South East Coast Ambulance Service NHS Foundation Trust

Inspection report

Nexus House
4 Gatwick Road
Crawley
RH10 9BG
Tel: 03001230999
www.secamb.nhs.uk

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Ratings

Are services well-led? Inadequate

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

We award the Use of Resources rating based on an assessment carried out by NHS Improvement. Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Overall summary

What we found

Overall trust

Our reports

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This report describes our judgement of the quality of care provided by this trust. We base it on a combination of what we found when we inspected and other information available to us. It includes information given to us from staff at the trust, people who use the service, the public and other organisations.

Overall Summary

Our overall rating of well-led went down. We rated it as inadequate and the chief inspector of hospitals has recommended to NHS England and NHS Improvement (NHSEI) that it be placed in the Recovery Support Programme.

A trust may be placed in the Recovery Support Programme for quality reasons when:

- It is rated 'inadequate' in the well-led key question (because there are concerns that the organisation's leadership is unable to make sufficient improvements in a reasonable timeframe without extra support)
- A trust placed in the Recovery Support Programme receives intensive support to help it improve. It must produce an improvement plan setting out what it will do to bring services up to the required standard.

Our findings

During this inspection we identified further checks we needed to carry out. In the meantime, we have suspended the trust's overall rating. This will be reviewed once the checks are completed.

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) was established on 1 July 2006. On 1 March 2011 SECAmb became a Foundation Trust.

The trust covers 3,600 square miles which includes densely populated urban areas, sparsely populated rural areas and some of the busiest stretches of motorway in the country. It serves a population of over 5 million people.

The trust employs over 4,500 staff working across 110 sites in Kent, Surrey and Sussex. Almost 90 per cent of the workforce is made up of operational staff – those caring for patients either face to face, or over the phone at the trust emergency dispatch centre where the trust receive 999 calls.

Patients range from the critically ill and injured who need specialist treatment, to those with minor healthcare needs who can be treated at home or in the community.

As well as a 999 service, the trust also provides the NHS 111 service across Kent and Sussex. The trust also has a Hazardous Area Response Team (HART) which was not inspected at this time.

During March 2022, we undertook a focused inspection of the Emergency and Urgent Care services as part of a pilot approach of the urgent and emergency care pathway across Kent and Medway. This was to assess how patient risks were being managed across health and social care services during increased and extreme capacity pressures. A short notice period was given prior to the inspection. We also undertook an inspection of the Emergency Operations Centre and 111 service using our comprehensive inspection framework and due to concerns about leadership quality and culture in the organisation we inspected the well-led key question for the trust. We did not inspect the resilience core service (HART) on this occasion.

Following this inspection we have suspended the overall ratings for the trust while we carry out further checks on all the provider's locations.

- In 111 the overall rating stayed the same. We rated safe, effective, caring, and well-led as good. We rated responsive as requires improvement.
- In Emergency Operations Centre the overall rating went down. We rated the caring domain as good however, we rated safe, effective, responsive and well-led as requires improvement.
- The Emergency Urgent Care service was unrated due to being part of a system review to ensure consistency with other ambulance trusts.
- The ratings for the well-led inspection went down.
- In rating the trust, we took into account the current ratings of the other core services not inspected this time.

What we found.

111 Service

Our ratings for the service stayed the same. We rated it as Good.

Our findings

- The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients were able to access care and treatment from an integrated service with specialisms to meet their needs.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

However:

- The trust was not meeting the key performance indicators on clinical call back times, call abandonment rates and call response times.
- The trust did not always support the workforce in order to reduce the pressure and improve staff morale.

Emergency Urgent Care. Due to the focused nature of the inspection, we did not rate the core service. The previous rating of outstanding remains.

