SECAMB Board

Summary Report on the Audit & Risk Committee (AUC) Meeting of 12th December 2019

Date of meeting	**12th December 2019**
Overview of issues/areas covered at the meeting:	The key areas covered in this meeting were • Internal Audit Progress Report • Counter Fraud Report on Annualised Hours Contracts • External Audit plan for the year end 31 March 2020 • Plan for production of the Annual Report • Management Update on Driving License checks • Data Quality • Whistleblowing • Risk Management Review and Board Assurance framework Risk Report
Internal Audit Progress Report	AUC was pleased to note the Reasonable Assurance outcomes from the audits of • Properties – Capital & Maintenance • Staff Wellbeing, Culture and Freedom to Speak Up AUC was disappointed with the outcome of the Targeted Follow Up review (for example 7 out of 11 high priority actions remain outstanding) but pleased to see evident focus from the new Chief Executive to ensure more consistent and more timely execution of agreed audit actions in the future.
Counter Fraud **External Audit Plan** **Plan for production of the Annual Report** **Driving License Checks**	The Committee received a Counter Fraud Report on Annualised Hours Contracts which had been commissioned by the Executive. The committee was assured that the executive is aware of, and had made a comprehensive response to, the issues raised. WWC will oversee issues resolution in due course. The Committee received a proposed audit plan from KPMG in respect of the year to 31 March 2020. Following discussion, the Committee approved the plan The committee asked to see a draft of relevant parts of the annual report at its meeting in March 2020 to ensure that overall message(s) are appropriate and consistent The Committee noted early progress (around 15% of licenses checked in the first two weeks) and requested a further update in March 2020
Date Quality	The committee received a paper on the processes deployed to assure Data capture/quality. Following discussion, the committee was assured by evident management focus on data

	quality and robustness.
Whistleblowing	AUC received a paper setting out the routes available for internal whistleblowing. To date use of those routes has been limited. Following discussion, the Committee was assured by the range of routes available to raise issues.
Risk Management Review	The Committee received and, overall, was assured by the Risk Management Report; better calibration of scoring is being addressed through training. EU Exit risk management was discussed at some length. A proposal as to a broad/high level Risk Appetite will be brought to the Committee in March 2020
Board Assurance Risk Report	Whilst some concerns were raised concerning the low score for culture related risks, overall the Committee was assured by the report and happy to recommend it to the Board

SECAMB Board

Summary Report on the Charitable Funds Committee (CFC) Meeting of 9th July 2019

Date of meeting	**12 December 2019**
Overview of issues/areas covered at the meeting:	The key areas covered in this meeting related to Accounts and Governance
Governance	A Full/Comprehensive Review of the Trust's Charitable funds and the role of the Charitable Funds Committee remains outstanding due to prioritisation of other activity. After 18 months this is now a matter of significant concern. It was agreed that the Executive would prepare a paper for the private session of the January Board meeting setting out a clear roadmap for resolution of governance matters.
Charitable Fund Accounts	The Committee determined to recommend the formal Financial Accounts of the Charity (year end March 2019) to the Corporate Trustee, subject to an amendment stating that a full governance review to be completed early 2020/21 which would be reported in the next set of accounts.

SECAMB Board

Finance and Investment Committee Escalation report to the Board

Date of meetings	16 January 2020
Overview of key issues/areas covered at the meeting:	This meeting focussed on the following areas: **Operational Performance Partially Assured** Overall, given the review including the Christmas and New Year period, performance was relatively stable. The committee explored in some detail the strong link between resource and performance and noted how the Trust compares nationally, which helps to set into context the pressures across the system. Call answer performance has been exceptional and in the reporting period, SECamb's performance is the best across all ambulance services in England. The committee recognises the efforts of all the staff involved in achieving this. It also asked for a paper next time to set out how we have made such significant improvement. The issue of resilience was discussed, and the committee acknowledged the fragility, in particular with regards abstraction. The deputy director of operations attended the meeting and, on this point, outlined the approach to 2020/21, whereby Key Skills (key aspect of abstraction) will be delivered over 38 weeks. A paper on this was due to be considered by QPS committee – see separate escalation report. The committee also explored the variance across the region and was assured by the focus and planning in place to ensure this is managed and there is efficient use of available resources. Sickness levels continues to be a concern and the committee has asked this to be specifically considered by the Workforce and Wellbeing Committee, especially the trend over the last six months in front-line operations. Finally, the committee reinforced that while its level of assurance needs to be informed by past performance, going forward greater focus will be placed on the expected resilience over the next 3 months. Overall, while the committee acknowledges that there is good management focus and grip, it can only be partially assured given the current position and levels of resilience expected over the next few months. **111/CAS Mobilisation Partially Assured** The committee considered where the Trust was against the mobilisation plan and the summary is that there are currently two main risks. Firstly, there is a delay with the telephony supplier; an interim solution has been agreed internally and the Trust is working with the relevant stakeholders to out this plan in place. Secondly, as the Board has been made aware previously, there is a continues risk relating to e-prescribing. There is increasing hope that the supplier can obtain accreditation sooner than initially expected, but in the meantime an interim solution is being worked through with IC24.

