas of concern in which Delta variant surge testing had been implemented.

310. From June 2021 onwards the process for registering for LAMP testing moved from a manual data inputting to using the NHS Digital 'HiPRES' app. The move to HiPRES made the process of submitting saliva samples quicker. Results were then sent directly to staff via their email and mobile number. The app sends test results and reminders to undertake testing.

<u>Infection Prevention and Control</u>

311. With respect to Infection Prevention and Control (IPC) NWAS followed the guidance set out by NHSE and PHE that was published through government websites and via letters to Trust CEOs, Medical Directors and Chief Nurses.

312. The guidance in the very early days of the pandemic was very generic and focused on the acute setting. This guidance therefore had to be adopted by the ambulance sector as best we could.

313. As the pandemic developed AACE produced ambulance specific guidance adapted (where necessary) from the national guidance to suit the ambulance sector. This was written in conjunction with the IPC leads from each Trust and signed off by QIGARD at national level, with some involvement from national trade union representatives. This guidance was then disseminated through the National Ambulance Service IPC Group (NASIPCG) to the IPC leads of each Trust and their Directors.

314. As the pandemic continued the NASIPCG Specialist Advisor was also part of the national NHS (NHSE and devolved nations) IPC cell which developed the pandemic guidance over a two-year period thus enabling the ambulance specific guidance to be developed alongside other health care guidance. This was published on the NHS/UKHSA website alongside the generic guidance.

315. NWAS would review this guidance as it came in and discuss with identified leads from across the Trust to decide how best to introduce it into the Trust. Initially, this was with the IPC Covid-19 Core Team and then the IPC cell which had members from IPC, Medical Directorate, Operations, Contact Centres, Communications, HR, Estates and Facilities etc.

316. Guidance was reviewed by this group to agree the necessary actions and implementations across the Trust. The main local adaption to the guidance was in relation to specific areas such as the 'Working Safely' document which the Trust would review in order to identify which areas needed specific mitigations in place i.e. screens in EOC etc.

IPC Module

317. The IPC Module was developed in response to the high number of outbreaks across the Trust. The purpose of the module was to support IPC practices across NWAS. The module has been designed to help the Trust:

- Understand where their IPC priorities are.
- Use a Plan, Do, Study, Act cycle to implement small tests of change to improve IPC within working environments.
- Have a standardised approach to manage IPC.

318. The IPC module promoted the principles and implementation of a safe system of working for all staff throughout NWAS across all departments. The module was particularly important and relevant during the Covid-19 pandemic. The module can be used by any staff member managing an IPC issue. All the guidance in the module is underpinned by the most up-to-date evidence from PHE and AACE.

319. The IPC module provides:

- Signposting to NWAS IPC training material.
- Case study examples of how quality improvement models/methods can be used to identify IPC problems and ways to implement small tests of change.
- Learning from Covid-19.
- Covid-19 and changes to IPC practices.
- Assurances around IPC governance processes (which was inherent to how the Trust would achieve 'Operation Outstanding' by March 2022).

320. The IPC module is available on the Electronic Staff Record (ESR) for staff to use. The module uses a step-by-step approach with a narrative to assist in completion of the written training material. Alternatively, coaching can be provided by the Quality Improvement team as required.

321. The IPC module has testing sites, located at NHS 111 Middlebrook and PTS Broughton. The IPC leads attended weekly coaching sessions and benefitted from sharing ideas and learning within their services.

IPC within ambulance vehicles

322. During the course of the pandemic many considerations had to be taken into account in relation to IPC within vehicles.

323. NWAS were involved in transporting the first group of cases that arrived into the UK and were placed at Arrowe Park Hospital. During this period, the Trust agreed to use specific ambulance vehicles stripped out of non-essential kit to transfer these patients from airport to hospital and to facilitate ongoing inter-hospital transfers.