- The significant rise in numbers of callers to 999, in excess of what the trust was commissioned for combined with crews being delayed at emergency departments meant the trust was unable to reach all patients in a timely way. As a result, the service was not meeting any NHS constitutional ambulance response times, which was a similar picture across the ambulance services nationally.
- The exceptional demand was increasing, and this was becoming unsustainable for staff across the service.
- There were additional risks for patients from handover delays for ambulance crews at emergency departments which were unable to take patients due to their lack of capacity.
- Due to delays in response times as a result of increased demand, there were risks of harm to patients who were in the community.
- The service planned care to meet the needs of local people, however it didn't always take into account patients' individual needs and did not provide people with information on how to give feedback.
- The trust did not always support staff to develop their skills. Managers and staff told us that any additional training courses had to be self-funded and completed in their own time.
- A high proportion of staff had not received an appraisal.
- Not all staff felt connected to other teams and sites within their service and to the organisation as a whole.
- Learning from low level harm and near miss incidents was not embedded and staff often did not get feedback from incidents they had reported.
- Leaders were not always aware of the risks in their service or themes and trends in patients' complaints.
- There was a lack of a clear strategy and consistent approach in the management of ambulance response categories 3 and 4.
- Staff felt there was an overall lack of a strategy and vision for the organisation.

However:

Our findings

- Staff worked well together for the benefit of patients and focused on the needs of patients receiving care.
- Local leaders ran services well using reliable information systems.
- The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs and helped them understand their conditions. They provided emotional support to patients, families and carers.
- There had been some excellent multidisciplinary working and mutual aid to and from the service. For example, an ambulance staffed by a paramedic and police officer to support patients experiencing severe mental ill health.
- Despite the immense pressure faced every day, staff were kind, compassionate and supportive.

Emergency Operation Centre

Our rating for the service went down. We rated the Emergency Operations Centre core service as Requires Improvement.

- The service did not always have enough staff to care for patients and keep them safe.
- There was an expectation on staff to work overtime even though they were exhausted.
- Staff were not up to date with mandatory training and training in key skills. Staff did not receive adequate training on patients who had mental health needs and felt this was a risk to the safety of their service.
- The service did not manage safety incidents well. Incidents were often not investigated in a timely fashion and learning from incidents was not consistently shared with all staff.
- The service did not ensure all staff had an appraisal and appraisal rates for the service were poor.
- Staff understood how to protect patients from abuse, however safeguarding training compliance was worse than the trust target.
- People could not always access the service when they needed it. Since the rise in demand and strain on response times, the service was no longer able to always meet the needs of patients.
- People who did not speak English could sometimes not access the service in a timely way.
- Leadership at a local level was good. However, staff did not feel visible or appreciated by senior leadership.
- Not all staff felt respected, supported and valued. Not all staff felt they could raise concerns without fear, even though there was a freedom to speak up guardian in post that staff were aware of.
- Leaders did not support staff to develop their skills. Opportunities for development were limited and staff were expected to do any continuous professional development in their own time.

However:

- Staff assessed risks to patients, acted on them and kept good care records.
- Staff worked well together for the benefit of patients.
- Staff treated patients with compassion and kindness, even when they were under a vast amount of pressure themselves. They were focused on the needs of patients requiring care.

Our findings

- There were processes in place to ensure the service could continue in the event of a business continuity incident or other events that could stop the service running effectively.
- Staff knew about the values of the service.

Trust wide

- Leaders had the experience, capacity and capability to lead effectively. However, the current leadership style and relationships in the executive team were not operating as effectively or cohesively as it should.
- Communication at all levels was poor. Staff provided us with many examples of this during the inspection.
- Leaders were out of touch with what was happening on the front line, and they were not always aware of the challenges in the service.
- Leaders were not visible and did not act in line with the trust's own values when staff raised concerns.
- Not all staff felt respected, supported and valued. Staff were focused on the needs of patients receiving care.
- Not all staff felt they could raise concerns without fear of reprisal.
- Staff reported low levels of satisfaction and high levels of stress and work overload.
- We found high levels of bullying and harassment, inappropriate sexualised behaviour and a high number of open grievances.
- There was insufficient resource allocated to FTSUG, safeguarding and medicine management team.
- The governance systems at the trust were not operating in a way that protected patients or staff from the risk of harm.
- Key reports to board were not prepared in a standardised way.
- Risk, issues and poor performance were not always dealt with appropriately or quickly enough.
- We found a back-log of 1500 incidents on the incident reporting system.

However:

- We found good collaborative working between the FTSUG and union representatives.
- The trust had an award-winning wellbeing hub that provided invaluable cost-effective support to staff.
- The trust was making progress with the equality, diversity and inclusion agenda.
- The trust was well on its way to becoming a digitally mature organisation. There was record investment in IT infrastructure to future proof the organisation
- The trust had used the pandemic to improve its visibility, influence and focus in the local system. We saw improved levels of engagement with other key stakeholders. The trust had become a more outward facing organisation.
- The strategy director work programme was having a positive impact on the trust's ability to translate data into service planning, delivery and organisational strategy.

