

**The Report of the Independent Review in to alleged failures
of patient safety and governance at the North East
Ambulance Service (NEAS)**

Dame Marianne Griffiths DBE

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Open letter to Amanda Pritchard, Chief Executive Officer of NHS England

The services that ambulances deliver form a vital part of our urgent care response in the NHS. The public depends and relies on those emergency services at particularly vulnerable and worrying times and the need for confidence and trust is paramount.

The investigation in this report specifically addresses issues where this confidence and trust has been lost and has been made in response to a whistle-blowing allegation revealed in the Sunday Times on 22 May 2022. This allegation was that the North East Ambulance Service NHS Foundation Trust (NEAS) covered up fatal paramedic errors and deliberately altered or omitted important facts that families and the relevant coroners had a right to know. In addition, the whistle-blower alleged that they were bullied and victimised for raising these concerns.

The investigation team spoke to four of the families that were named in the report and there is no doubt that their concerns expressed about openness and candour are justified. In addition, for most of these cases, the management of their concerns and complaints were poorly handled. The families simply wanted an acknowledgement of the complaint, acceptance of accountability and a full apology. They also wanted assurance that the organisation would learn from these episodes and deliver actions that would reduce the risk of these shortcomings happening to anybody else in the future.

Whilst there has been a genuine desire by NEAS, the Integrated Care Board and the North East and Yorkshire Region to understand the concerns and address them, the issues are complex, and some are long standing.

Several other external reviews have been commissioned, which have been very thorough and helpful and have made reasonable recommendations within the scopes of their Terms of Reference. Each has addressed a particular issue or problem area, but there has been no general holistic review that looks more broadly across the organisation to understand the culture and leadership systems that have led to the concerns being raised. The Terms of Reference for this review does incorporate these elements, and the findings of the other reviews have been taken into account. This report, then, does present a holistic review.

The findings from our investigation do highlight some significant cultural and behavioural issues that will have contributed to the failings experienced by the families. However, I do also believe that the new leadership team in place is committed to addressing these issues, though they will require some support to do so.

Governance processes in NEAS were found to be weak in some areas. The policies and processes are in place, but it is the consistency of application that needs some significant improvement and specialist support particularly in the area of serious incident management and Duty of Candour.

In addition, there was an overreliance on certain individuals giving reassurance on existing processes that was not found to be warranted.

The Coronial Service within NEAS has had a difficult time and communications between teams within the Trust have not been operating effectively. The failure of this has significantly contributed to the lack of transparency experienced and observed both in respect of the Families and the Coroner and the weaknesses in Governance.

This was not helped by some dysfunction that existed in the executive team which was addressed by the Chief Executive at the time but unfortunately the damage was done. It should be noted that the Trust is now in a much better place.

The Trust has devoted significant effort to improving the systems and staff have reported improvements but also recognise that there is more to do.


These concerns were made public by a whistle-blower and related to incidents that occurred in 2018 and 2019. The whistle-blower had raised concerns within the Trust, but the experience of that was poor.

The Freedom to Speak Up processes were flawed and need to be amended. There were divergent opinions on whether people would speak up if required and “defensive culture” was cited as a long-term challenge. The Trust have accepted these challenges and are implementing changes to improve.

We were disappointed that the whistle-blower would not engage with us as we were very keen to hear from him and his contributions would have been valued by us.

Finally, it is important to acknowledge how NEAS like all other ambulance trusts are experiencing very challenging capacity constraints and this affects its ability to deliver timely urgent care and safe and effective systems.

As it is a particularly small trust, it does need to be resourced to deliver a quality and safe service so that public confidence is sustained.



Dame Marianne Griffiths DBE
Chair of the Independent Review

December 2022

Acknowledgements

We would like to express our sincere thanks and appreciation to the four families we interviewed as part of our review for sharing their experiences and for the openness with which they told their stories even though this was very difficult and challenging for them.

They have been extremely generous with their time throughout the process and we are deeply appreciative for this and grateful to them for the contributions they have made throughout.

Our thanks also go to everyone who assisted with this review including staff from North East Ambulance Service and NHS England, South Western Ambulance Service NHS Foundation Trust; representatives who worked in Northumberland Clinical Commissioning Group; representatives from the Integrated Care Board; NHS Employment Services; NHS Improvement and Lynn Woolley, special advisor to the panel.

Background

On 22 May 2022, media coverage in the Sunday Times alleged that the North East Ambulance Service NHS Foundation Trust (NEAS) was covering up evidence in relation to patient deaths and withholding key evidence from Her Majesty's Coroners (HMC) linked to service failures. The news article made reference to seven incidents and the names of five individuals were included. The report said that families were not always told the full facts of the circumstances surrounding the death of their relatives.

In addition, the whistle-blower who reported these concerns to the Sunday Times also alleged that he had raised concerns about patient safety in NEAS a number of times and that he was bullied and victimised as a result of his actions.

Some of the concerns raised by the whistle-blower were known in NEAS and the wider NHS system particularly in relation to some specific complaints from families and the robustness of coronial processes and reporting. The alleged incidents took place between December 2018 to December 2019.

Whilst we have focussed on these specific cases, we have also reviewed the findings of the previous external reports which look at a greater number of patients. We have similarly examined the underlying systems and processes within NEAS in a holistic way and as such our conclusions are pertinent to all.

Consequently, a number of specific pieces of work were commissioned from independent sources to test whether the concerns were real and justified. Each of these reports produced a set of improvement recommendations.

In addition, an internal task and finish group was set up to undertake a comprehensive review of action taken to address identified weaknesses.

A Desk Top Review was also commissioned by NHS England and the ICB Chief Executive Designate and carried out by three directors of nursing from NHS Northumberland Clinical Commissioning Group (CCG), NHS England and Improvement (North East and Yorkshire Region) and NHS Newcastle Gateshead CCG. The key task was to assess whether recommendations from other reviews were implemented and to ensure that improvements had been made.

It is also important to note from a background point of view that there have been significant executive changes since 2018 including Chief Executive Officer, Chief Nurse, Chief Operating Officer, and leadership of the HR function. Many other key staff in place at this time have also either left for other posts or have retired. It should be noted that the new ICB did not formally come in to being until July 2022.

Following concern expressed after the Sunday Times article, on 14 June 2022 the then Secretary of State for Health and Social Care Sajid Javid confirmed that the NHS had agreed to an Independent Review. This Independent Investigation began on 17 August and was scheduled to be completed in four months. This Report is the outcome of that work.

Its Terms of Reference are set out as the headings of each Chapter of this Report. We have looked at the circumstances of each case, the findings of previous reports, our own investigation evidence and set out our own findings.

We have considered the coronial processes. These are the internal NEAS arrangements for communicating with the Coroner.

We have then reviewed the effectiveness of NEAS arrangements for communicating with the Coroner, the governance framework, the HR and Freedom to Speak up processes, and finally set out our overall conclusions and recommendations.

The Terms of Reference for this investigation can be found in Appendix A.

Chapter 1: Terms of Reference 1

“To fully understand the concerns raised in relation to the cases being considered, and the impact both of the incident and the subsequent processes, through speaking with families, where possible, and relevant stakeholders.”

Introduction

1.1 We reviewed four of the five cases that were identifiable by the whistleblower. We could not establish the whereabouts of the family of the fifth despite efforts made by NHS England to track them.

1.2 We contacted and wrote to the four families in August 2022 to seek their agreement to participate in the investigation and contribute to the final Terms of Reference.

1.3 They all agreed to do so and have been extremely generous with their time and contribution throughout the process. We are genuinely grateful to them for telling their stories and being so open even when at times this proved difficult.

1.4 The final Terms of Reference for the investigation and amendments were all agreed, and the families' needs and concerns were incorporated into the review.

1.5 We also met or spoke with them to hear their stories and views and have listened carefully to their concerns and kept them updated on our progress.

1.6 We have also taken into account findings from previous independent reviews and where appropriate have considered them as additional evidence in coming to our conclusions.

1.7 We have also conducted interviews, reviewed policies and procedures, read all the existing reviews and have sought from the Trust all relevant documentation relating to the cases in question. The four families have also contributed considerably to the body of evidence that has enabled us to come to our conclusions.

1.8 We have not adopted a criminal standard of proof in this investigation but have come to our views based on all the evidence outlined above, and on our own experience and skills, and have looked at the balance of probabilities and tests of reasonableness in arriving at our conclusions.

The Cases

Case 1, Patient A – 09 December 2018

The facts

1.9 This is a terribly sad case where a 17-year-old girl (A) was found hanging from a tree a short walk away from her home on 09 December 2018. A 999 call was made, and police officers arrived within minutes. They cut her from the tree and immediately commenced cardiopulmonary resuscitation (CPR) believing they had felt a pulse. The family are keen to stress that A's feet were on the floor at this time.

1.10 A rapid response paramedic (Paramedic 1) was one of the first staff to attend the scene. Paramedic 1 very quickly declared 'ROLE' (Recognition of Life Extinct) which meant that all CPR attempts were ceased and no further Advanced Life Support (ALS) given.

1.11 Following that declaration of ROLE, a community paramedic (Paramedic 2) arrived on the scene soon followed by two further ambulance crew members (Paramedic 3 and Paramedic 4).

Declaration of ROLE

1.12 The declaration of ROLE by Paramedic 1 is the first area of contention between the family and NEAS and is a substantial element of the family's complaint.

1.13 The two attending ambulance crew members (Paramedic 3 and Paramedic 4) had significant concerns about how the ROLE process had been enacted. They contacted their Clinical Care Manager (CCM) to express concerns and they attended the scene later to discuss those concerns with them. They then had to take A to the Royal Victoria Infirmary (RVI) but got together later with their CCM to complete the NEAS07 incident form and submitted it on 10 December. The incident was formally about the conduct of Paramedic 1 and whether they had sufficiently undertaken all the tests required before declaring ROLE.

1.14 In addition, a further NEAS07 was completed by the clinical audit team raising the same concerns again, within 24 hours of A's death.

1.15 The declaration of ROLE is a major decision and is governed by very clear national guidelines set by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). NEAS has developed its own guidelines in line with national policy.

1.16 In terms of NEAS's own ROLE forms, there is a Group B category that sets out the circumstances where CPR does not need to be initiated or in this case continued. The guidelines clearly state that to establish no realistic chance that CPR would be successful, all of the following must be present:

- No CPR over a period of 15 minutes since the onset of cardiac arrest (e.g., no bystander CPR)

- No evidence of drowning, hypothermia, poisoning, overdose or pregnancy
- A reading of asystole (a flat line) for a period of 30 seconds as shown on the Electrocardiogram (ECG) monitor (Defibrillator) and rhythm strip to be taken

1.17 Once the NEAS07 form was received, the standard procedures were initiated.

1.18 The NEAS07 is the internal incident reporting system for NEAS. If the completed form is assessed at level 3 or below it will go directly to the CCMs to investigate. If marked 3 or above it goes to the Clinical Operations Managers (COMs) initially before dissemination to the wider team.

1.19 In this case the risk was judged to be 5 and was sent to one of the COMs to investigate and COM 1 undertook this investigation.

1.20 The aim is to complete the investigation within 28 days, enacting Duty of Candour within that timescale. However, the investigation was complex and took longer, and the investigator report was completed and sent to managers for review on 18 March 2019 (over two months late).

1.21 The initial report prepared by the Investigator found that ROLE had not been enacted correctly but this report was directed to be altered by a Strategy Group who disagreed with the outcome.

Communication and Duty of Candour

1.22 This leads us to the second point of contention. Once an incident has been raised, there is an expectation that the family members should be notified about it within 28 days. It does not matter whether an investigation is taking place or that the findings are not yet known.

1.23 This did not occur and indeed the family were unaware of any concerns until 15 April 2019 when they were visited by the Family Liaison Officer (FLO) a few days before the first inquest hearing was scheduled. Here they were briefed that an administration error had occurred and that Paramedic 1 had filled out the ROLE form incorrectly and that they would receive additional training. They were not aware that any investigation had taken place into Paramedic's 1 response at the scene or informed of any concerns raised at the time.

1.24 NEAS did say that the FLO mentioned above had tried to telephone a few times but got no answer. The family say that they were there, but no calls were received or missed calls registered. In addition, there was no formal Duty of Candour letter written and sent to the family. The reason given for this is that the Trust and partners did not want to distress the family prior to the funeral. The family do not believe that NEAS should have taken that stance as it was not for them to determine what was best for the family at that time.

1.25 It wasn't until 19 April 2019, the Thursday before the Easter bank holiday, that the investigation report was received by the family (without appendices). The inquest was due to be heard on the Tuesday after the bank holiday.

1.26 The family were shocked and deeply distressed by what they read and could not understand how what they read in the body of the investigator report reconciled with its conclusion. In addition, they were shocked that nobody had shared these concerns with them earlier.

1.27 They did attend the inquest and listened to the report writer give evidence to the hearing. It became apparent at the outset that the family had not received all of the information relevant to the case. They felt that the investigator struggled with explaining the conclusions and asked relevant and searching questions. Only then, were they given all the papers including the appendices.

1.28 Given the issues and concerns now raised about the investigator report, the Assistant Coroner was not happy to come to a conclusion and adjourned the hearing to 01 August 2019. The Assistant Coroner wanted to call an expert witness to review the incident and provide a report. The family was very unhappy with the way the process was managed by the Trust and believed that the Trust was pushing for the inquest to continue and to come to a conclusion.

1.29 An expert witness was commissioned and made their report in June 2019. The expert's findings were that the ROLE was made without good cause and was inappropriate at the time as the criteria for ROLE was not met. They would have expected the paramedic to continue with resuscitation efforts and transport A to an Emergency Department. However, they did also add that whilst all effort should have been made and may have increased chances of survival, they still felt that on balance A would not have survived. However, the failure to provide advanced life support made her death a certainty. Paramedic 1 disagrees with the conclusion and believes that their declaration of ROLE was appropriate.

1.30 The family submitted a complaint to NEAS on 05 June 2019 following the inquest and registered their significant concerns. They also secured some legal representation to support them through the process.

1.31 In response to the complaint the Trust commissioned Ward Hadaway to do an independent review of the case. The investigation report was commissioned on 13 June 2019 and completed and submitted on 23 September 2019.

1.32 As a result of the investigation, the inquest scheduled on 01 August 2019 had to be adjourned again at the family's request as they wanted to see the findings from the report before the inquest recommenced.

1.33 The inquest into A's death resumed in October 2020 (following a series of delays, some due to the pandemic) and the Coroner recorded a narrative verdict.

Governance of incident

1.34 The third area of contention and concern for the family lies with the internal governance processes surrounding the investigation report.

1.35 As stated earlier, a NEAS07 form had been submitted with an initial assessment of a level 5 severity of harm. This warranted investigation and in

accordance with the Trust's own policy should have been presented at the Clinical Review Group (CRG) to review the case and assess the actual categorisation against the National Reporting and Learning System (NRLS) definitions, as well as to agree next steps. Any incident graded as moderate or higher is then allocated a senior investigating officer.

1.36 There were a number of delays due to insufficient information and the case was deferred to a meeting of the CRG on 20 December 2018. This too did not happen and was again deferred to 17 January 2019.

1.37 Prior to the December meeting, a group met, commonly referred to as a Strategy Group at that time, (these are meetings that look at Fitness to Practice issues) which decided that the incident was not deemed as a serious incident (SI) but no other categorisation was agreed. This group did not hold the remit or have the delegated power to make this decision, and this should not have occurred.

1.38 The CRG did take place on 17 January 2019 but did not really discuss the merits of the case and simply noted the outcome and decision from the strategy meeting. Duty of Candour also appeared to be questioned at this point. Delays were also attributed to other parallel reviews ongoing.

1.39 Despite this confusion and complexity, the investigation report was completed by the Investigating Officer (COM 1) on 18 March 2019. This original and primary report was judged to be thorough by Ward Hadaway. The investigator did interview all the NEAS staff connected with the incident including Paramedic 1. They also checked the ECG recordings and other evidence to establish the facts. The only element that could have been stronger but was addressed by Ward Hadaway themselves was the fact checking over an assertion that the printer wasn't working on the scene and concerns that emerged about this issue (see 1.43 below).

1.40 On completion of the report, COM 1 forwarded it to their line manager (acting Clinical Services Manager), Head of Patient Safety and Head of Risk and Regulatory Services. COM 1's final report on the investigation was discussed at the extraordinary Strategy Group that met on 26 March 2019. In attendance were the Medical Director, Deputy Director of Quality and Safety, Head of Patient Safety, Lead Consultant Paramedic, Head of Risk and Regulatory Services and line manager.

1.41 In summary, the investigator found:

"In conclusion, in relation to this incident, the investigating officer has established that local procedures and JRCALC guidelines with regards to Recognition of Life Extinct have not been applied correctly. Equally, the NEAS ROLE form and initial recordings on ePCR has not been completed to the expected standard. Given the circumstances, recorded and explained by all who attended. Advanced Life Support could and should have been provided".

1.42 This conclusion was attributed to two key factors. One was that the ECG recording only lasted for 16 seconds and not 30 seconds, as is required in both national and local guidelines, and secondly it did not indicate a reading of asystole (a flat line). It did indicate significant disturbance throughout with no rhythm recognition.

However, the investigator wishes to stress that the initial conclusions were derived from all of the presenting information gathered whilst compiling the investigation report. The other related to the fact that bystander CPR had been given and was not continued by Paramedic 1.

1.43 In addition, there was no rhythm strip printed, as is the normal procedure, as Paramedic 1 said that the printer was broken. This was retrieved from the stored data but there was concern whether this had occurred as no fault could be found on the printer.

1.44 The investigator also wrote that following the conversations with Paramedic 1 on the rationale used to come to this decision that Paramedic 1 confirmed on reflection that he should have provided ALS at the incident.

1.45 A discussion was held in the Strategy Group (referred to in 1.40) on the investigation and some members of the Strategy Group felt that the report should be changed including the conclusion reached by the Investigating Officer. The reasons for this were not minuted but essentially some senior members of the Strategy Group felt that A would not have survived further intervention and discussions with those present attest to this. The severity attributed to the case was also reduced to a 2. The Lead Consultant Paramedic was delegated to draft the agreed amendments outside of the meeting. It should be noted however, that the acting Clinical Services Manager and COM 1 believed the findings in the initial report were factual and did not support the changes.

1.46 The amendments were made in four key areas of the report and one of the appendices removed. It has been made clear to the investigation team that these amendments were not discussed or agreed with all those attending the Strategy Group. The amended conclusion was as follows: -

“In conclusion, in relation to this incident, the investigating officer has established that local procedures and JRCALC guidelines with regards to Recognition of Life Extinct have not been applied correctly. However, the decision not to start ALS upon reflection was the correct decision, the patient had fixed and dilated pupils, had absent pulses and purple ligature markings around the neck and CPR with ALS would not have had a positive outcome. It was found however during the investigation that the NEAS ROLE form and initial recordings on ePCR has not been completed to the expected standard and further training is required to ensure these issues are addressed.”

1.47 References to the investigator’s findings relating to the ECG only being recorded for 16 seconds were removed from the narrative as were the sentences where concern was expressed about the fact that no efforts were made to clear the patient’s airways, and that Basic Life Support (BSL) was not continued, and ALS not given.

1.48 And finally, the lines referencing Paramedic 1 himself having acknowledged that he should have done it differently were also removed.

1.49 The Investigating Officer (IO) who wrote the report was asked to accept the amendments and he did (although reluctantly). He did not agree with the

amendments and raised concerns at this and discussed with his line manager who supported and agreed with him. He feels disappointed that this happened and would never allow it to happen again.

1.50 The amended report was the one that was shared with the family and the Coroner. The original investigator report was forwarded to the Coronial and Claims (C&C) Team and only came to light through the Ward Hadaway investigation and was then shared with the family.

Coronial processes

1.51 There were also concerns expressed by the staff about the coronial processes in this case. Ward Hadaway undertook an independent investigation into the management of coronial cases following concerns being raised. This was a separate and different investigation to Case 1.

1.52 The Coroner was not notified about the concerns and investigation by the Trust as it was obliged to do. The Coroner approached the Trust on 20 March 2019 to say he had been advised by the Police Professional Standards Body that the Trust was carrying out an investigation in relation to CPR on A at the scene and asked why the Coroner was not told about it. The Coroner then requested as a matter of priority the outcome of the investigation as the inquest was due to be heard on 23 April 2019.

1.53 The Trust responded and said that the report was going through internal governance processes and would be with the Coroner on 29 March 2019. The report was sent but without the appendices that were critical to the report. The report was also shared with Ward Hadaway.

1.54 On 1 April 2019 the Coroner asked the Trust whether the report could be sent to the family. The Trust agreed to do so without redaction, but this was not shared until later in the month.

1.55 There appeared to be significant confusion during April between the various NEAS teams about what had been sent and what should be sent to the Coroner. Ward Hadaway contacted the C&C Team in NEAS to enquire if all documents were sent to the Coroner and asked for appendices to the COM 1 report. Further reports were sent on 18 April 2019 to Ward Hadaway who disclosed them to the Coroner.

1.56 It was also agreed that all hard copies would be made available at the inquest on 23 April 2019. Some of these documents had not been seen by NEAS's own C&C Team.

1.57 Disclosure from the Coroner was then received and sent through to the Trust on 17 April 2019. This included statements from the Police who had attended the scene. Some inconsistency regarding observations carried out on A were noted.

1.58 The inquest on 23 April 2019 was adjourned due to the issues that were raised about CPR until August 2019. An expert witness was going to be called and a

statement from the Clinical Manager who signed off COM 1's report. This statement was delivered on 07 May 2019.