324. At the start of the pandemic, when Covid-19 positive numbers were small, general ambulances were not used for transportation of Covid-19 positive patients and HART team vehicles were used instead, again with all non-essential equipment removed to aid cleaning.

325. When positive cases started to increase general ambulance vehicles were used to transport all potential Covid-19 and positive Covid-19 cases.

326. Ambulances were 'de-cluttered' to ensure that no overstocking of non-essential equipment remained within the vehicles. PPE was enhanced and additional supplies made available on all vehicles.

327. Vehicle cleaning was enhanced and 'make ready' teams utilised. Additional cleaning teams, managed by NWAS, were established at all the major hospitals to ensure that cleaning was completed after each patient encounter in a speedy and effective manner. In addition to the 'fixed' teams at the larger hospitals we also had mobile teams going around sites to support ambulance cleaning. This was facilitated by an external company managed by the Trust's Estates and Facilities Team.

328. In 2022 an evaluation of the cleaning project was undertaken to see how it was working and to see if there were any lessons to be learnt; the results were presented to the Trust Executive Leadership Committee. The findings of the evaluation were that the cleanliness of ambulance cabs was within the expected NHS standard regardless of whether the cleaning was undertaken by contract cleaners or ambulance crews. The cleanliness of some equipment (particularly oximeters and blood pressure cuffs) did not meet expected standards regardless of whether the cleaning was undertaken by contract cleaners or ambulance crews.

G: THE TRUST'S FUTURE RISKS, REVIEWS, REPORTS AND LESSONS LEARNED

The Trust's reflections – What worked well?

329. AACE produced a national review document entitled 'Ambulance Response to Covid 19 - What Went Well' **[DM/8 – INQ000249085]**. NWAS were asked to provide their reflections to AACE as part of this review and the key points arising from an NWAS perspective are summarised below:

Matching Capacity with Demand

- Increased workforce capacity by:
    - Utilising volunteers.
    - Returning Staff / utilisation of students.
    - Patient Transport Service (PTS) to Paramedic Emergency Service (PES) - 150 staff and 80 vehicles.
    - Additional staff in Emergency Operational Centres (EOC) and 111 centres.
    - NWAS boosted its workforce by more than 450 extra workers to the frontline across 111/ PES and the EOCs.
    - Volunteers over a two-month period (end March to end May) volunteered 9,685 hours of their own time.
- Calls were filtered out from PES stack by clinicians.
- Business as usual was suspended early and acute capacity opened up and out of hospital provision.

Reduced Emergency Department Conveyance

- Increased Hear &Treat (H&T), See &Treat (S&T) and reduced See & Convey (S&C):
    - H&T – Locally H&T increased by 5-10% during the first two months.
    - S&T – Increased by up to 17%.
    - S&C – Reduced by 25%.

Integrated Urgent and Emergency Care

- Close integration of NHS 111 / PTS:
    - Both 111 and PTS provided crucial support during this period.
    - 111 took non-emergency calls in a safe manner whilst PTS staff and vehicles were utilised on the front line with the 999 service to provide an additional resource.
    - Both 111 and PTS provided invaluable resilience, flexibility and coordination of resources.

Other factors

- Introduction of pandemic triage protocols therefore preserving capacity for higher acuity patients .
- National lockdown reduced the normal demands we would have experienced.
- Change in public behaviour resulted in reduction in non-Covid-19 related activity.

- Diversion of non-emergency calls by BT from PES to NHS 111 and working together arrangements between EOCs for call taking.
- Provision of early clinical guidance allowing ambulance clinicians to determine when alternative pathways can safely be used.
- No competing demands for service (Covid-19 onset in Spring).
- Homeworking was quickly identified as a workable option for frontline and non-frontline staff. Clinicians in NHS 111 and the Clinical Hub worked from home over the Covid-19 period to provide the resilience for the NHS 111 and PES services.

