I5 SECAMB Board

Finance and Investment Committee Escalation report to the Board

Date of meetings	17 October 2019
Overview of key issues/areas covered at the meeting:	**999 Performance Not Assured** The committee explored the steps being taken to help ensure improvement in operational performance. A very detailed update was provided by the director of operations, setting out the areas of focus within the recovery plan. This includes specific attention to efficiency metrics, such as responses per incident (RPI), job cycle time and those related to ensuring more available resources, i.e. hours booked on. In overall terms, there is good progress against the efficiency metrics, for example RPI was at a level that difficult to improve on and job cycle time is 5 minutes short of the target. However, there continue to be challenges in getting the right number of hours booked on, although the incentive scheme for specific shifts has helped ensure better utilisation of hours, such as at weekends. Management very clearly demonstrated to the committee that it is now data-led. This is helping with understanding the issues and therefore where to focus. For example, the data helps to demonstrate the correlation between training abstraction increasing from September, and a downturn in performance. The committee is aware of the scrutiny provided by the quality committee, on the delivery of key skills and the difficult balance there is between arranging abstraction and ensuring maximum hours. The committee also noted that investment in the recruitment pipeline is helping to ensure the Trust is at least meeting, in overall terms, the numbers planned as part of the demand and capacity review. However, there is significant shortfall of PAP hours, against the same plan, hence the shortfall in hours booked on. The committee challenged the executive to be clearer with its expectations on when it reasonably believes we are likely to meet the ARP targets. It asked for a trajectory so that it and the Board understands what it can expect, and it can then hold management to account for the same. The committee also asked for this so the Board could be clear with commissioners. It was told that there is a workshop being held with Deloitte / ORH to re run the model with more accurate assumptions and current ARP data. This will determine the trajectory. There was then a detailed discussion about the gap in hours, which the committee acknowledged was complex and multi-factorial; it asked the executive to provide a clear story that narrates this and draws the link between workforce and performance. In summary, the committee is assured that the executive has identified all the major issues to be tackled to achieve sustained performance. It recognised that the next six months will be difficult, but felt that management is doing all it we can to ensure timely response to patients. A clear communication plan is required to ensure key stakeholders understand the issues and what we are doing to address them, and to ensure expectations are managed.

	111/CAS **Partial Assurance** An update was provided on the progress with finalising the prime and sub-contracts. The committee sought assurance that the key risks are being mitigated as far as reasonably practicable. No specific concerns were escalated by the executive at this stage. In terms of mobilisation the committee asked for a paper that sets out the plan / timetable and the governance arrangements. **EU Exit** **Assured** The committee noted the plans to prepare for EU Exit (which at the time of the meeting was scheduled for 31 October 2019, and explored the principal risks. The committee was assured that the Trust was as well prepared as it could be in what is a very difficult and high risk situation. **Finance** **Partial Assurance** At month 6 we are still on plan. However, the committee is aware that the end of year position relies on discussions with commissioners about the income shortfall. In meantime, management is ensuring there is grip on the internal efficiencies. In terms of the cost improvement programme (**CIP)** while the committee noted that we are on track for delivery against the target at M6 much of this is non-recurrent. A different approach is needed for 2020/21 to ensure more transformational change.
Any other matters the Committee wishes to escalate to the Board	The committee reviewed the current assumptions underpinning the **Financial Long Term Plan**, which was received by the Board at its meeting on 31 October 2019. As confirmed then the committee explored the CIP assumptions and the significant challenge this will be. The **Fleet Strategy Implementation Plan** was not received as planned, due to other priorities, including planning for EU Exit. The plan is to bring this to the meeting on 14 November.

I6 SECAMB Board

Finance and Investment Committee Escalation report to the Board

Date of meetings	14 November 2019
Overview of key issues/areas covered at the meeting:	This meeting focussed on three areas: **Fleet Strategy Implementation Plan** **Partial Assurance** A high level update was given outlining the approach to the fleet strategy implementation plan. This will be informed by Deloitte / ORH workshop in December 2019, which will determine the final plan. In the context of the assumptions in the demand and capacity review, the committee tested the extent to which they are being met, and confirmed that the Trust is ahead of schedule; there have been over 100 new fleet added in the past 12 months. However, despite having the number of vehicles they are not always in the right place and so operations is looking at how to better utilise the fleet. The committee noted that while it has previously commended management for being data-led, it was not sure confident this is the case when it comes to vehicle utilisation. It acknowledged the plans to remedy this, with the new fleet system helping to ensure data informs decision-making and planning. The aim is that this will be in place by January 2020, The committee is confident that we are moving forward and will review the plan at its next meeting. **EPCR** **Assured** An update was received on the current position, with the plan to have full roll out by the end of November being on track. The KPI is that by the end of 2019/20 60% of EPCR forms will be used; at the meeting the figure was 62.6%, so well ahead of plan. Phase 2 of the project will focus on the use of EPCR from the perspective of quality. **111/CAS** **Assured** As agreed by the Board on 31 October, the committee sought assurance on the main areas, such as IT, deliverability, contract conditions, finance, and the risk and contingency planning. It was assured that there has been considerable review of the contract and was confident that the Trust is now in a position to sign the contracts, subject to the Chairman having sight of the legal report that will follow.
Any other matters the Committee wishes to escalate to the Board	None.

I7 SECAMB Board

QPS Committee Escalation report to the Board

Date of meetings	09 September 2019
Overview of key issues/areas covered at the meeting:	This meeting considered a number of ***Management Responses*** (*response to previous items scrutinised by the committee)*, including: **CFRs Partially Assured** A paper was received in May, which addressed concerns of the committee about how we are approaching CFRs who are not compliant with specific requirements, such as training. The committee acknowledged that this has caused some confusion and ill-feeling, but was assured that a proper process had been followed. The committee also tested the mechanisms in place to ensure timely and effective communication with CFRs; for example, how we get important messages through if an urgent issue arises. Management confirmed some of the things in place, which includes having a database for every CFR; email addresses; and meetings led by the head of community engagement. The Chief Pharmacist also confirmed that with regards medicines, we can now link pouches to individuals. However, the committee had continuing concerns about some aspects of communication and so asked for further assurance. The response did not fully assure the committee that the measures in place ensure that all urgent messages get through in a timely way. Further assurance will be requested in due course. **Key Skills Delivery Not Assured** In June the committee supported the plan to phase Key Skills differently, and asked management to provide assurance that it would be delivered by March 2020. The paper received in July did not assure the committee that there are robust plans in place and so it asked management to set out the current positon, and evidence that there is a plan by OU to ensure delivery by March 2020. It also asked for a review of the risks, including how the risk of abstraction will be mitigated in the likely event that the performance challenge will continue through the year, compounded by the EU Exit. The committee agreed that there is a significant risk to delivering all three days of Key Skills by March 2020 and, in the event of this risk materialising, supported a plan to extend this in to 2021, noting the provision required when planning the Key Skills programme for 2020/21. A paper has been requested for the October meeting to set out an assessment of what training is at greatest risk and the consequences of any delay. The committee also asked the finance and investment committee to review the extraction rate as the Trust appears to require a greater number than it is commissioned for. The meeting also considered a number of ***Scrutiny Items*** *(where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas),* including;

EOC Clinical Safety **Partially Assured**
This has been a standing agenda items for several months now and this latest update demonstrated a good understanding of where there continue to be challenges; specifically the committee received much comfort by the governance oversight and grip that is in place.