	At its meeting in March, the QPS Committee will be reviewing the quality and safety aspects of the mobilisation and, specifically, these two interim solutions. **Financial Performance 2019/20 Assured** The Trust is on track at month 8 to deliver against plan. The underlying position is broadly the same as last month and the income risk remains, subject to the conclusion of the discussions with commissioners; the income risk is circa £2m. The priority for the committee will be to test the extent to which the operating model delivers efficiency and is sustainable. It will explore this is greater detail at the next meeting. Subject to the outcome of the discussions with commissioners, the committee is assured that the Trust will deliver the year end forecast. There was also a review of the initial planning assumptions for 2020/21. The committee will consider next time in the context of the budget, how best to allocate resources to deliver operational (ARP) performance. **Outline Business Cases** The committee was really pleased to consider two outline business cases for the Medway and Banstead MRCs. Both are recommended to the Board for approval. Aligned to our estate strategy, this is a really positive step forward and helps to demonstrate the Board's commitment to meeting the needs of staff in delivering the best possible care to patients.
Any other matters the Committee wishes to escalate to the Board	The committee supported the plan to refresh the assumptions in the **demand and capacity review**, which will inform the plan and expected performance trajectory for next year. The committee was expecting to receive the **fleet strategy implementation plan** but instead received a position statement. There was a wide-ranging discussion about this, which resulted in an action to set up a workshop, to include NEDs. This will aim to clearly define a plan that sets out how we achieve the fleet profile needed for the future. Finally, in reflection of the meeting itself, the committee will work to ensure the papers received strike the right balance between detail and strategic overview.

SECAMB Board

QPS Committee Escalation report to the Board

Date of meetings	17 January 2020
Overview of key issues/areas covered at the meeting:	The committee was attended by both the Chair and the Chief Executive. This meeting first considered several ***Management Responses*** (*responses to previous items scrutinised by the committee)*, including: **Safeguarding Training Assured** In November 2019, the Trust Board asked the committee to consider its concern from the IPR about the relatively low completion of safeguarding training. A good paper was received which assured the committee that the 85% training target would be met by March 2020 (progress had been made since the November Board meeting). The committee was equally assured by the awareness of staff demonstrated by the positive level of safeguarding referrals. **Communication with CFRs Partially Assured** This related specifically to how urgent messages are communicated to CFRs. The committee was told that while management can be clear about messages being sent, there is currently no mechanism to ensure these are received, read, and understood. Two solutions are being explored to address this, informed by meeting held recently with South Central Ambulance Service, about how they support CFRs. **SI Actions Not Assured** As confirmed in November, the committee was concerned by the timeliness with which SI actions are closed, and so asked for a further management response to confirm progress. While it acknowledged the focus this is being given, it remains not assured. The committee therefore will continue to monitor this at each meeting until sustained improvement is made. **EPCR Assured** The committee received a good quality paper, which helped to demonstrate not just that this project has been a success, but why it has succeeded. This includes the way in which management ensured good staff engagement from the very outset and throughout. The project is in the continuous improvement stage; tweaking the system to help ensure it works more intuitively. The committee suggested there be a 'Board story' on the impact of EPCR and will receive an update at its meeting in May, about the percentage of staff using it. **Quality Impact Assessments (QIA) Assured** The committee is now assured about the QIA process having received evidence about the good awareness among staff regarding the need for a QIA, and about changes that were not approved due to the assessed adverse impact. The committee asked the executive to review how decisions are communicated and

	noted the approach to ensuring consistency with QIAs, with the Trust's supply chain partners. **EOC Audit Partially Assured** There is some increased capacity with non-clinical audit, and the Trust is now very close to compliance with NHS Pathways. However, audit of clinicians continues to be an issue due to clinical auditors being more difficult to recruit. There is much focus in this area to ensure a consistent approach to the audits and how these are fed-back to staff. The business case approved by the Board last year has still to be fully delivered, due to some HR-related issues scheduled to be resolved by March. Overall the committee felt assured by the approach to ensuring audit compliance, but remains concerned by the current gaps. It has asked for a further update in March. The meeting also considered several ***Scrutiny Items*** *(where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas),* including; **Key Skills Partially Assured** In November the committee received a paper quantifying the risk by OU, of delivering all Key Skills. This meeting focussed on the approach for 2020/21, and the need to 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. The committee welcomed the different approach for next year, whereby abstraction will be spread over 38 weeks. It also felt that the process is robust for agreeing what is included and acknowledged that there is positive feedback regarding the quality of training. In terms of this year, it is likely that some Key Skills will falls in to Q1 of 2020/21; up to 15%. However, the committee agreed with management that the probability is high that a DCA would have at least one member who has completed Key Skills. The committee will confirm in March the latest completion numbers. **Clinical Supervision Not Assured** A paper was received that set out an approach to clinical supervision, but it did not really provide assurance about the extent to which it is being carried out. The committee also felt that there needs further thought about what is needed, acknowledging that clinical supervision is not a well-established within ambulance services. This is an area that will likely be a focus within the Trust's Quality Account for next year, and the committee reinforced the need to explore the different models and guard against confusing clinical supervision with appraisal/1:1s. Although the committee is not yet assured, this is in the context of clinical supervision