How we carried out the inspection

Our findings

- We looked at information such as staffing number and rotas, staff training, clinical stack management.
- We looked at medicines management, checked equipment, medical devices and consumables.
- We reviewed information provided by the service following the inspection.

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

What people who use the service say

Most patients praised the care, treatment and support they received from the service. However, we also saw concerns about the excessive ambulance waiting times and staff attitude.

Outstanding practice

111 Service

- In March 2022, the engagement work undertaken to involve patients and volunteers in the development and procurement of the NHS111 service had received a 'Healthwatch Recognition Award'.
- Having worked with the commissioners and other external organisation to establish a Direct Access Booking (DAB) service, approximately 30% of all triaged patients received a DAB into an external provider. This service improvement had resulted in a Health Service Journal improvement Award was for 'Best Acute Sector Partnership with the NHS'.

Areas for improvement

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 ensure all staff complete mandatory, safeguarding and any additional role specific training in line with the trust target. (Regulation 18 (2) (a)).
- The trust must improve the culture and ensure all staff are actively encouraged to raise concerns and improve the quality of care. (Regulation 12 (1) (2i)).
- The trust must ensure it takes staff's concerns seriously and takes demonstrable action to address their concerns. Regulation 17 (2)(b).
- The trust must ensure that all incidents investigations are completed in a timely way to allow opportunity for action on learning to be shared and action taken swiftly. Regulation 17 (2) (b) (e)).
- The trust must ensure it works collaboratively with system partners to improve category 2, 3 ,4 response times. (Regulation 12, (1) (2) (a) (I)).
- The trust must ensure the governance and risks processes are fit for purpose and ensure the ongoing assessment, monitoring and improve the quality and safety of the services provided. (Regulation 17, (1) (2) (a) (b)).

Our findings

- The trust must ensure it seeks and acts on feedback from relevant persons and other persons on the services provided for the purpose of continually evaluating and improving services. (Regulation 17, (2) (e)).
- The trust must collect and analyse the End of Life (EoL) calls and share the analysis with ICS stakeholders, with the objective of reducing the needs for unanticipated EoL care by emergency and urgent care services (Regulation 17, (1) (2) (a) (b) (c)).

The trust should consider:

- The trust should ensure it provides appraisals and continuous professional development to all staff.
- The trust should ensure blood glucose (sugar) machines are calibrated.
- The trust should consider how to recruit to staff vacancies.
- The trust should consider how to improve communication and relationships between staff and senior leaders.
- The trust should consider a consistent approach in the management of ambulance response to categories 2, 3 and 4 calls.
- The trust should ensure that it continues to work towards meeting the key performance indicators on clinical call back times, call abandonment rates and call response times.
- The trust should ensure it continues working towards supporting the workforce in order to reduce the pressure and improve staff morale.
- The trust should consider how to improve engagement with staff.
- The trust should consider how to improve engagement with patients.
- The trust should better understand the role of the FTSUG to improve the speak up culture.
- The trust should consider how to drive the improvements needed to achieve key performance indicators on clinical call back times, call abandonment rates and call response times in 111.
- The trust should continue working towards supporting the workforce in order to reduce the pressure and improve staff morale.

Is this organisation well-led?

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders had the skills and abilities to run the trust. However, they did not always understand or manage the priorities and issues the trust faced. They were not visible and approachable and did not act in line with the trust's own values when staff raised concerns. Staff were not supported to develop.

Leaders had the experience and abilities to lead effectively. However, the current leadership style and relationships in the executive team were not operating effectively or cohesively. We recognise the significant impact the Covid 19 pandemic had on healthcare organisations. As a result, the trust was operating a control and command style of leadership. However, we were told there was an imminent plan to move away from this leadership style as a result of the known and inherent risks of a command and control culture. The organisation were still trying to address the concerns outlined in the 2017 Lewis report in relation to this leadership model.

Our findings

Staff knew who their leaders were. However, staff did not feel they were empowered to make decisions or lead in a progressive or constructive way. Staff told us decisions were made in isolation by a small number of individuals rather than using the expertise, experience and clinical knowledge in the organisation. Decisions were frequently made outside of the trust's own policies, governance and risk systems.

