Care Quality Commission
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Mr T Brown
HM Senior Coroner North Northumberland
17 Church Street
Berwick upon Tweed
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3 July 2015

Dear Mr Brown

Re: Inquest into the death of Barbara Patterson.

We were sorry to read about the death of Ms Patterson and the circumstances in which she died. Thank you for your report and the requirement for us to review what actions should be taken.

Please treat this letter as the formal response of the Care Quality Commission (CQC) to your report dated 21 May 2015.

In your report and pursuant to the requirements under paragraph 7, schedule 5 of the Coroners Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, you require the CQC to provide details of any action that has been taken or which is proposed to be taken in response to the concerns highlighted in your report, or an explanation as to why no action is proposed if appropriate.

Background

Before the death of Barbara Patterson we carried out unannounced visits to North East Ambulance Service NHS Foundation Trust (NEAS) which involved visits to four ambulance stations and the emergency control centre on 4, 5, 6, 7 and 13 February 2014.

Following that inspection we identified areas of non compliance against the following regulations detailed in the Health and Social Care Act (2008):

- Regulation 10 (1)(b)(2)(b)(i) Assessing and monitoring the quality of service provision;

- Regulation 13 Management of Medicines;
- Regulation 23(1)(a) Supporting Workers;
- Regulation 21(a)(i) Requirements relating to workers;

Following submission of the final report we instructed NEAS to submit an action plan. The Action Plan was duly presented to CQC by NEAS within the required timescale and, recognising that the Service required a reasonable period of time to implement the proposed measures, regular meetings were scheduled and conducted between CQC and NEAS, to monitor the progress of their implementation. This process was undergoing at the time of Mrs Patterson's death.

Matters of Concern

1. **The failure of the call handler to give out timely advice in respect of CPR.**

The CQC intend to carry out a planned comprehensive inspection of North East Ambulance Service (NEAS) as part of its ongoing inspection process. During this inspection we will investigate to what extent and degree call handlers are supported by systems and procedures already in place. We will also require NEAS to furnish oral and written evidence to demonstrate that they understand their role and responsibilities in relation to call handlers and that they provide regular monitoring to ensure that the system is functioning at an appropriate level.

2. **Deficiencies in Pathways System**

As recognised in your report, the *Pathways* system is a National Programme, piloted in the North East, which has been introduced in other areas of the country. We have written to NEAS to instruct them to submit evidence of how they are mitigating the risk within the Pathways system and also how they are working with Pathways to improve the system.

3. **Failure of ambulance dispatcher to dispatch an ambulance closer to the deceased's location**

This issue will be included as part of our planned comprehensive inspection and investigated to ascertain whether procedures presently in place by NEAS relating to the dispatch of ambulances is appropriate and what, if any, improvements can be made to the current system. Additionally, we will be meeting with NEAS in September 2015 to discuss how they are managing the process of dispatching ambulances.

4. **Target time for arrival of ambulance in 8 minutes was breached.**

This issue will be included as part of our planned comprehensive inspection and investigated to ascertain whether procedures presently in place relating to dispatch

of ambulances is appropriate and what, if any, improvements can be made to the current system. We have written to NEAS to instruct them to submit evidence of their current position around breaches of arrival times of their ambulances together with providing evidence of how they are mitigating the risk for of reducing the missed target times of ambulance arrivals.

5. **National shortage of paramedics, which is particularly acute in the North East**

We will be meeting with NEAS in September 2015 to discuss and monitor how they are managing their delivery of the service, what is their current position of staffing levels and identified vacant posts and their current recruitment position.

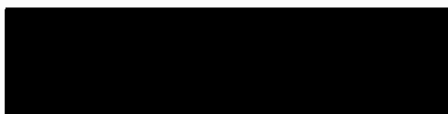
6. **Delay at handover of patients to A & E staff which jeopardises availability of ambulance staff**

We will be meeting with NEAS in September 2015 to discuss how they are managing the handover process to A & E services and how they are working collaboratively with all providers and stakeholders to ensure a smooth and timely handover process. In addition, this issue will be reviewed as part of our planned full comprehensive inspection of North East Ambulance Service (NEAS).

We greatly appreciate the information you have provided us in your report and please do not hesitate to contact me with any further questions you may have.

With best wishes.

Yours sincerely



Head of Hospital Inspections – North East