	being new to ambulance services and is relatively low risk. A further paper will be considered later in the year. **EOC Clinical Safety Partial Assurance** The focus this meeting was on the impact of clinicians within the EOC. The committee noted that while the Trust is getting closer to its target establishment of 43 clinical supervisors (current at 34), this is not translating into the hours being provided; quite often the EOC is running with less than 50%. The committee will seek to get a deeper level of assurance in March, when it will review more specifically the role of clinicians and how they manage patients waiting for a response. **Clinical Outcomes – Cardiac Arrest Assured** The committee has a focus at each meeting on clinical outcomes and at this meeting the focus was cardiac arrest. The committee noted that the Trust benchmarks positively against the national average and received information about the steps being taken to further improve the management of patients in cardiac arrest. The committee is assured by the comprehensive approach being taken, supported by this being a quality priority for the past two years. The committee also received reports under its section on *Monitoring Performance*, including: **Vehicle Cleanliness – follow up** While the committee noted that the deep cleans are not being undertaken in line with the agreed schedule, the evidence (random swab testing) is demonstrating that the vehicles are clean in the context of infection prevention and control. The committee therefore wondered whether the cleaning schedule is too onerous, which management is exploring. **Safeguarding - Mid-Year Review** Safeguarding referrals continue to increase (by 18%), which helps to demonstrate good awareness and effectiveness of training. There is a 77% increase in referrals relating to domestic abuse, which is consistent in other parts of healthcare.
Any other matters the Committee wishes to escalate to the Board	**Serious Incident Thematic Review** Following a report earlier in the year, the committee explored the link between spikes in activity and SIs. It was surprised from the evidence provided that there is in fact no correlation identified between periods of surge / activity / handover delays. **Volunteer Strategy** There was a good discussion about the draft community resilience (volunteer) strategy. The committee provide feedback on different aspects of the strategy, including the need to guard against considering community resilience about just CFRs, but instead to demonstrate how the Trust is the architect of urgent and emergency care, engaging in placed based care / population health. This needs to link to the new Trust strategy and so will be reviewed in the light of this and come to the Board via

	the committee in March. Finally, overall the meeting was very constructive, supported by good quality papers.

South East Coast Ambulance Service NHS Foundation Trust

Workforce and Wellbeing Committee (WWC)

Terms of Reference

1. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Workforce and Wellbeing Committee (WWC) 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 the workforce (encompassing resourcing, staff wellbeing and HR processes) are designed appropriately and operating effectively.

3. Membership

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

The members of the committee shall be:
Terry Parkin, Independent Non-Executive Director (Chair)
Al Rymer, Independent Non-Executive Director
Laurie McMahon, Independent Non-Executive Director
Adrian Twyning, Independent Non-Executive Director
Executive Director of Operations
Executive Director of Strategy
Executive Director of Nursing & Quality
Interim Director of HR

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

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
- HR Business Support Manager

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. Members unable to attend should identify, with the committee chair's agreement, an appropriately informed deputy to attend the meeting.

5.4. With the agreement of the committee 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 and annual cycle of business, 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 necessarily 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, the HR 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	12 July 16	26 July 16	Committee established July 16 based on principles set out in Board paper 'governance improvements' at May 16. WDC dis-established June 16. Discussed at Board June 16. Ratified 26 July 16 Board.
1.1	20 Sept 16		Minor amendment proposed at para 5.3 see italicised changes.
2.0	04 October 2017		Change in Chair and Membership Additional regular attendees Administrative support provided by the HR Business Support Manager; from the corporate governance dept.
2.1		25 May 2018	Updated membership Reduced frequency to minimum 4 times a year (from 6)
2.2			Updated membership Increased frequency to minimum 6 time a year (from 4)

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Appointments and Remuneration Committee (ARC)

Terms of Reference

1. Constitution

1.1. The Board hereby resolves to establish a Committee of the Board to be known as the Appointments and Remuneration Committee (ARC).

2. Purpose

2.1. The Committee is responsible for identifying and appointing candidates to fill all the executive director positions on the Board and for determining their remuneration and other conditions of service.

2.2. The Committee is also responsible for determining the remuneration and terms of service for any other senior employee appointed on terms outside of the Agenda for Change framework, i.e. where their remuneration exceeds Band 9.