One of the continuing challenges are with welfare calls and clinical reviews, and while some improvement was noted the committee will continue to monitor this to ensure it continues.

Private Ambulance Providers **Assured**
This paper provided a summary of the current Trust governance mechanisms and oversight of Private Ambulance Providers contracted to undertake work on behalf of the Trust, including their levels of compliance.

The committee remains assured, but asked for a paper to come back to a future meeting to confirm where there is third party assurance. It also asked the finance and investment committee to review the related supply chain risks, in light of what has happened with SSG.

Medical Equipment **Partially Assured**
In February, the committee asked specific questions which were addressed by this paper and reviewed against the Improvement Action Plan. The committee noted that the issues re leadership and stability of the team, and some posts are still covered on an interim basis, and that a business case is to be developed to ensure more robust grip and control. The committee was therefore partially assured by the good progress being made.

Complaints **Partially Assured**
The committee received a good report, which helped focus the discussion on the quality of complaints management. The current backlog of complaints was the primary reason only partial assurance was noted. A management response will be considered next time to confirm when the backlog will be reduced.

Dispatch Safety Model **Assured**
The committee reviewed the changes to the dispatch arrangements should certain risks materialise following the UK's exit from the EU. It was assured by the rationale, and the balance of risk that has been considered.

The committee also received two *Enabling Strategies*:

Infection Prevention and Control Strategy
The committee reviewed this enabling strategy, and provided some specific feedback, such as being clearer about the improvement plan and the objectives, and making the strategic themes more holistic. Subject to these changes the committee recommends this strategy to the Board (agenda item 60-19).

	Volunteer Strategy The committee acknowledged that volunteers are a core part of the Trust's workforce. It provided feedback on how to be clearer in the strategy, especially as it set out as much a plan than a strategy. Specifically, the committee noted that it needs to set out how CFRs will be able to raise issues, as they might arise, and how to recognise CFR team members that aren't CFRs. Overall, it was agreed that the strategy needs to be brought together more. The aim will be to bring to the Board in November 2019. The committee also received a number of reports under its section on *Monitoring Performance*: **Accountable Officer for Controlled Drugs** This annual report was well received by the committee. It reflected the good work with medicines management, as reflected by the CQC following its recent inspection. The committee specifically noted the improvement in breakages, which has been an issue for the Trust in the past. **Safeguarding Annual Report** The committee reviewed this annual report which is also on the Board agenda (item 61-19), and acknowledged the positive progress in this important area. **Quality and Safety Report** This temporary report which is considered at each meeting until the new IPR is introduced. There was nothing specific to escalate this month and the committee will receive an update in October, on progress with the learning from deaths policy now the national guidance has been provided. The policy will come to the Trust Board in November.
Any other matters the Committee wishes to escalate to the Board	**CFR Administration of Salbutamol** The committee considered this as delegated to it by the Board at its meeting in August. There was a detailed discussion about the pros, cons, risks and benefits and the committee unanimously supported the re-introduction of the use of Salbutamol for CFRs and Co-Responders. It concluded that with the plan to only use this drug for patients who are already prescribed it and with the strong governance arrangements in place, the benefit outweighs the risks. It asked that there be a review after 6 months. **Complaints / Incidents Trends** At its meeting in July the committee received a thematic review of serious incidents. In the context of the challenges to ensure adequate resource/hours at specific times of the day/week, it hypothesised that there would be a correlation to the times of the day/week that lead to complaints and incidents. The committee therefore asked management to test this hypothesis, and to set out from the data the categories of complaints/incidents. It came as some surprise that this is not supported by the data, as there are no specific spikes at evenings or weekends. The committee will continue to monitor any trends.

I8 SECAMB Board

QPS Committee Escalation report to the Board

Date of meetings	24 October 2019
Overview of key issues/areas covered at the meeting:	This meeting was Chaired by Laurie McMahon, as Tricia McGregor was not able to join the meeting in person; instead taking part by teleconference. This meeting considered a number of ***Management Responses*** (*response to previous items scrutinised by the committee)*, including: **CAS Alerts Assured** The committee was assured by the process in place to manage alerts; specifically those that come through out of hours. On an annual basis the committee will ask for an assurance statement, with evidence that the process is working effectively. **SI Investigations Partial Assurance** This related to the extent to which there is timely closure/actions from the learning identified from SIs. Partial assurance was obtained on the basis of the relatively new process in place. However, the committee remains concerned by the high number of actions still open; some are very old, and so has asked for a further management response to confirm progress. The committee acknowledged the context to this where it has been difficult to unpick historical practice and in obtaining the evidence to enable closure of some of the SIs that pre-dated many of the current staff. It therefore supported management to take a pragmatic view on some of these actions, especially those several years old. **Key Skills Delivery Not Assured** The paper received by the committee helped to quantify the risk by OU, of delivering all of Key Skills. There is greater confidence in some areas compared with others, with the view of management being that, subject to some risks, the majority of OUs should be able to deliver by April 2020; two specific OUs were assessed as requiring 4-5 weeks longer. The committee received comfort by the way management is prioritising specific elements of training. For example, the medical director explained that some elements that are more safety-related, such as resuscitation, are prioritised over some of the other elements more quality-related, where the focus is on reinforcing existing practice. This is in the context of needing to continually balance the need for abstracting staff at a time when there are operational performance challenges. The planning for 2020/21 Key Skills will be reviewed by the committee in January 2020, to help ensure there is careful planning for abstraction, acknowledging the balance of risk between abstracting for training and ensuring maximum hours to ensure operational performance/quality.

