Wellington House

133-155 Waterloo Rd

London

SE1 8UG

david.radbourne@nhs.net

21 December 2022

Will Hancock

Chief Executive Officer

South Central Ambulance Service NHS Foundation Trust

By email: will.hancock@scas.nhs.uk

Dear Will,

South Central Ambulance Service NHS Foundation Trust Undertakings

Thank you for confirming agreement of the Trust's s.106 undertakings on behalf of the Trust Board. These were approved by SE Regional Support Group on 8 December 2022 and I now attach a final signed version.

We ask that the Trust takes these to its next public Board meeting. NHS England will publish the undertakings on the Provider Directory area of its website. The Trust, ICB and NHS England have already agreed the support offer through the national Recovery Support Programme to help it deliver its comprehensive improvement plan. NHS England and ICB colleagues look forward to continuing to work with the Trust to support its critical improvement work.

Yours sincerely

David Radbourne

Regional Director of Strategy and Transformation

NHS England and NHS Improvement - South East

Enforcement notice with s.106 undertakings

(RSG approval 2022/12/8)

ENFORCEMENT UNDERTAKINGS

LICENSEE
South Central Ambulance Service NHS Foundation Trust
Unit 7-8 Talisman Business Centre
Talisman Road
Bicester
Oxfordshire
OX26 6HR

DECISION

NHS England, on the basis of the grounds set out below, and having regard to its Enforcement Guidance, has decided to accept from the Licensee the enforcement undertakings specified below pursuant to its powers under section 106 of the Health and Social Care Act 2012 ("the Act").

GROUNDS

1. Licence

The Licensee is the holder of a licence granted under section 87 of the Act.

2. Breaches

2.1. NHS England has reasonable grounds to suspect that the Licensee has provided and is providing healthcare services for the purposes of the NHS and is in breach of the following conditions of its licence: FT4(4), FT4(5)(b) and (c), FT4(6) and FT4(7).

2.2. In particular:

2.2.1. On 6 and 7 April 2022 and 10 and 11 May 2022 the Care Quality Commission (CQC) undertook a comprehensive inspection of the Licensee. The inspection resulted in a section 29A Warning Notice being issued to the Licensee on 24 May 2022 notifying the Licensee that it had formed the view that the quality of health care provided by the Licensee required significant improvement. The inspection report was published on 25 August 2022. Reasons given for the significant improvement needed were:

2.2.1.1. Poor governance arrangements that did not identify shortfalls in care provision, did not ensure the board was sighted on risks and did not always mitigate those risks or share learning

2.2.1.2. The Licensee did not have effective systems of the identification, reporting, investigation and learning from Serious Incidents

2.2.1.3. The Licensee had an ineffective process for identifying and responding to adverse incidents which has resulted in several incidents related to failed defibrillators and a potential increase in avoidable harm

2.2.1.4. The Licensee did not have effective oversight of safeguarding

2.2.1.5. Failure to respond appropriately to people raising concerns

2.2.1.6. Failure to respond appropriately to allegations

2.2.1.7. Failure to mitigate the risks of a pigeon infestation

2.2.2. The CQC inspection identified significant concerns regarding the effectiveness and functioning of the Licensee's Board, which has led the CQC to rate the Licensee's Well-led domain as 'Inadequate'.

2.2.3. The CQC identified some immediate significant improvements to be made by the Licensee by 31 October 2022 in addition to longer term improvements to be made.

2.3. The failings noted by the CQC as listed above at point 2.2.1.1 to point 2.2.1.7 constitute a breach of the License. The failings noted demonstrate a failure of governance arrangements by the Licensee including, in particular, failure to:

2.3.1. establish and implement (FT4(4)):

(a) effective board and committee structures;

(b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and

(c) clear reporting lines and accountabilities throughout the organisation

2.3.2. establish and effectively implement systems or processes (FT4(5)):

(a) for timely and effective scrutiny and oversight by the Board of the Licensee's operations;

(b) to ensure compliance with healthcare standards binding on the Licensee; and

(c) to address matters relating to quality of care (FT4(6))

2.3.3. ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its licence (FT4(7)).