2. Membership

3.1. The Committee shall be composed of all the independent non-executive directors. However, when appointing or removing executive directors (other than the Chief Executive) the Chief Executive will be a member, as described in Schedule 7, 17 (3) of the NHS Act 2006, as amended by the Health & Social Care Act 2012.

3.2. The Trust Chair will determine who should be Chair of the committee.

4. Quorum

4.1. The quorum necessary for formal transaction of business by the Committee shall be three members.

5. Attendance

5.1. Only members of the committee have the right to attend committee meetings.

5.2. The trust secretary shall be secretary to the committee.

5.3. At the invitation of the committee, meetings shall normally be attended by the director of human resources.

5.4. Other persons may be invited by the committee to attend a meeting so as to assist in deliberations.

5.5. Any non-member, including the secretary to the committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

6. Frequency

6.1. Meetings shall be called as required, but at least twice in each financial year.

7. Authority

7.1. The Committee is constituted as a standing committee of the trust's board of directors (the board). Its constitution and terms of reference are as set out in these terms of reference, which are subject to amendment at future board meetings.

7.2. The Committee is authorised by the board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the committee

7.3. The Committee is authorised by the board to instruct professional advisors and request the attendance of individuals and authorities from outside the trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

7.4. The committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

8. Duties

8.1. Appointments – the committee will;

i. regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the board, making use of the output of the board evaluation process as appropriate, and make recommendations to the board, and nomination committee of the council of governors, with regard to any changes;

ii. give full consideration to and make plans for succession planning for the chief executive and other executive board directors taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the board in the future;

iii. keep the leadership needs of the trust under review at executive level to ensure the continued ability of the trust to operate effectively in the health economy;

iv. be responsible for identifying and appointing candidates to fill posts within its remit as and when they arise;

v. when a vacancy is identified, evaluate the balance of skills, knowledge and experience on the board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates the committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria;

vi. ensure that a proposed executive director is a 'fit and proper' person as defined in law and regulation;

vii. ensure that a proposed executive director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the board as they arise;

viii. ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported;

ix. carefully consider what compensation commitments (including pension contributions) the directors' terms of appointment would give rise to in the event of early termination to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw back provisions should be considered in case of a director returning to the NHS within the period of any putative notice;

x. consider any matter relating to the continuation in office of any board executive director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract

8.2. Remuneration – the committee will

i. establish and keep under review a remuneration policy in respect of executive board directors [and senior managers on locally-determined pay];

ii. consult the chairperson and/or chief executive about proposals relating to the remuneration of the other executive directors.

iii. In accordance with all relevant laws, regulations and trust policies, decide and keep under review the terms and conditions of office of the trust's executive directors [and senior managers on locally-determined pay], including:

- salary, including any performance-related pay or bonus;
- provisions for other benefits, including pensions and cars;
- allowances;
- payable expenses;
- compensation payments.

In adhering to all relevant laws, regulations and trust policies:

iv. establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the trust;

v. decide whether a proportion of executive director remuneration should be structured so as to link reward to corporate and individual performance;

vi. make sure that any performance-related elements of executive remuneration are stretching and promote the long-term sustainability of the foundation trust, and take as a baseline for performance any competencies required and specified within the job description for the post;

vii. consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements;

viii. use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors [and senior managers on locally-determined pay], while ensuring that increases are not made where trust or individual performance do not justify them;

ix. be sensitive to pay and employment conditions elsewhere in the trust, especially when determining annual salary increases;

x. monitor and assess the output of the evaluation of the performance of individual executive directors, and consider this output when reviewing changes to remuneration levels;

xi. monitor procedures to ensure that existing directors are and remain 'fit and proper' persons as defined in law and regulation.

8.7 In accordance with the Standing Financial Instructions, the Committee will consider and approve individual redundancy payments that fall outside of the employees' contract / standard AfC terms and conditions

8.8 The Committee will also consider and approve large scale redundancies, e.g. as a result of re-organisation.

8.9 The Committee will consider any other workforce issue referred to it by either the Chief Executive, the Chairman or a Committee member, where the nature of the discussion is considered to be sensitive and not appropriate for more general discussion at one of the other Board Committees.

9. Reporting

9.1. Formal minutes shall be taken of all committee meetings

9.2. The Chair of the Committee shall report a summary of the proceedings of each meeting to the Board and draw to the attention of the Board any significant issues that require disclosure.

10. Support

10.1. The secretary to the committee shall support the committee by:

- Agreeing meeting agendas with the Chair of the Committee;
- Providing timely notice of meetings and forwarding details including the agenda and supporting papers to members and attendees in advance of the meetings;
- Recording formal minutes of meetings and keeping a record of matters arising and issues to be carried forward.
- Advising the Chair and the Committee about fulfilment of the Committee's Terms of Reference and related governance matters.

11. Review

11.1. 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.

11.2. 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.