	Overall, and in the context of the existing risks and the unknown (EU Exit) the committee could not be assured that Key Skills will be delivered. However, it was assured by the way management is seeking to prioritise. **Operating Model (right staff at right time) Assured** The committee explored how management uses data to allocate the resources to best effect. It was impressed by the way operations uses the rich data that is available. It noted the balance between offering flexible working in a way that meets needs of patients, and supported the ongoing policy work to ensure the right balance is struck. **Agile Working Assured** The committee received assurance that following agile (home/remote) working for clinicians, no adverse clinical safety incidents have been reported as a result. It acknowledged that workforce committee is reviewing this from a HR perspective, and that this type of agile working has been in place for some time in 111. The committee is assured it is working as intended and that there are no issues. **EOC Complaints Partial Assurance** There is still a significant backlog of complaints. While it was reassuring to hear that more resource has been secured to deal the backlog, with a clear timeline, the committee could not be assured until the targets are back on track. The meeting also considered a number of ***Scrutiny Items*** *(where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas),* including; **EOC Clinical Safety Partial Assurance** The focus this meeting was on clinical recruitment and welfare check compliance. In terms of clinical capacity, the Trust remains fully compliant with the NHS Pathways license. However, in relation to quality, to help close the gap while recruitment continues there is use of BANK and agency. Going forward the committee has asked for a breakdown of actual clinical hours versus the target / what is planned. The committee is currently unable to confirm it assurance in relation to welfare calls due to the way the data is captured. It has therefore asked for a management response to show a timeline to develop this data so that it is clearer whether we are complying with the requirements. EOC has been a standing agenda item now for several months and this latest update helped to demonstrate the good level of understanding that exists about where there continue to be challenges. Specifically, the committee received much comfort by the governance and management oversight and grip that is in place. One of the continuing challenges is with welfare calls and clinical reviews, and while some improvement was noted the committee will continue to monitor this to ensure it continues.

Frequent Callers Assured
The number of frequent callers is increasing and the individual risk assessments help to ensure we can prioritise the individuals we need to develop plans for. The committee is assured that all plans are in place for all frequent callers that have been identified as needing one. It noted that a new strategy is being developed and it will review progress in six months' time.

Patient Records / EPCR Assured
In the context of the false start with EPCR in 2016/17, the committee is really pleased to be assured by the good progress being made with implementing EPCR; over 50% of patient care records are now electronic.

QIA (mid-year review) Partial Assurance
An update was received on the now well-established QIA process; from April to September 2019 352 QIAs have been completed.

The committee could not be fully assured as the paper omitted to include the number of changes not initially approved and/or rejected, on the basis of the assessed impact on quality. This is being provided at the next meeting.

In addition, while the process is well-embedded, there are still occasions where management identify changes that have been made without a QIA. When identified these are done retrospectively, and the committee has asked for a management response on this, to confirm the action being taken to ensure all staff are aware of the requirement.

The committee also received a number of reports under its section on *Monitoring Performance*, including:

Clinical Audit Review
The committee noted that the audit programme is on track, although there was some discussion about developing the "so what"– how it is making a difference to patients.

Quality Account
The Q1 update confirmed that progress against the priorities are on track to deliver. The committee was assured that the priority on cardiac arrest is not affected by the issue with key skills, as it is one of the areas prioritised.

For the next update the committee has asked management to demonstrate more clearly the impact of the actions being taken.

Learning from Deaths Policy
The committee acknowledged that this policy follows a national template. It was supportive and recommends it to the Board for approval.

The committee explored the issue of 'responsible NED' and felt that this probably ought to be a member of the committee, if not the Chair, on the basis that it is about assuring delivery, which is the role of the committee. It will regularly test the compliance and effectiveness of the policy.

Any other matters the Committee wishes to escalate to the Board	During Q4 the TOR will come to the Board, along with the other board committees, but in the meantime the committee is planning to move from 6 weekly to bi-monthly meetings, to align with the frequency of the other main board committees.

South East Coast Ambulance Service NHS Foundation Trust

Finance and Investment Committee ('FIC')

J1 Terms of Reference

1. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Finance and Investment Committee ('FIC') referred to in this document as 'the committee'.

2. Purpose

The purpose of the committee is to acquire and scrutinise assurances that the Trust's system of internal controls relating to finance, corporate services and investments in future operational capability, are designed appropriately and operating effectively.

3. Membership

Appointed by the Board, the membership of the committee shall constitute three independent Non-Executive Directors and three Executive Directors. Executive Directors shall number no more than the Non-Executive Directors.

The members of the committee shall be:
Michael Whitehouse, Independent Non-Executive Director (Chair)
Angela Smith, Independent Non-Executive Director
Adrian Twinning, Independent Non-Executive Director
Lucy Bloem, Independent Non-Executive Director
Executive Director of Finance & Corp. Services (Executive Lead)
Executive Director of Strategy & Business Development
Executive Medical Director

4. Quorum

The quorum necessary for formal transaction of business by the committee shall be two Independent Non-Executive Director members and one Executive Director.

5. Attendance

5.1. In addition to the members, the following individuals shall regularly attend meetings of the Committee:

- Company Secretary
- Deputy Director of Finance
- A senior manager from operations

5.2. At the request of a committee member, other directors, Trust leads, managers and subject matter experts shall be invited to attend or observe full meetings or specific agenda items when issues relevant to their area of responsibility are to be scrutinised.

5.3. With the agreement of the chair, members of the committee or other Trust managers and officers may participate in a meeting of the committee by means of a tele/video conference. In such instances, it is a requirement that all persons

participating in the meeting can hear each other. Participation in the meeting in this manner shall be deemed to constitute the presence in person at such a meeting. A member of the committee joining the meeting in this way shall count towards the quorum.

6. Frequency
The committee shall meet at least six times a year and extraordinary meetings may be called by the committee chair in addition to discuss and resolve any critical issues arising.

7. Authority
The committee has no executive powers. The committee is authorised to seek and scrutinise assurances that Trust's the system of internal control is designed well and operating effectively. The committee will seek assurance (i.e. the elimination of reasonable doubt) from sources and systems including the front line operations, corporate services and from external independent sources such as peer review; internal audit, local counter fraud service, external audit and others, including legal or other professional advice when required.

8. Purview
The purview of the committee is set out in the accompanying purview document, which is approved by the Board along with these Terms of Reference**.** The committee will prioritise the acquisition and scrutiny of assurances according to the Board's requirements, using a risk based approach to prioritisation. The committee will not review all aspects of the system of internal control identified in the purview in every year.

9. Support
Under the guidance of the Company Secretary and, in conjunction with the committee chair and executive lead, the Business Support Manager will provide secretarial support to the committee, including planning meetings twelve months in advance, setting agendas, collating and circulating papers five working days before meetings; taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

10. Reporting
The committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure.

11. Review
The committee shall reflect upon the effectiveness of its meeting at the end of each meeting. The committee shall review its Terms of Reference at least once a year to ensure that they fit with the Board's overall review of the system of internal control. Any proposed changes shall be submitted to the Board for ratification.

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0	21 July 16	26 July 16	Committee established July 16 based on principles set out in Board paper 'governance improvements' at May 16. FBDC dis-established June 16. Discussed at Board June 16. Ratified 26 July 16.
1.1	19 October 17	23 October 17	Update to membership Inclusion of additional regular attendees Administrative support provided by the HR Business Support Manager; from the corporate governance dept.
1.2		25 May 2018	Update to membership
2.1			Update to membership Increased frequency for 4 to 6 meetings

South East Coast Ambulance Service NHS Foundation Trust

Audit & Risk Committee (AuC)

J2 Terms of Reference

1. Constitution

1.1. The Board hereby resolves to establish a Committee of the Board to be known as the Audit & Risk Committee (AuC), referred to in this document as 'The Committee'.

