South Central Ambulance Service NHS Foundation Trust

Quality Report

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Overall summary

South Central Ambulance Service NHS Foundation Trust (SCAS) provides a range of emergency, urgent care and non-emergency healthcare services, along with commercial logistics services. The trust delivers most of these services to the populations of the South-Central region – Berkshire, Buckinghamshire, Milton Keynes, Hampshire and Oxfordshire. In addition, they provide a non-emergency patient transport services (PTS) in Surrey and Sussex.

There is also Resilience and Specialist Operations offering medical care in hostile environments such as industrial accidents and natural disasters. This team is known as Hazardous Area Response Team (HART) based in Hampshire.

SCAS is the main provider of 999 emergency ambulance services within the South Central region (as are all English ambulance trusts in their defined geographical areas); all other services the trust delivers are tendered for on a competitive basis.

Services are delivered from the trust's main headquarters in Bicester, Oxfordshire, and a regional office in Otterbourne, Hampshire. Each of these sites includes an emergency operations centre (EOC) where 999 and NHS 111 calls are received, clinical advice is provided and from where emergency vehicles are remotely dispatched if needed. There is a PTS contact centre at each EOC. The trust also works with air ambulance partners; Thames Valley and Chiltern Air Ambulance (TVAA) and Hampshire and Isle of Wight Air Ambulance (HIOWAA). The trust serves a population of over seven million people across the six counties. They employ approximately 3,300 staff who, together with over 1,000 volunteers, operate 24 hours a day, seven days a week.

We carried out this short noticed focused inspection because we received information of concern about the safety and quality of the service.

Concerns raised related to the safeguarding arrangements at South Central Ambulance Service NHS Foundation Trust. The focused inspection only considered how well the trust was delivering their safeguarding responsibilities.

Post inspection we raised concerns with the trust about issues we had found. The trust took immediate action and provided assurance all concerns raised would be addressed which included a given timeframe.

How we carried out the inspection

We spoke with staff and looked at a wide range of documents including policies and procedures, audit reports, meeting minutes and trust board papers. We spoke with other agencies concerned with the safeguarding of people who used the trust services.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of findings

Our inspection team

The team that inspected the service comprised a CQC inspection manager, two additional inspectors and two specialist advisors with experience in ambulance safeguarding and NHS trust governance. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

- The trust must review their safeguarding objectives and strategy.
- The trust must review their safeguarding governance structure and reporting from front line to Board.
- The trust must review board oversight of safeguarding at SCAS.
- The trust must review their safeguarding policies and polices relating to safeguarding.
- The trust must review their safeguarding education provision.
- The trust must review the structure of the safeguarding team including roles and responsibilities within the team.
- The trust must reviewtheir safeguarding team resources, competence, and effectiveness.
- The trust must review their IT systems to make sure they are fit for purpose.
- The trust must review their safeguarding systems and processes to make sure they keep service users safe.

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Safeguarding

Operational staff had an understanding of how to protect patients from abuse and the service worked with other agencies to do so. However, policies were ambiguous or incorrect, and whilst compliance in level 1 and 2 mandatory training in safeguarding was almost within trust target, level 3 training was well below due to the COVID-19 pandemic but with no clear action plan to address this. Leaders and teams did not consistently use systems to manage safeguarding reporting effectively. Risks and issues were not always identified and escalated. Reliable

data was not always collected and analysed to understand performance, make decisions and improvements. There was insufficient resource to cope with current safeguarding demands.

The trust had no strategy or strategic objectives for safeguarding. Prior to the inspection there had been an away day to consider safeguarding arrangements and leadership responsibilities. However, there had been no involvement from the trust board non-executive director safeguarding lead and limited involvement by the executive lead for safeguarding. No formal action plan from the day had been produced. We could not find evidence that safeguarding was being steered by those with strategic responsibility.

The Safeguarding Adults Policy (dated November 2021) and the Safeguarding Children Policy (dated October 2021) both contained outdated references and advice which had the potential to confuse staff. The policy statements were not deliverable due to the size of the region covered by the trust and the limited resources within the safeguarding team. For example, the Safeguarding Adult Policy contained out of date references such as to the domestic abuse definition from the Home Office (2013) rather than referencing the Domestic Abuse Act (2021). This meant the policy was not using current legislation as a basis from which to protect people from harm.