2.4. Need for action

NHS England believes that the action, which the Licensee has undertaken to take pursuant to these undertakings, is action to secure that the breaches in question do not continue or recur.

3. Appropriateness of Undertaking

In considering the appropriateness of accepting in this case the undertakings set out below, NHS England has taken into account the matters set out in its Enforcement Guidance.

UNDERTAKINGS

NHS England has agreed to accept, and the Licensee has agreed to give, the following undertakings, pursuant to section 106 of the Act:

1. Quality

1.1. The Licensee will develop and agree a comprehensive improvement plan with Board level accountabilities, incorporating (as appropriate) feedback from the Improvement Director, NHS England and any external reviews commissioned as part of Board development and improvement work.

1.2. The plan will:

1.2.1. set out the Licensee's priorities and actions in relation to the areas for improvement as identified by the CQC in its report dated 25 August 2022. The full report can be found on the CQC's website
1.2.2. address (as a minimum) all CQC's May 2022 Warning Notices and Must do actions (these can be found at Appendix A)
1.2.3. set out a clear approach and plan for engaging and supporting staff in the improvement plan
1.2.4. set out a clear approach and plan for addressing safeguarding issues in the improvement plan
1.2.5. ensure transparent internal processes and reporting is available to provide staff with the confidence to raise concerns without fear of detriment and feeling supported in doing so
1.2.6. respond effectively to staff feedback including Staff Survey findings, grievances, complaints and whistleblowing concerns
1.2.7. ensure effective mechanisms for all staff to provide feedback and respond effectively to this feedback, including staff survey, complaints, and whistleblowing concerns
1.2.8. deliver against the approved workforce plans for the FY 22/23, and demonstrable sustainable workforce plans will be in place for beyond 22/23, inclusive of realistic recruitment, retention and abstraction plans
1.2.9. include ongoing triangulation of the impact of improvement actions with wider quality metrics including patient and staff feedback incidents and complaints.

1.3. The Licensee will demonstrate ongoing delivery of the comprehensive improvement plan through an open and transparent reporting framework.

2. Governance

2.1. The Licensee will:

2.1.1. ensure there is sufficient capacity and capability to lead and oversee the successful delivery of the comprehensive improvement plan
2.1.2. establish effective risk management arrangements including a comprehensive, up to date Board Assurance Framework with Board level oversight and accountabilities and clear escalation routes for risks and concerns from frontline services to the Board
2.1.3. ensure effective Board oversight and accountability for incidents, clinical harm, complaints and patient feedback

2.1.4. ensure it has effective Board-level governance arrangements to oversee all aspects of the comprehensive improvement plan, inclusive of organisational and quality improvement priorities, and sustainability plans
2.1.5. co-commission a Well-Led Review with the scope and timing agreed with NHS England, and take action as appropriate to address the recommendations of this review
2.1.6. share its comprehensive improvement plan with Hampshire Isle of Wight, Buckinghamshire, Oxfordshire and Berkshire, and Frimley ICSs and with NHS England.

3. Improvement Director

3.1. The Licensee will co-operate and work with any Improvement Director who may be appointed by NHS England to oversee and provide independent assurance to NHS England on the Licensee's delivery of the recovery plan and improvement of quality of care the Licensee provides.

4. Programme management

4.1. The Licensee will implement sufficient programme management and governance arrangements to enable delivery of these undertakings.

4.2. Such programme management and governance arrangements must enable the board to:

4.2.1. obtain clear oversight over the process in delivering these undertakings;
4.2.2. obtain an understanding of the risks to the successful achievement of the undertakings and ensure appropriate mitigation; and
4.2.3. hold individuals to account for the delivery of the undertakings.

5. Meetings and reports

5.1. The Licensee will attend meetings or, if NHS England stipulates, conference calls, at such times and places, and with such attendees, as may be required by NHS England.