2. Purpose

2.1. The purpose of the Committee is to provide the Trust with a means of independent and objective review of internal control over the following key areas:

- Financial systems
- The information used by the Trust
- Assurance Framework systems
- Performance and Risk Management systems
- Compliance with law, guidance and codes of conduct

2.2. In undertaking such review, the Committee provides assurance to the Chief Executive and to the Board about fulfilment of the responsibility of the Trust's Accounting Officer, who under the terms of the National Health Service Act 2006 is held responsible to Parliament by the Public Accounts Committee for the overall stewardship of the organisation and the use of its resources.

3. Membership

3.1. The Committee shall have not less than three members, appointed by the Board from amongst the independent Non-Executive Directors of the Trust. The Chairman of the Trust shall not be a member. One of the members having recent and relevant financial experience shall be appointed Chair of the Committee by the Board.

3.2. **Current members:**

- Angela Smith, Independent Non-Executive Director (Chair)
- Michael Whitehouse, Independent Non-Executive Director
- Al Rymer, Independent Non-Executive Director
- Tricia McGregor, Independent Non-Executive Director
- Terry Parkin, Independent Non-Executive Director

In addition, each Independent Non-Executive Director (save the Chairman) will be an ex-officio member of the committee.

4. Quorum

4.1. The quorum necessary for formal transaction of business by the Committee shall be two Independent Non-Executive Directors.

5. Attendance

5.1. In addition to the members, the following individuals shall regularly attend meetings of the Committee:

- Chief Executive
- Executive Director of Finance & Corporate Services
- Executive Director of Nursing & Quality
- Company Secretary
- Internal Auditor
- External Auditor
- Counter Fraud

5.2. The Chairman and organisational managers and officers may be invited to attend meetings for specific agenda items or when issues relevant to their area of responsibility are to be discussed.

5.3. Officers unable to attend a meeting are required to send a fully briefed deputy or provide a written update to the Committee members at least two working days beforehand.

5.4. The Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should non-attendance jeopardise the functioning of the Committee the Chair will discuss the matter with the members and if necessary seek a substitute or replacement.

5.5. Attendance at Committee meetings will be disclosed in the Trust's Annual Report and Accounts.

6. Frequency

6.1. The frequency of meetings will be agreed at the start of each financial year, ensuring the committee meets at least four times a year. Extraordinary meetings may be called by the committee chair in addition to those agreed, to discuss and resolve any critical issues arising.

6.2. At least once a year the Committee shall meet privately with the External and Internal Auditors. The External Auditor or the Internal Auditor may request a private meeting if they consider this to be necessary.

6.3. Meeting dates will be diarised on a yearly basis.

7. Telephone Conference

7.1. With leave of the Chair of the Committee, any member or attendee of the Committee may participate in a meeting of the Committee by means of a teleconference/videoconference where circumstances require it or similar communications equipment whereby all persons participating in the meeting can hear each other and participation in the meeting in this manner shall be deemed to constitute presence in person at such meeting.

8. Authority

8.1. The Committee has no executive powers. It is authorised to seek and scrutinise assurances that Trust's the system of internal control is designed well and operating effectively. The committee will seek assurance from sources and systems including the front line operations, corporate services and from external independent sources such as peer review; internal audit, local counter fraud service, external audit and others, including legal or other professional advice when required.

8.2. The Committee is authorised by the Board to investigate any action within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

8.3. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers necessary. It may challenge the reports and duties of other Committees to ensure due and robust business processes are in place.

9. Duties

9.1. The subject matter for meetings will be wide-ranging and varied but in particular it will cover the following:

9.2. Governance, Risk Management and Internal Control

9.2.1. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives.

9.2.2. In carrying out this work, the Committee shall primarily utilise the work of Internal Audit, External Audit and other assurance functions, but shall not be limited to these audit functions. It may seek reports and assurances from directors and managers as appropriate. The Committee may also take assurances from work undertaken by other established committees of the Trust Board.

9.2.3. Reviews by the Committee shall concentrate on the overarching systems of integrated governance, risk management and internal control, together with

indicators of their effectiveness. This shall be evidenced through the Committee's use of an effective Assurance Framework to guide its work and the work of the audit and assurance functions that report to it. In particular, the Committee shall review the adequacy of:

i. All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, External Auditor's opinion or other appropriate independent assurances, prior to endorsement by the Board;

ii. The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks (including through review of the Risk Register and Board Assurance Framework) and the appropriateness of the above disclosure statements;

iii. The processes for ensuring compliance with relevant regulatory, legal and code of conduct requirements;

iv. The policies and procedures for all work related to fraud, corruption and security management as set out in the NHS Standard Contract which requires providers to put in place appropriate arrangements for counter fraud and as required by NHS Protect;

v. The Trust's whistleblowing policy(s) so test that arrangements are in place for proportionate and appropriate investigation;

vi. The Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation.

9.3. Internal Audit

9.3.1. The Committee shall ensure that there is an effective Internal Audit function established by management that meets mandatory Public Sector Internal Audit standards and provides appropriate independent assurance to the Committee, Chief Executive and Board. This shall be achieved by:

vii. Consideration of the provision of the Internal Audit service, the cost of the service and any questions of resignation and dismissal;

viii. Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Assurance Framework;

ix. Consideration of the major findings of Internal Audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources;

x. Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

xi. Annual review of the effectiveness of Internal Audit.

9.4. External Audit

9.4.1. The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This shall be achieved by:

xii. Consideration of the appointment and performance of the External Auditor in so far as compliance with governance codes permits;

xiii. Making a recommendation to the Council of Governors on the appointment, reappointment or removal of the External Auditor; and if the Council of Governors does not accept the Committee's recommendation, ensuring that the Board includes in the annual report a statement from the Committee explaining its recommendation and setting out reasons why the position of the Council of Governors was different;

xiv. Discussion and agreement with the External Auditor, before audits commence, about the nature and scope of the audit ensuring coordination, as appropriate, with other External Auditors in the local health economy;

xv. Discussion with the External Auditor concerning assessment of the Trust with regard to locally evaluated risks, and the associated impact on the audit fee;

xvi. Reviewing all External Audit reports, including agreement of the ISA 260 before submission to the Trust Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

9.5. Financial Reporting

9.5.1. The Committee shall ensure that systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

9.5.2. The Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

xvii. The wording of the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;

xviii. Changes in, and compliance with, accounting policies and practices;

xix. Unadjusted mis-statements in the Financial Statements;

xx. Major judgemental areas;

xxi. Significant adjustments resulting from audit.

9.6. Other Assurance Functions

9.6.1. The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider any implications for the governance of the organisation.