Communication at all levels was poor. Staff provided us with many examples including email trails showing key decisions and changes were not always communicated effectively in the executive team, or amongst the senior leaders or their teams working at core service level.

Leaders were out of touch with what was happening on the front line, and they were not always aware of the challenges in the service. We found many examples of staff raising concerns relating to the challenges they faced that went unaddressed. Not all executives were able to demonstrate a knowledge of what was happening at core service level.

Leaders were not always clear about their roles and their accountability for quality. There was insufficient challenge at executive and senior levels. We saw a wide range of committee and subcommittee meeting minutes which failed to provide assurance of enough challenge or healthy debate in these forums. There was a perception of a 'power imbalance' at executive level that posed a potential organisational risk. We were aware relationships in the executive team were sometimes fraught. This had an impact on the executive's ability to work as a cohesive team but also had an impact on leaders within their individual core services. Whilst the trust had recently recruited a small number of new executives there was still a risk of legacy behaviours affecting the cohesiveness in the wider executive team.

Staff were not supported to develop. The recent pandemic had a significant impact on the trust's ability to support staff to train and develop. Many staff were promoted into leadership roles but were not provided with the necessary training to support them in that role. Mandatory training rates throughout the trust were low. Annual appraisal rates were also low. There was a recognition that training, development and annual appraisals were important at all levels. As a result the trust were in the process of addressing how to manage this given the current demands on the service. However, a formal recovery plan had yet to be signed off by the board.

CQC carried out an Emergency and Urgent Care and Emergency Operations Unit staff survey before inspecting the trust. Staff were provided with a free text box to make comments about issues important to them. Many staff told us they were worried about the cultural decline in the organisation and referred to the senior leadership as 'dysfunctional'. Most staff we talked with during our inspections gave us a similar message.

Leaders were not visible and did not act in line with the trust's own values when staff raised concerns. Staff told us their senior leadership team were not visible and some went as far to say leaders were not approachable. Many staff described a 'disconnect' between the executive team and the staff delivering care. Staff felt raising concerns was futile and would negatively impact their future careers if they continued to bring concerns to the attention of the senior leadership team.

We reviewed the personnel files for four members of the executive team. Appropriate checks had been carried out in accordance with 'Fit and Proper Person' requirements. The executive team had an appropriate range of skills, knowledge and experience.

During the pandemic some members of the executive team went out to meet staff and support welfare initiatives. This included but was not limited to providing food and drinks to staff who struggled to get meal breaks and the medical director worked alongside crews.

Our findings

Vision and Strategy

The trust had a clear set of values and were developing a new operational change model. The new operational model was not developed with input from staff, patients or other key stakeholders. The operational change model was focused on the sustainability of services and to some degree was aligned to local plans within the wider health economy, however it was not incorporated in the trust strategy.

The trust values were, taking pride, demonstrating compassion and respect, acting with integrity, assuming responsibility and striving for continuous improvement. There were firmly embedded in the trust.

The new operational change model, was known as Better by Design (BDB). The change programme was felt necessary to support improvement to make the trust 'Best placed to care, the best place to work': and to be a better partner in the wider NHS system. BBD had three main aims, the delivery of timely patient care though delivering response targets, becoming an outstanding organisation as measured by CQC and patients and improved long-term resilience. The programme also had three guiding principles to guide change: these were 'getting it right first time, standardisation of tasks and processes and strategic alignment'. The BBD framework also focused on seven additional key areas to drive service improvement. BBD had the potential to bring about positive changes, however, it also carried a significant risk to the organisation due to the potential gaps and weakness that undermined its credibility. For example, people who use the service, staff expected to deliver key changes and trust governors were not engaged in its creation or development. All staff we talked with had heard of BBD. However, we spoke to many staff, at all grades and no one could tell us what Better by Design was, how it would impact them and what it meant for patients. Many staff told us they spent the last 12 months feeling worried about their job security because they simply did not know what BBD would mean in practice. At the time of inspection, the trust had not updated their strategy to incorporate the BBD framework and staff had not received any information about the change programme. The operational change model was only one strand of the better by design programme.