5.2. The Licensee will provide such reports in relation to the matters covered by these undertakings as NHS England may require.

The undertakings set out above are without prejudice to the requirement on the Licensee to ensure that it is compliant with all the conditions of its licence, including any additional licence condition imposed under section 111 of the Act and those conditions relating to:

- compliance with the health care standards binding on the Licensee; and
- compliance with all requirements concerning quality of care.

Any failure to comply with the above undertakings will render the Licensee liable to further formal action by NHS England. This could include the imposition of discretionary requirements under section 105 of the Act in respect of the breach in respect of which the undertakings were given and/or revocation of the licence pursuant to section 89 of the Act.

Where NHS England is satisfied that the Licensee has given inaccurate, misleading or incomplete information in relation to the undertakings: (i) NHS England may treat the Licensee as having failed to comply with the undertakings; and (ii) if NHS England decides so to treat the Licensee, NHS England must by notice revoke any compliance certificate given to the Licensee in respect of compliance with the relevant undertakings.

LICENSEE

Signed:

Will Hancock

Chief Executive

Dated: 18th December 2022

NHS ENGLAND

Signed:

David Radbourne,
Regional Director of Strategy and Transformation, NHS South East
Member of the South East Regional Support Group

Dated: 21st December 2022

Appendix to enforcement notice:

South Central Ambulance Trust

CQC findings relating to licence condition FT4 (NHS foundation trust governance arrangements)

Leadership

FT4 - 6 (d) Some leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced but **the board was not always aware of risks that were not shared at board level**.

FT4 - 6 (e) Some executives were visible and approachable in the service for patients and staff, but **many staff reported a disconnect and did not know who their senior leaders were**. Most leaders had the experience and abilities to lead effectively however this was not consistent across all leadership which increased risk.

FT4 - 6 (a) There was a board that included a mix of skilled and knowledgeable members. However, **there was not always enough challenge**.

FT4 - 4 (b) **Some executives and senior leaders were less aware of their roles and responsibilities**. This meant that the focus of their work, their decision making, and their priorities may not always have been in the interests of patients and the staff they managed.

FT4 - 4 (c) **There were no designated deputies for the executive roles**. The organisation had no succession planning but did manage contingency cover.

FT4 - 6 (a) They considered themselves an organisation that developed their staff and who were committed to learning, but the **opportunity to build and practice the skills required for executive posts was not made available in a planned way.**

FT4 - 7 **Patient safety was the area most affected by increased demand and shortcomings in governance.** There had been several changes of senior management over a short period. At local level, **increased demands and staffing vacancies also meant that patient safety was the area most affected when the system escalation levels increased**. **Middle managers and clinical educators were covering an increased number of shifts and this resulted in their core leadership, supervision and educational roles taking a back seat.**

FT4 - 4 (b) **The line of leadership on safeguarding was unclear**. Despite the letter of intent issued following an inspection in November 2021, there remained poor and unclear leadership of safeguarding at SCAS. The current safeguarding team in SCAS consist of interim and agency staff.

FT4 - 4 (c) & 6 (c) and (d) The **Serious Incident reporting was also an issue the board was not sighted on**. **Information presented to the board was not an accurate reflection of the level of incidents occurring** and so they were not in a position to be clear about their responsibilities regarding action to mitigate the risks.

Their **ability to provide challenge was limited because they were not provided with accurate information.**

Safeguarding

FT4 - 5 (b) and (c) & 6 (b) **Safeguarding was not given enough priority**. There was insufficient assurance that processes were protecting people, despite the Commission raising concerns with the trust in November 2021.

FT4 - 5 (c) & 6 (c) and (d) **The identification, reporting, investigation and sharing of learning from serious incidents was not in accordance with the NHS Serious Incident Framework**. Trends in incidents, when identified, were not investigated or responded to in a way that mitigated future risks to patients. Essential equipment was not always available and working, when needed. The trust was not meeting the statutory Duty of Candour requirements.

