21 December 2022

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 whistle-blower 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 it's 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 desktop 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 polices 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.