1.59 The expert witness statement was also shared with the Trust in June 2019, the findings of which have been shared earlier in this report.

Other areas of concern

1.60 Concerns have been raised by the family on other matters within the Trust. These include accountability, sickness return policies, HR processes, including fitness to practice, learning from incidents, equipment management within the Trust and social media behaviour.

1.61 We have focussed this investigation on the large key issues which do also have a bearing on all the other concerns raised. Many of the other concerns have been raised as part of a formal complaint and the Trust have responded.

1.62 We have also assessed the thoroughness of the Ward Hadaway Report and have found their findings to be sound and reasonable in all the other domains.

1.63 Unfortunately, the whistle-blower has refused to meet with us, so we have no new evidence from him to add in this particular case.

What we found

Declaration of ROLE

1.64 As can be seen above, there is a significant difference between the Trust and the initial view of the investigator and indeed the Ward Hadaway and Coroner's expert findings in respect of the application of ROLE in Case 1.

1.65 The policy derived from national guidelines is clear about the criteria that must all be checked before ROLE can be performed. The guidelines clearly state that to establish no realistic chance that CPR would be successful, all of the following must be present:

- No CPR over a period of 15 minutes since the onset of cardiac arrest (e.g., no bystander CPR)
- No evidence of drowning, hypothermia, poisoning, overdose or pregnancy
- A reading of asystole for a period of 30 seconds as shown on the ECG monitor (defibrillator) and rhythm strip to be taken

1.66 It is quite clear in terms of the evidence that the first and third part of these criteria was not complied with. Paramedic 1 did not get a reading that lasted a minimum of 30 seconds and the reading that was recovered did not indicate a reading of a flat line. The evidence seen by all concurs with that. This is disputed by Paramedic 1. Point One was also not met within the facts of the Investigation – No CPR over a period of 15 minutes since onset of cardiac arrest.

1.67 The interpretation of the importance and mandatory nature of the guidelines is a point of difference. The Trust's most senior paramedic and some other clinical members of the group believed that these can be overridden if there is a strong clinical case to do so. The Investigating Officer and his line manager, Acting Clinical Services Manager, did not agree with the line taken by senior managers as they did view them as mandatory.

1.68 This approach is also at odds with other paramedics views who were also connected to the case where the guidelines are seen as mandatory, and this indeed was why the ambulance crew escalated their concerns in the first place. This is also not substantiated by the expert witness at the inquest.

1.69 Even if this was the case, we did not see any evidence that was presented to the Strategy Group or reasons recorded or any request for additional information that might be relevant to overriding national guidelines that are in place.

1.70 The investigator's report was the only evidence on which this decision was made. The report was not questioned in thoroughness or approach by the Strategy Group and the conclusion was not agreed by all the members attending.

1.71 There were some genuine flags to note in this report which would reasonably suggest the need for further evidence before any decision was made to deviate from guidelines. Two different NEAS07 forms had been submitted by different staff to raise professional concerns about this case.

1.72 It was also noted that Paramedic 1 seemed concerned that he was due to finish his shift and was wanting to leave. That of itself is not unreasonable but would signal a further conversation and exploration of the case given that ROLE was not appropriately carried out. In our interview with Paramedic 1, they still do not agree with conclusions that ROLE was not carried out appropriately. They genuinely believed that they relied on their extensive experience in calling ROLE and that further interventions were not necessary.

1.73 Other worrying indicators included reports that Patient A was warm, may have had a radial pulse when Police arrived. It would be reasonable to exhaust all lines of ALS given the circumstances and age of A, however slight the chances of recovery might be. There had also been no evidence, documentation or stated attempt of airway management prior to cessation of bystander CPR. ALS was not commenced and the investigator believed the guidelines and protocols had not been followed.

1.74 There were also inconsistencies in what was reported to have been seen on the monitor and on further investigation by Ward Hadaway, the ZOLL¹ specialist has clarified that what you see on the screen is what is printed out. This was not a flat line. It is accepted that it did not have a recognisable rhythm but there were some fluctuations to be seen.

1.75 Paramedic 1 also stated that the printer was not working and could not print out the reading taken. This had not been reported prior to the incident and the printer

¹ Zoll is the manufacturer of defibrillators

appeared to be working after the incident. The reading is fortunately recorded on the system which enabled the staff to access it later.

1.76 The major issue that concerned Paramedic 1's colleagues, was the timescale within which ROLE was called. It was called very quickly and before a full ECG reading of 30 seconds was achieved. The reading only lasted 16 seconds.

1.77 Given the issues outlined above and the investigator's conclusions, we cannot support the direction given to the investigator to change the report and delete parts of the report and alter the conclusion. Questions should have been asked at this meeting to elicit responses that were pertinent to the case and more information required if relevant from the crew who submitted the NEAS07. There is no record of any discussion other than from those interviewed recently and that is only from memory.

1.78 We have spoken to members of the Strategy Group including the Lead Consultant Paramedic who drafted the amendments about this on behalf of the Strategy Group, but our concerns remain. As stated in 1.77 above, more details should have been sought, and further investigations carried out on the case before any addendum if required was agreed. The original document should never have been changed in any circumstances. Concerns about coronial processes had also been raised at this meeting by the Acting CSM and Head of Risk and Regulatory Services.

1.79 We cannot assign intent as to the reasons the Strategy Group made the decision to alter an independent investigation report other than they agreed with Paramedic 1's actions. However, if the Group felt strongly about their reasoning for this then they should have provided an addendum to the report. The original report should have remained intact.

1.80 Whilst the Investigating Officer raised his concerns about the changes to his report, he was overruled and adhered to the decision made by his senior managers. He still felt very concerned about the changes and did communicate that to his colleagues. We also believe that the Trust should not have put him in a position to attend the inquest to defend a conclusion he had not reached.

1.81 In summary, we have come to the view that Paramedic 1 did not adhere to national and local guidelines and consequently did not provide any ongoing CPR or provide ALS for A. However small the probability of recovery was, A deserved that chance and so did her family.

1.82 The Trust has apologised for many aspects of this case to the family, but at the time this report was written it had accepted the argument that the non-adherence to these guidelines was reasonable and within Paramedic 1's scope of practice. We disagree. We have recently been told that the Trust's position has shifted on this. The family still feel that a full personal apology has not been given to them face to face.

1.83 The Trust had supported the decision of the Strategy Group whilst it recognises that the Group was operating outside of its remit.

1.84 The Trust also claims that the investigator went along with the suggestions for change but, we are not sure that that conclusion is reasonable. The Investigating Officer was dealing with very senior managers whom he professionally trusted. He did share his concerns but believed that the senior managers must be aware of other matters and went along with their recommendations to change.

1.85 In the light of all the above, we believe that the family deserves an unreserved, unconditional apology for the impact this has had on them.

1.86 Nobody disputes the fact that the likelihood of recovery was very slight, but all can recognise the importance of believing everything was done to save their child and the distress that follows when you believe this not to be the case.

1.87 This is particularly relevant to A's family. The shock on receiving the report outlining the investigation and then believing that the Trust was not acting in an open and transparent manner has been devastating to them. Their one other child (a son) has since ended his own life and the family believe that the death of A and the way it was handled was a large contributing factor to this.

Governance of incident

1.88 The governance surrounding this incident has also been poor. The normal policies and processes were not followed. There appeared to be no clear accountability or ownership of the case and decisions were made in groups that had no remit to do so.

1.89 There are some concerns also about how serious incidents are dealt with and criteria being consistently applied. This incident was downgraded from a 5 to a 2 and to our mind that was not substantiated.

1.90 The Trust has acknowledged that the process failed the family, and the current Chief Executive has written to the family and stated:

"All the errors in the handling of the investigation into A's death were made with good intentions, but were disorganised, fragmented, outside of the scope of usual processes, not followed up quickly enough, and allowed to drift from timeframes which are set and agreed specifically to stop this type of situation from occurring".

"The investigation was not listed on any trackers, did not have a root cause analysis (RCA) scheduled to discuss it with a multi-disciplinary team, and the report was therefore not scheduled to be delivered anywhere for oversight or challenge."

1.91 We will pick up recommendations later in the report when we look at governance issues more widely.

Duty of Candour

1.92 Duty of Candour was not followed and applied and indeed the general communications with the family were very poor initially. This too was acknowledged

by the current Chief Executive in her letter to the family and subsequent correspondence.

1.93 There is a concern for us that Duty of Candour is only seen as important when an incident has been classed as moderate or higher. Candour and good communication should be operating at all levels and at all times within the organisation.

1.94 There are of course legal imperatives within the legislation that must be met, it should be the underpinning principle for all incidents and communication.

1.95 This pertains to patients and families but also there is also a clear expectation on public bodies to be open and candid in their communication with coroners. *(Please refer to Chapter 5 for more details on Duty of Candour)*

Coronial processes

1.96 The evidence in this case clearly indicates that the Trust's coronial processes were not followed.

1.97 The Coroner was not informed of the initial investigation as would be required and this affected the whole timescale and added to the complexity of the case and distress to the family. It was the Police Professional Standards body who made the Coroner aware of what was happening in terms of the investigation.

1.98 In addition, the C&C Team within the Trust were equally not informed or included in the relevant discussions.

1.99 There is evidence that when disclosures are required to be sent to the Coroner this ends up in information being passed from one team to another for permission to send and this adds to the delays in the process.

1.100 We will pick up some more specific issues in relation to wider coronial processes later in Chapter 3 of this report.

1.101 Obviously, the key coronial process concern in this case was that not all information was passed to the Coroner initially and then disclosures had to be made later. This also materially affected what the Coroner could share with others including the family.

Case 2 – Patient B – 14 March 2019

The facts

1.102 This is a case where a 62-year-old gentleman (B) who was experiencing shortness of breath made a 999 call. On further discussion on the call, it was noted that B had a medical history including Chronic Obstructive Pulmonary Disease (COPD) and required 24-hour home oxygen therapy.

1.103 The purpose of the call was to report a power cut which had resulted in the oxygen supply ceasing (as it relied on electricity) and B who was alone could not get out of bed to access the alternative oxygen cylinder. B was very reliant on this oxygen and was now suffering with shortness of breaths.

1.104 The call was triaged using the NHS Pathways System and a Category 2 disposition was given.

1.105 An ambulance crew was allocated from the nearest ambulance station (only 3 minutes away). However, the ambulance crew were unable to leave the station as the power cut had also affected the local ambulance station and the automatic gates would not open. The crew allocated to this case did not know how to use the manual override and were unable to depart.

1.106 Once this was known, a second ambulance crew was allocated to the case, but this crew was delayed due to refuelling enroute to the property.

1.107 There was a further delay encountered when the crew could not find the key safe to access B's property.

1.108 The key was finally found, and the crew were able to access the property but B was declared dead on the scene.

1.109 The family have a number of concerns relating to their father's case. They do not feel that NEAS have acknowledged process failings and their contributing factor to their father's death.

1.110 They also have concerns about the plans and timescales in place to improve that clearly demonstrate organisational learning and action.

Delays to opening gates at ambulance station

1.111 The first issue to explore is the delay associated with opening the gates at the ambulance station.

1.112 As stated earlier, the ambulance was allocated to the incident from an ambulance station only a 3-minute drive away from the patient's home. Unfortunately, the power cut affected the ambulance station also and the crew did not know how to operate the manual override system.

1.113 On reading the Strategic Executive Information System (StEIS) investigation report, NEAS recognises that at the time of the incident, staff were not trained in how to manually override ambulance station gates in the event of a power failure.

1.114 They also found that subsequent efforts to source assistance from both the Emergency Operations Centre and a CCM were also unsuccessful.

1.115 There were also no readily available information sources to support teams should this occur.

1.116 The 999 call was initially received at 4.01am on 14 March 2019 and the first ambulance crew was allocated to the case at 4.04am. This meant that if all had gone well, the first ambulance crew would have arrived outside the property at 4.07am approximately.

1.117 Given the failure to open the gates a second crew was allocated and despatched at 4.15am (14 minutes after the 999 call). The lag between first and second allocation is assumed to be down to attempts to open the gates and leave the ambulance station. However, witness statements were not provided from the first ambulance crew.

Delays associated with refuelling of ambulance

1.118 When the ambulance was activated to attend B they requested to refuel enroute to the incident. The Control Team confirmed this was ok. The newly qualified paramedic who requested the refuel states: -

“I was aware that we needed fuel so had requested to refuel and used the phrase ‘we only have one bar’”, as I had heard that phrase used before, but I was actually unsure of the meaning of this phrase.”

1.119 On investigation, the fuel capacity at the time of incident was recorded and at 3.58am prior to refuelling the ambulance tank had 29 litres of fuel remaining which is close to half a tank full. In other words, there was more than enough fuel available to get to the incident without stopping.

1.120 General guidance on training suggests that it is good practice to try and keep the tank half full in case of emergencies and on handover to new shifts. However, there is no policy that stipulates when a vehicle should be refuelled so the “one bar” rule is not actual policy although in this case there was more than one bar in the tank.

1.121 The family were provided with the newly qualified paramedic’s statement which outlines this. However, the same statement sent to the Coroner has an additional note from the same paramedic handwritten on it which says: -

“At the time I was not corrected by my crew mate for the terminology used and that we had enough fuel”.

1.122 The delay added to the journey for refuelling was four and a half minutes approximately.

Delay associated with accessing the property

1.123 On arrival, the crew were unable to find B’s key safe. They tried to ring B for more information but did not get a response. At this point they were considering forced entry but then did find the safe so that was averted. The crew contacted the Emergency Operations Centre informing them that the key safe had been located and they were about to enter the premises.

1.124 The delays in finding the keys and accessing the property were nearly 12 minutes in total.

1.125 The main contributor here was the inability to find the key safe. The family believe that clear instructions were given on the initial 999 call. We have listened to the call and B does state that there is a key safe and it is “up the drive” and what the passcode is. It doesn’t specify further but we are not quite sure what the specific difficulties were in accessing it.

1.126 It would have also been very dark as there was an ongoing power cut and this may have affected visibility.

What happened when crew accessed the property?

1.127 When the crew did access the property, they found B lying in bed with a nasal cannula in place attached to a portable oxygen machine that was running, which suggested that he had accessed the extra oxygen. The BIPAP (Bi-Level Positive Airway Pressure) machine was unattached to B at that point.

1.128 The crew checked for signs of life but assessment revealed B was deceased. It is also worth noting that the power was still cut off at that point.

1.129 The crew also stated that later when they returned to the property and the lights were on that they discovered a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) on the top of the microwave. This however was not relevant as the ROLE had been called prior to the discovery of this.

The use of Low Harm categorisation

1.130 This incident was initially categorised as a Low Harm. The explanation for this is that NEAS arrived within the National Standard applicable to a Category 2 incident which is 90% of patients to have received a response within 40 minutes and overall average to be within 18 minutes.

1.131 The ambulance crew arrived at the scene which was 36 minutes and 37 seconds after the initial 999 call was received which means it was within the 90% standard.

1.132 In addition, the explanation for this categorisation which was agreed in April 2019 *“to downgrade the incident to low harm as the root cause of patient harm was the lack of/battery malfunction in the CPAP equipment”*.

1.133 The other consequence is that there is no regulatory Duty of Candour if the incident was graded as low.

1.134 The family’s contention is that if the ambulance had got there sooner their father might still be alive and that it was NEAS’s failures in processes that contributed to the likelihood of death. Their belief and experience of their father’s condition is that he could manage for about 20 to 30 minutes without oxygen. They

also contend that he was very clear about the urgency of the oxygen when the 999 call was made. We have listened to the call and can attest to this fact.

1.135 They therefore believe that this should have been treated from the onset as a serious incident.

1.136 They are also distressed that all investigations and responses to date have focused on his underlying health condition and the DNACPR.

Communication with coroners

1.137 Given the case was graded as Low Harm, the Trust took the same stance that it did on Duty of Candour in Case 1 and did not let the Coroner know about the delays and reasons for delays.

1.138 The inquest was delayed but the Coroner requested a statement from the responding paramedic in October 2019. The incident and the Coroner's request were reviewed at a meeting called SEACARE (Patient Safety incidents, patient Experience concerns, Adult safeguarding concerns, Children's safeguarding concerns, Audit from the learning from deaths process, Risk which incorporates coronial requests and concerns and External requests for information related to care provided by NEAS).

1.139 It was requested by SEACARE for a new statement to be provided by the paramedic because the previous statement was deemed to be about the incident and refuelling rather than one drafted for a coroner. This second statement focussed only on the oxygen issues and did not mention any issues about delays.

1.140 The family do not believe this to be transparent and do not understand why the original statement was not shared with the Coroner.

1.141 In May 2020, following an independent review of the coronial processes within the Trust, additional documents were provided to the Coroner in this case. These included all the paramedics reports and the incident reports.

Communication with families

1.142 As stated earlier, the incident was deemed to be Low Harm and consequently the family were not informed of the delay issues.

1.143 The matters came to their notice due to the whistle-blowing processes where their case was used as an example of a cover up.

Learning from incidents

1.144 This is the second most important ask of the families. There is a sense that action plans are not actively implemented and are not robustly governed. Consequently, the learning coming from these are diminished. This is a concern also that has recently been picked up by the Care Quality Commission (CQC).

What we found

Delays to opening the gates

1.145 The most recent investigation by the Trust is clear that no real process or policy existed in respect of manual overriding of gates at the time of the incident and consequently staff were not trained to deal with the incident.

1.146 The report made three recommendations which we believe are sensible and we support. These are:

1. Trust wide communication to be issued via Operational Alert identifying how to manually override a station gate. Supporting information to include invoking business continuity should a station gate fail to open.
2. Information regarding how to manually override a station gate to be added to the Care Platform and included within 1-2-1 ride outs conducted by Clinical Team Leaders with staff members. Training to include both a demonstration and test exercise.
3. Information regarding how to manually override a station gate to be added to stations in a location that is deemed to be easily accessible and in the same place in every station, for example, in the garage, near the garage door.

1.147 Unfortunately, this newer investigation found that recommendations made after the incident were not systematically applied across all stations within the Trust. Only one cluster fully complied. In addition, the CQC shared that this was also a concern in their recent inspection.

Delays associated with refuelling of ambulance

1.148 As mentioned previously, there were no clear policies within the Trust that set out the guidelines when a vehicle should be refuelled. Some custom and practice behaviours have grown in the absence of a clear policy.

1.149 Again, the Trust have recognised this and have agreed to:

1. Develop a new policy that is relevant for the service.
2. Develop guidance and a roll out plan to support implementation of said policy.

Delay associated with accessing the property

1.150 It was deeply unfortunate that a delay occurred. Although B did mention that the key box was “up the drive” the instructions were not very specific. It might be useful for the call handler to try and extract some more details that would be useful to crews to avoid any future delays.

What happened when the crew accessed property?

1.151 No recommendations to make. The crew appeared to carry out all relevant assessments as would be required of ROLE.

The use of Low Harm categorisation

1.152 NEAS believes that they met the response standard for Category 2 in this case so did not believe that this was a serious incident at the time (2019). In addition, they also contend that one of the real problems associated with this case is the fact that the machine did not have a failsafe battery in the event of a power cut.

1.153 We agree with NEAS in respect of the need for wider learning in this case. There are questions that need to be addressed across the wider system to improve learning and avoid future deaths.

1.154 What we do not agree with is the fact that this was never called as a serious incident in the first place, however it is important to note that the Trust have retrospectively classified the incident as an SI in 2022 and it has now been investigated.

1.155 It is factually correct that the national standard in respect of time was met. However, there is no doubt that this patient could have been seen earlier if processes were operating effectively and this earlier intervention could have led to a very different outcome.

1.156 The fact that the response standard was achieved appeared to inhibit an objective review of the incident and was not sufficiently patient or family focussed.

1.157 There are sufficient concerns about failures in processes, unnecessary delays and other wider issues that to our estimation make this a serious incident. Even with a legitimate delay while searching for the key safe, B could have been seen earlier and may not have died on that day.

1.158 This position is strengthened by other general concerns about oxygen provision and failsafe policies where wider learning would also have benefitted the system.

1.159 The family also feel that a huge amount of effort went into saying that B had a very serious life-threatening condition which was indeed true and B had a DNACPR. This appeared to deflect the focus from the issues and concerns in hand.

1.160 There were some questions to explore about oxygen provision but the reality was that if the ambulance crew had arrived earlier than they did, the patient may not have deteriorated so rapidly and died.

1.161 Also, an automatic Duty of Candour should have been in place and the family would have had time to react and deal with their grief. (See *Paragraph 5.12*)

Communication with coroners

1.162 As stated earlier, the fact that the ambulance paramedic was asked to provide a separate statement is a little unusual and, unfortunately, we have not been able to secure additional evidence as to why this was done. All documents have now been provided to the Coroner in May 2020 following a recommendation from a previous review and the Coroner has had all the information to come to their own view.

1.163 The decision not to share the original statement in 2019 has however affected the confidence of the family in respect of NEAS's candour and transparency.

Communication with families

1.164 Given that this case was originally deemed to be Low Harm, the family were not contacted or aware of potential process failures and delays.

1.165 They only found out about issues when the whistle-blower raised concerns. This is obviously not an ideal situation, and the family are very upset about this.

1.166 The Trust has tried to rectify the situation and believes it is now in close communication with the family. The family does not support that assertion and feel the communications they have had have been reactive and not proactive. They believe they have had to chase for responses and there is no doubt that their trust has been lost.