11.3. These Terms of Reference shall be approved by the Board and formally reviewed at intervals not exceeding two years.

Approved by: Trust Board
Approved date:
Review Date:

Workforce & Wellbeing Committee	Executive Lead	14 May 2020	02 July 2020	22 October 2020	21 January 2021	11 March 2021	
ADMINISTRATION							
Apologies	Chair	√	√	√	√	√	
Declarations of Interests	Chair	√	√	√	√	√	
Minutes	Chair	√	√	√	√	√	
Action Log	Chair	√	√	√	√	√	
Next Meeting Agenda / Forward Look	Chair	√	√	√	√	√	
Meeting Effectiveness	Chair	√	√	√	√	√	
SCRUTINY							
Programmes (overview of progress against objectives)							
HR Transformation Plan	Executive Director of HR & OD	√					
Clinical Education Plan	Executive Medical Director	√	√	√			
HR Service Centre							
Payroll Discrepancy - effectiveness of policy	Executive Director of HR & OD	√					
Payroll Contract	Executive Director of HR & OD	√					
Workforce Planning							
Workforce delivery (Demand and Capacity Review Phase 1)	Executive Director of HR & OD	√	√	√	√	√	
Workforce delivery (Demand and Capacity Review Phase 2)	Executive Director of HR & OD					√	
Student Paramedics - recruitment and support	Executive Medical Director						
Workforce Governance							
Personnel Files	Executive Director of HR & OD		√				
Pre-Employment Checks	Executive Director of HR & OD		√		√		
Clinical Education							
External Compliance (Ofsted; Fquals; ESFA)	Executive Medical Director					√	
Annual Training Plan	Executive Medical Director	√		√			
Key Skills Annual Plan* / Progress**	Executive Medical Director			√**		√*	
Workforce Education Development Review (B5>6 uplift / mentorship)	Executive Medical Director						
Continuous Professional Development - clinical staff	Executive Medical Director				√		
Driving Standards	Executive Medical Director		√				
Apprenticeship Governance	Executive Medical Director					√	
Higher Education Institution - partnerships with Universities	Executive Medical Director			√			
Employee Relations							
Bullying & Harassment	Executive Director of HR & OD						
Grievances	Executive Director of HR & OD	√					
Equality, Diversity, Inclusion & Wellbeing							
Equality Delivery System - EDS2 Goals, Delivery on the WRES, DES, Equality Objectives, Gender Pay gap.	Executive Director of HR & OD						

Workforce & Wellbeing Committee	Executive Lead	14 May 2020	02 July 2020	22 October 2020	21 January 2021	11 March 2021	
Learning & OD							
Management Training - Fundamentals	Executive Director of HR & OD			√			
Staff Induction Programme	Executive Director of HR & OD		√				
Health & Safety							
Health & Safety Management systems	Executive Director of Nursing & Quality				√		
MONITORING PERFORMANCE & QUALITY							
Staff Survey Results / Next Steps	Executive Director of HR & OD					√	
Committee Dashboard - Power BI, incl. H&S	Executive Director of HR & OD	√	√	√	√	√	
Annual H&S Audits	Executive Director of Nursing & Quality						
Annual Wellbeing report	Executive Director of HR & OD						
Annual Inclusion report (including an overview of stat and legislative requirements: Equality Delivery System (EDS2), Delivery on the WRES, DES, Equality Objectives, Gender Pay gap, etc)	Executive Director of HR & OD						
MANAGEMENT RESPONSES (delete once received)							
STRATEGIES							
People Strategy	Executive Director of HR & OD						
Clinical Education Strategy	Executive Medical Director						
Inclusion Strategy	Executive Director of HR & OD						
Retention Strategy	Executive Director of HR & OD						
GOVERNANCE & RISK MANAGEMENT							
Board Assurance Framework / Strategic Risks relating to committee purview	Company Secretary	√	√	√	√	√	
Committee Annual Self-Assessment: Cycle of Business Terms of Reference	Company Secretary				√		
Internal Audit Plan 2020 / 21							
Recruitment Process & Governance			√				
Workforce / Resourcing				√			
Clinical Education						√	

Workforce & Wellbeing Committee	Executive Lead	14 May 2020	02 July 2020	22 October 2020	21 January 2021	11 March 2021