Policies linked to safeguarding policies were not in line with current safeguarding arrangements and lacked oversight from a safeguarding perspective. For example, there was no evidence the Discipline and Conduct Policy (first issued 2011 and last reviewed March 2020) had been reviewed from a safeguarding perspective in 2020 or the intervening decade. There had been significant legislative and national guidance changes in that time, such as the Disclosure and Barring Service (Core Functions) Order 2012, the Safeguarding Vulnerable Groups Act 2006 (Miscellaneous Provisions) Regulations 2012, Working together to Safeguard Children (July 2018) and the Care Act (2014). There was no evidence these changes had been considered in the development and review of the policy. Service users could be exposed to the risk of harm as safeguarding policies were ambiguous or incorrect. Policies were not in line with national statutory guidance and did not have oversight from safeguarding professionals. This meant staff were not offered the correct guidance about how to respond in some situations.

Safeguarding was part of the staffs' induction and mandatory training. Staff were allocated the appropriate level of safeguarding training for their role. Staff compliance training rates showed that safeguarding adult level 1 and 2 and safeguarding children level 1 and 2 was slightly below the trust compliance target of 95% at 92%. However, safeguarding level 3 was at 21%. The trust explained this was because level 3 training was a face-to-face training course and due to the COVID-19 pandemic this type of training had been suspended, recommenced and suspended again. Although there was a training trajectory for level 3 safeguarding training this had not been reviewed or revised due to the changing circumstances caused by the pandemic over the last year. There was no clear plan, including a date for when the minimum compliance would be met, on how safeguarding level 3 training was to be delivered to staff going forward. This meant there were clinical staff who had not received safeguarding training at a suitable level for their role and training was not updated at the appropriate intervals.

Roles and responsibilities for staff working in the safeguarding team were unclear, there was conflict in the team and management of the team was poor, with no clear accountabilities. Some staff said that they did not know who they reported to and who line managed them. Not all members of the team had yearly appraisals or safeguarding supervision. This meant staff were not supported appropriately, staff found it hard to raise concerns and there was no formal meeting to identify good or poor performance or training needs. Service users could be placed at risk as the safeguarding team could not function effectively without effective leadership and opportunities for learning and organisational development could be missed.

The trust had reduced the number of governance meetings due to pressures caused by COVID-19. At the time of the inspection, staff said that there had been no safeguarding committee meeting for over a year. As part of the factual accuracy process, the provider told us that there had been a meeting on 22 April 2021, although the minutes of this were not provided. Staff told us

safeguarding was discussed in other meetings such as the clinical governance meetings for the different clinical areas at the trust, the patient safety group meeting and the quality and safety group. Post inspection we requested minutes of these meetings and could see safeguarding was a standing agenda at these meetings. However, these meetings had a much wider agenda then the safeguarding committee meeting and therefore limited time for consideration of safeguarding concerns and performance. Safeguarding was escalated by exception from the patient safety group to the quality and safety committee who reported upwards to the board by exception. This meant the board was not well sighted on safeguarding risks and incidents.

Staff gave us conflicting reports of how safeguarding was addressed in these meetings, the time allocated to safeguarding concerns, who attended the meetings to represent the safeguarding team, how regularly meetings were attended by a safeguarding team member and how information was reported up to the board.

The assistant director of quality, who line managed the safeguarding team, trusted the head of safeguarding to address any concerns, escalate risks and to keep them informed. However, during the inspection, we found this was not always occurring. For example, they were unaware of section 42 delays and how delayed or missed referrals had been reported. Those with line management responsibility for safeguarding did not always have a good understanding of the quality of the work being undertaken and assurance that the work was keeping people safe.

With no safeguarding committee meeting there had been reduced oversight of safeguarding which meant risks were not being identified and escalated appropriately and that any risks to people were not being monitored and mitigated.

Staff we spoke with told us although there was a computer based system for managing safeguarding referrals, they needed to manually check that all the referrals had been forwarded, as necessary to the local authority. They felt the processes were burdensome and took up a lot of their time. The provider has confirmed referrals that cannot be processed automatically need to be screened before being forwarded to the multi-agency safeguarding hub.

Staff told us that in August 2021 about 750 safeguarding referrals had been found on the computer system that had not been automatically sent to the relevant local authorities multi agency safeguarding hub. The system failing was identified by chance when the safeguarding team had been asked to follow up on a referral from a private ambulance provider who carried out work for SCAS.

The trust provided evidence these incidents were escalated and reported externally to commissioners on their detection and that all the referrals had been reviewed for any patient safety risks due to the delay and none were found.

Senior members of the safeguarding leadership team gave us contradicting information about these delays and whether they were reported as a serious incident. The head of safeguarding said they had not been reported as a serious incident and the assistant director of quality saying they were reported and reviewed as a serious incident. However, after following the trust's serious incident procedures, the incident was not reported as a serious incident as no actual patient harm had been identified. We found no mention of this incident in any board minutes which meant that the board was not sighted on the level of risk this situation posed. It also meant that the need for strategic and operational improvements to safeguarding were not identified.