9.6.2. These shall include, but shall not be limited to, consideration of any reviews by Department of Health arms length bodies, regulators or inspectors (e.g. NHSI, Care Quality Commission, NHS Resolution etc.), or professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

9.6.3. In addition, the Committee shall review the output of other committees established by the Board, whose work can provide relevant assurance to the Committee's own scope of work.

10. Reporting

10.1. The Committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure.

11. Support

11.1. Under the guidance of the Company Secretary and, in conjunction with the committee chair and executive lead, the Business Support Manager will provide secretarial support to the committee, including planning meetings twelve months in advance, setting agendas, collating and circulating papers five working days before meetings; taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

12. Review

12.1. The Committee will undertake a self-assessment at the end of each meeting to review its effectiveness in discharging its responsibilities as set out in these Terms of Reference.

12.2. The Committee shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. Any proposed changes shall be submitted to the Board for approval.

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0		March 2016	
1.1		May 2018	1. Amend to Audit and Risk 2. Included members 3. Amended attendees 4. Quorum from 3 to 2 NEDs to reflect other committees. 5. Authority section to be consistent with other committees 6. Amended the admin support arrangements 7. Included review from every 2 years to annually to be consistent with other committees
2.1			Updated membership and revised wording on frequency.

	Lead	13 May 2019	18 June 2019	8 August 2019	17 October 2019	14 November 2019	16 January 2020	19 March 2020
ADMINISTRATION								
Apologies	Chair	√	√	√	√	√	√	√
Declarations of Interests	Chair	√	√	√	√	√	√	√
Minutes	Chair	√	√	√	√	√	√	√
Action Log	Chair	√	√	√	√	√	√	√
Meeting Effectiveness	Chair	√	√	√	√	√	√	√
SCRUTINY								
999 Transformation & Delivery / Operational Performance*	Exec Director of Operations	√	√	√	√	√	√	√
Financial Results / Forecast	Exec Director of Finance	√**Q4**		√**Q1**	√**Q2**		√**Q3**	
Financial Planning 2020/21	Exec Director of Finance						√	√
Capital Programme 19/20	Exec Director of Finance	√			√			
Reference Costs	Exec Director of Finance				√			
ERIC Return (Estates)	Exec Director of Finance							
Financial Viabilty of SSG (PAP) - from QPS Feb 185/19	Exec Director of Operations	√						
Cost Improvement Programme / Overview of Schemes	Exec Director of Finance		√		√			
Projects Deep Dive TBC	TBC		√	√	√	√	√	√
Procurment (compliance with legislation)	Executive Director of Finance			√		√		
Management of Sub Contractors TBC	TBC					√		√
Fleet Servicing	Executive Director of Operations				√			
IT - staffing resilience	Executive Director of Finance					√		
Monitoring Performance								
IT Dashboard/KPIs	Exec Director of Finance	√			√			√
Estates Dashboard/KPIs	Exec Director of Finance	√			√			√
Business Cases								
Business Case Schedule / Tracker	Exec Director of Finance		√		√			√
Business Cases TBC	TBC							
Return on Investment / Benefits Realisation	TBC							
Strategies								
Fleet Strategy	Exec Director of Operations	√						
Estates Strategy	Exec Director of Finance							√
Digital / ICT Strategy	Exec Director of Finance				√		√	
Partnership and Commercial Strategy	Exec Director of Strategy							
Treasury Policy	Exec Director of Finance				√			
Governance & Risk								
BAF Risks	Company Secretary		√	√		√	√	
Annual Review of Risk Register (linked to purview)	company Secretary			√				
Committee Annual Self-Assessment	Company Secretary		√					
Cycle of Business	Company Secretary	√						
Terms of Reference	Company Secretary	√						

*This standing item focusses on use of resources (investment) and assurance that the Trust's delivers the expectations set out in the demand and capacity review

AUC	Lead	20 May 2019	11 July 2019	19 Sep 2019	12 Dec 2019	12 March 2020	Private Meeting with External Auditor
ADMINISTRATION							
Apologies	Chair	√	√	√	√	√	
Declarations of Interests	Chair	√	√	√	√	√	
Minutes	Chair	√	√	√	√	√	
Action Log	Chair	√	√	√	√	√	
Next Meeting Agenda / Forward Look	Chair	√	√	√	√	√	
Meeting Effectiveness	Chair	√	√	√	√	√	
FINANCIAL STATEMENTS & THE ANNUAL REPORT							
Annual Report & Accounts -External Audit Report -ISA260 Report (Audit Hilights Memo) -Management Representations Letter on the financial statements -Management Representations Letter on the quality report	Exec Director of Finance KPMG	√				√Draft see action 06 19 May 19	
Annual Governance Statement	Company Secretary	√				√Draft	
Accounting Policies	Exec Director of Finance			√			
Accounting and Reporting Systems	Exec Director of Finance						
Financial statements - integrity / judgments	Exec Director of Finance				√		
Losses and Special Payments [incl. baseline numbers / % as per action 164-19 04.03.2019]	Exec Director of Finance					√	
INTERNAL AUDIT							
Counter Fraud Progress Report	RSM		√	√		√	
Counter Fraud Work Plan	RSM					√	
Counter Fraud Annual Report incl. SRT	RSM					√	
Internal Audit Progress Report	RSM		√	√	√	√	
Internal Audit Annual Plan	RSM	√				√	
Annual Report to include Internal Audit Opinion	RSM	√				√Draft	
Private meeting of committee to review annual report with IA	RSM	√					
EXTERNAL AUDIT							
External Audit Finding Report	KPMG	√					
Report to Governors on Quality Report	KPMG	√					
Limited Assutance opinion on Qualiry Report Indicators	KPMG	√					
Progress Report / Technical Update	KPMG					√	
Audit Plan	KPMG				√		
GOVERNANCE & RISK MANAGEMENT							
Plan for the production of the Annual Report & Accounts (from 20.05.2019)	Chief Executive				√		
Business Continiuty	Exec Director of Operations		√				
Data Quality	Exec Director of Strategy				√		
Whistleblowing	Exec Director of Nursing			√			
Decl. of Interests	Company Secretary			via IA report			
Policy Review	TBC		√		√	√	
Board Assurance Framework Review	Company Secretary		√			√	
Risk Review, incl. BAF Risk Report	Executive Director of Nursing / Company Secretary		√	√	√	√	
Risk Management System / effectivess of the policy and procedure	Exec Director of Nursing			√		√	
Annual Review of SO's/SFI's	Exec Director of Finance		√			√	
Annual Self Certification GC6/COS 7	Company Secretary	√					
Corporate Governance Statement	Company Secretary	√				√Draft	
Integrated Performance Report Annual Review	Exec Director of Strategy		√				
Information Governance (incl. *Annual Report)	Exec Director of Nursing	√*	√*		√		
Annual Review of Cycle of Business	Company Secretary	√					
Annual Self-Assessment	Company Secretary		√				
Review of Terms of Reference	Company Secretary						
Review Purview / TOR of other Board Committees	Company Secretary					√	
MANAGEMENT RESPONSE							
Fleet IA - Driving License Checks (from 20.05.2019 action 12 19)	Exec Director of Operations				√		

KPMG

Independent auditor's report

to the Council of Governors of South East Coast Ambulance Service NHS Foundation Trust

. REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of South East Coast Ambulance Service NHS Foundation Trust ("the Trust") for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note one.