ARC ANNUAL CYCLE OF BUSINESS 2020-21

Appointments & Remuneration Committee	Executive Lead	25 June 2020	24 Sept 2020	21 January 2020			
ADMINISTRATION							
Apologies	Chair	√	√	√			
Declarations of Interests	Chair	√	√	√			
Minutes	Chair	√	√	√			
Action Log	Chair	√	√	√			
Next Meeting Agenda / Forward Look	Chair	√	√	√			
APPOINTMENTS / GOVERNANCE							
Executive Succession Planning / Skills Gap Analysis / Diversity	Chief Executive	√					
Annual Review of structure, size and composition of the Board	Trust Chair	√					
Fit and Proper Persons Test Annual Review	Company Secretary	√					
Committee Annual Review / TOR	Company Secretary			√			
REMUNERATION / APPRAISALS							
Executive Director Remuneration Framework	Chief Executive		√				
Annual Review of Executive Remuneration	Chief Executive		√				
Chief Executive Appraisal / Objectives Incl. 'Earn Back' Review	Chair	√ **A**	√ **EB**				
Executive Director of HR & OD Probation Outcome	Chief Executive	√					
Executive Director Appraisals	Chief Executive	√					
*Staff Remuneration Outside of AfC / Interims & Consultants to be Approved	Chief Executive						
*Redundancy / Exit Packages to be Approved	Chief Executive						

*AS REQUIRED

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Council of Governors

G - Quality Account/Quality Report Audit Recommendation

1. Introduction

1.1. The Trust is required by the Department of Health and NHS Improvement/England to publish an annual Quality Account and Quality Report.

1.2. A Quality Account sets out key areas of focus for improving the quality of care for our patients, and the Quality Report includes everything in the Quality Account plus some additional requirements because SECAmb is a Foundation Trust (FT). in practise we combine the two elements and produce one document.

1.3. As part of the annual process, Governors are invited to participate in a workshop (alongside public members, staff and other stakeholders) to agree the Quality Account measures/objectives for the year. This took place on 28 January 2020. There are some mandatory areas we are required to report on in the combined document (including 'category A' response rates and clinical performance indicators) while other local indicators are determined in conversation with stakeholders.

1.4. The Department of Health requires the Trust to evaluate key processes and controls for managing and reporting against the mandatory indicators and to undertake sample testing of the data used to measure how well the Trust is doing against them – also called an audit.

1.5. NHSI/E demands an additional requirement as an FT:

1.6. NHS foundation trusts also need to get assurance through substantive sample testing over one local indicator included in the quality report… Depending on the specialist nature of the indicator selected, external auditors may wish to build on the expertise of others, including internal auditors' peer review, specialist review or a combination of these methods. The local indicator will be selected by the trust's governors.

1.7. The audit needs to be undertaken before the deadline for the production of the Quality Account and while KPMG, our external auditor, is working on validating other data required for the Annual Report and Quality Account, i.e. by

2. Process for selecting a 'local indicator'

2.1. Judith Ward (Deputy Chief Nurse who has overall responsibility for collating our Quality Account) attended the Governor Development Committee

meeting on 13 February 2020 to discuss Governors' initial thoughts on which local indicator we might ask the auditor to check.

2.2. It is vital to note that the auditor *only* checks the validity and quality of our data i.e. that Governors can be assured that the figures we report are correct and fairly put together; the audit does NOT go into any of the finer details of e.g. quality improvement work undertaken.

2.3. Several suggestions were made at the GDC and one (on Section 136 conveyances) was checked with the auditors as to whether a meaningful audit was possible. Subsequent to the GDC, Governors also had an email discussion which led to several other suggestions for audit areas.

2.4. Thanks to all Governors who submitted such thoughtful suggestions.

2.5. We have spoken with the auditors and checked the availability of data in order to recommend three possible areas for audit to you. The table below sets out the reasons the other suggestions are not recommended, and then we set out the three areas we do recommend and ask Council to select from these.

2.6. In considering the suggestions made by Governors, the team considered first whether the audit might lead to improvements in either patient care or Trust performance more widely (i.e. would the audit tell us anything useful) and then whether the data was available and could meaningfully be audited by KPMG.

3. Suggestions we don't think would provide useful data

	Suggestion from the Council	**Rationale for not auditing**
1	Are we clear how the Trust reviews its data quality in the first place? What is the process for developing, reporting and checking data is in place – and how is this then audited as an organisation?	Category 1, 2 and other nationally required data (i.e. our core performance indicators) are audited by KPMG (our external auditors) as part of the Quality Account, and is validated by NHS England when submitted. Our own programme of clinical audit validates other clinical data throughout the year. However, see recommendation to consider around validating Category 3 and/or 4 data below.
2	Is it worth reviewing the data on the conveyance to different acute trusts and how this relates to pressures in the system?	Unfortunately, this audit wouldn't tell us anything about the relationship between the data and system pressures – all it could tell us was whether our data was correct. We are required to transport to the nearest hospital in most cases and the conveyances are tracked by satellite data so are (hopefully) accurate. It's not felt an audit of this type would lead to improvements in patient care or Trust performance.
3	Data quality on the use of IBIS?	The team considered what could usefully be audited around IBIS and spoke to the IBIS team about how they currently validate their data. Data is variously updated via the CAD in EOC (which we should