The organisational strategy was due to expire in 2022. The current strategy outlined how the trust ensured the provision of safe, quality care. The pandemic meant service delivery changed and the trust's scope broadened to ensure it could meet the overwhelming demand. The challenges led to an improved focus to system health care delivery. The trust became a vital partner and key support to other stakeholders as a result. It also brought about new and interesting ways of delivering a service. It led to improved healthcare pathways, cohesive system working and career development. However, there was also a potential risk to the trust given the task to meet the vast needs and expectations in the system particularly given the risk related to category three and four response delays. Staff were very proud of what they achieved during the last two years. However, many staff we talked to told us they were unsure of what their roles had become and felt the lack of an updated strategy was problematic.

The trust recently developed an Executive Director of Planning and Business Development role. Whilst in its infancy, this role was having a positive impact on the trust's ability to translate data into real time service planning, delivery and organisational strategy. We found proactive system development to capture live data that could be used for system planning based on population health.

The trust recently launched a Green strategy. The trust had invested in electric vehicles which were already in use. There was a range of other green initiatives all aimed at reducing the trust carbon footprint.

Our findings

Culture

Not all staff felt respected, supported and valued. Staff were focused on the needs of patients receiving care. Not all staff felt they could raise concerns without fear of reprisal, and when concerns were raised, staff felt they were not listened to. There were low staff appraisal rates. The service had made some progress in promoting equality and diversity in the organisation.

The executive team told us they ensured a fair and just culture. Executives felt they role modelled a compassionate leadership style. The executive team described the culture of the organisation as 'good'. However, staff did not feel this was the case. It was clear from the trust and CQC surveys and the number of whistle-blowers we talked with there was a potentially closed culture developing. Staff told us they feared reprisal for raising concerns. When we asked staff to describe the culture of the trust the word 'toxic' was frequently used. This was a marked deterioration since our last inspection.

We found low levels of staff satisfaction and high levels of stress and work overload. Much of this related to the burn out from the pandemic. However, this also related to the challenges staff felt when trying to raise concerns. Staff told us about their frustration and disappointment when potentially serious concerns went unheard. Many staff turned to their Freedom to Speech Up Guardian (FTSU) guardian and Union representatives for support. However, it appeared these avenues of escalation were also futile.

We found high levels of bullying and harassment, inappropriate sexualised behaviour and a high number of open grievances. The trust reported reducing the number of grievances from 200 to 70. Staff raised concerns about grievance processes and the introduction of policies that may unfairly discriminate against different groups of staff.

The organisation employed in excess of 4,500 staff but only had one Freedom to Speak up Guardian (FTSUG). This role was greatly under resourced given the number of staff and the volume of contacts. The role of the FTSUG was poorly understood by the executive team. There was a widespread perception the FTSU function only related to patient safety issues. During interviews we were told more than once the FTSU role was a 'victim of its own success' and many of the issues raised 'did not concern' a FTSUG. Staff at all grades told us they contacted the FTSUG to raise concerns when they did not feel listened to or where their concerns were not taken seriously. These concerns related to patient safety, bullying and harassment, lack of meal breaks, inappropriate sexualised behaviour, wellbeing and work-related HR concerns.

As a result of a lack of understanding of the role and remit, many concerns raised by the FTSUG were not addressed.

We found good collaborative working between the FTSUG and union representatives. There were obvious trends and themes in the concerns raised by the unions and FTSUG. These did not appear to be recognised or responded to in line with the trust own polices, values or behaviour framework.

The CQC and trust staff surveys indicated worrying levels of concerns relating to the culture of the organisation. We were concerned the trust was reverting to 'normalising' many of the concerns raised. Staff told us the culture was 'not as bad as it was', which may indicate a potential acceptance of the cultural decline.

The trust recognised the risk of inappropriate sexualised behaviour. In 2021, an audit was undertaken into all allegations following a rise in reported cases. As a response to the report the trust had recently launched a sexual safety at work programme and have sought volunteers to support the development of a campaign. However, at the time of the

inspection many staff were unaware of the programme. Not all staff felt that when concerns relating to inappropriate sexualised behaviours were raised, they were always heard, understood or tackled equally across all levels of the organisation, with the approach being that issues were either 'clumsy, creepy or criminal'. As a result, there was a risk that behaviours judged by those not affected could be deemed 'clumsy' and not appropriately addressed.