Learning from incidents

1.167 We think all the families recognise that mistakes can happen and that there are a number of human factors in play in busy NHS organisations. However, they do demand that mistakes are acknowledged and communicated and that organisations demonstrate a willingness to learn if trust is to be maintained.

1.168 This is an area where there are some opportunities for improvement in NEAS. First, it is important to acknowledge and recognise the mistake. Secondly, it is important to engage and communicate with patients and families on those mistakes and thirdly, it is essential that a clear robust monitoring system is in place to follow up any actions agreed.

1.169 In this case there are weaknesses in the first two areas which has led to lack of confidence on the third action. It would also be the case to say that later reviews have also found that not all actions have been properly or effectively followed through.

1.170 We think trust could be improved by including families in implementing and monitoring recommendations and learning processes.

1.171 This is a very important governance issue that will be picked up in its entirety later in this report.

Case 3 – Patient C – 19 December 2019

The facts

1.172 This case is about a 62-year-old gentleman (C) who fell onto a washing basket and suffered a penetrating injury from a piece of wood. The family made five calls over an hour period and regrettably the patient was in cardiac arrest when the ambulance arrived an hour and 8 minutes after the initial call and died. The call had been categorised as a Category 2.

1.173 The family were deeply upset and traumatised and struggle to understand why NEAS did not escalate the severity of the case sooner to a Category 1. The family were present (including the niece of the gentleman who is a nurse) and were able to communicate the deterioration of C with each successive call. They suspected the patient had a punctured lung and he was actively bleeding.

NHS Pathways categorisation

1.174 The first 999 call was made at 10.15am on 19 December 2019. The family told the call handler about the fall and that C may have possibly punctured his lung. C was confirmed as breathing and confirmed after questioning that nothing was stuck in the wound. The call handler was also informed that he had lost about a pint of blood.

1.175 This first call was categorised as a Category 2 call in accordance with the NHS Pathways tool. Heavy blood loss is identified in NHS Pathways as being over two mugs full of blood and is categorised as a Category 2.

1.176 A Category 2 call should be responded to within 18 minutes or 90% of the time no later than 40 minutes.

1.177 It is possible to override NHS Pathways disposition if the clinician within the Emergency Operations Centre (EOC) feels that is appropriate given the clinical presentation.

1.178 The second call was made at 10.28am by C's niece who is the nurse. This is 13 minutes after the first call. Concerns were raised about C and the family's inability to stop the bleeding despite pressure being put on the wound. Again, nothing was confirmed as being stuck in the wound. This was still judged to be a Category 2 disposition by the computerised system.

1.179 The third call was made at 10.56am (41 minutes after the initial 999 call) again by C's niece. This time additional concerns were raised about C becoming drowsy and bleeding had not slowed down and indeed fresh blood had spurted when he moved. The nurse expressed worry that C was going into shock. This was still assessed as a Category 2 case by the computerised system.

1.180 The fourth call was made at 11.04am (49 minutes after initial 999 call). C's niece once again described a further deteriorating situation and stated that he was

dying, he was unable to breathe and was actively bleeding. Those on the scene had managed to acquire a defibrillator and this was attached to C's chest.

1.181 At this time the family were told that a clinician would ring them back.

1.182 A fifth call was made at the same time by C's sister initially, but the phone was handed to the manager of the housing facility where C lived. The Housing Manager reiterated that it was a suspected lung puncture, and that C was struggling to breathe and appeared to be in shock and that there was heavy bleeding. The case remained as a Category 2.

Escalation to clinician

1.183 The clinician who had been requested to ring the family back at 11.04am didn't manage to ring back until 11.14am and then spoke to the Housing Manager at 11.14am. C was reported as barely conscious and breathing. C was still bleeding but while still on the call he stopped breathing and CPR commenced. At this point the clinician upgraded the incident and Category 1 was now called at 11.19am. This means that response should be within 7 minutes and for 90% of cases no longer than 15 minutes.

1.184 The clinician's call to the family had been delayed due to the inability to access C's case as the notes were locked (only one member of a team can amend a case at any one time). This happened a number of times.

1.185 However, an emergency rapid response car (RR) was allocated at 11.09am to the incident prior to the clinician speaking to the family. A double crew ambulance was despatched once the case was upgraded to Category 1 at 11.20am.

1.186 The RR arrived at 11.22am (one hour and eight minutes after first 999 call was made).

1.187 At this point too, the Great North Air Ambulance Service (GNAAS) also assigned a resource once they were aware of CPR.

1.188 Full ambulance crew arrived at 11.26am and GNAAS arrive at 11.39am. In addition, a specialist major trauma NEAS practitioner was also assigned to the case and arrived at the scene at 12.11pm.

1.189 Full resuscitation attempts were made until 12.26pm when the decision was made by GNAAS to cease.

1.190 On review, it is clear to see why this has been so hard for the family concerned. All attempts were made by the family to escalate concerns and to clearly depict a growing concern about the level of deterioration in the condition of C. These concerns were fully grounded, and C ended up dying.

1.191 The impact and ongoing distress the family has experienced has been significant. The stain that the blood left on the carpet in the corridor outside C's flat was a daily reminder of the trauma. C's sister who had lived next door had to

eventually move to stop reliving the details of the incident.

Communication and behaviours

1.192 Another issue that also contributed to the family's distress and difficulties were the perceived poor behaviours on some of the interactions with NEAS staff, and this has formed part of the family's complaints.

What we found

NHS Pathways categorisation

1.193 The NHS Pathways tool would not categorise a major haemorrhage a Category 1 unless the patient is unconscious and not breathing. As can be seen from the case above, this was not the case until the very end. This is based on evidence that if the crew achieved normal Category 2 wait times that that should be safe practice.

1.194 There are two issues at play in our opinion, one is why the response time was so delayed and the other question to be answered is why didn't the existing protocol get overridden given the level of deterioration of C?

1.195 With respect to the first issue, the Trust did carry out a detailed review of the contributing factors that led to this substantial delay. One of the reasons for delays was the increased number of 999 calls that the ambulance service was experiencing at the time of the incident. Another reason given was that some of the ambulance resources were tied up in hospitals where there were significant handover delays thus not releasing ambulances to respond to incidents. There were also some shortfalls in staffing at the time which also had an impact on the availability of ambulances to respond.

1.196 At 10.00am there were 51 999 calls and 11 urgent cases awaiting ambulance allocation, this rose to 69 outstanding 999 calls and seven urgent cases. In this scenario, given the Category 2 allocation, it was inevitable that some delays would occur. This is an issue across all ambulance trusts in the country now and is also a resource issue for NEAS.

1.197 Unfortunately, in this case, the ambulance service did not meet the standard wait time for Category 2 waits and the outcome was catastrophic for C. If the national standard had been met then C may not have died.

1.198 NEAS is a relatively small ambulance trust and evidence suggests that it has not been adequately funded for the service required. Some progress has already been made on securing additional investment for front line services from the Commissioners. It is important to continue to review, monitor and benchmark the service to support it to deliver what is required from a patient safety and quality perspective and avoid harm.

1.199 The second issue as to why the designation of Category 2 didn't change in the light of the level of deterioration of C is a little more complex.

1.200 The NHS Pathways Tool is based on a set of algorithms which support decision making in ambulance services. This is a national tool and is used by many ambulance trusts in the country. However, whilst it is good practice to adhere to these algorithms it is also accepted that clinicians can use their judgement and experience to override these in certain circumstances.

1.201 Indeed the initial investigation and response stated that:

“Once there have been three calls received from people at a scene (the initial call, and then two ETA calls) this should be identified for highlighting to a clinician who may then determine that the response needs to be upgraded if there is evidence of sufficient patient deterioration”.

1.202 This was obviously not complied with in this circumstance. At call two NEAS were informed by C's niece (who was a nurse) that he was having trouble breathing and that the bleeding was not under control. C was unable to speak after this call and his niece was advised to get a defibrillator.

1.203 At call three, the ambulance service was again informed that C was deteriorating further in terms of being able to breathe and when moved, blood was spurting out of the wound. The niece stated that her uncle was going into shock.

1.204 In accordance with the policy, that should have been the time to engage a clinician and potentially upgrade to a Category 1 disposition. That might also have alerted GNAAS and other specialist trauma paramedics to attend the scene and stabilise the bleeding to support transfer to a trauma unit and thus improving the chances of survival. Unfortunately, others only got involved when C went into cardiac arrest and was receiving CPR.

1.205 When this lack of adherence to the policy was challenged by the family through a complaint, it emerged that the report was factually incorrect. The policy referred to in the report was not in place when this incident occurred and had only been put in place on 31 December 2019 which was after the date of the incident. The staff member who wrote the report had made an error.

1.206 The policy actually in force at this time was that the Estimated Time of Arrival calls (ETA) would not be highlighted to a clinician but would remain on the Dispatch “stack” to be reviewed. A clinician would then contact the patient or caller where possible, to reassess the patient and to determine whether a different response would be appropriate. Given the demand on the service at the time, this was not done in a timely way.

1.207 The fact is, had the new policy been in place at the time, a clinician could have contacted the family much earlier and this may have led to a very different outcome.

1.208 However, irrespective of which policy was in place at the time, we find it difficult to understand why nobody appeared to recognise that the level of deterioration was rapid and life threatening and thus seek help.

1.209 Policies, protocols, and systems are of course important and there to assist the staff member but not at the expense of sound professional judgement. It is imperative that staff have the permission to raise clinical concerns at any time in the process irrespective of policies in place at the time.

1.210 This did not happen in this case and given that the deterioration was being communicated very clearly by a qualified and experienced nurse, we find the response inadequate and think further steps should be taken to remind all staff of the supremacy of safety in all clinical matters.

1.211 The Trust have been open and acknowledged failings in this case. They have also responded to the family's complaint and apologised for the delay and the consequences of those delays and the impact that has had on the family.

1.212 NEAS has also contacted NHS Pathways about this case and have asked them to consider this scenario in the future as a Category 1 with the focus being on uncompressible or uncontrollable haemorrhaging continuing over a period of time. This was agreed by NHS Pathways and the new pathway was implemented in April 2021. In addition, they will be carrying out a larger piece of work with stakeholders on catastrophic blood loss more generally.

1.213 It is good to see that learning has taken place in this case and that steps have been taken to both learn and improve for the future. There were also additional learning points picked up about inputs into "crew notes" or "call notes" that got confusing for those accessing the notes. This is a process issue that the Trust is also intending to address.

Communications and behaviour

1.214 With respect to the concerns raised about the behaviour of an individual at the scene of the incident, this too has been investigated and an apology given to the family. However, in an earlier communication with the family, the Trust got the details of the person being complained about wrong which distressed the family further. It remains clear that the patient's family perceive the interactions with the individual that was complained about very differently to that of the staff member.

1.215 However, the Trust have acknowledged the further distress caused to the family and have apologised further. It is also important to stress that everyone else involved in the direct care at the scene behaved very professionally and this was appreciated by the family.

1.216 The family are still not quite assured about the robustness of the response and would want the case to be used as a learning exercise for staff training and insight.

1.217 In terms of the communication with the family, there have been a number of instances where the exchanges of information and the style of those communications could be improved. Some of these concerns related directly to the incident itself.

1.218 As this was judged to be a serious incident, a Family Liaison Officer (FLO) was assigned to the case and part of their role is to be the conduit between the Trust and the family and to make sure that good communications operate. They will also pick up the concerns of the family and seek to address those.

1.219 The family were concerned about the time taken to investigate the case and the fact that the report was significantly delayed. These concerns were raised and communicated to the FLO.

1.220 They were also upset that nobody contacted them when they received the report to check if they needed any support. The normal expectation would be for the FLO to hand the report directly to the family and go through the details with the family.

1.221 The Trust reports that due to Covid and staff illness this did not occur. The family do not accept this excuse and feel that given the nature of the complaint somebody should have been on hand to help the family or rearrange a time that would have been mutually accepted.

1.222 In addition, there were also concerns mentioned earlier, that the first report sent to them had a number of factual inaccuracies which caused further distress to them and the report had to be resent with revised addendums.

1.223 There were also concerns raised about the style of interaction experienced from a clinician who did eventually ring the family during the incident. The Trust has acknowledged this and has dealt with the concern appropriately.

Case 4 – Patient D – 30 November 2019

The facts

1.224 This is another sad case that related to the inability of NEAS to respond within national standards to a 999 call. The case refers to a 52-year-old lady (D) who rang 111 at 6.36am complaining about pain in her shoulder and arm and who was also experiencing difficulty in breathing.

1.225 The call was classified as a Category 2 at 6.43am which again meant that D should be seen within 18 minutes or in 90% of cases no longer than 40 minutes.

1.226 D made a further call at 7.04am to report that she was now experiencing tightness in her chest as well as pain. This was again triaged as Category 2. The crew finally arrived at the scene at 7.50am and very sadly D was declared deceased at 8.03am.

1.227 This means that the attendance occurred one hour and 14 minutes after the call was made, or one hour and seven minutes after the call was categorised. This was 34 and 27 minutes outside of the national standard waiting times respectively.

1.228 The family were contacted by the Trust and spoken to, and an investigation was initiated in January 2020.

What we found

1.229 The family had two questions that they wanted answering, namely, why did it take so long for the ambulance to get there, and would it have made any difference if the ambulance had got there earlier?

1.230 The internal investigation was completed on 18 February 2020 and the family were contacted on the telephone on 19 February 2020 to discuss the findings. A formal letter was sent to the family on 21 February 2020 to respond to the family's concerns.

1.231 The reasons for delay were again attributed to high demand that outstripped available resource and again there were some impacts due to the inability to hand over patients in hospital in a timely manner. There were also some shortfalls in staffing that contributed to the pressure.

1.232 The reports state that there were 46 emergency patients queuing and 10 urgent cases queueing at the time of the initial call.

1.233 There had been an ambulance assigned at 7.20am but unfortunately this got reassigned to a Category 1 case who was a patient that was unconscious and needed to be urgently seen.

1.234 The Trust did not escalate the categorisation of D to a Category 1 as the patient was conscious and still breathing at that point.

1.235 There was a review of all the dispatch data at the time of the incident and the Trust believes there was nothing further that they could have done given the pressure on the system at that time.

1.236 With respect to the family's second question, it is difficult to answer in the absence of a clinical judgment on the matter.

1.237 The Trust did consider the question and carried out a multidisciplinary review of the case. Their conclusion was that an earlier ambulance was highly unlikely to have changed the outcome for D.

1.238 The family had shared the results of the post-mortem and that the Coroner deemed the patient had died from natural causes, specifically that part of a blockage had travelled into the Aorta. The family felt that it was highly unlikely that patient D would have survived.

1.239 On speaking to the family, they are obviously devastated to lose a relative so unexpectedly but are satisfied with the responses received and do not want the issue to go any further. They did not speak to the Sunday Times and simply wish to move on and deal with their grief as a family. We have respected their wishes and have not taken this case any further.

1.240 However, there is one more key point to make about this case which is about the coronial process.

1.241 The Trust as part of their own Coronial Process Task and Finish Group identified that the information first sent to the Coroner had inaccuracies in it on this case. This summary report stated that the ambulance response times were only 13 minutes outside of national standards which was incorrect, and the summary did not disclose any learnings.

1.242 The Trust disclosed a further 10 documents to the Coroner and apologised for the lack of disclosure which should have been sent at an earlier stage. They also felt that the timing error was a typing one as the timeline enclosed had the real times stated.

1.243 The issues arising from concerns about coronial matters will be picked up in Chapter 3 of this report.

Conclusions

1.244 These cases have been difficult to review and there is no doubt that if the failings identified had been acknowledged earlier, accountability accepted and a robust process for overseeing the recommendations and involving the families, then the Trust and confidence between families and NEAS would be very different.

1.245 There are some similar themes emerging about governance, compliance with existing policies and procedures, openness, candour, judgement and timely communication which can be seen in the cases reviewed. There are also concerns emerging about the capacity of the ambulance trust to meet national waiting standard and the risks that that brings.

1.246 In addition, there are consistent messages in relation to the coronial processes. We will explore the latter in more detail later in the report.

Chapter 2: Terms of Reference 2

“NEAS has previously commissioned six independent reviews / audits, and seven reports which were published between August 2019 to May 2022.

Review the seven reports and any associated relevant documentation, and determine:

- The quality of the investigations and reviews, sufficiency of enquiry and adequacy of their findings, recommendations, and subsequent action plans
- The progress made to implement the learning and recommendations to date
- Whether changes implemented within the Trust’s governance, and coronial processes have resulted in effective and measurable improvement
- Whether there is further work required to ensure improvements to governance, and specifically coronial processes, are sustainable”

Introduction

2.1 The Trust has commissioned several external reports over the last few years in response to the whistle-blowing allegations and the families’ complaints. There has also been a Desk Top Review carried out by professionals in the system to test the effectiveness and implementation of recommendations made and the Trust itself had set up a task and finish group led by a non-executive director to address the issues raised by the reports in 2019/20 and ensure recommendations were implemented by 2020/21. None of these reports were shared outside of the organisation or published via Board.

2.2 We have reviewed these documents and evaluated them against a number of criteria agreed with NHS England as outlined above.

What we found

2.3 A summary of the external reviews is found below and our overall view of the quality and sufficiency of the Reports. It needs to be remembered that the Terms of Reference for some of these are very specific and do not cover wider issues. We are judging against the agreed scope and not any wider considerations:

Document	Scope of Investigation	Quality of Investigation	Sufficiency of Enquiry	Number of Findings or Recommendations
(1)Ward Hadaway Review of Coronial Cases August 2019	Independent Review of 4 NEAS Coroners Cases arising	Good	Yes	5 Findings

	from concerns raised			
(2)Ward Hadaway Review of 'A' Case 23/09/2019	Conduct an investigation into Case 'A', determine facts where appropriate and make recommendations	Good	Yes Very thorough Report	9 Recommendations made in respect of specific incident for improvement
(3)Workforce One Interim Report 20/03/2020	To establish whether Trusts coronial process meets legislative and policy requirements particularly in respect of the accuracy and completeness of information disclosed. Also tested whether Ward Hadaway recommendations implemented	Good and adhered to own Terms of Reference	Yes	5 Recommendations made all relating to Coronial Processes
(4)Workforce one - Review of 'A' Case 01/06/2020	To check whether the Trust's coronial process meets legislative requirements. The investigation was to incorporate a review of sample cases including Case 'A'	Good	Yes Very thorough	6 Recommendations made
(5)Workforce one - Final Report 19/06/2020	Builds on interim report and tests whether concerns	Good	Yes	Concludes that concerns not fully addressed 7 Recommendations

	raised by Ward Hadaway have been addressed and implemented			Made
(6)Capsticks 02/12/2021	To support Coronial and Claims Team for 3 months and suggest improvements	Good	Yes but scope limited	6 Recommendations made all relating to Coronial Improvements
(7)Internal Audit- Compliance Review of Coroners Processes 20/05/22	To test the application of key controls focussing on specific aspects of the Coroner Process	Good	Yes but scope limited	5 recommendations about compliance with control framework and 1 recommendation on design of framework

2.4 As mentioned earlier, as a result of investigations one to five above, and the fact that some of these reports had stated that some of the recommendations from earlier reports hadn't been implemented, a Coronial Process Task and Finish Group was formed by the new Chief Executive and Chair in April 2020. (The Terms of Reference for this can be found in Appendix C)

2.5 This group comprised of three non-executive directors, two executive directors alongside the relevant subject matter experts.

2.6 The scope of the Coronial Process Task and Finish Group was to consider the findings and recommendations from the independent reports.

2.7 The group met weekly from 28 April 2020 to 14 August 2020. It then met fortnightly up until September 2020 and then held monthly meetings in October and November 2020 and January 2021. The Trust Board agreed to close the Coronial Process Task and Finish Group on 25 February 2021.

2.8 Aside from reviewing the recommendations arising from the independent investigations, the task and finish group was to undertake a review of historic cases.

2.9 They first looked at 208 coroners' cases between 6 June 2019 and 31 May 2020 and the findings were discussed on 12 June 2020.

2.10 There were cases where not all the appropriate information had been sent to coroners. The Medical Director then wrote to all coroners and provided additional data where relevant and apologised for oversight.

2.11 The second review covered the period 9 June 2020 and 29 December 2020 and also looked at another 208 cases. The findings from this were reported back on 15 January 2021. Assurances were provided that NEAS's systems and processes

were working. There were no serious concerns raised although some minor errors noted.

2.12 On 22 May 2022, the Sunday Times ran a story alleging that NEAS was covering up the truth about patients' deaths.

2.13 A whistle-blower had contacted the newspaper and had provided information to show that NEAS had withheld key evidence from coroners and the families involved that would implicate them in terms of service failures.

2.14 The news article made reference to seven incidents and five individuals' names were also included.

2.15 In responding to the Sunday Times story, the lead commissioner for the ambulance service NHS Northumberland Clinical Commissioning Group (CCG) undertook to set out the chronology of events. This was discussed with the Chief Executive designate of the newly forming/shadow Integrated Care Board (ICB) and a decision was made to undertake a Desk Top Review to inform further action. A final report was completed on 11 August 2022.

2.16 The review team acknowledged that they did not interview staff as part of this review and the scope was limited to a review of documentation.

2.17 The review focussed on five things:

1. Have recommendations from internal and external reviews, investigations and audits been implemented?
2. Has due process been followed in the historical cases referenced in the media report?
3. Is there assurance that current practices are safe and effective?
4. Reflections
5. Recommendations as to next steps

2.18 With respect to the implementation of recommendations from the independent reviews we will take the reports one by one.