		expect was reasonably accurate) or by third parties e.g. GPs or community services (which will only be as accurate/useful as what's entered on the system). It was unclear to us what Governors felt the benefit of a data quality audit in this area would be, however as with most SECAmb systems improvements are planned and this may be worth further discussion next year to revisit.
4	Staff appraisals data in the Integrated Performance Report – how robust is the data? I would like KPMG to go back to staff and ask them if the discussion they are recorded as having actually did take place in the format/outcome described.	The current appraisal system is being changed in the coming year and we now that recording of appraisal conversations using the current system is sporadic. While it may be useful if the auditors could spot check whether recorded conversations had actually happened, it would be more useful to undertake work in relation to this once the new system has been introduced, to check it works going forward (rather than doing it based on a system we know needs improvement and is being changed for that reason already).
5	Handwash audit - is that robustly carried out and recorded at each station?	This was looked at by the Infection Prevention and Control Team in detail last year which identified variations in practice in undertaking and recording handwashing. The Trust is aware of the areas where there is poor practice and is working to support teams to improve. It's not sure what extra value would be obtained from a data quality audit.
6	Is it possible to ask them to audit the data quality on something clinical from the internal clinical audit programme?	We discussed the options and checked with the Clinical Audit Lead, as we had felt something around the data quality re the STEMI bundle might be useful. Clinical Audit advised that: not sure of the benefits it would bring to audit this area because we have low volume approx. 100 patients per month, we follow national guidance and level ourselves with other ambulance services. Data's collected through Doc Works (clinical audit system) so I guess if anything it would enable us to test the functionality and accuracy of the software. However, this is felt not to be a priority given a) it's externally developed and managed software and b) there are more pressing and potentially useful areas to consider.
7	Infection prevention and control (IPC) audits on Trust vehicles (Make Ready process/deep cleans/swabs)	Data is reported electronically by managers. Investigations have already shown variations in practice and work was underway to standardise Make Ready centre processes in relation to IPC. This could be far more worthwhile next year once this remedial work had been done to check the new standardised process if effective.
8	Accuracy of reporting of violence and aggression against staff	The only current reporting mechanism is using the Trust's incident reporting system, Datix, which involves a staff member completing a Datix form. The team were unclear what the auditors could realistically audit in relation to this, save checking that when someone presses 'submit' a form is submitted.

4. Suggestions we think would provide useful data

	Suggestion from the	**Rationale for auditing**

	Council	
1	Monitoring and analysis of meal break compliance	This data is already collected by the Trust's Business Intelligence Unit and the team believe auditing this would be of value to ensure that the Trust has a clear and accurate picture of meal break compliance in the Trust (i.e. can we trust our data). Colleagues regularly still raise the issue of meal breaks and yet our data shows that only 4% of colleagues don't get a meal break. We know that giving staff meal breaks is an essential part of our duty to protect wellbeing and that tired, hungry colleagues do not necessarily provide the best quality care they are capable of. This is both a staff welfare issue and patient care issue, and validating this data would be beneficial. KPMG have stated they would use the they would use parameters set within the policy to reconcile against BI data and probably focus on: 'demonstrating compliance of 90% of all meal breaks being taken within the window that has been agreed' which is a Key Performance Indicator in the Meal Break policy.
2	Validity of data set used by SECAmb to monitor and report on Section 136 conveyance	This data is collected by the Trust's Business Intelligence Unit and the team believe auditing this would be of value to ensure that the Trust has a clear and accurate picture of S136 conveyances. The quality of this data can potentially impact on patient care and on the Trust's reputation and its partnership working. The team believe that this audit of SECAmb data would be worthwhile because it would bring assurance regarding the methods used to collect our data in this area. KPMG are able to audit SECAmb's data but say they may well not be able to investigate why there are differences compared to Sussex Partnerships' data.
3	Category 3 / 4 reporting data	This data is collected by the Trust's Business Intelligence Unit and the team believe auditing this would be of value to ensure that the Trust has a clear and accurate picture of Category 3 and 4 performance. This data is not audited/validated nationally and given the large number of patients, particularly falling into Category 3, validating data which has the potential for impacts on patient care and Trust performance may be useful. KPMG say they can audit this but suggest Governors may find more 'variety' (by which I assume they mean variation) from looking at one of the other two areas suggested.

5. Recommendation

5.1. Governors are asked to select their preferred area for audit this year.

Izzy Allen

Assistant Company Secretary

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Governor Development Committee

Council of Governors' Self-Assessment

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. A self-assessment enables Governors to hold the Trust to account for providing the support and structures Governors need to fulfil their role, and also enables Governors to hold each other to account for being effective in the role.

1.3. The last self-assessment was undertaken in mid 2018 and a further self-assessment was due and has been undertaken alongside a '360' review of Council effectiveness by key stakeholder.

1.4. For the first time, an assessment of the Lead Governor role was also included.

1.5. This paper sets out the full results for the Council to review. The results have already been reviewed by the Governor Development Committee who make some recommendations to the Council in respect of actions needed to improve Council effectiveness.

1.6. It should be noted that the survey questions were revised from previous years to improve response rates by shortening the survey to focus on key questions, so no comparison with previous results is possible.