The trust had an award-winning wellbeing hub. The hub was established to provide a wide range of support to staff, who all recognised the invaluable support the hub provided. However, many expressed fears about its current capacity and future in the organisation when BBD was launched. Themes from concerns and support provided was not formally monitored. As a result, there was missed opportunities to use the information to from themes and trends to support cultural improvement. For example, high numbers of staff who used the service reported excessive stress and bullying and harassment. This was not formally being captured or used to address the underlying issues. A recent review had been carried out to assess the value of service provision which reported the service provided value for money to the trust through the staff support it delivered.

The trust was making progress with the equality, diversity and inclusion agenda. However, there was a perception not all executives were fully committed to this work. The trust monitored their workforce data in relation to the protected characteristics as defined by the Equalities Act 2010. The trust was in the process of developing a live database capable of monitoring all aspects of diversity for example, training, talent management and turnover. However, we identified an imbalance that meant the work focused more on staff inequalities rather than patient inequalities. The trust acknowledged more work was needed to meet its requirements for staff and patients.

Governance

The trust did not operate effective governance processes. Staff at all levels were unclear about their roles and accountabilities. The weak governance processes meant the trust missed opportunities to learn and improve performance.

The governance systems at the trust were not operating in a way that protected patients or staff. The systems failed to assess, monitor and drive improvement in quality and safety. The processes were complex and poorly understood. There was a range of sub committees that fed into the governance system. However, these systems and processes lacked clarity and did not work effectively. Sub committees were inconsistent and lacked a focus on quality and service improvement. Executives felt there was discussion at board about quality, however a review of board and sub committee papers did not demonstrate this clearly.

We found a lack of clarity about who had the authority to make decisions. The trust was using a 'bridged governance' approach during the pandemic. As a result, key decisions appeared to be made by a few key individuals. This was a potential risk as important decisions were made in isolation of constructive challenge or healthy debate despite the wealth of experience in the trust. Staff were unable to explain how this approach worked. Staff and their managers were not clear about their roles or accountability during this time. Staff were unsure of who's direction to follow when key decisions were made that did not follow the expected scheme of delegation or current trust policies.

The Director of Finance (FD) was supported by an experienced finance team led by the Associate Director of Finance. Whilst the FD reported that the Trust was reviewing its offer to improve retention of finance business partners, the team was generally well staffed and had low turnover. The inspection team noted evidence of good financial governance discipline in respect of financial accounting. The Trust had undertaken significant work over the last five years to improve the financial control environment and had updated its standing orders and standing financial instructions. The business case process had been updated and the Trust was in the process of reviewing it to ensure that it added value without being unnecessarily bureaucratic.

Our findings

The trust had an external company to assist with an independent financial assessment. They issued an unqualified audit opinion and a value for money conclusion in 2021 and did not identify any significant weaknesses in the Trust's financial systems. The trust also had a team to provide internal audit function. There was evidence that the Trust has good and constructive working relationships with both internal and external audit firms.

The Trust developed a draft plan for 22/23 with a stated deficit of £39.9m which is 14.6% of turnover. There was a consistent recognition of the financial challenges. There was evidence of good financial understanding at board level, but the board papers did not fully reflect the financial sustainability challenge and the Trust's response. As a result, it was not possible to be assured of a well-developed plan to return to a financially sustainable position. The Better by Design strategy was frequently cited as a key part of the Trust's response. However, this was in the early stages of development and the external financial environment was frequently referred to as the source of the Trust's financial challenge.

Management of risk, issues and performance

Leaders and teams used systems to manage performance, although there were times when this was not effective. While known risks were identified and high-level risks were escalated with identified actions to reduce their impact, there was variability in the way risks were identified, recorded and mitigated, with some known risks being unmanaged.

The trust operated a risk register. However, the information we reviewed did not provide sufficient assurance the entries reflected the true risk or had appropriate mitigations. The trust had a risk management policy and procedure which covered the process for recording the closure of risks.

However, staff could not confidently tell us the frequency or process used to review risks. Risks were described as having 'disappeared' from the register with no formal record kept of the decision to delete/remove entries. There was no communication with the staff groups the risks affected. The trust operated a Board Assurance Framework (BAF). The BAF should bring together the information on the organisational risks to the trust's strategic objectives. The trust executives felt the BAF risks were linked to the trust strategy. However, the inspection team did not see how BAF was not linked to the trust strategy or objectives, and the BAF did not reflect the true risks in the organisation at the time of the inspection.

Risk, issues and poor performance were not always dealt with appropriately or quickly enough.