Report 1 – Ward Hadaway Review of NEAS Coroner Cases

2.19 The report came up with a number of findings, which were as follows:

- Coroners have not always been made aware of internal investigations
- Too many people were involved in investigations and it was unclear who was the decision maker
- NEAS internal teams working in silos and not sharing information
- Protracted investigations caused distress to families and potentially raised other issues
- They did not believe in three of the cases reviewed that information was being deliberately withheld but it was being delivered in an untimely and uncoordinated way

2.20 In essence, this report describes the ineffectiveness of the existing systems and identifies the key components of the problem.

2.21 We could not see an actual action plan that was put in place to address these issues at the time, but the solution was deemed to be setting up SEACARE Group which was believed to be the process that would address sharing of information.

Report 2 – Ward Hadaway Independent Review of Case 1 (A Case)

2.22 This report is the outcome of findings in respect of Case 1 that we have already described earlier in the report.

2.23 There were nine recommendations in this report and discussions about them with the Director of Quality and Safety went on for some months. The Director of Quality and Safety has subsequently stated that the action plan work was halted by the Chief Executive and on that basis was not progressed and that concern about that was expressed at the time.

2.24 We have seen some draft actions, but they read more as statements of intent. We have not seen an action plan that is time phased, has measurables and staff assigned to own actions. We also cannot see any evidence that an action plan was delivered and signed off by the Trust Board and executive team. This was acknowledged by the incoming new Chief Executive who joined in September 2019 and who requested the Workforce One investigation.

2.25 The Ward Hadaway Review Team stated that a further review into this case happened (Workforce One - Report 4) and that the actions from this review superseded the actions alluded to in this report.

2.26 However, Report 4, which we will come to, did not report until 01 June 2020 nearly 9 months later.

Report 3 – Workforce One - Interim Report looking at Coronial Cases and Report 5 – Workforce One - Final Report

2.27 The interim report had six recommendations and the final report had seven. The reviews were targeted at concerns raised by the previous reports and to see if recommendations had been implemented.

2.28 The reality was that the team doing this review concluded that NEAS had not followed the advice of the previous reports in 2019 and had therefore not acted on recommendations.

2.29 The same challenges identified in the first report were still present at this time.

2.30 This was not to say that action hadn't been taken. Indeed, the Trust had run a Rapid Process Improvement Workshop (RPIW) in response to the need to improve coronial processes and developed 'SEACARE' as a response in May 2019. Unfortunately, this new process appeared to add to the confusion and add even further delays to information being shared with the coroners.

2.31 The outcome of the RPIW was not really owned by the Coronial and Claims Team (C&C Team) and the reports concluded that it was not fulfilling expectations to ensure quality assurance and quality control in the delivery of disclosure to the coroner. It was causing lengthy delays and the coroners were not being made aware of investigations being carried out by the Trust.

2.32 It was these particular reports that led to the Coronial Process Task and Finish Group to be set up in April 2020 to find solutions for these problems.

Report 4 – Workforce One - Review of individual Case 1 (already reviewed in Report 2 by another Independent Investigator)

2.33 The focus of this report was to follow up on the first and second reports and to do an end-to-end review and to see if the Trust adhered to coronial legislation and whether the Trust adhered to guidance and policies relevant at that time in relation to the coronial process.

2.34 Again, this report went over the details of Case 1 to test it against the aims of the investigation. They did not believe in this case that the Trust adhered to the coronial legislation and in some instances did not adhere to the Trusts' own policies and processes.

2.35 They made a further number of recommendations similar to those that had gone before.

2.36 The recommendations were accepted by the Trust, and the task and finish group was set up to implement the changes to make the improvements.

2.37 Again, we have seen from the task and finish group meetings and closure report that a lot of effort and work has gone into trying to get the processes, systems, and communications to improve.

2.38 However, we have had difficulty reconciling all those actions to the actual recommendations arising from the reports. In addition, the Review Team who did the Desk Top Review reported that not all the recommendations had yet been implemented.

Report 6 - Capsticks

2.39 This report was written by a seconded Capsticks employee into the C&C Team.

2.40 This was a reflective piece of work, but the author made six recommendations that he felt would add benefit to the team and process.

2.41 The Review Team were unsure whether this was being followed up corporately or just left to the internal team. Actions have certainly been taken to improve the data processing and address some of the functional constraints in the system. There has also been a reorganisation and the responsibility for the team has

transferred which is seen as a positive. However, once again, we cannot see a real action plan that responded to this.

Report 7 - Internal Audits Review of Coronial Controls

2.42 This was the latest report and again looked at the compliance review of coroner processes. This covered the period 01 April 2021 to 14 January 2022.

2.43 The auditors concluded that the governance processes and risk management arrangements in place provide reasonable assurance and that risks are managed effectively. However, compliance with the control framework was not always consistent and some recommendations for improvement were made.

2.44 One of the comments that was made was that the rationale for downgrading incidents was not always complete. Minutes were still not being routinely taken and target date for responses to coroners not met. 75% of referrals had target dates that had lapsed.

2.45 The Review Team had looked at 41 out of 440 delayed responses and discussed this with the Trust. It was found that an internal target of 10 days was set although this was not made by the Coroner. The Review Team didn't agree with this and suggested a change back to the accepted 60 days for serious incident cases.

2.46 At the time of the review the action plan was in development, but we have since been advised the plan is now in place, although we have been unable to check this.

Conclusions

2.47 Our overall conclusion is that the seven independent reports discussed in the table have been of good quality and have addressed the areas that were in the scope of their enquiry.

2.48 However, it is important to note that some former NEAS executives did not agree with the Ward Hadaway reports and conclusions as they felt they had no input to factual accuracy. These discussions contributed to delays in responding to the recommendations in 2019. It is our assessment given further reports and interviews with staff that the conclusions are still reasonable and in line with what we heard.

2.49 There is no doubt that a lot of focus and effort has been given to improve the coronial processes by the task and finish group, but we are not yet persuaded that this effort has translated into the delivery of all recommendations (as described above), and not all of the required improvements have yet been realised.

2.50 The conclusions arrived at by the Task and Finish Review Team in respect of whether findings and recommendations from all the independent reviews had been implemented was "yes" in broad terms.

2.51 However, we do not agree with their conclusion as they themselves picked up that some of the recommendations had not been fully implemented. We do agree with their view that the improvement journey is a “work in progress”.

2.52 We also believe that the Chief Executive and Trust are taking the concerns raised seriously and indeed some improvements have been made (which have been acknowledged by staff in the C&C Team in our interviews) but this is more of a work in progress and the senior management have themselves acknowledged that.

2.53 There has been a huge investment in reviews and commissioning reviews, we believe that the focus now needs to be on moving on from identification of problems to investing in the solutions and improvements.

2.54 The key issues drawn from these reports are in part attributed to culture, governance, openness and transparency, legal understanding, difficult relationships that previously existed between teams in NEAS and of course some issues of process also.

2.55 All need to be addressed to run a safe and effective service. The rest of this report will focus on this.

Chapter 3: Terms of Reference 3

“Benchmark the Trust’s current coronial processes against peer organisations to determine whether processes are comparable in relation to timeliness and quality of evidence submitted to Coroners and suggest areas for further improvement if required.”

Introduction

3.1 For the timeframe of this enquiry, we reviewed NEAS processes in terms of policies, and compared them to other ambulance trusts. National guidance was available for all ambulance trusts at this time.

3.2 Regarding timeliness and quality of reporting, we were only able to review NEAS’s processes – but the benchmarks for these are set in law; the main piece of legislation referring to these issues is to be found in Schedules 5 and 6 of the Coroners and Justice Act 2009.

What we looked at

- Benchmarking
- NEAS Coroner processes - timeliness and quality of evidence submitted to His Majesty’s Coroner, and the Law
- NEAS response to date
- Developments in ways of working in the NHS more generally

Benchmarking

3.3 In terms of benchmarking the coronial process, NEAS’s own processes are set out in the NEAS *Learning from Deaths Policy (December 2019)* which states in paragraph two that “The purpose of the Learning from Deaths policy is to outline how NEAS will respond to deaths, identifying and consistently reviewing, then supporting staff and families whilst striving for continuous improvement in the clinical care provided.”

3.4 This document references (and to a great extent is based upon) The National Quality Board’s *National guidance for ambulance trusts on Learning from Deaths: A framework for NHS Ambulance Trusts in England on identifying, reporting, reviewing and learning from deaths in care*.

3.5 That document is also referenced in a further five Ambulance Service learning from death reports (out of the ten Ambulance Services in England) which can be found by internet search, those being - the *North West Ambulance Service Policy on Learning from Deaths*, the *East Midlands Ambulance Service learning from deaths policy and procedure*, the *South Central Ambulance Service Policies Procedures and strategies*, the *South East Coast Ambulance Service Learning from Deaths policy*, and the *East of England Ambulance Service Learning from Deaths Policy*.

3.6 Whilst not directly referenced, the *Yorkshire Ambulance Service learning from deaths policy* is significantly similar in content. All were easily found by an internet search. The South Western Ambulance Service also has a Learning from Deaths policy that was not easily found by internet search but is available (ascertained by private communication). Policies for the London Ambulance Service and West Midlands Ambulance Service were not easily found by internet search (but this does not mean they do not exist).

3.7 Issues with reviews into the deaths of patients in England are not new.

3.8 The national guidance for ambulance trusts on learning from deaths references the CQC publication of December 2016 entitled *Learning, candour and accountability - A review of the way NHS trusts review and investigate the deaths of patients in England*. This review considered “all NHS acute, mental health and community trusts, including both inpatient services in hospitals and community services”. However, it “did not review ambulance trusts or other NHS-funded care settings such as independent healthcare providers, primary care services or nursing homes”. One of the key findings was that “There is variation and inconsistency in the way organisations become aware of the deaths of people in their care across the NHS. This was found to be an issue for acute, community and mental health trusts equally”.

3.9 The Francis report of 2013 pre-dates this guidance and has amongst its recommendations that there should be independent review of deaths to enhance the accuracy of their reporting. Despite the Francis report, and the CQC’s noting that ambulance service trusts (amongst others) were at the time of their report outside a formal mechanism for the independent review of deaths, there seems to have been no subsequent change in recommendations for ambulance trusts to promote independent oversight.

3.10 It was out of scope of this enquiry for us to attend the relevant committees and meetings of all ambulance trusts to compare in practice, but a member of the investigating team did attend the NEAS Executive Safety Panel meeting of 11 November 2022. It was noted to be well chaired, quorate, with an agenda and relevant accompanying paperwork distributed in a timely manner. Discussions were challenging, and the recent inclusion of a Non-Executive Director to the attendees added some degree of oversight and independence.

3.11 What was notable (by absence) was a truly independent senior doctor’s opinion. This however is not unique to NEAS.

3.12 Further comment regarding independent review will follow later in this chapter.

What we found

3.13 Based on the above, most (if not all) ambulance services in England use national guidance as a template and produce their own Learning from Deaths report(s) based on it with adaptations for their own service(s). NEAS therefore benchmarks well against its peers in terms of policies.

NEAS Coroner processes - timeliness and quality of evidence submitted to His Majesty's Coroner (HMC) and the Law

3.14 Whilst it has not been possible to benchmark by visiting other ambulance services and studying their working processes in detail, we reviewed issues with the working processes at NEAS.

3.15 The relevant law pertaining to disclosure to HMC is that found (mainly) in the Coroners and Justice Act of 2009, Schedule 5. The main point being that a person is required to produce any document which is relevant, should they possess it. Schedule 6 of the same legislation sets out that it is an offence to distort or alter evidence, or to prevent evidence from being produced.

3.16 The C&C Team at NEAS – whose role should have included communicating with and referring cases to HMC - raised concerns in April 2019, regarding the quality and timeliness of documents and reports being passed to HMC. A RPIW was held in an attempt to improve matters. This resulted in the establishment of SEACARE (Patient **S**afety incidents, patient **E**xperience concerns, **A**dult safeguarding concerns, **C**hildren's safeguarding concerns, **A**udit from the learning from deaths process, **R**isk which incorporates coronial requests and concerns and **E**xternal requests for information related to care provided by NEAS) in May 2019. Whilst intended to promote cohesiveness, it actually further fragments ways of working.

3.17 The C&C Team raised the point that SEACARE was in fact making the issues worse on 26 June 2019, and were supported in this conclusion by subsequent reports – such as that by Workforce One who found that SEACARE was “not fulfilling its expectations”. Significantly, SEACARE was found to “not provide a robust tracking and monitoring system”, caused “long delays in disclosure” and “making the conscious decision not to disclose documents”.

3.18 In Case 1, Patient A, as timetabled in Audit One's *Counter Fraud, Workforce Investigation: HMC 2011 Report, North East Ambulance Service NHS Foundation Trust*, this case should have been escalated to HMC on 13 December 2018 (following the patient's death on 9 December 2018).

3.19 Despite multiple issues being raised in this case (NEAS07 647233, and NEAS07 647259 – the internal NEAS reporting system), four reports being available and that the death should have been reported as a serious incident as per NHS England's Serious Incident Framework, this was not done. (The relevant area of the serious incident framework being “expected or avoidable death... This includes - suicide/self-inflicted death... Caused or contributed to by weaknesses in care/service delivery (including lapses/acts and/or omission)”). To an outside observer, a serious incident clearly applies in this case.

3.20 The C&C Team were not aware of the above case until 20 March 2019, several months later, and in fact were themselves advised by HMC, not by NEAS – their employers.

3.21 In the meantime, various clinical review group meetings (with no minutes) had been held, and a “strategy call” made. Timelines are detailed in the above report, but by 27 March 2019 the stage is reached where NEAS’s conclusions had been changed significantly as stated in 1.41 and 1.46.

3.22 Amendments to the original reports were also made. The internal report submitted to HMC is clearly a change to the original report.

3.23 Additionally, in-house reviews removed the following sentences preventing their consideration by HMC:

1. The attending Paramedic has stated asystole was witnessed on the ZOLL monitor. Retrieval of this activity on the ZOLL does not confirm this.
2. Subsequently Paramedic 1 has confirmed that on reflection they should have provided Advanced Life Support at this incident.
and
3. Concerns remain in relation to the ECG with no evidence of an asystolic reading. There are additional concerns that no effort was made to clear the patient’s airway, that Basic Life Support was not continued, and Advanced Life Support was not attempted.

3.24 The above shows both:

- (i) a failure to provide the appropriate documentation to HMC, as the C&C Team seem side-lined from the main purpose of their remit; and
- (ii) considerable change in the information provided to HMC.

3.25 The emphasis of NEAS’ conclusion was to change a serious incident into an incident needing lesser scrutiny. The first iteration of the report contained the facts, the second contained amendments following an internal review.

3.26 Whilst it is appropriate to have internal review for reaching conclusions about one’s own institutions standard of care, and learning lessons, this is for internal improvement purposes only. It may be useful to HMC to be aware that internal review has occurred, lessons learned and changes applied, as this may help HMC decide as to whether a “preventing future deaths report – Regulation 28²” is necessary or not. However, such evidence is not to be confused or conflated with the factual evidence required by HMC in law.

3.27 At the time of the issues that are the subject of this report (2018/19), processes seemed unclear. The C&C Team had an extensive list of responsibilities, as detailed in the report of Capsticks Solicitors LLP *3 Month Secondment Synopsis following Secondment to North East Ambulance Service NHS Foundation Trust*. One of the responsibilities not listed however is the responsibility to refer cases to HMC that the C&C Team deem appropriate. In fact, sometimes the C&C Team seem to be the last to become involved. It seems clear to us that the C&C Team were not the

² *If any information is revealed as part of the Coroner’s investigation or during the course of the evidence heard at the Inquest, which gives rise to “a concern that circumstances creating a risk of other deaths will occur, or will continue to exist in the future;” and if the Coroner is of the opinion that action needs to be taken, under Paragraph 7 of Schedule 5 of the Coroner and Justice Act 2009, the Coroner has a duty to issue a report to a person, organisation, local authority or government department or agency.*

focal point for administering issues that should have been their responsibility to raise for consideration by HMC. This issue has previously been raised to NEAS in the “counter fraud, workforce investigation: interim report” where the point is well made that “if the team are not aware of reports and other documents, there is a very real risk that information which should be given to the Coroner by the Trust is missed”.

3.28 NEAS therefore, in their dealings with incidents, conflated internal governance requirements with their legal obligation to HMC.

3.29 Internal meetings such as NEAS’s Quality Review Panel and Executive Safety Panel are a valuable forum for review and learning. However, documentation from such sources should be clearly indicated as such. Internal (educated and advised) opinion will always be internal opinion and not the source material. This should always be made clear.

3.30 Of the three other cases reviewed, two showed similar errors where the C&C Team were not included in the case management, and HMC was thus provided with incomplete documentation or no documentation.

3.31 In Case 2, Patient B “the Coroner is clearly not aware of the NEAS delay investigation”.

3.32 In Case 4, Patient D “The Coroner was made aware of the delay in ambulance attendance by police. It appears a delay investigation had already been completed ... but the Coroner had not been notified by NEAS”.

3.33 For a period of time therefore, cases were not passed to HMC appropriately. NEAS were made aware of this by the Audit One report of 20 March 2020 stating “It is the duty of the Coroner to establish the causes and circumstances surrounding a person’s death. This is not the duty of the Trust. The duty of the Trust is to disclose to the Coroner any information (document or thing) relevant to an inquest and/or investigation into the death of that person”.

3.34 The trend for NEAS to provide confusing/conflated material from its own processes rather than original material, or providing material with delays, or in some cases not at all was – for a period of time – a consistent feature.

3.35 Following an investigating team member attending an Executive Safety Panel of 11 November 2022, and review of action points in the minutes of the subsequent meeting of 16 November 2022 to ensure cases received appropriate follow up, we are clear that there is now a greater understanding of serious incident requirements and coronial requirements, though still room for improvement.

3.36 As an observer, it was not easy to recognise the flow of information. There are several departments within NEAS, each controlling different aspects of a single case. This has been noted before in an independent investigation by a partner at Ward Hadaway who commented “the reality is that so many people and groups are involved in the NEAS system of reporting and investigation of adverse events that the lines of accountability have become blurred”. Whilst no one structure is suitable for all organisations, streamlining/simplifying of these flows is recommended, and a

template should be sought from a comparator organisation.

What we found

3.37 The C&C Team were often not included and therefore could not act appropriately.

3.38 The C&C Team were not always given source information for passing to HMC.

3.39 Decisions were made during meetings without minutes taken.

3.40 Internal learning (not original documentation) was passed to HMC.

3.41 Information flows were unclear.

NEAS response to date

3.42 There have been many reports into the concerns about governance and coronial processes. In order for NEAS to mitigate the risks raised, and address the recommendations made, an internal task and finish group was established to consider coronial process.

3.43 The task and finish group reviewed many areas in which there had been noticed to be deficits both internally and when judged against the external reports that had been commissioned at that time. We noted their outputs as:

- improved relations and regular interactions with HMC, including ongoing dialogue during active cases and templates to aid information exchange
- funding secured for the training of 160 investigators for the (then) soon to be introduced PSIRF
- recognition that SEACARE was counterproductive
- improved peer support mechanisms
- advice sought from the Yorkshire Ambulance Service regarding process
- restructuring of the Directorates to promote closer working/flow of information
- improvements to the Ulysses data system
- a review of 416 historical cases
- internal teambuilding meetings
- a system for the internal escalation of “cases which cause concern”

3.44 The task and finish group was stood down by the Trust Board in February 2021, having noted the above. One of the outputs of the task and finish group was to have commissioned an internal audit of compliance with the Coroner’s processes. Work against this again had many outputs, and these were formally presented at the Quality Committee Extraordinary meeting on 23 September 2022. The main outputs are listed below:

- All incidents involving deceased patients, whereby the harm level is downgraded to below moderate (HMC referral threshold) should have the rationale behind the change in harm level clearly documented
- All Clinical Review Panel meetings should have minutes taken, reflecting the discussion and rationale behind the decision-making process for the actual harm level
- Streamline the reporting mechanisms to the Coroner
- Ensure relevant staff are all compliant with the Patient Safety Incident Response Framework (PSIRF) which replaces the current Serious Incident Framework
- Ongoing monitoring of coronial cases to be conducted via internal governance framework.

3.45 The Quality Committee is to continue to monitor compliance with respect to the above.

3.46 Importantly, the Patient Safety Team and the C&C Team are now managed within the same reporting structure within the Quality and Safety Directorate. This prevents silo working, encourages good working relationship and provides a robust governance structure.

3.47 There have also been positive comments from team members, one saying how “communications...have definitely improved” and that as far as it is possible to tell, “all available documents related to the various coroner’s cases are now being shared”. Another more general comment being that “things are much better”, especially “in relation to behaviours”.

3.48 Clearly good progress is being made, but one of the main root causes of the issues remains unaddressed, which is “Ongoing monitoring of coronial cases to be conducted via the internal governance framework”. This does not change in any way the process that led to the commissioning of this report. If review continues to be undertaken by the internal framework – there is no impartial/independent review and the same problem may recur.

3.49 The issue regarding the extra expenditure required for an independent person (or persons) to scrutinise such deaths is already recognised by NEAS and is on the risk register: “Additional resource will be required to effectively deal with the potential increased workload as a result of the significant high profile adverse national media coverage/ publicity and the resulting loss of confidence in the organisation”.