In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of its income and expenditure for the year then ended; and

— the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2019 and the Department of Health and Social Care Group Accounting Manual 2019.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview	
Materiality: financial statements as a whole	£4.4m (2017/18: £4.5m) 2% (2017/18: 2%) of revenue

Risks of material misstatement		vs 2018
Recurring risks	Recognition of NHS Income	◀▶
	New: Recognition of Expenditure	▲
	Valuation of Land and Buildings	◀▶

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. We summarise below, the key audit matters in decreasing order of audit significance, in arriving at our audit opinion above together with our key audit procedures to address those matters and our findings from those procedures in order that the Trust's governors as a body may better understand the process by which we arrived at our audit opinion . These matters were addressed, and our findings are based on procedures undertaken, in the context of, and solely for the purpose of, our audit of the financial statements as a whole, and in forming our opinion thereon , and consequently are incidental to that opinion, and we do not provide a separate opinion on these matters.

	The risk	Our response
Recognition of NHS Income (Patient Care Activities: £218.7 million; 2018: £206.9m Provider Sustainability Funding and Education and Training: £5.3m; 2018: £7.2m) *Refer to page 11 (Audit Committee Report), page 15 (accounting policy) and page 26 (financial disclosures)*	**Effects of Irregularities** Professional standards require us to make a rebuttable presumption that the fraud risk from revenue recognition is a significant risk. We recognise that the incentives in the NHS differ significantly to those in the private sector which have driven the requirement to make a rebuttable presumption that this is a significant risk. These incentives in the NHS include the requirement to meet regulatory and financial covenants, rather than broader share based management concerns. The estimation risk arises where the receipt of the full income amount is dependent on the achievement of KPIs at year end, and on potential additional funding through achieving forecast budgets.	Our procedures included: — **Tests of Detail:** — We confirmed the proportion of Revenue from Patient Care Activities which relates to the NHS (£218.7m) and Sustainability and Transformation Fund (£4.4m); — We reviewed contracts with commissioners and confirmed that all contracts have been agreed and signed for 2018/19 and that income received during the year was in line with contracted values; — We examined the terms of the additional funding agreed with commissioners as part of the Demand and Capacity Review and the impact this has on the value of income due to the Trust in 2018/19; — We confirmed that income has been recorded in the correct financial year for transactions recorded around 31 March 2019; — We inspected supporting documentation for variances over £300k arising from the Agreement of Balances exercise to critically assess the Trust's accounting for disputed income; and — We reviewed the Trust's calculation of its achievement of Provider Sustainability Funding (PSF) to verify that it was entitled to receive any funding recorded. **Our findings** We found the estimates used in calculating the income balances to be balanced. (2018: balanced)

2. Key audit matters: our assessment of risks of material misstatement (Contd)

	The risk	Our response
Valuation of land and buildings (£35.6 million; 2018: £35.3m) *Refer to page 9 (Audit Committee Report), page 17 (accounting policy) and page 35 (financial disclosures).*	**Subjective valuation** Land and buildings are required to be held at fair value. The Trust uses the Existing Use Valuation (i.e. the price achievable in an open market) method based on advice from its valuer, Montagu Evans, in 2016-17. There is a risk around the subjective nature of this valuation, considering the multiple operating locations used by SECAmb and the choice of indices used. The Trust completes full valuations every five years, within interim desktop exercises in some intervening years. The Trust is planning a revaluation this year. This is a significant risk due to the size of the balance, the judgement as to the level of specialism of the Trust's assets, market trends in the areas served by the Trust and how the Trust's assets are affected by these, and the level of expertise required to perform the valuation. The effect of these matters is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole. The Trust chose to perform a desktop valuation in-house, instead of outsourcing to an expert	We performed the following procedures: **Tests of Detail**: — We assessed the assumptions applied by management in developing the valuation for the Trust's land and buildings to assess their appropriateness; — We assessed the adequacy of the valuation index used by the Trust via comparison to market trends; — We assessed the process by which management selected its valuation index and appraised alternative options available to the Trust; — We considered the impairment assessment completed by management regarding the land and building assets; and **Our findings** The estimates used by the Trust in valuing the land and buildings are balanced (2018: balanced).

2. Key audit matters: our assessment of risks of material misstatement (Contd)

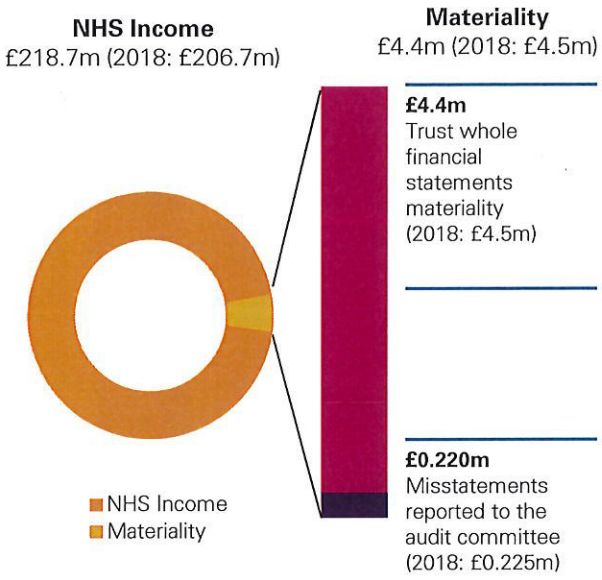
	The risk	Our response
Recognition of expenditure (Excluding payroll expenses, depreciation, amortisation, and impairment; £72.8 million; 2018: £72.7m) *Refer to page 13 (Audit Committee Report), page 16 (accounting policy) and page 27 (financial disclosures)*	**Effects of Irregularities** The amount of expenditure to recognise at year end is subjective, particularly in relation to estimating accruals. In the public sector, auditors also consider the risk that material misstatements due to fraudulent financial reporting may arise from the manipulation of expenditure recognition (for instance by deferring expenditure to a later period). This may arise due to the audited body manipulating expenditure to meet externally set targets. As most public bodies are net spending bodies, then the risk of material misstatement due to fraud related to expenditure recognition may in some cases be greater than the risk of material misstatements due to fraud related to revenue recognition and so the auditor has regard to this when planning and performing audit procedures.	**Our procedures included:** — **Test of details:** We tested expenditure transactions that spanned the financial year end to assess whether the expenditure had been recognised in the correct financial period; — **Test of details:** For a sample of accruals recognised at the financial yearend we assessed the appropriateness of the existence of the accrual and the reasonableness of the accrual valuation. — **Controls re-performance:** We tested the operation of budgetary controls throughout the year; — **Controls evaluation:** We assessed the application of appropriate segregation of duties between those responsible for monitoring budgets (e.g. General Managers) and those preparing the financial statements (Finance Team); **Our findings** The estimates used in making the year end accruals are balanced.