We saw many examples of key concerns being raised that were not dealt with or not given necessary priority. For example, in June 2021 the Association of Ambulance Chief Executives (AACE) requested all ambulance trusts in the country to make changes to the management of 999/111 stacks. These changes related to patients presenting with overdoses and the potential threat of suicides being upgraded to a category two call to minimise the risk of a long wait. The AACE request to automatically transfer unvalidated 111 calls to the 999 queues for category three and four call after 30 minutes in the 111 stacks. We asked for assurance this request had been carried out. We were told the trust went live on the 26 October 2021 and the final upgrade to iron out issues was implemented on the 16 March 2022.Computer aided dispatch (CAD) functionality was developed to provide automation of auto-dispatch. The trust told us 95% of all cases were validated within a 30-minute timeframe. However, we were not provided with the audit data or the timeframe the audits were carried out. We requested additional information to show the workaround was reviewed through the trust governance and risks processes. We also asked for a better understanding of the time taken to address the request. However, we were not provided with the necessary assurance that the risks to those waiting were being sufficiently managed. User acceptance testing and full impact analysis within 999 has not been completed at this stage, which is required in accordance with the Trust full Risk Analysis prior to implementation of new CAD functionality.

Our findings

The trust carried out serious incident and harm reviews. However, the quality and learning from these was inconsistent. There were missed opportunities to identify trends and themes. The learning identified was sometimes weak. When learning was identified it was not always shared with staff. There was an absence of audit processes to check if identified changes were embedded or were keeping people safe. We saw some obvious trends and themes relating to medicines management and failed dispatch which had not been identified or addressed. We were also not assured the level of harm was always correctly identified.

There were low levels of confidence in how incidents were managed. The trust was not proactively learning to prevent incidents recurring. There was a back-log of 1500 incidents on the incident reporting system. There were incidents that had been reported but not addressed as not all staff identified as incident handlers had been trained to review them. Some staff did not always report incidents because they felt there was 'no point'. Where staff did report incidents, they did not always receive feedback to evidence that learning had occurred as a result.

The pandemic placed an increased pressure on the trust to manage capacity. We had serious concerns about patients categorised as a three or four call (categorised as those requiring non urgent assistance). The clinical risks of those waiting was not always appropriately managed as there were insufficient numbers of practitioners employed to monitor the clinical risk in the stack. Staff in this role showed high levels of stress due to their inability to manage the risks given the number of patients. Many staff told us how upset and worried they were about patients experiencing long waits. Staff gave us examples of attending calls where patients' conditions had deteriorated whilst waiting. However, this was not always formally recorded as an incident. Staff also told us of calls attended where an ambulance was not necessary. This placed an unnecessary pressure on an already stretched service.

There were insufficient staff in the safeguarding team to manage the safeguarding function. This was identified as a potential risk to the organisation. Safeguarding policies were not in date. There was no risk assessment to mitigate the risk of out of dates policies. However, we saw evidence of functioning safeguarding processes that protected patients from the risk of abuse. Examples included identifying a sudden rise in calls from a care home for patients with breathing difficulties. The trust proactively reviewed all the calls and raised a safeguarding with the local authority.

There were several risks relating to medicines management. The pharmacy team did not have enough resource to manage a service of its size. The Medicines team received approximately 100 incident reports a month relating to medicines management. There were insufficient resources to manage these. Where serious incidents occurred that related to medicines, the team were not always informed in a timely way. A significant number of Oxygen and Entonox cylinders could not be accounted for. The trust was not fulling it's duty to safely manage medical gases.

Paramedics did not have their competencies assessed to supply or administer specific medicines. Patient Group Directions (PGDs) provide a legal framework allowing some registered health professionals to supply and/or administer specified medicine. There were risks associated with the lack of training and competencies-based assessments. The trust was mitigating the risk by using a competency-based questionnaire and had recently introduced an eLearning PGD module. Paramedics could self-assess their own competencies.

During the pandemic the trust recognised a need to adapt service delivery to meet the needs of patients who may require End of Life Care (EoLC). This cohort of patients did not always have advanced care planning in place, and other providers did not have capacity to be responsive to their individual needs in a timely way. The trust ensured these patients received timely care at home. However, the trust was not comprehensively collecting or analysing the End of Life (EoL) calls/attendance and sharing the analysis with ICS stakeholders, with the objective of reducing the need for emergency and urgent care services to deliver predictable EoL care.