330. In addition to the AACE review, the Trust have identified the following actions, which when taken early allowed us to respond efficiently and effectively to the demands of Covid-19:
    - Increase in the Resource Escalation Action Plan (REAP) level to REAP 3 and increased as required by our Demand Management Plan (DMP) levels, which is our pre-determined action to mitigate risk similar to OPEL in Acute Trusts.
    - Increase in staffing within EOC, PES and NHS 111.
    - Stopping business as usual and redeploying a significant number of corporate staff to support front line operations.
    - Ceased most non-emergency PTS journeys and redeployed staff to three priorities; discharges, vulnerable patient group and supporting 999.
    - Full command and control in place.
    - Identification of staff that can work from home and also who can support the front-line staff during this time.

331. In addition, The Trust quickly established a staff testing cell as part of its plans to manage the impact of the virus which was initially set up to support the swab testing of relevant staff.

332. Stakeholder communication and engagement was key throughout the pandemic. As an NHS provider, operating two key service lines at the forefront of the pandemic, our staff and the public would look to us to provide reassurance and instil confidence that we are working to protect them. The Trust's Communications Team were winners in the category of 'Most Effective Essential Worker Communication Strategy' at the Covid-19 Communications Awards 2020.

333. A staff survey titled "*Learning from the Trust's response to the pandemic*" was conducted across the organisation with responses requested from both front-line staff and managers / non-frontline staff. The survey was conducted in June 2020 and the response rate was 232 returns from managers/non-frontline staff and 500 returns from front line staff. Some of the key positive opinions drawn from that survey are outlined below:

- Working from home with additional infrastructure
  - 29% of managers/staff believe that working from home and the utilisation of MS Teams has worked well during the pandemic.
  - 12% of managers/staff state that with a bit more development that this could be improved further.
  - 49% state that flexible homeworking should continue.

- PPE Review
  - 19% stated that PPE brought real benefits for our patients and worked well.

- Status Quo and Cleaning
  - Over 20% of frontline staff reported that their role hadn't changed during the pandemic.
  - 17% of frontline staff saw real benefits in the cleaning of vehicles at Emergency Departments and this was a change that they wanted to continue.
  - 15% also wanted to normalise the use of PPE.

- Support from the Trust
  - 48% of managers/staff and 21% of frontline staff felt supported to "a great extent" by the Trust during the pandemic.

<u>The Trust's Reflections – Challenges and areas for improvement</u>

334. The Trust faced a number of challenges over the course of the pandemic, a summary of these is included below.

<u>IPC outbreak management</u>

335. Defined as where there were two or more confirmed cases of Covid-19 among individuals associated with a specific non-residential setting with illness onset dates within 14 days of direct exposure.

336. All Trust sites which were subject to an outbreak received enhanced help to support the local outbreak management team, including more frequent IPC audits and daily operational IPC leadership calls. Escalated sites were de-escalated after 14 days without a positive case and formally closed after 28 days clear of infection. During the height of the pandemic a number of outbreak sites were closed to external visits.

Access to adequate PPE

337. The Procurement Team worked tirelessly to ensure that essential PPE supplies were always available. This required us to work within new systems for stock distribution from NHS suppliers who adopted a 'push' system. In practice this meant that NWAS was sent the available PPE not the PPE we needed to replenish depleted socks.

338. Our Procurement Team actively participated in NHS exchange schemes to balance supplies between NHS providers and were constantly monitoring stock levels to ensure a constant supply. At no point did NWAS run out of supply of any PPE stocks and constantly reviewed available alternative options for PPE if the stock of the preferred PPE were unavailable. Stock levels were examined daily and low stock levels escalated to the National Supply Disruption Response. Mutual aid was accessed from partnering Trusts via the NHSE North West Incident Co-ordination Centre and maximising the preferred PPE items through national and local supply. The contingency plan was designed to support the significant risk to national supply routes and to ensure staff and patient safety.

