North East Ambulance Service NHS
NHS Foundation Trust

Ambulance Headquarters
Bernicia House
The Waterfront
Goldcrest Way
Newburn Riverside
Newcastle upon Tyne
NE15 8NY

Tel: 0191 430 2000
www.neas.nhs.uk

Private and Confidential

Mr Derek Winter
Senior Coroner for the City of Sunderland
Civic Centre
Burdon Road
Sunderland
SR2 7DN

23rd April 2018

Ref: YO/AG/HMC1519

Dear Mr Winter

Inquest into the death of Raymond Henry Davidson (Deceased)

Response of the North East Ambulance Service NHS Foundation Trust (NEAS) to the Regulation 28 Report to prevent future deaths

I am writing in my role as Chief Executive of NEAS and further to your Regulation 28 Report for the prevention of future deaths dated 27 February 2018 as issued following the Inquest into the tragic death of Mr Davidson.

In your report, you highlighted the following concerns:

"This is the third such report about the same issue that I have written in recent months as I consider that there is a risk of future deaths. An urgent review of resources and their application is needed.
Finally from the evidence, there was frequent telephone contact made, but this was not with the patient directly, which may have impacted on the less than robust initial clinical review of Raymond's condition".

I will address each point you have raised in your matters of concern below.

Review of Resources

Over the past three years we have had a number of external reviews, each looking in detail at different aspects of the service, which all identify that NEAS is under-resourced. These findings have come from the CQC inspection November 2016; the National Audit Office report in January 2017; and the most recent Carter Review.

The Trust Board has also expressed serious concerns about patients' safety due to the lack of resources to send to patients waiting on the stack for an ambulance to arrive, and this has also been mirrored in correspondence from Senior Coroners.

The National Audit Office report (January 2017) indicates that the Trust has the lowest levels of funding in England. The scale of variation - almost £10 per head of population across ambulance trusts in England - indicates the challenge we face if we are to meet our performance standards. If the Trust had the same level of income as the England average,

based on achievement of the historic performance standards the Trust would benefit from an additional £15.6 million.

The Trust in collaboration with our lead commissioner, Durham Dales Easington and Sedgefield Clinical Commissioning Group (CCG), jointly procured Operational Research in Health Limited (ORH) to undertake a Demand and Capacity Review of the Trust. This included drawing a line under our historic funding issues. The report by ORH, who are specialists in emergency services modelling, sets out clear recommendations for the Trust and the commissioners.

The overall aim of the review was to determine the underlying capacity required to deliver ambulance response time performance across the North East Ambulance operational area, designed to meet the new national ambulance targets and the Trust's own performance objective in the period to 2021/2022.

The scope of the review focused upon the following areas;

- Demand predictions to 2021;
- Model performance to 2021 with current resourcing;
- Identify potential efficiencies;
- Model performance impact of each potential efficiency;
- Model resource needs to bridge any performance shortfall.

I am cognisant that I have previously detailed the work we are undertaking to address our recruitment and performance challenges. I therefore intend on omitting these details from my response and shall focus on the findings detailed within the report.

Report Findings and Trust Actions

We believe the implementation of the ORH recommendations will enable a safe and responsive service to be delivered to our patients; including 100 additional paramedics required.

Delivery of the new ambulance response standards is dependent on receipt of a recurrent annual cost of investment of £10.4 million, identified from the ORH report, of which:

- £3.9 million is funded recurrently from additional investment made by commissioners in 2017-18 in recognition of our CQC rating and NAO report;

- £2.6 million is funded recurrently from a 2.5% uplift in 2018-19 contract variation agreed with commissioners;

- We have jointly agreed with commissioners that the shortfall of £3.9 million is to be discussed to allow the CCGs to better understand the details of the ORH recommendations before making any further future commitment;

    - We are aiming to develop and approve an action plan by the end of May 2018 that will include timescales to address the shortfall in funding and deliver the ARP standards;

    - Within this agreement, an assumption is made in the ORH report that abstraction rates of frontline staff are reduced from 34.4%. A target abstraction level of 25%,

agreed by the Trust, would require a relief rate of 33.3%. Assuming this 33.3% relief rate, 1,219 whole time equivalents are required to put out the planned rosters without dropping shifts due to absences. We have committed to achieve this efficiency, which will realise £7.4 million efficiencies over the next five years, as an equal share of the funding commitments required to achieve the ARP standards.

Separately, we have raised a significant patient safety concern with commissioners over their decision to withdraw £1.3 million from our 999 emergency operations centre by September 2018. This removes a significant number of clinical support advisers to our 999 call takers and dispatchers. Commissioners have communicated that they will address our concerns in September 2018 after the completion of the NHS111 procurement process in the North East of England.

In detail, the ORH report highlighted a number of areas of focus, which is pertinent to this particular case:

1. **Benchmarking indicated that a significant improvement in control activation times is feasible, aiming to reduce average C1 activation times from 2 minutes to 60 seconds by 2021/22.**

We are working towards an improvement in control activation times, compared to other Trusts. These have deteriorated within NEAS over the last two years. We aim to reduce C1 activation times from 2 minutes to 60 seconds by 2021/22.

The delay in allocation of an ambulance response to this call was unfortunately due to the demand placed upon the service at the time. The dispatch team do endeavour to move available resource into an area depleted of available cover to ensure a suitable response can be activated. However in this instance all resources were responding and dealing with emergency calls in the surrounding areas.