Our findings

There was also a risk relating to medicines pouches. The trust held data that showed a potential 10% harm to patients. However, the trust had yet to set out its objectives to address this risk.

The pandemic had affected the trust's audit cycles and schedules, with many being put on hold or stopped. Full auditing processes had only just been recommenced. There was continuous monitoring of national performance statistics, but service quality did not have the same level of scrutiny.

The trust had put in place a strategic and tactical in response to the COVID-19 pandemic. This was focused on three key areas: to manage demand, increase capacity, and system working. The service had been at REAP level 4 (extreme pressure) since July 2021 and this was only reduced to level 3 ('severe pressure) in January 2022. A recovery plan was being developed to show how the trust would support both colleagues and our patients moving forward.

Information Management

The trust collected data and analysed it. Data was used to understand performance and make decisions. However, data was selective and was not always used in a way to improve services, quality or safety.

The trust was well on its way to becoming a digitally mature organisation. There was record investment in IT infrastructure to future proof the organisation. There was an embedded electronic records system. All crews had access to handheld devices which were password protected and designed to capture data in real time. The devices meant staff could report incidents and safeguarding concerns in real time without having to report to their base. Information was kept confidential and stored securely.

The service used a computer-based system to plan to use long-term data and analysis of demand and in response to the changing needs of a system or community.

Engagement

Leaders did not actively and openly engage with patients; However, the trust had changed how it collaborated with partner organisations to help improve services for patients in the wider healthcare system. Staff engagement had notably worsened since our last inspection

The trust had a Patient and Family/Carer Experience Strategy 2020 – 2025 which was developed in collaboration with stakeholders. The strategy helped identify what the trust did well in addition to areas requiring improvement. There was minimal engagement with people who use services in the development of that strategy. However, patient stories were presented at board meetings. This was in line with national guidance and provided a patient's perspective of using services.

Staff engagement had notably worsened since our last inspection. Whilst the challenges during the pandemic will have impacted this, this is not the sole reason for the decline. Staff at all levels reported feeling disconnected from the senior leadership team.

There were twice weekly conference calls open to all staff, on a Monday and Friday. These were used to discuss current and projected operational concerns, trust updates across and any other new and important information. These meetings gave staff the opportunity to ask questions or give feedback. However, staff told us they were not able to attend these as they were too busy. Operational bulletins were also used to communicate with staff.

Our findings

The workforce at the trust was highly unionised. Relationships between the union representatives, Human Resources and the executives appeared strained. There was much work needed to ensure all parties worked collaboratively to ensure fair, transparent and productive ways of working that incorporated staff voice.

The trust had become a more outward facing organisation and had used the pandemic to improve its visibility, influence and focus in the local system. We saw improved levels of engagement with other key stakeholders and greater partnership working, especially in times of extreme system and national pressure.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. The command and control approach in use stifled innovation in the organisation. Staff did not feel empowered to innovate or improve working practice.

Most staff felt unable to engage in improvement or innovation, citing reasons such as the control and command culture coupled with the continued challenges of delivering the service.

The Executive Director of Planning and Business Development work programme was having a positive impact on the trust's ability to translate data into service planning, delivery and organisational strategy. We found proactive system development to capture live data that could be used for system planning based on population health. The trust was using real time data to predict surges in activity. Dual trained staff were then redeployed to the surge areas. The trust was using data to proactively manage high demand.

Some staff had been dual trained in responding to 999 calls and 111 calls. This allowed a more flexible approach to managing the staffing needs of both elements.

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Not rated	Not rated	Not rated	Not rated	Inadequate Jun 2022	Not rated

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
South East Coast Ambulance Service NHS Trust Headquarters	Good Aug 2019	Requires improvement Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019
Overall trust	Not rated	Not rated	Not rated	Not rated	Inadequate Jun 2022	Not rated

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for South East Coast Ambulance Service NHS Trust Headquarters

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good Aug 2019	Requires improvement Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019

Rating for ambulance services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Emergency operations centre (EOC)	Requires Improvement ↓ Jun 2022	Requires Improvement ↓ Jun 2022	Good → ← Jun 2022	Requires Improvement ↓ Jun 2022	Requires Improvement ↓↓ Jun 2022	Requires Improvement ↓ Jun 2022

Overall ratings for ambulance services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.