339. The volumes required by all NHS organisations put a significant strain on the supply chain meaning that security and visibility of future deliveries of PPE stock was on a 24-hour basis. Planning for surges in activity and for recovering of services was extremely challenging. The reliability on national supply routes was a significant risk to NWAS.

Demand outstripping resources when easing of lockdown

340. Whilst the demand reflects NWAS only, the pattern of pressure experienced by NWAS was mirrored across the blue light services, specifically police. In essence we observed stepped reductions in demand broadly in line with lockdowns and a stepped increase in demand in line with easing of restrictions.

341. At the point of the first lockdown (March 2020) 999 call demand dropped by almost 50%. The record low level of calls reflected the public behaviour and limited mobility of the population. This was again reflected in November 2020 and briefly in January 2021.

342. The significant challenge in terms of demand was experienced post easing of restrictions. It should be recognised that locally defined tiering of Covid-19 measures blurred the lines somewhat. Following the first two phases of easing of restrictions, demand returned to 'normal' levels of activity pre pandemic. However, the easing of restrictions in the third phase saw demand increase well past the 'normal' point of demand pre pandemic. These pressures peaked in July 2021 with demand into NWAS, the sector and BT national call handling reaching the highest levels of all time. At this stage BT reporting record levels of demand, outstripped a New Years Eve. BT were required to operate at 'black alert' for the majority of the month and call answering standards steeply declined for NWAS and the sector overall. As the population returned to normal activity and with Covid-19 still prevalent within the population demand increased.

343. The Trust did observe a similar but less extreme trend post lockdown one and two and through this point we observed unusually high levels of patients under 18 requiring ambulatory support. This was primarily related to respiratory problems and highly likely to be linked to children returning to school.

344. The sector has not returned to pre pandemic levels of call demand with the new norm tracking above the pre pandemic norm. The only exception was in early 2023, likely influenced by Industrial Action (IA).

345. It is also worth noting the impact on NHS 111 demand which shifted from the onset of the pandemic. Historically the majority of NHS 111 call volume occurred within the out of hours period (evenings and weekend). This shifted during the pandemic and in hours demand increased significantly.

346. Again, this shift in demand has never returned to pre pandemic. It should be noted that the influencing factor differed. Lack of access to primary care was, and still is the most significant factor, alongside at the outset of the pandemic 111 becoming the point of contact for Covid-19 patients who were not acutely unwell.

347. Whilst demand was the primary challenge for the sector, abstractions were a significant factor as well. Abstractions increased post lockdowns at the point demand into 999 was increasing. This issue was also experienced at Christmas 2021 where across EOCs and the ambulance sector, abstractions reached peak levels. This was potentially the most challenging time. The demand and abstraction issue was mirrored within the operational teams as well.

Plans for resourcing and prioritising the response of ambulance related services to any future pandemic.

348. NWAS has seen a significant increase in operational funding since the pre-pandemic era of approximately 40%. This has allowed the Trust to have an increased operational baseline and an ability to respond more flexibly.

349. In partnership with the trade unions NWAS developed systems to quickly upskill staff groups to be able to respond to emergency calls which ultimately will improve operational resources.

350. During the Covid-19 pandemic NWAS developed clinical safety plans which allowed the Trust to alter its responses to varying levels of activity. This means we can escalate our responses to react to increased demand or pandemic situations.

351. The Trust have effective and sound financial management systems in place and this includes an assessment of resources required to undertake its business across the trust, and specifically services line of 999, NHS 111, PTS.

352. Financial plans were, and continue to be, submitted to the ICS which identify specific cost pressures as a result of Covid-19 pandemic, and post the pandemic the financial resources required to meet demand across the service lines.

353. The Trust have also invested in the Resilience Service Line (September 2022) to ensure it delivers on its legislative and contractual requirements under the Civil Contingences Act and EPRR.

354. The Resilience Team are currently reviewing the Trust's resources required to deliver its response to all large-scale incidents and major incidents including pandemics. This is an ongoing process and will require further investment.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 23 August 2023.