What we found

3.50 Good progress is being made, but there remains a lack of independent review.

Developments in ways of working (in the general NHS)

3.51 One of the recommendations of the Francis report was the creation of a Medical Examiner (ME) service to ensure an independent review of deaths. Whilst

the initial remit of the ME service was to review deaths occurring in acute trusts, the service is currently expanding to cover independent healthcare providers, primary care services, community and mental health trusts, and nursing homes. This service is currently non-statutory but has been incorporated into legislation via the Health and Care Act 2022, and will become statutory shortly. The ME service has a remit to review all non-coronial deaths.

3.52 This relatively new service has been generally well received. In the words of the (then) Minister of State at the Department of Health and Social Care, Nadine Dorries, in April 2021, “every one of us, no matter who we are, deserves dignity – whether that’s at the end of our life or when we’ve lost someone who is close to us. That’s what our new medical examiner system does so well, by establishing a vital point of contact for bereaved families, by providing greater safeguards for the public and for being that trusted professional voice at a time of such sensitivity”.

3.53 The purpose of the medical examiner system is to:

1. Provide greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths
2. Ensure the appropriate direction of deaths to the Coroner
3. Provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
4. Improve the quality of death certification
5. Improve the quality of mortality data.

3.54 One of its main functions is to consider: “Are there any clinical governance concerns? (ensuring the relevant notification is made where appropriate)”. This is clearly stated in *Implementing the medical examiner system: National Medical Examiner’s good practice guidelines*.

3.55 Whilst the ME service was not initially set up to review deaths reported to the Coroner, the issues from the enquiry into the concerns raised about NEAS suggest that this is an area that could be explored within NEAS.

3.56 The current procedure is for NEAS to pass information from their Learning from Deaths systems to HMC. When this occurs, there is no independent Senior Doctor reviewing the deaths. Independence of the scrutiny of deaths was a key recommendation of the Francis Report, mentioned on several occasions. In NEAS, when a death occurs, it is reported to either the patient’s General Practitioner (in the case of an “expected death”), or the coroner - usually via the Police Force (for “non-expected deaths”).

3.57 In the case of an “expected death” where the patient has clearly been deceased for some time and therefore there has been no medical intervention by NEAS following their arrival at scene, the case will pass directly to HMC. However patients that have been subject to medical care (or should have been subject to an appropriate medical care which was omitted) by NEAS either on scene or in transit, and die prior to reaching a Hospital, will also pass directly for review by HMC. The medical care (or lack of appropriate medical care) provided will therefore not be subject to any independent Senior Doctor review.

3.58 As the ME service becomes part of normal processes in the wider NHS, the deaths that are attended by NEAS and are considered “expected” will be scrutinised by the ME service, via the General Practitioner. Unexpected deaths will continue to pass to HMC.

3.59 These deaths, although of course subject to trained and experienced independent legal opinion, are not subject to a trained and experienced independent senior doctor’s medical opinion, as stated above.

3.60 This is one of the main points raised by the NEAS investigation in terms of the Trust’s coronial processes. Whilst the organisation did pass information to the coroner, it was not independently assessed, and led in part to the claims made by the whistle-blower.

3.61 Whilst NEAS is not an outlier when compared to other ambulance services, this practice is not in keeping with the scrutiny applied (or currently being developed to apply) to other patients whilst in the care of an NHS body.

3.62 The National Quality Board’s report referred to above, does, in paragraph 4, refer to the introduction of the ME system. That National Quality Board recognises that its own guidance should be reviewed in the future to take account of ME system development. Of all the documentation regarding Learning from Deaths in ambulance services available for review online, only the Yorkshire Ambulance Service, in its Learning from Deaths policy, has a protocol for ME service interaction. Although this only refers to questions sought from the ME service regarding deaths reviewed that occurred in other Trusts where there had at some point in care been ambulance service involvement, it does show progress.

3.63 As stated earlier in this report, the support to the families in the cases that are the subject of this inquiry was poor.

3.64 There was no independent communications with families, again one of the Francis Report recommendations. Family interaction was also one of the recommendations of the Third Report of the Shipman Inquiry. The ME service would greatly improve on the current support (or lack thereof) provided to the bereaved in this context. One of the reasons for the introduction of the ME service was to “provide bereaved families with greater transparency and opportunities to raise concerns”. As stated in the ME good practice guide on supporting the bereaved “...the service is set up for supporting the bereaved, by being compassionate and sensitive ... and aware that the bereaved have heightened emotions – denial, anger, guilt and despair which may affect how they behave”. One of the main functions is to “communicate sensitive information with tact and empathy, appreciating its potential impact”. Particularly pertinent to this report - “there are likely to be cases where the bereaved raise concerns that require action, which the service is designed to act upon”.

3.65 Such a service would have lessened the trauma suffered by the relatives in these sad cases.

3.66 As working relationships with HMC are paramount, it is important to recognise that the ME system is valued by HMC in areas where it is already functioning. His

Honour Judge Thomas Teague QC, Chief Coroner, noted³ the “practical benefits that the medical examiners scheme can bring to the death investigation process”, and that when he questioned local coroners regarding the process, was “heartened by the positive feedback” that he received.

What we found

N/A to this section.

Conclusions

3.67 It is reasonable to say that NEAS has processes equivalent to those of most (if not all) other Ambulance Services.

3.68 It would seem however that in the cases that are the subject of this report, those processes failed in 2018/19.

3.69 Internal review was not centred around the Serious Incident Framework.

3.70 Investigation reports and the obligation to provide HMC with original documentation were conflated.

3.71 Multiple teams were involved, when the C&C Team should be the only team to have dealings with HMC. They should have been provided with all original documentation in a timely manner, for onward transmission to HMC.

3.72 There is a lack of clarity about the flow of documentation and responsibilities.

³ 2022 National ME Conference

Chapter 4: Terms of Reference 4

“Review the Trust’s Serious Incident process and determine whether SIs are reported and actioned in accordance with best practice, local policy, and national guidance, identifying both areas of good practice and any areas of concern.”

Introduction

4.1 The NHS aims to deliver high quality and effective care. However, sometimes things can go wrong for a variety of reasons. The public understand that and still retain high confidence and satisfaction. However, they also demand candour and transparency when things go wrong and want to be assured that learning has taken place so that the NHS can continually improve the safety and quality of the care provided to patients.

4.2 Although like all NHS organisations, NEAS are currently transitioning to the Patient Safety Incident Response Framework (2022), during the reference period, the service would have been working to the NHS Serious Incident Framework (2015) which emphasises the importance of serious incident investigation in relation to learning and prevention.

4.3 The national Serious Incident Framework states that:

“The occurrence of a serious incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm...Serious incidents therefore require investigation in order to identify the factors that contributed towards the incident occurring and the fundamental issues (or root causes) that underpinned these. Serious incidents can be isolated, single events or multiple linked or unlinked events signalling systemic failures within a commissioning or health system.⁴”

4.4 The framework also states that:

“Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm- including those where the injury required treatment to prevent death or serious harm, abuse, Never events, incidents that prevent (or threaten to prevent) an organisation’s ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

The needs of those affected should be the primary concern of those involved in the response to and the investigation of serious incidents. Patients and their families/carers and victims’ families must be involved and supported throughout the investigation process”.

⁴ Serious Incident Framework (2015) NHS England Patient Safety Domain. Page 12

4.5 The Trust has, as would be expected, a Serious Incident Policy based on the national framework.

4.6 As stated earlier in the report, a new national Patient Safety Incident Response Framework (PSIRF) was published which supersedes the previous 2015 Serious Incident Framework. The PSIRF makes no distinction between “patient safety incidents” and “Serious Incidents”. As such it removes the Serious Incidents classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement. This is a transition year and most organisations will be positioned to go live in April 2023 once incident reporting systems are aligned and must be completed by Autumn 2023.

4.7 The new PSIRF advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents, embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management. We would expect the Trust to be preparing for this now.

4.8 NEAS07 is the internal system adopted by the Trust for the reporting of incidents including those giving rise to patient safety concerns under the previous framework and was in force at the time of these cases. The impact of the incidents is graded 1 to 7 on the form, 1 being no harm, 2 low harm, 3 moderate harm, 4 severe harm, 5 death, 6 near miss and 7 harm not related to NEAS.

4.9 The person completing the NEAS07 grades the actual impact at the time of submission on the form, however, the grading can be changed once the incident is fully reviewed by the Clinical Review Group (CRG).

4.10 Incidents graded 3 and above are allocated to a clinical operations manager (COM) for investigation and those below a 3 to a clinical care manager (CCM). The form includes a section named Outcomes Details which records significant events during the investigation.

What we found

4.11 If we reflect on the cases discussed in Chapter 1, we can see that in some cases the serious incident process was not enacted in the spirit of the framework and the consequences of that were material for the patients and families involved.

4.12 In Case 1, the NEAS07 was initially graded as a 5 which seemed appropriate at the time. In line with the process, a COM was involved, and an investigating officer appointed to carry out the investigation.

4.13 A CRG was called on 13 December 2018. The purpose of this group is to ensure adherence to the NHSE Serious Incident Framework.

4.14 The Patient Safety Team has the responsibility to record and note all written outputs from the meeting and to record who was present and of course agree the

agenda and ensure papers are ready and available. They also must record the agreed outcomes on serious incidents.

4.15 For the meeting on the 13 December 2018, Case 1 was added as AOB (any other business) and both the Investigating Officer (IO) and the COM were in attendance. No minutes were taken but NEAS07 had commented that the Strategy Meeting on 17 December 2018 would establish if it was a serious incident. This contravenes the Trust's own policy.

4.16 It did emerge that an email suggested that Duty of Candour applied which suggested some discussion at that meeting. Given that the key people attended this meeting and had access to all the details at that time that it could have been dealt with there. It was also true that it should have also been disclosed to the Coroner.

4.17 The Strategy Group held in December 2018 downgraded the incident even though it had no delegated powers to do so. Again, no minutes were taken of the meeting outlining the rationale for the decision.

4.18 The second CRG was held without the IO and COM on 20 December 2018. They were not aware of decision of the Strategy Group in relation to the serious incident.

4.19 The case went for a third time to the CRG on 17 January 2019 where the Strategy Group decision was noted.

4.20 Given the seriousness of the concerns, the death of a 17-year-old girl and the fact that two NEAS07 forms were raised and that there were initial concerns that adherence to ROLE had not occurred, there is no reasonable explanation as to why the incident was downgraded. As a result, the family were not informed, the Duty of Candour was not met, and the Coroner was not informed. The Trust's own serious incident process was not followed.

4.21 The same failing applies to Case 2, where similarly, an opportunity for learning was missed.

4.22 Evidence from some of the other independent reviews and investigations also pick up similar issues.

4.23 There is variation in interpretation among staff in NEAS about national standard waiting times for ambulances and the decisions arrived at in some cases. The fact that an ambulance arrives within the standard time does not exclude the possibility that harm, or omissions of care, may have occurred and there is learning to be gained from an appropriate investigation.

4.24 This thinking appears to have affected the rating in Case 2. This seems to miss a key point in the framework: that organisations should err on the side of candour and learning and not deal with cases in a mechanistic way.

4.25 It is not suggested that all staff do this, but this review heard evidence and has seen the outputs of the previous independent investigations that together with recent discussions with regulators, suggest that consistency remains an issue.

4.26 The issue of training and consistency raises the importance of peer review and challenge to maintain objectivity and focus on learning and improvement.

4.27 One of the other concerns raised by partners and by NEAS itself is the change in the numbers and ratios of serious incidents in the organisation relative to others over the last few years. The concerns being expressed by system partners and regulators is whether the thresholds for serious incidents have altered.

4.28 Previous Executives in NEAS also told us that the CQC on a previous inspection had said that their serious incidents were too high and this has completely changed to a point where it now appears very low comparatively. The CQC do not believe that to be true and had challenged the Trust when they heard it at the time. Serious incidents were monitored each month. In 2018 NEAS were the second highest reporting ambulance trust in the country. This is particularly significant as this is not a CQC position on reporting incidents where high reporting is encouraged and is an indicator of positive safety.

4.29 The Desk Top Review Team also decided to go beyond the scope of their review and looked at serious incidents more generally to gain insights into the learning culture of the Trust. They looked at quarterly reports prepared by the commissioners. The data indicated that the numbers of serious incidents reported by NEAS are low, compared to the amount of activity and patient contacts.

4.30 We have spoken to the commissioners (the former CCG) of the service and have discussed our concerns in respect of the low numbers of serious incidents. They too had concerns and have increased their own oversight of the quality and governance issues within the Trust. They now always attend the Quality Review Group (QRG) and recognise that their own commissioner processes were not as robust as they should have been. When the whistleblowing came to light the commissioner established a risk escalation group.

4.31 The commissioners were concerned about not being sighted on NEAS internal incidents and that some wider learning opportunities had been lost.

4.32 They have reflected on this and are considering the case for the adoption of the National Ambulance Framework for Commissioning of Ambulance Services with specialist oversight. We support this approach and believe it will provide a better framework for NEAS to operate in.

4.33 We have also asked the lead commissioner for the ambulance service to provide us with the latest quarterly data which can be found below:

North East Ambulance Service NHS Foundation Trust
Incident reporting data 1 January to 31 October 2022

Organisation	Degree of Harm	Q4 Total March - 22	Q1 Total June- 22	Q2 Total Sep-22	Overall Total
EAST MIDLANDS AMBULANCE SERVICE NHS TRUST	Death	0	0	0	56
	Severe	21	18	17	
EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST	Death	0	3	0	89
	Severe	16	39	31	
LONDON AMBULANCE SERVICE NHS TRUST	Death	2	3	13	28
	Severe	2	2	6	
NORTH EAST AMBULANCE SERVICE NHS FOUNDATION TRUST	Death	0	2	2	21
	Severe	0	3	14	
NORTH WEST AMBULANCE SERVICE NHS TRUST	Death	5	21	10	46
	Severe	0	6	4	
SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST	Death	27	43	39	146
	Severe	4	16	17	
SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST	Death	0	2	0	30
	Severe	3	14	11	
SOUTH WESTERN AMBULANCE SERVICE NHS FOUNDATION TRUST	Death	0	0	0	8
	Severe	8	0	0	
YORKSHIRE AMBULANCE SERVICE NHS TRUST	Death	8	4	8	65
	Severe	11	11	23	
WEST MIDLANDS AMBULANCE SERVICE NHS FOUNDATION TRUST	NOT AVAILABLE				

4.34 The commissioners have raised this apparent disparity with the Trust on a number of occasions and the responses appear to suggest that not all ambulance trusts count incidents in the same way or share common thresholds for serious incidents. This is difficult to validate and is an area of work where we will make a recommendation for the commissioners of the service.

4.35 In addition, we have reviewed the Board's papers and looked at data in respect of serious incidents. There were no serious incidents reported by NEAS in Quarters 3 and 4 of 2021/2022. Numbers since then still appear to be small in single numbers up until September.

4.36 Report 7 also incorporated a view on the controls in place in respect to the classification of harm within incidents.

4.37 Auditors took an extract from Ulysses (which is the Trust's incident recording system) showing all incidents where the harm level had been downgraded. All incidents were between the dates of 01 April 2021 to 14 January 2022.

4.38 The audit team filtered the extract to show all incidents where initial harm level was Death and the actual harm level was Low Harm or below.

4.39 A sample of 10 was chosen randomly and checked to test whether the harm level changes had a rationale behind the change recorded.

4.40 20% of the sample did not have a rationale to support the downgrade. In the absence of evidence to support recategorising the level of harm, the organisation would be unable to defend the decision not to refer to the coroner and enact the Duty of Candour with the family.

4.41 The auditors also reviewed the minutes of the Clinical Review Panel for a period of five weeks to ensure that any incident with a harm of moderate or above was adequately reviewed and discussed.

4.42 For the 10 meetings, only five sets of minutes were available. There had been one cancelled meeting. Again, this is not in compliance with the Trust's own policies. For the cases identified for more senior review by the Executive Safety Panel (ESP) the auditors identified that in eight out of 11 reviews there were no details or evidence of the reviews taking place or having been recorded and actions taken.

4.43 The Trust has acted and developed an action plan to respond to the Audit recommendations. A further review of cases on Ulysses was carried out and other actions reported to the Board's Quality Committee on 23 September 2022. There were still some data issues found but certainly some evidence of improvement.

4.44 Due to the scope and limited time tabling of this review, we were not able to review all serious incidents or do an in-depth evaluation of all related management systems. We do however suggest that this is done, and specialist advisors brought in to support the Trust.

Conclusions

4.45 The review finds that the Trust do have reasonable processes and policies in place, but that the thresholds adopted for serious incidents are variable and that there are potential risks that may lead to understating the number of serious incidents and missing the opportunity for learning.

4.46 It should also be noted that there appears to be wide variation nationally on reporting of serious incidents. Further work would be helpful to provide more focussed guidance to help ambulance trusts.

4.47 It is also evident that the processes in place are not always followed, and the Trust needs to improve the compliance culture within the service.

4.48 In respect of the cases discussed in Chapter One, there was a failure in two of the cases (Case 1 and Case 2) in respect of the missed opportunity to declare a serious incident sooner. This would have made a significant difference to the families and to the establishment of trust between NEAS and the families.

Chapter 5: Terms of Reference 5

“Consider whether the statutory Duty of Candour is appropriately applied within the Trust’s Serious Incidents process and procedures and consider specifically its application in relation to the specific cases being considered.”

Introduction

5.1 The Duty of Candour is a general duty to be open and transparent with people receiving care from you.

5.2 There are two types of Duty of Candour, statutory and professional. Both have similar aims: to make sure that those providing care are open and transparent with the people using their services, whether or not something has gone wrong.

5.3 The CQC regulates the Duty of candour as part of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20, while the professional duty is overseen by regulators of specific healthcare professions such as the General Medical Council (GMC), Nursing and Midwifery Council (NMC), the General Dental Council (GDC) and the Health Care Professionals Council (HCPC).

5.4 The statutory duty also includes specific requirements for certain situations known as “notifiable incidents”. A notifiable safety incident must meet all three of the following criteria:

1. It must have been unintended or unexpected.
2. It must have occurred during the provision of an activity that the CQC regulate.
3. In the reasonable opinion of a healthcare professional, it already has, or might, result in death, or severe or moderate harm to the person receiving care.

5.5 This element varies slightly depending on the type of provider. If any of these three criteria are not met, it is not a notifiable safety incident but the overarching Duty of Candour, to be open and transparent, always applies.

5.6 Regulation 20 (7)⁵ defines the harm thresholds for Health Service Bodies:

In the reasonable opinion of a healthcare professional, the incident could result in or appears to have:

- resulted in the death of the person - directly due to the incident, rather than the natural course of the person's illness or underlying condition
- led to the person experiencing severe harm, moderate harm or prolonged psychological harm. These definitions of harm are linked to the National Reporting and Learning System (NRLS) definitions.

⁵ The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

5.7 Once a Duty of Candour requirement has been called then the Trust should (as required by the legislation):

1. Tell the relevant person, face-to-face, that a notifiable safety incident has taken place.
2. Apologise. Regulation 20: Duty of Candour Page 19 of 28.
3. Provide a true account of what happened, explaining whatever you know at that point.
4. Explain to the relevant person what further enquiries or investigations you believe to be appropriate.
5. Follow up by providing this information, and the apology, in writing, and providing an update on any enquiries.
6. Keep a secure written record of all meetings and communications with the relevant person.

5.8 The Trust has developed and indeed updated its policy on 28 October 2022 and monitors it through a Duty of Candour Dashboard that is presented to the Trust Board on a Quarterly basis.

5.9 The Policy appears to have encapsulated the key themes outlined in the Regulations and Professional Duty of Candour guidance.

5.10 We have looked at Board Reports and an SPC chart depicting Duty of Candour notified within 28 days is in the pack. Currently the Duty of Candour notification compliance has dropped to 14.2% due to the increased number of serious incidents and moderate harms declared and a shortage of available FLOs due to operational pressures.

What we found

5.11 The Trust have a plan to train some more FLOs and hope to improve performance once that has taken place. Given that the Board are monitoring the data, we have more assurance that focus is being given to it.

5.12 With respect to the cases discussed in Chapter 1, it is already clear that in two of the cases (Case 1 and 2) that Duty of Candour was not declared due to the grading of the incident not being above moderate harm and not appropriate. Because of this, Duty of Candour was not applied in our view as it should have been.

5.13 The Duty of Candour was enacted in Cases 3 and 4, although in Case 3, the family did not have face to face contact initially and feel that communications were not handled well at all. This was more difficult as it was in one of the acute phases of Covid but the Trust itself acknowledged that it should have done better.

5.14 NEAS have recognised the importance of Duty of Candour, but this also relies on incidents being flagged for the duty to be enacted. As stated previously, this still appears to be a challenge.

5.15 The Trust have already identified appropriate action to improve the timeliness of enacting Duty of Candour and we do not have any further recommendation.

Chapter 6: Terms of Reference 6

“Seek to determine whether the arrangements in place for staff to escalate concerns, both during the period under review and now, are effective and appropriate. Including whether the Trust provides an environment in which staff feel safe, supported, and encouraged to report and escalate concerns.

This will include formal Freedom to Speak Up arrangements. The review will include speaking with relevant staff and leaders and a desktop review of relevant data.”

Introduction

6.1 A safe, healthy culture in the NHS relies on everyone in the organisation being able and willing to speak up about anything that concerns them.

6.2 For people to speak up they have to know it's expected of them; they have to understand how important it is and have that message consistently reinforced; they have to feel safe to speak up without fear of detriment or censure; they have to feel it's worth their while (in other words, know how to raise their concern and have faith it will be addressed), and see improvements happen as a result.