3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £4.4 million (2017/18: £4.5 million), determined with reference to a benchmark of revenue (of which it represents approximately 2%). We consider revenue to be more stable than a surplus- or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £220k million (2017/18: £225k), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was all performed at the Trust's headquarters in Gatwick.



4. We have nothing to report on going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

Our responsibility is to conclude on the appropriateness of the Accounting Officer's conclusions and, had there been a material uncertainty related to going concern, to make reference to that in this audit report. However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks to the Trust's business model, including the impact of Brexit, and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period. We evaluated those risks and concluded that they were not significant enough to require us to perform additional audit procedures.

Based on this work, we are required to report to you if we have anything material to add or draw attention to in relation to the Accounting Officers statement in Note 1 to the financial statements on the use of the going concern basis of accounting with no material uncertainties that may cast significant doubt over the Trust's use of that basis for a period of at least twelve months from the date of approval of the financial statements.

We have nothing to report in these respects, and we did not identify going concern as a key audit matter.

5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Corporate governance disclosures

We are required to report to you if:

— we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or

— the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or

— the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 174, the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

Our conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources is qualified

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

Qualified conclusion

Except for the matters outlined in the basis for qualified conclusion paragraph below we are satisfied that in all significant respects South East Coast Ambulance Service NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

Basis for qualified conclusion

In November 2018 the CQC published its inspection report of the Trust. This noted some significant improvements in performance. However, the Trust is still in special measures and continues to be classed as 'Requires improvement' by the CQC.

As a result of this inspection, we consider there to be a significant risk related to the Trust having proper arrangements for informed decision making.

We note that there have been improvements in the Trust's performance, and the Trust has made significant efforts to address the results of the inspection, including creating a demand and capacity review and 999 action plan, and demonstrating improvements in their governance arrangements. There have also been improvements in the Trust's staff survey results.

However, despite this, there are a number of areas where the Trust is not meeting performance standards:

- The Trust is not meeting the national 999 response targets (now known as Category 1, 2, 3 and 4);
- The Trust is not effectively monitoring and assessing the quality and safety of services, and the risks to those services;
- The Trust does not yet have fully embedded systems for identifying and mitigating risks.

Because of the issues outlined above we consider there are weaknesses in the Trust's arrangements for informed decision making.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources .

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out below together with the findings from the work we carried out on each area.

Significant Risk	Description	Work carried out and judgements
Informed decision making – Special Measures	In 2017/18 we issued an adverse value for money conclusion. This centred on continued regulatory action, poor performance against performance indicators, breaches in medicines management, medical devices, and hospital handover. There was a need to further embed improvements in governance. In November 2018, the CQC published its latest inspection. Whilst the Trust's rating has improved, the Trust remains in special measures and there are still significant concerns surrounding performance against national performance indicators, the embedding of cultural change and improved governance, and a breach of a legal requirement. In particular, this relates to understanding and using appropriate and reliable financial and performance information to support informed decision making and performance management.	Our work included: • **Action plans**: We inspected the Trust's action plans in response to the latest CQC inspection and assessed the evidence to support the progress made to date and the actions that the Trust still needs to embed; • **Correspondence with regulators**: We inspected correspondence between the Trust and both NHS Improvement and the CQC; and • **Response KPIs**: We inspected the Trust's action plan in relation to improving 999 response times and noted the progress made in the year to 31 March 2019 and the ongoing actions that the Trust is required to take. **Our findings:** The Trust has made progress towards embedding governance arrangements and developing action plans to address underperformance. However there are still issues with the Trust failing to meet national performance standards.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of South East Coast Ambulance Service NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Fleur Nieboer

for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants

15 Canada Square

London, E14 5GL

24 May 2019

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Council of Governors

L - Council of Governors' Self-Assessment 2019

1. Introduction

1.1. It is recommended that Councils of Governors undertake self-assessment of the Council's effectiveness annually. This enables the Council and the Trust to understand:

1.1.1. The Council's view of the effectiveness of the Council as a whole, and

1.1.2. The effectiveness of the processes to support the Council that have been put in place.

1.2. The last self-assessment was undertaken in mid 2018 and a further self-assessment is due and recommended.

1.3. A self-assessment enables Governors to hold the Trust to account for providing the support and structures Governors need to fulfil their role, and enables the Council to hold itself to account for being effective in its role.

2. Self-assessment process

2.1. The GDC worked with the Trust to design the self-assessment process and has met to review and refine it this year.

2.2. The process in previous years was as follows:

2.2.1. Constituency meetings held with the Chair;

2.2.2. Completion of an online survey (anonymous);

2.2.3. Survey sent to the Non-Executive Directors and CEO; and

2.2.4. Review and collation of all feedback with the GDC prior to sharing with the Council and Board.

2.3. The GDC considered that a similar process should be adopted this time, noting:

2.3.1. 12 out of 19 Governors responded to the online survey last time (down from 17 of 21 the previous year). This was disappointing and despite many reminders and fairly strong requests. However, it's not clear what better way there is to collate anonymous feedback and the GDC advised that they were keen that all Governors complete the survey.

2.3.2. Constituency meetings with the Chair have been set up in February-March 2020, however the self-assessment could be undertaken sooner if it was restricted to survey feedback. The benefit of this would be that those up for re-election in February would definitely be able to provide feedback. **Council are asked their view on this.**

2.3.3. Governors have not previously held a meeting to discuss the performance and effectiveness of the Council in the round. It may be that Governors wish to have e.g. a phone conference to this effect to collectively feed into the process. Alternatively, a group discussion at the next GDC could be fed in. **Council are asked their view on this.**

2.4. The survey used in previous years was long and based on a best practice example the provenance of which is lost in the mists of time. The GDC were clear that a more succinct survey may elicit more responses and the Lead Governor kindly canvassed opinion on changing the survey. The resulting suggested survey is attached as Appendix 1.

2.5. A 360 degree review survey for NEDs, CEO and Corporate Governance team members to complete will also be used, using similar questions.

3. Lead Governor assessment

3.1. This year, it is proposed that we introduce a mechanism for enabling feedback on the role of the Lead Governor and whether there are any improvements Governors would like to see to either the role/responsibilities or activities of the Lead Governor.

3.2. This would be a light-touch review that refrains from being too personal about the individual but could provide pointers and feedback to the Lead Governor and for future Lead Governors about what their fellow Governors want from the post-holder.