Although a major failing was identified in the computer system which resulted in referrals not reaching their destination, and this occurred over a period of 17 days. There was no mention of this incident in subsequent quality and safety meeting minutes or in board papers. This meant the board and senior staff responsible for safeguarding did not have sight of this issue or assurance that the issues leading to the delayed referrals had been appropriately addressed and this would not occur again. Service users will or may be exposed to the risk of harm if safeguarding referrals are not made in a timely way.

We were shown a commissioned internal Safeguarding Children Audit (dated September 2021). This report identified several risks relating to child safeguarding. These included :staff lacked awareness of the standards and regulations and were incapable of delivering safeguarding guidelines because of the absence of comprehensive training, safeguarding referrals made by the trust were not consistently completed with sufficient

details and high-risk safeguarding referrals were not followed up by the safeguarding team once they have been delivered to the relevant local authorities. We saw no evidence that findings highlighted in the report were being actioned.

The safeguarding team had not completed any internal audits since January 2020. Staff told us they used to provide a quarterly report to the head of safeguarding, but the team no longer had capacity to do this work. The last audit completed was done by administrative assistants who had no training to complete audits. Audits are part of the assurance framework and a lack of audits meant there was a lack of clarity about performance. Post inspection, at the factual accuracy stage, the provider told us this was incorrect and audits had been carried out between January and March 2021 and staff had training to complete the audits. However, they did not provide evidence to demonstrate this.

In the 2020/21 there had been 38,250 safeguarding referrals made. In 2017/18 the total number of referrals made was 12,500. This is an increase of 206% in four years. Once a referral had been made and sent to the local authorities, the trust did not have oversight on whether the referral has been read and acknowledged by the relevant service, or whether reasonable action has been taken to ensure the concern was resolved. Due to the high level of referrals made by the trust full oversight was said not to be feasible. The internal Safeguarding Children Audit dated September 2021 noted some of the referrals were of high-risk including threat to life and self-harm, and it was also noted that the safeguarding team were unable to review these referrals prior to them being sent to the local authorities again due to the high levels of referrals made compared to the size of the team. The team were not sampling or auditing the high risk referrals when the safeguarding concern had not been mitigated to gain some assurance that concerns were identified, recorded, referred and acted upon appropriately. For example, when the patient had not been conveyed to hospital or other place of safety, or the police had not been on the scene. Therefore, the trust did not have the oversight and assurance safeguarding concerns were being actioned promptly and that the welfare of children and adults may have continued to be at risk of harm.

Section 42 of the Care Act (2014)requires that each local authority must make enquiries (or cause others to do so) if it believes an adult is experiencing, or is at risk of, abuse or neglect. When an allegation about abuse or neglect has been made, an enquiry is undertaken to find out what, if anything, has happened. The enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom. Whilst the administrative staff prioritised section 42 responses to the local authority, they were not meeting deadlines for section42.There was no record of how many were not met within 28 days. There was no record provided to demonstrate that this was being monitored. The head of safeguarding was aware of the delays, but it was not escalated through the governance structure as the safeguarding committee was not meeting. Post inspection at the factual accuracy stage the trust told us there was a record of 19 section 42 reports and four cases were delayed. They did not provide us any further information or evidence. For example, how many delayed section 42 reports there had been in the last year or how the trust monitored and reported this information.

The head of safeguarding confirmed that some section 42 deadlines were being missed but was unclear how many. The assistant director of quality, who was line managing the safeguarding team, was not aware of section 42 delays. There was no evidence provided and board papers did not show that the board were aware of or considered a strategic response to section 42 delays.

There was limited partnership working, in part due to capacity within the team, as an example, nobody had attended the Hampshire Local Safeguarding Children Partnership meetings for over a year, despite Hampshire being the largest county within the area covered by the trust. The head of safeguarding said that they tried to prioritise and rotate as there were so many partnership meetings to try and cover. Considering the geographical area covered by SCAS and the number of safeguarding partnerships and boards it is unrealistic that there is an expectation a small team can provide the level of engagement necessary without a supporting operational structure. There was no plan or policy decision about how partnership working would best be used to ensure that people were protected from harm.

We could not be assured that the board was sighted on all safeguarding risks, due to the governance and line management structure. We could not be assured that the board was sighted on all safeguarding risks, due to the

governance and line management structure. Although the board were given information through the quality and safety board report, the board papers from 2019 onwards, showed a lack of consideration of safeguarding, a lack of challenge and poor oversight of safeguarding with little action being taken in relation to the few identified issues. For example, there was little oversight of compliance with the training requirements for staff requiring level three safeguarding training. There was a message timeline that showed that training would be provided, but there was no clarity that it had been provided. There were several board papers that mentioned training would recommence at various points, but none that showed the numbers of staff who had completed training and what proportion of the staff this was. There was no evidence of challenge around the lack of delivery of level three training.