Culture

FT4 - 7 **Staff usually felt respected, supported and valued** and were focused on the needs of patients receiving care, **but felt capacity affected their ability to deliver to the standard they would want.**

FT4 - 6 (e) **Some staff said they were not listened to when they raised concerns** and felt things were "brushed under the carpet". This impacted on their morale.

FT4 - 6 (e) However, **there was evidence that the organisation did not respond well when people shared concerns internally, or outside the trust** because serious issues had not been addressed internally. People who raised concerns were not treated well and we saw evidence of executive leaders attempting to discredit people raising valid concerns.

FT4 - 6 (e) The service usually promoted equality and diversity in the organisation but there were **some concerns raised by staff and some areas for improvement highlighted by the Workplace Race Equality Standards survey data. Several people raised concerns about the treatment of women working at SCAS**, particularly younger, or more junior, women.

Governance

FT4 - 5 (b) **The governance systems at the trust were not operating in a way that ensured that patients and staff were protected**. The s**ystems failed to assess, monitor and drive improvement in the quality and safety.**

FT4 - 6 (d) The **board was not sighted on accurate evidence and information to use to provide effective strategic leadership**. **Governance was perceived as ineffective as information was not shared with the board or presented in a way that minimised the risks**.

FT4 - 4 (c) There was a range of sub committees, with good representation by non-executive directors that fed into the governance system. However, the **committees and the board members were not always sighted on key issues** such as safeguarding risks and the level of serious incidents that were occurring. The CQC felt

that there is a risk that the promotion of a seemingly very positive culture results in poor governance and minimising of governance failings.

FT4 - 6 (c) and (d) The **Board Assurance Framework (BAF) was seen as weak and had gaps in the level of assurance the board should be receiving**. The BAF had listed "Not having sufficiently robust systems of clinical governance, poor implementation of the patient safety framework and/or unable to effect and evidence of change robustly following adverse incidents or learning from within local health systems; affecting patient outcomes, reputation and adverse scrutiny" as the only strategic clinical risk. **This was scored as a significant risk**.

FT4 - 5 (b) and (c) & 6 (c) and (d) & 7 There were **several examples noticed of serious incident trends that should have been identified, investigated and acted upon to reduce future risks**. This had not always happened. There were **limited assurance mechanisms and no checking that staff had improved their ability to recognise severe breathing problems.**

FT4 - 7 The **second strategic risk focused on performance** and was recorded as, "**Lack of capacity to meet demand in all services due to: changing patterns post pandemic and as the NHS returns to 'business as usual' with the potential to result in long waits, delays, poor patient experience, safety issues and inability to meet targets and expectations."**

Management of risk, issues and performance

FT4 – 5 (b) and (c) & 6 (a) and 6 (b) **Leaders and teams did not always use systems to manage performance effectively**.

FT4 – 4 (c) 5 (b) and (c) **Not all risks were identified and escalated to the board**. Leaders held differing views on the high level risks. Mitigating action was not always effective.

FT4 – 6 (b/c/d/e/f) **The tools used were not presenting a clear picture of the risks to the board and sub committees.** This included low reporting and poor management of serious incidents, **inadequate Freedom to Speak-Up (FTSU) Guardian resources** and a line manager reporting structure that was a barrier to contacting the FTSU Guardian.

FT4 – 6 (e) **The leadership walkabouts were very limited, and many frontline staff did not know who their executive leaders were.** Non-executive visits had stopped to limit transmission of the Coronavirus.

FT4 – 7 The **highest scoring risk register entries were around hospital handover delays, ambulances having to wait outside of emergency departments with a patient onboard for several hours before the hospitals had capacity to accept them into the department**. It was recognised that this took ambulances off the road and that people suffered harm when ambulance availability outstripped demand. The local and corporate risk registers predominantly laid the blame with one hospital, but also talked about **demand for 999 calls outstripping resources.** There was mention of escalation to NHSE and demand meetings but no mitigating action by the Trust.