6.3 Safety therefore relies on having the right culture in place, and on robust systems and processes. We therefore looked at the systems in place to enable staff to raise concerns in 2018/19 and now. We describe these systems in some detail in other chapters (see Chapters 2, 4 and 7 specifically).

6.4 We looked at evidence of the culture in place during these periods of time, and whether that culture made staff feel safe, and encouraged to speak up. We looked at the previous reports, and the national staff survey results and Care Quality Commission (CQC) reports. We also spoke to staff in the organisation about systems and processes and the culture.

6.5 As the CQC were concurrently surveying staff regarding culture we did not replicate that but will reference their evidence and findings.

6.6 We reviewed the current Freedom to Speak Up (F2SU) arrangements. However, we are aware that the Trust is awaiting the outcome of a national review by the National Freedom to Speak Up Guardian (F2SUG) and will need to take account of that in finalising any review of its arrangements.

What we found

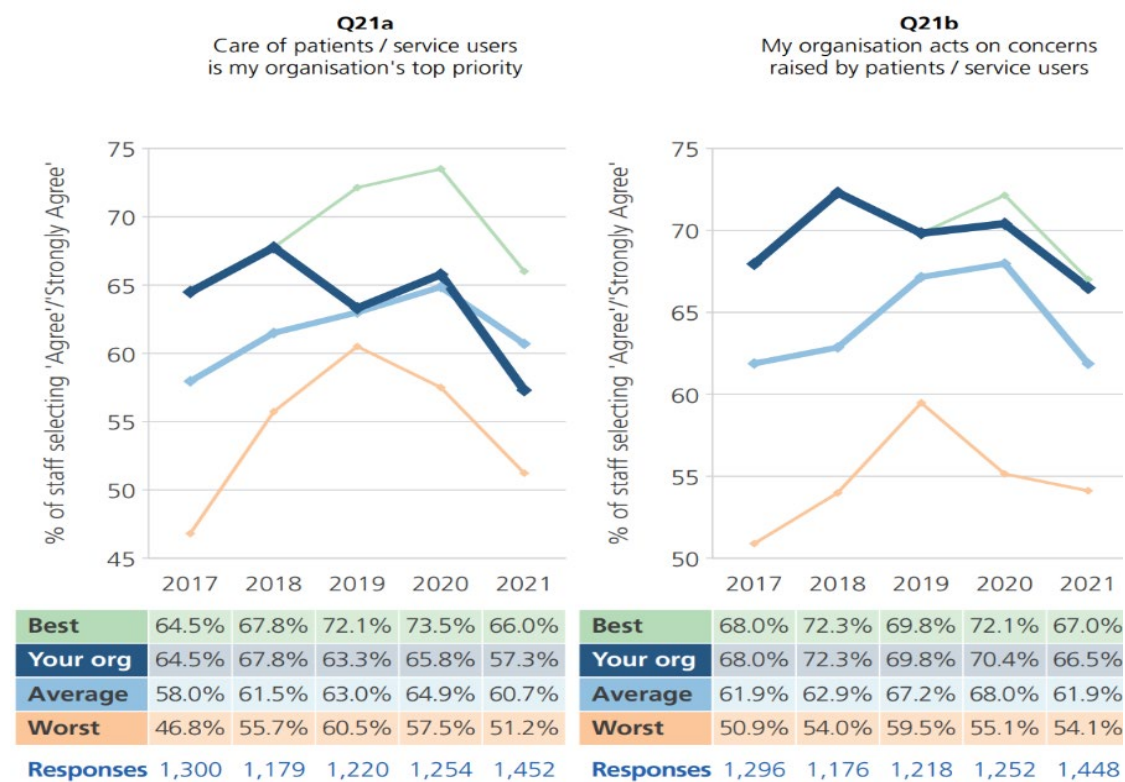
Culture

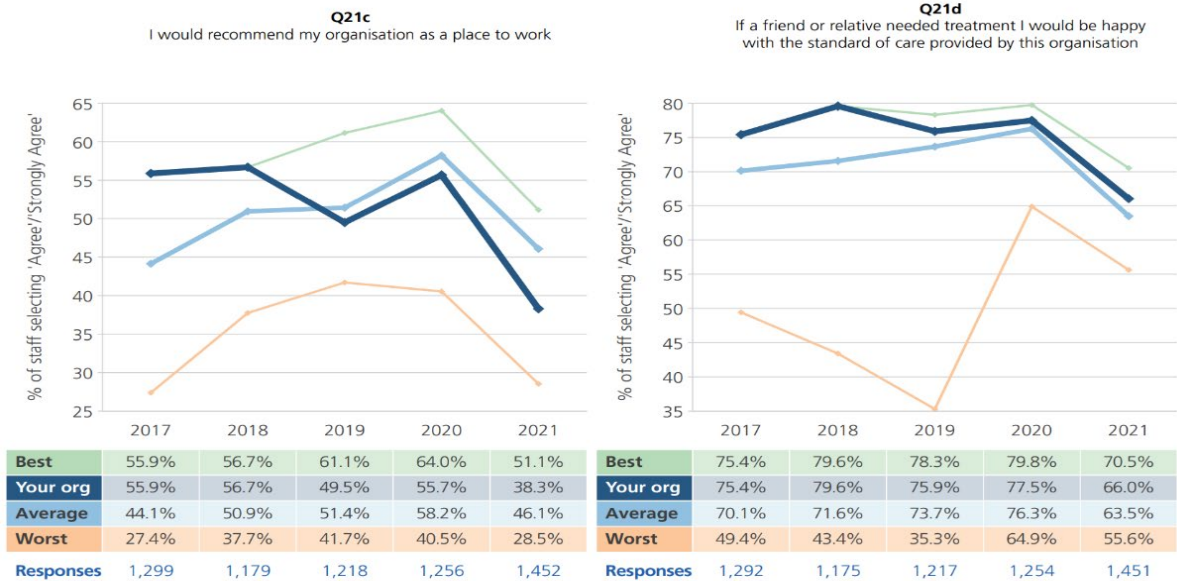
6.7 In early 2019 the CQC rated NEAS as Good overall, including Good for the Well led domain which takes account of staff engagement and morale. The report was largely positive regarding organisational culture.

6.8 The NHS National Staff Survey is the most comprehensive, benchmarked measure of staff engagement and morale in the NHS, and a basis on which to assess culture overall. There are also specific questions which give insight into the extent to which staff feel inclined and confident to speak up about any concerns.

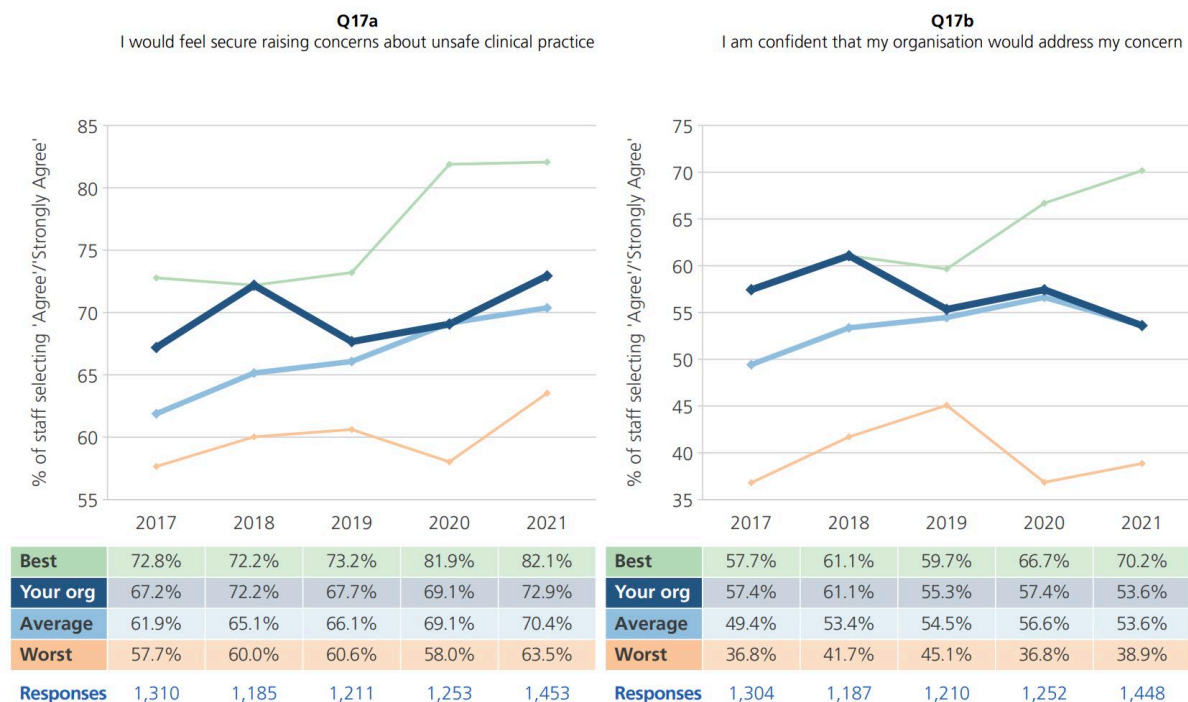
6.9 In 2018 (reported early 2019) NEAS had some of the most positive responses in the sector for the questions relating to overall morale and recognition of the values of the organisation – see below the extract from the national results portal.

6.10 However, by late 2019 and the next staff survey, results had deteriorated significantly against the national trend. We know there is a subsequent staff survey but this was not available to us at the time that the report was written. Apparently this demonstrates further deterioration.





6.11 In response to questions related to staff feeling able to speak up, again NEAS were in a positive position in 2017/18 and then saw a more mixed picture.



6.12 In 2018/19, the organisation started to take steps to make changes to improve the systems and processes for reporting and investigating incidents and the way those processes impacted on the organisational culture. Steps were apparently taken to decentralise some of the resource for investigating incidents and to engage others (for example, the broader quality and safety team, operational managers, and other clinical staff in investigations), and consequently improve organisational ownership and learning.

6.13 Some senior staff also expressed concerns that the processes for investigating incidents were feeling overly formal and potentially punitive such that the type of culture needed to encourage reporting was not flourishing and that staff were being treated in ways that could deter them from speaking up.

6.14 Work was started to implement a “just culture” and indeed was championed by the then CEO. This was also being supported by some directors based on experience of successful work done in other NHS sectors and involved workshops, training sessions and policy reviews.

6.15 We were repeatedly told that the working relationships between different members of the corporate teams involved in quality and safety processes were, at best “fractured” and generally “toxic” with personal as well as professional animosity reported. The changes being mooted to systems appear to have exacerbated those tensions. For example, a Strategy Group was put in place to deal with Fitness to Practice issues (such as whether suspension of an individual was warranted during an investigation). An aim of the group was to bring consistency and clarity to the decision making and ensure the decisions and the management of individuals was in line with good practice and “just culture”. However, we were told that it was undermined by the group exceeding its brief, and some of those involved not adhering to the process, and/or making “arbitrary” decisions outside of it.

Systems and processes

6.16 In addition to work to improve culture in late 2018-19, a need to improve the rigour, timeliness, connectivity, and transparency of how concerns and incidents were investigated emerged. The Quality and Safety team wanted to improve the organisation’s ability to join up the information it had and satisfactorily oversee and learn from incidents.

6.17 There are differing views as to whether the changes being made to systems, and to improve culture and encourage reporting were warranted and would be successful. Tensions between those involved were evident, whether fuelled by the need for change or as a result of changes being made is debated. The common examples given appear to have focused on those incident investigations that were within the remit of the Coroner, but it has also been suggested that there were similar underlying concerns related to other quality and safety incident issues and investigations.

6.18 To address these tensions and questions a series of changes were being proposed, and a Rapid Process Improvement Workshop was held in May 2019. The impact of these changes and how they operated, and were subsequently reviewed and changed, are described in detail in Chapter 7 in relation to specific concerns raised by staff involved in supporting those services at that time. They are also described in previous reports. In Chapters 2 and 3 of this report the frailties of the systems and the impact of that is also summarised. They are pertinent to the efficient running of the overall process and the impact that would have on staff confidence and inclination to raise issues and so do need to be noted here.

6.19 The frailties in the process for reporting incidents, grading, and investigating and reporting serious incidents is likewise pertinent and is detailed in Chapter 4.

Leadership

6.20 Several people in senior leadership roles at the time have commented on the dissonance between the cultures and expectations they had experienced in other sectors of the NHS and what they found in the ambulance sector. They cited examples relating to a command-and-control structure, and the paramedicine profession working differently to the nursing /medical framework in place, for example, in an acute trust. Indeed, the Nurse and Doctor roles on the Board, a feature of all NHS Foundation Trusts (NHSFTs), do not seem to have operated with the level of clarity, and of ownership of the quality, safety, and governance agendas one would expect.

6.21 The process for the reporting and investigation of incidents can be complex. It relies on people working together, particularly where several operational staff will be involved, and clinical judgements and decisions must be taken account of. Frequently, broader system issues and system partners need to be engaged. It is vital that a robust structure for reporting and investigating incidents is in place with clear leadership – that was not the case in NEAS at that time.

6.22 Whilst the need for change and improvement of culture and systems was recognised, the impact of the changes being made were compounded by tensions and disagreements within some of the senior leadership team and within the teams dealing with the issues.

6.23 The tensions within the teams appear to have been fed by a level of mistrust, for example proposed changes to the way investigations were to be done were seen as a desire to obfuscate or hide facts. The concerns being raised by the C&C Team, were seen as a desire to inappropriately maintain control of the wider patient safety agenda and “police” the workforce.

6.24 Some tensions are to be expected during a system change, and some attempts were made to address these tensions and improve working arrangements. However, it is also clear that very real tension existed amongst senior staff, and amongst executive directors too.

6.25 When the cluster of serious incidents arose in late 2018/19 (Case 3 Patient C in November 2018: Case 1 Patient A in December 2018: Case 2 Patient B in March 2019) the “new” SEACARE process was not in place until May 2019, and it is not clear what level of oversight and assurance, collectively, executive directors had, or had sought. Some of those directors one would expect to lead the quality and safety agenda, claim not to have been close to the details, and there is a sense that the C&C Team and Patient Safety teams were left to “fight it out” to the detriment of the care due to the families, to organisational learning and the cost to the individual members of staff involved through lack of support.

6.26 A feature of what we were told, and was described in previous reports, is that responsibility and accountability for some areas of work appear to be designated to

groups. Individual responsibility is vested in professional roles and cannot be abdicated to groups.

6.27 There still appear to be divergent views regarding the current processes, including the approach to investigatory processes, or regarding the approach to categorising serious incidents.

Board oversight

6.28 Boards of NHSFTs are jointly and severally responsible for the delivery of the entirety of the Trust's objectives in line with regulation. That will include delivery of quality, financial, and employment responsibilities and objectives. Executive directors will lead on specific portfolios in line with their professional expertise, but there is not a separation where a director is responsible for only one element. There is evidence that at that time, executive directors at NEAS were not acting collectively to ensure delivery of overall key objectives. For example, when reviewing the process for investigating and learning from incidents, clear ownership is not evident, nor is the challenge and collective attention one would expect to see. Several directors told us they were unaware, or not involved in some of the cases we were reviewing, or in dealing with the issues arising within governance processes.

6.29 On occasion, the executive directors appear to have been working in silos with both professional and personal tensions evident – these tensions were not just reported by executive directors themselves but by their teams. Modelling this uncoordinated way of working and lack of collective ownership and focus, as well as a level of mistrust and, in some cases, poor personal behaviours, impacted on the way others worked and behaved.

6.30 Clinical leadership must drive the delivery of NHS services. However, tensions between clinical and operational priorities, and clinical priorities and HR processes feature in the descriptions we were given and should have no place in the functioning of executive and senior teams in the NHS.

6.31 We know that the then Chief Executive was aware of this and did take action with the specific individuals to resolve. However, it appears that the damage to the teams involved was already significant and the consequences of that are evident in this report.

6.32 The role of Non-Executive Directors (NEDs) is to bring diversity of experience and insight to the Board and provide scrutiny and challenge on behalf of the population the Trust serves. However, some NEDs told us that they had concerns about transparency at that time, they had concerns about “ownership” of issues, and they witnessed unacceptable behaviours – but they found it difficult to challenge. There is no evidence of action to remedy the situation until May 2019 when the external review was commissioned, and action subsequently taken at the end of that year.

6.33 A NED-led task and finish group did provide focus and oversight to the implementation of the Ward Hadaway recommendations and appears to then have

had the confidence to handover to the new Director of Quality and Safety (See Chapter 2).

6.34 Between 2019-20 there was a significant change in executive leadership; a new Chief Executive (CEO) (following a gap of 4 months), new Director of Quality and Safety, new Finance Director and new (and the organisation's first substantive) Director of HR (HRD). The incoming CEO put the new executive team together including investing in Board development work. She also actioned the outcome of reports relating to behaviours and culture including meeting staff who had raised concerns.

6.35 However, it is noteworthy that for many of the incoming executive directors, this was their first Board level post and their first post in the ambulance sector. All of the individuals are capable and committed, however that collective lack of experience given the challenges faced by the organisation (including the pandemic) will have been extraordinary and could have contributed to some of the frailties in the organisation despite the very hard work of those involved.

6.36 Whilst relationships appear to improve then, there remains a lack of collective ownership of the quality issues and focus on resolving the outstanding areas of concern.

6.37 Staff Side organisations are formally recognised with a full-time Trade Union lead in place. Work has been done to develop relationships but given the opportunity for staff side to bring a perspective and level of challenge to these issues they should be developed, and the potential to expand their input explored further.

Speaking up, then and now

6.38 In the case of the incidents we examined for this report, there were clear failings in how staff were supported to speak up and have concerns addressed. Those issues are dealt with in Chapter 8.

6.39 Regarding speaking up more generally it is clear that there were attempts to improve the culture to support that in 2018-19.

6.40 A substantive HR Director (HRD) is now in post and there is some recognition that senior leaders are making efforts to engage with staff and listen to their concerns.

6.41 In the national Staff Survey (2021) the organisation was above average for staff being secure to raise concerns, but below average for trust in process or confidence.

6.42 The HRD has implemented a "case conference" approach to grievances and disciplinary matters to ensure there is transparency and consistency to how concern impacting or raised by staff are dealt with. This process involves colleagues from operational management and quality and safety and will report themes to the People and Development Committee.

6.43 An action plan to deliver improvements to culture has been developed in 2022/23 and forms part of a CQC improvement plan workstream. Its implementation will be overseen by the People and Development Committee.

6.44 A sense still pervades for some staff that someone will be blamed if a concern comes to light. An example given is that there is a structured process in place to audit calls and feed back to or offer coaching to, individuals. Despite the right intention, of monitoring quality and focusing on learning, it appears to some staff to be too focused on individual performance. However, they expressed frustration that a process for auditing the quality of the call handling system overall and ensuring the learning from that can inform quality assurance or feed a formal improvement process, appears confusing with no feedback loop.

6.45 As part of their recent inspection the CQC surveyed staff regarding speaking up. Too many staff feel that a blame culture exists and are either fearful of speaking up or are disinclined to as they don't feel things will change as a result.

6.46 The National Guardian's office has recently done a review of speaking up in Ambulance Services in England. It recommends that a review of broader cultural matters should be carried out in ambulance trusts. We support that view given our findings of this investigation. There is no doubt that this would be of benefit to NEAS.

Freedom to Speak Up

6.47 A formal process to support speaking up in the NHS was implemented following the Mid Staffordshire enquiry in 2013 and is described in *F2SU: Whistleblowing policy for the NHS*.

6.48 The Trust has recently (July 2022) revised its Freedom to Speak Up (F2SU) policy. It is in line with national expectation: they have a named NED in place, a named Guardian and a reporting structure in line with national policy.

6.49 The number of concerns raised through the process are reported to be lower than expected – that isn't necessarily a sign of concern and there is evidence of active engagement within the organisation to make staff aware of the F2SU role and encourage reporting.

6.50 The F2SU Guardian (F2SUG) role is currently vested in the Company Secretary role with the current postholder at the time of this review 'inheriting' it when they took up the Company Secretary role in 2021. It is supplemented by an additional F2SUG, the CQC Compliance Officer. Whilst both are experienced, and committed to the principles of F2SU, there are some questions that this raises:

- It was pointed out that there is an advantage to the F2SUG role being held by staff "close" to the senior team and Board. However, the perception of impartiality could be damaged by that closeness.
- Neither postholder would claim to be close to, or indeed demonstrably very familiar with, frontline services. Again, this could impact the perception of their accessibility and understanding of issues.

- Capacity is clearly an issue. Benchmarking the resource available needs to take account of other variables to make the capacity appropriate and will form part of the national review: however, concern was expressed at the lack of capacity and accessibility of the current resource available.
- There was a plan to recruit F2SU Champions. This would mean staff in a range of roles identified and trained to support the Guardians and increase access, but this appears to have faltered.

6.51 In November 2022 the Trust agreed, following consultation, a revised approach including the appointment of a new F2SUG with additional resource supported by a network of F2SU champions. They are in the process of recruiting to that role. It has shared its revised arrangements with the national F2SU Guardian.

6.52 NEAS has recently been included in a national review of F2SU in ambulance trusts and acknowledges it may need to look again at its revised arrangements once that review is published.

6.53 We note that one of the aims of the new operational management structure is to provide additional support to developing a speaking up culture.

Conclusions

6.54 NEAS did seek to improve the culture to enable staff to speak up in recent years but there was a lack of collective ownership of the approach being taken which undermined it. We believe the Trust would benefit from engaging with the wider national review arising from the National Guardian's recommendations into 'speaking up' in ambulance trusts published in 2023.