We are working with ORH to look to improve our crew shift start and finish times. This will also assist with better overall availability of crews throughout the shift. We are also looking to improve the productivity of the dispatch teams by reducing the number of ambulances managed by each dispatcher.

The Dispatch managers monitor on a monthly basis through audit, the allocation times of the dispatch team. The time frames are monitored in line with national guidance to ensure compliance. Individual training and actions plans can and are issued with any dispatcher who needs further support in ensuring calls are allocated within the given dispatch standard times

2. **Some reduction in conveyance rates is also feasible, with a corresponding increase in time at scene, particularly in Central and North divisions.**

We are undertaking a targeted piece of work to reduce conveyance rates. We aim to reduce C2 conveyance rates in Central (81%) division, which includes Sunderland, and North (79%) division to comparable levels with our South division (74%) by 2021/2022

We are working with Northumberland CCG to put in place a rapid response team who will provide a multidisciplinary team to respond to a wide range of lower acuity cases in the community to provide paramedics with an alternative option to ED. We have provided 50

additional E-Care course places to provide staff with the necessary skills to be able to safely and confidently leave patients at home who do not need to be transferred to hospital. We are seeking funding to be able to roll out paramedic pathfinder across the region to support the work that is currently being done in Sunderland to provide a range of alternative pathways for staff to refer patients to. This is dependent upon CCG funding.

3. **A reduction in time at hospital should be targeted, particularly in Central and North divisions, aiming to reduce to a 30-minute mean by 2018/19 in each division.**

We are actively working to reduce time at hospital and we acknowledge there have been significant increases in the last two years. We aim to reduce to a 30-minute mean by 2018/2019 in each division. An example of our work is the introduction of a new handover procedure and monitoring system. Upon introduction on 29 November 2017 we have witnessed a decrease in handover to clear times of approximately 5 minutes.

We are working with our partners across the region in a Task and Finish Group to focus on ambulance handovers. We hold a weekly conference call with all of the acute trusts, NHS England, NHS Improvement and the North East Urgent and Emergency Care Network to address issues and formulate strategies to improve handover. We have developed a joint standard operating procedure for handover across the region which has been in place since November. We are working together to ensure that there is a culture of accountability for handover embedded in both the acute and ambulance Trusts at grass roots level. Hospital Handover is part of every individual's objective and discussed during performance reviews and ride-outs. We are basing an Operational manager permanently within two acute trusts to monitor and manage the handover process and build relationships within the hospital to ensure that issues are escalated early so we can take proactive action before we start to experience handover delays

4. **In addition to these efficiencies, the ORH modelling went on to look at opportunities for rostering crews and vehicles more effectively, and ensuring that the resource mix is appropriate for the new ARP operational regime.**

In the re-rostered position, there is a shift from Rapid Response Vehicles (RRVs) and Urgent Care vehicles to Double Crewed Ambulances (DCAs), and resourcing has been reduced at night with a corresponding increase in the day. All six ARP measures are comfortably met in this scenario with the additional funding.

However, our ability to produce efficiencies requires more front line capacity to deliver service improvement. This is dependent on funding to invest in a higher skill mix of qualified staff to improve see and treat outcomes; and ambulance activation time improvements being achieved by having more vehicles available. Like other ambulance trusts, we are under huge financial strain and are adapting to the new targets in the midst of a major workforce shortage and a need to modernise our fleet. Our cost improvement programme currently stands at around £8 million. This represents more than 6% of our annual turnover.

The Trust has started to share the content of the ORH report with stakeholders via a number of engagement events. We have established an implementation group who will develop, implement and oversee a detailed implementation plan. This will include current rosters versus new, staffing implications, vehicles and estates. The Trust and partners are reviewing contractual implications alongside the approval processes.

Telephone Contact with Patient/Caller

I can confirm that the updated 'Urgent Ringback Procedure' was approved and implemented in February 2018. The updated procedure is available and communicated onto all Call Handlers, Clinicians and Team Leaders within the Trusts Emergency Operations Centre. The new procedure puts the emphasis on direct conversation with the patient wherever possible. In relation to the 111 Clinician, the individual was provided one-to-one feedback on this case and undertook a coaching session.

Since the end of 2016, the number of clinicians available within the Emergency Operations Centre to support both call handlers and patients who are waiting for a resource has increased. In addition, they are now supported and led by a larger team of Clinical Section Managers and are provided with appropriate coaching and feedback routinely.

Clinicians now adopt a more structured approach to support waiting patients to ensure that consistent contact is maintained. And a lead clinician or Clinical Section Manager oversees outstanding workload and ensures relevant support is provided to clinicians managing each area. Clinician's calls are also audited by a Clinical Auditor, auditing 4 calls per month. Feedback is then provided to the individual Clinicians on positive and developmental areas.

The Trust has also implemented a robust REAP / Escalation Policy which details very clearly the actions to be taken within the Emergency Operations Centre and by Operational staff in line with demand.

I can also confirm that in order to improve nationwide learning, the Trust have disseminated both the Regulation 28 Report and our response to other Ambulance Trust colleagues across the country. The Care Quality Commission is also aware of the Regulation 28 Report and shall receive a copy of this letter of response.

I hope that the steps that have been taken address the matters of concern which you have highlighted. If the Trust can be of any further assistance please do not hesitate to contact myself or Alan Gallagher, Head of Risk at the Trust.

Yours sincerely,

Yvonne Ormston.

Yvonne Ormston
Chief Executive