3.3. The questions will either be sent as part of the annual self-assessment or separately. **Council are asked for their view on this.**

3.4. The current Lead Governor has suggested the following areas could be explored in the assessment. **Council are asked for their view on these**:

3.4.1. Have the confidence of the CoG and the Board (360 appraisal)
3.4.2. Regular attendance and active participation at meetings, and participates in a range of opportunities to engage with the organisation (i.e. not just the x4 CoG formal meetings)
3.4.3. Effectively chairs and facilitates meetings
3.4.4. Fosters a collaborative approach, and pro-actively seeks CoG colleagues' views at all times
3.4.5. Works with the CoG team to enable the CoG to function as the most effective and cohesive team it can be in holding the NEDs to account for the performance of the Board
3.4.6. Takes positive steps to build the relationship between the Board and Governors.

4. Proposed timeline

Date	Activity

3 December 2019	Provide the Council with a paper setting out the GDC's proposal and draft survey etc for Council approval
December-January	Undertake self-assessment – unless Council wish to wait for meetings with the Chair
December-January	Circulate survey to NEDs and other stakeholders
30 January 2020	Close of assessment/feedback period
13 February 2020	Discuss findings and make recommendations at the GDC
5 March 2020	Final report to the Council

5. Recommendations

5.1. The Council is asked to:

5.1.1. Review the attached documents as recommended by the GDC and comment;

5.1.2. Comment on the methodology, and whether a Council discussion in some format would be useful as part of the process or only to discuss the results and any recommendations;

5.1.3. Comment on the proposed areas to cover in the Lead Governor assessment; and

5.1.4. Agree the process, content and timescales.

Izzy Allen, Assistant Company Secretary

Appendix 1: Council Annual Self-Assessment Survey

NB each question will have room for free text too.

	Assessment Criteria	Disagree	Not sure	Agree
1	I am clear about my role and responsibilities as a Governor.			
2	Administration support provided to the CoG is appropriate and effective.			
3	The number and constituencies of Governors on the CoG allow us to represent the interests of all stakeholders.			
4	I receive sufficient high-quality information about Trust activities to enable me to hold the NEDs to account.			
5	The CoG is well chaired and managed.			
6	The CoG has open, constructive discussions between its members, which focus on relevant issues.			
7	The Trust encourages open and honest communication between the CoG and the Board members.			
8	Council meetings focus on issues that are relevant to me.			

9	The level of participation of NEDs at Council meetings is appropriate.			
10	I am properly engaged in the strategic direction of the Trust.			
11	As a member of the CoG I feel a valued part of the organisation.			
12	I receive regular weekly information from the Trust, which is useful to understand the general business of the organisation			
13	By being part of the Council I feel I make a real contribution to SECAmb and the communities it serves			
14	The COG is informed of any issues that could cause public or media interest before they are a risk.			
15	The COG receives training or has issues explained that support understanding of topic.			
16	Is there anything else you would like to tell us about the effectiveness of the Council? (free text)			

Training and Development Needs		
Please let us know if you feel you would benefit from training/development in any of the following areas:		
1	Role and responsibilities of Governors	
2	NHS finances	
3	Holding to account	
4	Effective questioning	
5	Engaging with members	
6	Anything else? (free text)	

2020/21 Meeting dates for the Council of Governors

2020 Date	Meeting	Time	Venue
16-Jan	NomCom	2pm -4pm	McIndoe 3 Crawley HQ
30-Jan	Board	10am - 1pm	McIndoes Crawley HQ
12-Feb	IHAG	9.30am - 4pm	McIndoes Crawley HQ
13-Feb	GDC	2pm -4pm	McIndoe 3 Crawley HQ
17-Feb	MDC	10.30am - 3pm	McIndoe 1 Crawley HQ
05-Mar	Formal CoG	9.30am - 4pm	McIndoes Crawley HQ
26-Mar	Board	10am - 1pm	McIndoes Crawley HQ
09-Apr	Nom Com	2-4pm	McIndoe 3 Crawley HQ
14-Apr	GDC	2pm -4pm	McIndoes Crawley HQ
05-May	MDC	10.30am - 3pm	McIndoe 3 Crawley HQ
07-May	Joint CoG & Board workshop	10am- 1pm	McIndoes Crawley HQ
12-May	IHAG	tbc	tbc
28-May	Board	10am - 1pm	McIndoes Crawley HQ
04-Jun	Formal CoG	9.30am - 4pm	McIndoes Crawley HQ
23-Jun	GDC	2pm - 4pm	McIndoes Crawley HQ
23-Jul	NomCom	2pm-4pm	McIndoe 3 Crawley HQ
27-Jul	IHAG	tbc	tbc
30-Jul	Board	10am - 1pm	McIndoes Crawley HQ
20-Aug	GDC	2pm -4pm	McIndoes Crawley HQ
04-Sep	Formal CoG & AMM	9.30am - 4.30pm	TBC Kent
24-Sep	Board	10am - 1pm	McIndoes Crawley HQ
01-Oct	NomCom	2pm - 4pm	McIndoe 3 Crawley HQ
08-Oct	GDC	2pm - 4pm	McIndoes Crawley HQ
16-Oct	IHAG	tbc	tbc
03-Nov	MDC	10.30am-3pm	McIndoe 3 Crawley HQ
05-Nov	Joint CoG & Board workshop	10am-1pm	McIndoes Crawley HQ
26-Nov	Board	10am - 1pm	McIndoes Crawley HQ
01-Dec	Formal CoG	9.30am - 4pm	McIndoes Crawley HQ
15-Dec	IHAG/COG xmas event	10am-2pm	TBC

Key:

CoG Council of Governors – Governors should attend these meetings.

CoG & Board Joint Council & Board Workshop – Governors should attend these meetings.

Board Public Board meeting – Governors are welcome to observe

MDC Membership Development Committee – Governors should attend these meetings when possible

GDC Governor Development Committee – Governors should attend these meetings when possible

NomCom Nominations Committee – Governors stand for election to this committee.

SEF Staff Engagement Forum Dates to follow– Staff Governors should attend these meetings. Other Governors can request to observe*

IHAG Inclusion Hub Advisory Group- All Governors can request to attend these meetings*

*Please let Katie.Spendiff@secamb.nhs.uk know.

2021 Date	Meeting	Time	Venue
21-Jan	NomCom	2pm-4pm	McIndoe 3 Crawley HQ
25-Jan	IHAG	tbc	tbc
28-Jan	Board	10am - 1pm	McIndoes Crawley HQ
02-Feb	MDC	10.30-3pm	McIndoe 3 Crawley HQ
11-Feb	GDC	2pm -4pm	McIndoes Crawley HQ
04-Mar	Formal CoG	9.30am - 4pm	McIndoes Crawley HQ
25-Mar	Board	10am - 1pm	McIndoes Crawley HQ

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