6.55 Systems and processes were not in place that would enable best practice in reporting and, investigation. Thereby potentially hindering staff from speaking up and issues being addressed. These systems deteriorated because of the dissonance within the senior team.

6.56 Whilst data suggests staff will report concerns in that they know it is expected of them, they lack confidence in actions being taken, and still perceive a punitive approach in some cases.

6.57 Work to improve culture is actively ongoing; it would benefit from broader ownership, for example, the formal engagement of staff side in monitoring the plan. New operational leadership structures provide an opportunity to support cultural development further.

6.58 Revised F2SU arrangements have been agreed and are being implemented.

6.59 The Board has undergone considerable change and faces more with the appointment of a new Medical Director and Director of Quality and Safety.

Chapter 7: Terms of Reference 7

“Assess whether the action taken by the Trust in response to concerns raised by members of staff in Spring 2019 regarding safety matters and coronial processes were appropriate, and in compliance with best practice, local policy and national guidance in relation to HR practice, Whistleblowing and Freedom to Speak Up.”

Introduction

7.1 In the press article of May 2022, reference was made to how staff had tried, over a period of time, to bring their concerns to the attention of the organisation.

7.2 We reviewed the records of the concerns being raised at that time. These included those raised through line management channels, and through formal grievances and through the use of F2SU processes.

7.3 We looked at all the previous reports, and at the formal grievances and reports raised, and the outcome of them. We have relied on the content and findings of those reports as having been fully independent and sufficiently thorough in fulfilling their remits.

7.4 We also spoke to staff involved in the processes at that time to understand what happened, and to assess whether concerns were dealt with appropriately whether raised through formal processes or not. Whilst views were in some cases contradictory, we have taken the view that staff were reporting their experience in good faith.

7.5 In many of the examples shared with us a link was evident between the concerns staff had about safety matters and the frameworks and processes in place to manage them. A further link was also made to the behaviours exhibited by, or tolerated by, some people at that time. These were in some cases linked, as the behaviours were potentially attributed to staff having spoken up, or the behaviours were stopping people speaking up, or were hampering those concerns being addressed. Given the clear link between behaviour, culture, and safety, we have included the concerns regarding behaviours in our review.

7.6 Responsibility for ensuring appropriate processes for staff to raise concerns lies within management structures, and with professional and clinical leaders, and with those responsible for quality and safety governance processes, including the HR function. Consequently, we looked at how those functions were working, and how they were working together, at that time.

7.7 Concerns raised by other staff during that period, for example those about Case 1 Patient A, are referenced in Chapter 1 and therefore, not included here.

What we found

Safety and governance processes

7.8 In our meetings with staff, several described concerns and tensions about the Trust's approach to quality and safety governance processes, and the handling of coronial issues, emerging during 2018. They described the approach taken to specific incidents and a lack of structure and consistency in how they were investigated and handled.

7.9 Some senior staff were concerned that the approach to the investigation of incidents felt automatically punitive in the way staff were treated, they described staff involved in incidents being summoned to reviews that felt like "pseudo disciplinary" panels. Work was being done on culture and improving staff engagement across the organisation, and there were concerns that a different approach was needed to the investigation of incidents to ensure an open culture that encouraged staff to speak up about concerns.

7.10 We found that there were very strong, but dissonant, views about how that could or should have been taken forward. We were told that operational services were concerned with being able to "maintain control" of the workforce, with others leading what they saw as a "culture change" agenda designed to engage and empower staff.

7.11 There was a clear distinction in the views of those involved in operational management, leadership of quality and safety governance structures, risk management including the investigation and learning from incidents, and the handling of the responsibilities to the Coroner and the coronial process.

7.12 Staff involved in delivering the corporate services that were in place to support staff in raising concerns and ensuring they are dealt with – in Quality and Safety, Risk, Legal, Human Resources (HR); have all expressed frustrations at shortfalls in capacity, oversight, and a lack of collective working at that time. It is clear that in addition to a lack of an agreed collective approach, there was a significant lack of trust between some people and teams with a reluctance to share relevant information transparently and professionally.

7.13 Examples include the use of the Strategy Group. The remit of this group appears to have been to deal with Fitness to Practice issues, so to review what action was appropriate regarding an individual member of staff when an incident occurred thereby bringing consistency, transparency, and good practice to the process. We were repeatedly told that this group often exceeded its remit, dealing with matters that should have been formally discussed elsewhere. We were also told that some directors would overturn or change decisions outside of that meeting. The response to the overall concerns appears to have led, in early 2019, to the Rapid Process Improvement Workshop (RPIW) and subsequent setting up of SEACARE.

7.14 The RPIW was commissioned by two executive directors (the Director of Quality and Safety and the Medical Director) and facilitated by the Quality Improvement function. The directors were not present at the workshop.

7.15 Several staff at the RPIW expressed concern and frustration at some of the behaviours exhibited. Consequently, they felt they were not able to voice their concerns, or they were not heard. They were “shouted down” or intimidated. Their professional expertise was questioned and/or disregarded. Other staff suggest that some colleagues came along with an entrenched view and were determined not to contribute or make improvements.

7.16 Notwithstanding the difficulties at the workshop, the SEACARE group/process was set up as a result in May 2019.

7.17 SEACARE was described to us as making the process worse – too many people involved and a lack of clarity regarding decision making. A view subsequently supported by external reviews.

7.18 It appears to have led to further tensions and concerns being voiced and then several formal grievances being raised within weeks by staff, concerned that they did not have a clear process to follow, and that it was putting them and the organisation in an untenable position. These concerns were reported to the Board who commissioned Ward Hadaway to review Coronial Processes in May 2019. The conclusions reached in this report supported the concerns that staff were articulating.

7.19 As these concerns continued to escalate, people described colleagues being villainised – either for raising concerns with the original processes, or for raising concerns about the revised one.

7.20 No formal process appears to have been put in place to review the outcome of the RPIW, or SEACARE and its effectiveness, as would be expected following a formal Quality Improvement process. Given the feedback being given by staff and the concerns being raised, this was a serious misjudgement.

HR processes

7.21 Operational and clinical managers told us they were concerned about a lack of visibility of some process at that time, such as the length of time people were suspended following incidents. Concerns were also raised, including by the CQC, related to DBS checks and DBS risk assessments in August 2020. Indeed In August 2020, the CQC served the Trust with a warning notice under Section 29A of the Health and Social Care Act 2008 which required the Trust to make significant improvements in quality of health care. This was in relation to concerns raised about staff including safeguarding concerns, their conduct and managing positive disclosures on DBS checks.

7.22 Leadership of the HR function underwent considerable change during 2018-20. Until January 2019, executive leadership of HR sat in a mixed portfolio at executive level with strategy and transformation, and was led operationally by a Head of HR. On their retirement an interim HR Director was appointed (April 2019) with a substantive HR Director from March 2020.

7.23 HR practice in the NHS needs to take account not just of good employment practice, it must include the requirements of professional frameworks and

registration. So, for example, the technical recruitment process will be led by HR, but the identification of skills needed and the selection of staff is led by professional leads and operational managers. Ownership of other supporting governance processes including, for example, DBS checks, decisions relating to professional conduct and performance, must be carried out with the full support and direction of professional leads and operational managers.

7.24 HR staff reported feeling undermined, with their professional expertise not respected. Professional leads expressed frustration that they were not always aware of issues they felt related to their areas of professional responsibility, for example, decisions regarding DBS disclosures, referrals to professional bodies, details of individual practitioners being inappropriately shared during investigations. These comments again pointed to a level of mistrust between teams.

7.25 The Board was aware, and sufficiently concerned about the HR infrastructure issues to agree to strengthen the provision of HR and appoint a Board level HR Director in early 2019.

7.26 The tensions however appear to have persisted through to 2020, through three changes of executive oversight of the HR function.

Response to formal processes

7.27 Several formal grievances and F2SU reports were made during 2019-2020. It would not be appropriate, for the sake of confidentiality for individuals, to detail those here. They broadly covered two sets of concerns – those relating to safety matters and coronial processes, and those relating to the behaviours of some senior staff, and the impact of that. The issues and the responses are summarised here.

Concerns raised formally about the coronial/investigatory processes during 2019

7.28 Concerns, including a formal grievance, were lodged in early 2019 specifying the lack of a clear process for staff involved to follow. It included allegations of information being withheld or suppressed, and allegations of poor behaviour by senior staff.

7.29 An internal investigation into the formal grievance was initiated but stood down: this appears to be on the basis that the Board agreed that a Ward Hadaway (WH) review should be commissioned. The scope of that review was confined to the coronial process issues.

7.30 Whilst subject to delay the outcomes of this review in August did ultimately appear to deal with the issue regarding processes contained within the grievance. Action was also subsequently taken to support staff including training for those involved in the coronial processes, and work to improve the working arrangements and relationships between the Quality and Safety and Risk management teams. However, the grievance in June 2019 had also raised concerns regarding behaviours, and other staff had expressed concerns regarding behaviours exhibited

during this period – those concerns did not form part of the Ward Hadaway review.

7.31 The recommendation regarding the management of the grievance, the WH review, was made by the then Director of Quality and Safety. That director was responsible for the service that was the subject of the grievance, leading to the perception of partiality and a lack of transparency in proposing the way forward. Given the nature of the allegations regarding transparency this was unhelpful. It appears to have been assumed by the rest of the Executive that the WH review would deal with the totality of the concerns, which left part of it unattended.

7.32 The Interim Human Resources Director (HRD) at that time sought to conclude the grievance, writing to the individual in October 2019. An appeal was then lodged, and the individual made numerous efforts to be heard and have their concerns addressed and they were not.

7.33 An external review into the coronial processes was then commissioned by the new Chief Executive in February 2020 with the support of the Chair.

7.34 In May 2020, the CEO, and the incoming HRD, did meet the individual and attempted to resolve the outstanding issues, apologised for the delay and lack of adherence to process. The individual was acknowledged as a whistle-blower at that time.

Concerns raised formally through F2SU, December 2019

7.35 Concerns were separately raised relating to HR processes and professional employment matters and the behaviours of senior staff in December 2019 to the F2SUG.

7.36 An external investigation was commissioned by the F2SUG and lead NED with the support of the Chair. It was extensive and appears to have covered all the areas raised.

7.37 The concerns were partly upheld, and those individuals named were advised of that in June 2020.

7.38 The findings made clear that the functioning and leadership of HR, and relationships between senior staff, had been difficult for some time and had not been addressed effectively up to 2020.

7.39 Senior leaders had allowed dissent and factions to interfere with proper processes and therefore added to serious risk for HR and professional matters, and to the support given to the organisation, including to the staff raising concerns and grievances.

7.40 There was clear evidence of a lack of professional respect, and a lack of acknowledgement of professional duties and responsibilities and the consequent need to co-design processes.

7.41 There was a lack of transparency and consistency between the operational management of services and professional leadership.

7.42 It was agreed that a plan to make improvements to culture, based on the learning from the review, would be completed in October 2020. There was no formal report made in October. The recommendations were prioritised by the incoming HRD and there is a current action plan. Implementation of that plan is ongoing with oversight and assurance through the People and Development Committee.

Reflections on the current position

7.43 The current arrangements for quality and safety and coronial processes are detailed elsewhere in this report.

7.44 With regard to the confidence of the staff involved in delivering these services, some of whom were in place in 2018/19 and some who are new, they unanimously report that relationships have improved.

7.45 The Coronial and Claims service has moved back to the Quality and Safety Directorate and work done to ensure greater cohesion.

7.46 The process for raising concerns, and the supporting HR processes have been strengthened (See Chapter 6).

Conclusions

7.47 Staff worked hard and were right to raise their concerns about patient safety processes, specifically but not uniquely those related to the coronial process. However, the differing views of senior staff about how quality and safety governance systems should be managed appear to have hampered these being heard and /or a solution being found. This was a regrettable lack of leadership that impacted not just on safety but the wellbeing of staff who were left anxious, frustrated, and stressed. It undoubtedly led to a loss of expertise from the organisation and a loss of confidence in the calibre of the leadership, systems, and processes in place.

7.48 Whilst there will be reasons for delay and confusion in a busy service, it is hard not to conclude that in this case the delay in dealing with such serious allegations, and the way they were handled, had an impact on the organisations opportunity to work with the individual to satisfactorily resolve the issues – processes and executive ownership and oversight were neither efficient nor effective.

7.49 Assumptions were made about the motivations of some of the staff who were expressing concerns, and some of those dealing with them, which appears to have hampered all voices being heard. These concerns regarding behaviours and motivations should have been transparently addressed at the time.

7.50 Given the seriousness of the issues, and concerns being expressed it is unfortunate, and hard to understand, that the actions to resolve the safety

governance issues – the RPIW and consequent SEACARE process – did not have more senior support or its outcome more oversight, for example a formal review.

7.51 There appears to have been a reliance on the accountability and responsibility of “groups” to solve problems – with a gap in clear accountability and ownership by individual directors or senior members of staff to address the issues being raised.

7.52 It was known by the Board that HR processes were suboptimal and were being exacerbated by silo working and antagonism between lead executives and members of their teams. This continued despite an interim HRD being employed. Indeed, the situation seems to have worsened until a substantive HRD was appointed in early 2020. This should not have been allowed to continue and it created real risks to the organisation and stress to staff.

7.53 The formal F2SU process at that time worked effectively in that appropriate external reviews were commissioned, and things were moved forward – for further comment on F2SU see Chapter 6.

Chapter 8: Terms of Reference 8

“Review the Trust’s HR processes and policies and underpinning governance arrangements in relation to the use of settlement agreements and associated confidentiality clauses and determine whether the actions taken in the period since 2018 were in line with local and national policy, and guidance.”

Introduction

8.1 It was alleged in the press article in May 2022 that NEAS asked some members of staff to sign non-disclosure agreements (NDAs) in relation to the matters of concern, offering them more than £40,000 to do so.

8.2 We met with colleagues in NHS England to confirm national arrangements and expectations and reviewed national guidance and protocols (1), and the arrangements in place in NEAS.

8.3 We have looked at the Settlement Agreements (SAs) NEAS has made since April 2020 to date including those referenced in the media, and we have reviewed them against local and national guidance and looked in particular at the Non-Disclosure/Confidentiality clauses.

Settlement Agreements

8.4 SAs are used to manage the ending of an employment relationship. They can represent value for money and NHS guidance recognises that and does not preclude their use.

8.5 However, whilst they can be in all parties’ interest they should, in the NHS, be not just clear about representing value for money and be open to public scrutiny, but also be scrutinised to ensure they do not compromise best practice in terms of employment.

8.6 NHS guidance, issued by NHS employers in February 2019⁶ states that “they can ‘help minimise potentially long, drawn out processes, or where your employee has raised a grievance which you have not been able to resolve. In cases where Trust and confidence has irretrievably broken down, it can be mutually agreed that a termination of employment would be in everyone’s best interest.’ It is also clear that ‘Settlement agreements should not be used to short-cut any investigations in relation to any matter that may prevent an organisation from delivering high quality safe care.”

⁶ The use of settlement agreements and confidentiality clauses - Outline of the legal boundaries which employers need to think about when considering the use of settlement agreements when terminating employment. 18 February 2019

Non-disclosure/Confidentiality clauses

8.7 SAs will normally contain a confidentiality clause – ranging from not disclosing details of the agreement itself, for example the level of compensation agreed, to agreeing not to share any knowledge held due to the nature of the work undertaken.

8.8 It is unacceptable for a confidentiality clause in the NHS to fetter anyone from speaking up regarding a patient safety or health and wellbeing concern. The NHS Employers guidance contains model clauses to clarify these points.

8.9 NHS employment contracts, and any other contractual agreement, such as SAs must contain a “carve out” clause that ensures “a worker cannot sign away their rights to speak up about or disclose any issue which would be a protected disclosure under current law”.

What we found

8.10 NEAS have sought to make nine SAs since April 2020. One has since been withdrawn. We have not reviewed any agreement made prior to that due to a central record not being available.

8.11 There is no national data regarding whether this would be more or less than expected as reaching such agreements is a matter for the individual employer and necessity for their use will vary. NEAS appears to have predominantly considered the agreements it has made based on them representing value for money and/or concluding lengthy/long-standing processes by mutual agreement.

8.12 In some circumstances there is a requirement for oversight by His Majesty’s Treasury (HMT). It is not clear in reviewing the NEAS records whether they have consistently acted in line with that. This relates to the categorisation of some payments and approvals being sought retrospectively in, at least, one case.

8.13 In reviewing the details of the nine agreements, they appear to cover different circumstances and roles within the organisation, that is they have arisen from different issues and do not indicate a pattern of specific areas of concern.

8.14 Whilst pragmatic, SAs signal the end of an employment relationship and consequently good practice would be to ensure they are scrutinised for probity, and value for money, and to learn what went wrong and understand what has been done to learn and prevent the situation arising again. The Board are of the view that oversight has been managed by the People and Development Committee – this does not appear to be the case. Nor would the broader context of probity and reputational risk necessarily be the purview of that Committee.

8.15 The SA process was strengthened in July 2022, but it remained unclear where decisions would be made, how oversight of the circumstances and themes are scrutinised to ensure learning and prevention of future issues, nor consideration of any reputational issues or risks that may arise. A further revised process was

agreed in 2022.⁷ It is intended that this will be monitored by the People and Development Committee.

8.16 NEAS has confirmed that seven of the nine agreements met the standard NHS non-disclosure guidance, which makes it clear that the right to speak up on safety matters is not fettered by the agreement.

8.17 Two of the SAs contained non-disclosure agreements that were inappropriate in the circumstances because they related to individuals where safety concerns were at the heart of the issue, and the oversight of the decision making in offering these agreements is unclear. Given the circumstances of those agreements, they could be considered inappropriate.

8.18 NEAS accepts in hindsight that the circumstances of one agreement could have been construed as potentially fettering speaking up, despite them having taken legal advice at the time the agreements were drawn up. They then sought further legal advice in reaching this view and have taken account of that in revising their processes.

8.19 One of these SAs was enacted; it was agreed by the other party and is in place. That party has been invited to share any concerns with this review without any risk to the agreement; they have declined to do so.

8.20 One was amended to address that clause but has not in fact been enacted and has since been withdrawn.

8.21 Organisational learning and consideration of reputational risk has not been sufficiently visible at NEAS. The organisation has recently strengthened the oversight of SAs but need to further strengthen and embed the assurance of the process.

Conclusions

8.22 Except for the two cases quoted in the media, there is no evidence that NEAS has used SAs or NDAs inappropriately to fetter people from speaking up.

8.23 In those two cases, the circumstances were sufficiently sensitive and contentious as to make any form of proposed settlement open to potential misinterpretation. NEAS accept that there were perception issues with that, and its processes have been strengthened.

8.24 Of those two, there was only one agreement reached: that individual declined to speak to us or share any concerns.

8.25 In the case of the agreement drafted but not ultimately agreed, that individual declined to speak to us or share any concerns with this review.

⁷ Settlement agreement process at NEAS

8.26 There is no evidence of inappropriate use of public funds in reaching these settlements although it is not clear that proper process re HMT approvals has been followed in all cases.

8.27 There has been insufficient oversight of the SA process by the Board – this has been rectified with a proposed new process overseen by the People and Development Committee on behalf of the Board.

Chapter 9: Terms of Reference 9

“Identify any issues in relation to culture, capacity or resources that may have impacted on the Trust’s response to the concerns raised and, on the Trust’s current arrangements for ensuring safe and effective care.”

Introduction

9.1 This report focuses on answering the questions posed within the scope of the review. However, using the insight we have been given into the organisation and the context within which it was working, we were able to identify a number of additional points that we think worthy of note.

Executive leadership

9.2 NEAS is a relatively small organisation (the second smallest ambulance trust in the country). As we have noted elsewhere, they have undergone significant changes of leadership at executive level in the years since the incidents detailed in this report – they are going through more with a change to their Board level Medical and Nurse Director roles at present. Whilst all the directors we have met are capable and committed, at the time of writing the report, the organisation is presented with a challenge in that some new appointees will likely be taking on these roles without previous Board level experience and, in many cases without ambulance sector experience.

9.3 They also seem to have wrestled with being clear about the role of the Medical and Nurse Directors on the Board when the predominant clinical body is paramedicine. The Board took a decision in 2022 to appoint an additional Director of Paramedicine/AHPs – the individual is now in post.

9.4 Whilst they recognise the challenge, and have paid attention to Board development previously, they would benefit from ensuring individual directors, and the executive cadre collectively, have access to good quality mentoring and support. The Board should assess how it can be assured regarding professional competence and performance as would be expected by all NHS Boards.

9.5 The size of the organisation limits the relative capacity available at board level but does not limit the range of challenges it faces, or the need for a robust infrastructure through which to deliver. It would be helpful to assess whether there is sufficient capacity available or if other support for example sharing of some services, could be explored.

Commissioning

9.6 The services delivered by NEAS were commissioned by NHS Northumberland CCG as lead commissioner for the service until the ICB came into force in July 2022.

9.7 The lead commissioner is responsible for agreeing the contract with NEAS to deliver the services specified in the contract for an agreed sum of money.

9.8 The lead commissioner will usually act as the key contact in the system should any concerns or issues be raised.

9.9 They are also responsible through their contracting and quality teams to deal with any quality issues that may arise with a provider (NEAS in this instance) and report them to the other commissioners that they are being lead for.

9.10 They can ask a provider to develop action plans to improve and will seek assurance that those plans have been enacted. These actions are normally monitored through their Quality Review Groups (QRG) and through Contract Review Meetings (CRM). These CRM meetings have been held on a regular monthly basis throughout the last 4 years as have QRG on a two monthly cycle. A chronology of these meetings was captured by the 'Desk Top Review'.

9.11 From a commissioning perspective, there are two points that need to be asked:

1. Has the lead commissioner been sufficiently aware of the challenges facing the Trust and the consequent impact that has had on quality and risk within the organisation?
2. Has the commissioner done an impact assessment on the sufficiency of resources required for NEAS to run a safe and quality service?

9.12 With respect to question 1, we are not sure this was the case. The commissioners (as above) and Trust were meeting regularly but we were informed that they were not sighted on the significance of the issues that were reported to the press. The view of the commissioner was that some of the quality issues are discussed at NEAS private board and that they were not party to this information on occasions. We were concerned that more attention was not given to the serious incident issues given that they had dropped significantly and that none were reported at all for several months.

9.13 We appreciate that the lead commissioner was part of the Desk Top Review in June 2022 and the commissioners do look at serious incident reports and benchmarking, but we wonder if the approach and challenges were sufficient and effective prior to 2022.

9.14 Following the Desk Top Review, there was an initial rapid review made to the ICB in May 2022 followed by a final report in June 2022. A presentation was made to the risk escalation meeting in June 2022 which involved NHSE, lead CCG, the CQC and CEO designate of the ICB. The chronology and findings to date were reviewed. The outcome of that was to move the Trust in to a Quality Board Meeting which continues to this day. This reflects the seriousness of the issues which had been raised and need for greater oversight of those issues.

9.15 The CQC also have concerns about the oversight and implementation of action plans developed in response to incidents or issues raised.

9.16 We did discuss with the commissioner whether the current commissioning model was fit for purpose and whether there were any plans to change. It is a highly specialist function and perhaps need to be elevated to a larger and more specialist team that can focus on the characteristics of the service and provide a higher degree of oversight and assurance. Fortunately, the commissioners agree and are taking a paper to the ICB in January 2023 to propose a fundamental change. We would strongly endorse this. We do also think there is a need to review this nationally given the specialist skills required to do this well.

9.17 NEAS has also reported that they were one of the lowest funded service per capita (this has been validated by the commissioner) and we are aware that additional funding of £38 million was secured this past year. However, we are not aware of a medium-term financial plan that will enable the service to deliver what it needs to in the medium term, and what impact assessment has been carried out. Again, the commissioner has confirmed that that they are working on this plan. We would encourage that this is done as soon as possible.

9.18 We have been told that most of the additional funding will be targeted at the front line, but we are concerned that the infrastructure for governance does not feel robust and the teams are already struggling and not able to meet their own investigation and quality metrics and that a plan to address would also be important. We would suggest that some of this additional funding is allocated to improve the effectiveness of the governance system but only after a fundamental review of governance as per our earlier recommendation.

Quality governance and oversight

9.19 As can be seen from the earlier chapters, concerns regarding the robustness of Quality Governance Assurance Systems have been variable and does require significant attention. The basic policies and processes themselves are in place but the consistency of application and oversight is an issue.

9.20 Other concerns around the governance of some HR processes, Freedom to Speak Up and leadership behaviours have been addressed earlier and recommendations made. A comment made by this review team is that the quality of some of the action plans we have seen lack rigour and would benefit from actions being owned, time measured, and metrics being agreed.

9.21 Some focus needs to be given to general compliance culture within the organisation and this could be addressed as part of the Leadership Development Plan that is already underway. The Annual Audit Plan could also be used to provide assurance that this is progressing and presented to Board on a regular basis.

Information and Infrastructure

9.22 A frequent issue raised by staff has been the lack of agility within current systems and IT infrastructure to 'make the right thing to do the easy thing to do'.

9.23 Attempts have been made to improve current systems like Ulysses but staff still currently state that communications are not easy.

9.24 It may be useful for NEAS to consider whether a task and finish group could be set up to include C&C staff and others to try and remedy this. There is still some ongoing frustration with staff who recognise that efforts are being made to improve culture and transparency, but communication links and information are still somewhat of a constraint.

Conclusions

9.25 The Trust is a relatively small trust and has seen a significant amount of turnover of executive staff in the last few years. In most cases, these are first time Board roles and whilst the leaders involved are capable and committed, it is important to recognise this and ensure that support, coaching and mentorship or indeed sharing of functions with other trusts is considered by the Trust but also the ICB and the Region.

9.26 A Board Development Plan would also be of benefit and again needs to be delivered by experienced and skilled people.

9.27 We would also support the current commissioner's proposals to change those commissioning arrangements for the future. The proposals being made take into account the specialist nature of these services but also to provide an assurance framework that is more robust. This is also something which would be useful to explore nationally given the specialist commissioning challenge.

9.28 Given that NEAS have required additional funding and resources in 2022/23, it will be essential to include this as part of a medium financial plan that allows the Trust to plan effectively for its future.

9.29 As suggested earlier in the report, there is a need for a full governance review to support the Trust to ensure that it is delivering its governance responsibilities in the most effective way.

9.30 We would also like to suggest that the Trust does build on the improvements to the existing exchange of information processes and enhance them further to enable staff to deliver their roles more effectively.

Chapter 10: Conclusions and recommendations

Conclusions

10.1 The scope of the investigation has been broad and has revisited many of the themes raised in previous reports.

10.2 The case studies included in this investigation have been difficult to read and we know have been extremely challenging and upsetting for the families involved. We would hope that this report can serve to give some relief and closure to those families although we accept that their grief will remain a constant.

10.3 Both this investigation and previous reports have found a number of failings in how the Trust should have responded to the incidents and then in their response to concerns about how failings were accepted and followed up.

10.4 It is important that the Trust formally and publicly reiterates that there have been failings and restates its wholehearted apologies to the families concerned. It would also be positive to seek the families' engagement in the oversight and improvement that is currently underway. This could go some way to restoring confidence and trust in NEAS. The families may or may not wish to engage, but the proposal is a constructive one.

10.5 It is also important to recognise that the publication of this report will bring back difficult memories for the families affected. The Trust should consider offering access to counselling and support that best meets their needs.

10.6 There is no doubt that there are many wonderful staff and leaders in NEAS and the review team have met or spoken to many of them.

10.7 However, leadership dysfunction was allowed to continue for far too long and this had a major impact on how teams within different directorates operated. A defensiveness grew and affected team operations, transparency, candour and judgement. They also clearly impacted the health and wellbeing of staff.

10.8 The C&C Team particularly suffered as a result of this and were unable to discharge their roles in an effective way. Some of the coronial communication failures were not a direct fault of this team but down to the way information was exchanged within the organisation. This led to significant staff dissatisfaction and suspicion and may have tainted the way the organisation responded to concerns being raised.

10.9 In some cases, the families believe that changes to reports and not sending original documentation to the Coroner was a deliberate act to avoid negative attention and accountability. We cannot say what the intent was of those individuals who authorised those changes or did not share information as we were not there, but we have looked in detail at the reasonableness of those decisions and have expressed our views earlier in the report. We have not agreed with some of those decisions taken or some of those judgements made and believe that there are

significant learning opportunities to be gained in the organisation in using these cases as a vehicle for improvement.

10.10 The executive team have undergone numerous changes since 2018 and there is broadly a new team in place that is responsible for driving forward improvements. For some, this is their first Board role or CEO role, and others are new to the sector.

10.11 We do believe that the Board are taking the concerns seriously and some improvements have been made and progress has been acknowledged by the staff involved. We do feel however that some of those improvements should have happened sooner. Discussions reveal that there was some delay in acting due to the defensiveness of some senior executives and an overreliance on reassurances given to the Board.

10.12 Governance management systems and compliance would benefit from some specialist support to assist the Trust in moving forward. It may require some additional investment, as the teams are small, but this would be subject to the specialist assessment.

10.13 We think the executive team and the Board would benefit from some development work both individually and as part of a team to grow their confidence and skills to meet the challenges of a post pandemic ambulance service. This is particularly important given the newness of some of the executive team with other changes pending.

10.14 There have been some cultural issues found and some staff still report being frightened to raise concerns or to challenge those in authority. Some have shared their fears directly with us and we know the CQC have similar concerns following their latest inspection. There are wider national concerns that a more focussed review of culture should be undertaken in response to the recommendations arising from the National Guardian's speaking up review of ambulance trusts. We support that recommendation and believe it would benefit trusts like NEAS.

10.15 The Trust recognise this and are putting some focussed cultural work in place and amending their Freedom to Speak Up Arrangements. We suggest that these are reviewed after six months, and findings presented to the Board for assurance that changes are being implemented.

10.16 NEAS will also need the support of their ICB and Regional colleagues particularly in addressing the commissioning, governance and resource challenges. The service has been historically one of the lowest funded services in England and whilst additional funding was secured this year, a medium-term financial plan would be an essential step for securing service sustainability.

10.17 We also believe that Ambulance Commissioning arrangements have not been as robust as they might have been and we very much support consideration being given to strengthen these arrangements. These changes would also fit with the national direction for ambulance commissioning.

10.18 Talking to the families it is clear that they were devastated in how their loved ones and their concerns were responded to by the Trust. We know that a concern of theirs is that no other families experience similar trauma.

10.19 We strongly endorse this and believe that the Trust now needs to focus on implementation and driving the improvements required throughout the organisation.

10.20 We believe that time and focus would now be better spent in delivering the planned improvements and strongly recommend the Trust to put in place an oversight committee to assure that the organisation is delivering the safe and effective emergency services for the people that they serve.

10.21 The Oversight Committee should in its first meetings agree the detailed actions arising from the recommendations and assign accountability, timeframes for delivery and who is carrying the responsibility for the task in hand. Once that is agreed, the Implementation Programme should be signed off by Oversight Committee and presented to each sovereign Board involved in the discharge of the action plan.

10.22 We also believe that the Oversight Committee might benefit from having a Chair independent of the Trust to oversee implementation and report back through existing Governance Structures to ensure that all organisations involved have full transparency and understanding of progress being made. The Oversight Committee should remain in place until all actions have been delivered and assurance secured.

Recommendations

Our intention is that all of these recommendations are in direct response to the issues raised by the families and take account of our determination to improve things on their behalf.

Apology to the families

1. NEAS to meet with families and formally apologise for failings and impact on them.

Governance

2. To undertake a specialist support review of governance in the Trust with specific attention being given to Serious Incident management and compliance processes.
3. To address concerns that reports were changed inappropriately and consider whether accountability arrangements in the organisation have been followed through and whether further action needs to be taken.
4. To ensure that training given to all call handlers and health advisors reinforces the need for staff to ask for help where clinical safety of patients is an issue.

5. The Board should seek assurance of the ongoing coherence and confidence of the Quality and Safety directorate given the painful experiences they have had during this period and the imminent further change of executive leadership of that function.
6. To develop an oversight committee with family involvement to ensure that all recommendations made in respect of the cases and this independent investigation have been sustainably implemented. It is also suggested that the committee should have a Chair independent of the Trust to oversee these arrangements. (See 10.22)
7. A Senior Doctor, independent of the Trust, is included in the review of deaths, their referral to HMC, and engages with the families in an appropriate and timely manner. To facilitate this at speed, the organisation should consider adopting the Medical Examiner model into its processes.
8. The teams should have a clear structure for information flows, clear responsibilities, and the C&C Team acting as the only conduit to HMC.
9. The function of statutory reporting to HMC via the C&C Team and internal governance processes should be explicitly separate.

Governance in relation to the use of Settlement Agreements

10. NEAS's latest revised process should be followed, and assurance arrangements put in place by the Nomination and Remuneration Committee to ensure it is.
11. All situations leading to potential settlement agreement should be scrutinised on behalf of the Nomination and Remuneration Committee, including independent challenge, to ensure best practice is assured.
12. The Nominations and Remuneration Committee should consider requesting a report providing assurance about any SAs agreed prior to April 2020.

Leadership and Culture

13. External support for developing, and providing support and challenge, to the Board overall and new directors specifically should be commissioned and a process for rigorously assuring performance put in place.
14. The revised F2SU arrangements must be implemented as a priority and external review of them, and any recommendations from the national review, commissioned at an appropriate time.
15. The Culture Development plan should be prioritised and a process to assure delivery put in place by the Board.

- 16.** We recommend that the Trust needs to engage with the forthcoming national review of broader cultural matters in ambulance trusts arising from the National Guardian’s speaking up review report.⁸

Commissioning

- 17.** To support the proposal currently being put forward by the commissioners to improve the commissioning arrangements moving forward. We would also recommend that that the National Framework for the Commissioning of Ambulance Services be updated to better reflect the commissioning complexity and specialist nature of these essential services and improve the governance and oversight arrangements.
- 18.** To develop a coherent Medium Term Resource plan with ambulance commissioners to secure safe and sustainable services.

⁸ Listening to Workers
A Speak up Review of ambulance trusts in England (February 2023)
National Guardian Freedom to Speak Up

Appendix A: Terms of Reference for an Independent Review of NEAS

Terms of Reference for an Independent Review into alleged failures of patient safety and governance at the North East Ambulance Service (NEAS)

Introduction and background

On 22 May 2022, media coverage in the Sunday Times alleged that the North East Ambulance Service (NEAS) was covering up evidence in relation to patient deaths and withholding key evidence from HM Coroners linked to service failures. The news article made reference to seven incidents and the names of 5 individuals were included. The report said that families were not always told the full facts of the circumstances surrounding the death of their relatives.

On the 14 June 2022 the former Secretary of State for Health and Social Care Sajid Javid confirmed that the NHS has agreed to an independent review.

Purpose and scope of the review

NHSI/E has commissioned the Independent Review which will be led by an independent leader with appropriate experience and impartiality, supported by recognised, impartial subject matter expertise, to focus on **patient safety and governance processes** within the Trust, to:

- Establish the facts surrounding the individual cases highlighted by the whistleblower in May 2022
- Critically analyse the sequence of events following concerns first raised by Trust staff in spring 2019
- Review the processes surrounding coronial investigations during the period when the alleged incidents took place (December 2018 – December 2019) in comparison with the processes in place today
- Determine whether changes implemented to coronial processes following the previous reviews and investigations undertaken have resulted in the expected and required improvement
- Seek to understand the extent to which the culture of the Trust enables staff to feel safe, supported and encouraged to report and escalate any concerns, including through Freedom to Speak Up arrangements.
- Review the Trust's Serious Incident (SI) process and determine whether SIs are reported and actioned in accordance with best practice, local policy and national guidance, identifying both areas of good practice and any areas of concern
- Review the Trust's HR and whistleblowing processes and the handling of concerns raised by staff since the issues were first raised in spring 2019

It is anticipated that the review will take up to 4 months, depending on any other required lines of enquiry identified as a result of review activity.

Involvement of the affected patients' families and staff

The independent, external review will include input from the families of the patients identified, i.e., within the previous investigations and the reviews undertaken, and the concerns raised by the whistle-blower in May 2022. It will also include input from staff (past and present) involved with those concerns, the escalation of them or the relevant governance processes of the Trust during the period of the specific concerns, and currently.

The independent reviewer will ensure that affected family members and relevant staff are fully informed of the review process, understand how they can contribute to the design of the final Terms of Reference and will maintain contact and update individuals throughout the review as appropriate.

Terms of Reference (ToR)

These Terms of Reference have been developed in collaboration with the independent Chair/ reviewer, key stakeholders, key individuals, affected patients' families and staff.

1. Fully understand the concerns raised in relation to the cases being considered, and the impact both of the incident and the subsequent processes, through speaking with families, where possible, and relevant stakeholders
2. NEAS has previously commissioned 6 independent reviews / audits, and 7 reports which were published between August 2019 to May 2022. Review the seven reports and any associated relevant documentation, and determine:
 - The quality of the investigations and reviews, sufficiency of enquiry and adequacy of their findings, recommendations, and subsequent action plans
 - The progress made to implement the learning and recommendations to date
 - Whether changes implemented within the Trust's governance, and coronial processes have resulted in effective and measurable improvement
 - Whether there is further work required to ensure improvements to governance, and specifically coronial processes, are sustainable
3. Benchmark the Trust's current coronial processes against peer organisations to determine whether processes are comparable in relation to timeliness and quality of evidence submitted to coroners and suggest areas for further improvement if required.
4. Review the Trust's Serious Incident process and determine whether SIs are reported and actioned in accordance with best practice, local policy, and national guidance, identifying both areas of good practice and any areas of concern.

5. Consider whether the statutory Duty of Candour is appropriately applied within the Trust's Serious Incidents process and procedures and consider specifically its application in relation to the specific cases being considered.
6. Seek to determine whether the arrangements in place for staff to escalate concerns, both during the period under review and now, are effective and appropriate. Including whether the Trust provides an environment in which staff feel safe, supported, and encouraged to report and escalate concerns.

This will include formal Freedom to Speak Up arrangements. The review will include speaking with relevant staff and leaders and a Desk Top Review of relevant data.

7. Assess whether the action taken by the Trust in response to concerns raised by members of staff in Spring 2019 regarding safety matters and coronial processes were appropriate, and in compliance with best practice, local policy and national guidance in relation to HR practice, Whistleblowing and Freedom to Speak Up.
8. Review the Trust's HR processes and policies and underpinning governance arrangements in relation to the use of settlement agreements and associated confidentiality clauses and determine whether the actions taken in the period since 2018 were in line with local and national policy, and guidance.
9. Identify any issues in relation to culture, capacity or resources that may have impacted on the Trust's response to the concerns raised and, on the Trusts, current arrangements for ensuring safe and effective care.

Deliverables

A final written report will be made to NHS England, it is anticipated it will be delivered within four months. It is planned to be published to support wider learning.

The report will clearly identify any areas of best practice, opportunities for learning and areas where improvement are required.

Based on the review findings, the report should make organisational specific outcome-focused recommendations for improvement, propose priority ratings and expected ownership and expected timescales for completion.

The review team will operate in accordance with data protection legislation, ensuring compliance with GDPR and the Data Protection Act (2018), and Confidentiality: NHS Code of Practice. Information sharing and record storage systems utilised by the review team will be sufficiently secure as to ensure all personal data held and processed by the review team is safeguarded at all times.

Appendix B: Investigation Team

Panel members

Dame Marianne Griffiths DBE (Chair)
Denise Farmer
Dr David Crossley, Independent Medical Examiner

Specialist Advisers

Lynn Woolley, SIs and Duty of Candour

Secretariat

Sian Finlay

Appendix C: Coronial Process Task and Finish Group Terms of Reference

Coronial Process – Task and Finish Group Terms of Reference

Background

Following concerns raised through a number of channels about the robustness of the Trust's coronial process, the Trust Chairman initiated an independent review, duly conducted by WorkforceOne.

The review revealed areas of the Trust's processes which fall short of best practice and made several recommendations outlining where processes could be improved.

Purpose

The task and finish group has been established to take forward the recommendations and oversee the implementation of an action plan to address the shortcomings.

The task and finish group should not limit its activities solely to the WorkforceOne report recommendations and should establish a root and branch principle to implementation.

Membership and reporting lines

The task and finish group will report directly to the Board of Directors via the Audit Committee and have the following composition:

- Non-Executive Director (Chair)
- Non-Executive Director
- Non-Executive Director
- Medical Director
- Director of People and Development
- Head of Risk and Regulatory Services
- Trust Secretary
- Secretary to meeting

The above individuals should form the core standing membership of the task and finish group, with additional attendees on an "as required" basis at the invitation of the Chair. Additionally, the group should ensure that there is appropriate involvement in "solution testing" by those NEAS staff associated with the coronial process.

Reporting

The group shall report to the Board of Directors via the Audit Committee.

The group should conduct its initial meeting by 30 April 2020 (by video conferencing) and produce a first progress report to the subsequent meeting of the Audit Committee. The action plan should be targeted to be implemented by 30 June 2020, with the task and finish group retained for a period to ensure that the improvements are fully embedded.

In order to meet the timescales set the group shall meet weekly.

Appendix D: Glossary of Terms

ALS	Advanced Life Support
BIPAP	Bi-level Positive Airways Pressure
BLS	Basic Life Support
C&C	Coronial and Claims Team (at NEAS)
COPD	Chronic Obstructive Airways Disease
CPAP	Continuous Positive Airways Pressure
CPR	Cardiopulmonary Resuscitation
CQC	Care Quality Commission
CRG	Clinical Review Group
DNACPR	Do not attempt Cardiopulmonary Resuscitation
ECG	Electrocardiogram
ePCR	Electronic Patient Care Record
FLO	Family Liaison Officer
F2SU	Freedom to Speak Up
GNAAS	Great Northern Air Ambulance Service
HMC	His/Her Majesty's Coroner
IO	Investigating Officer
JRCALC	Joint Royal Collages Ambulance Liaison Committee
ME	Medical Examiner
NEAS	North East Ambulance Service NHS Foundation Trust
NDA	Non-Disclosure Agreement
NHS	National Health Service
NRLS	National Reporting and Learning System
PSIRF	Patient Safety Incident Response Framework
ROLE	Recognition of Life Extinct
RPIW	Rapid Process Improvement Workshop
RR	Rapid Response
RVI	Royal Victoria Infirmary
SA	Settlement Agreement
SEACARE	SEACARE (Patient S afety incidents, patient E xperience concerns, A dult safeguarding concerns, C hildren's safeguarding concerns, A udit from the learning from deaths process, R isk which incorporates coronial requests and concerns and E xternal requests for information related to care provided by NEAS)
SI	Serious Incident
StEIS	Strategic Executive Information System