2. Self-assessment process

2.1. The GDC worked with the Trust to design the self-assessment process and is asked to review and refine it each year.

2.2. The process was/is as follows:

2.2.1. Completion of an online survey (anonymous);

2.2.2. '360' survey sent to the Non-Executive Directors and CEO; and

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

2.3. Responses to the self-assessment, 360 assessment and Lead Governor assessment are set out in full below.

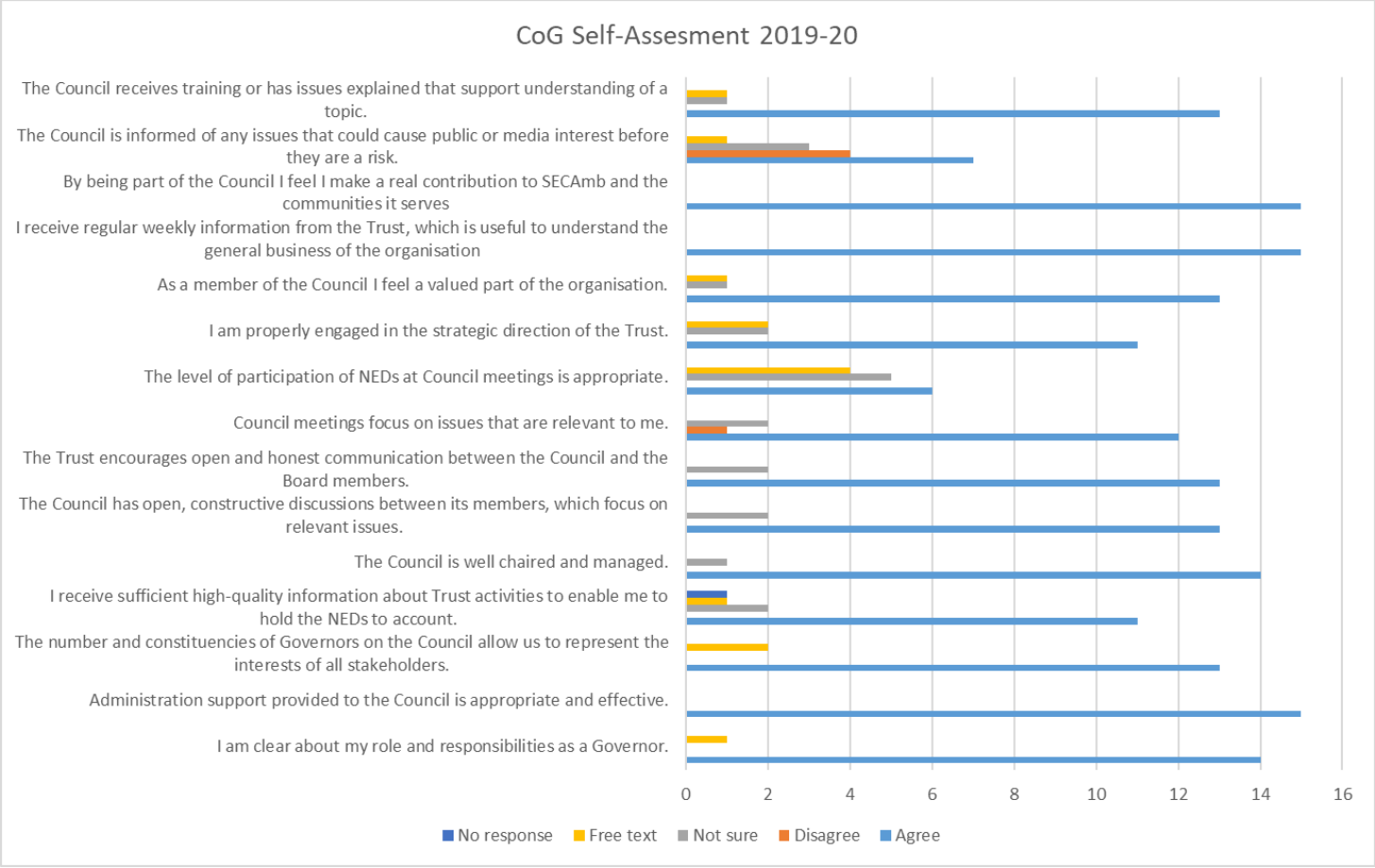
3. Response rates

3.1. 21 Governors were in post at the time the self-assessment and Lead Governor survey was sent out (December 2019). 15 survey responses were received, a response rate of 71%.

3.2. It would be helpful to discuss whether it is worth raising again the question of why colleagues may not have completed the survey. Several reminders were sent out.

3.3. 12 NEDs and other key stakeholders (CEO, Corporate Governance staff) were sent the 360 survey and we received eight responses, two thirds (66.6 recurring %) of respondents.

4. Council of Governors self-assessment 2019-20 results

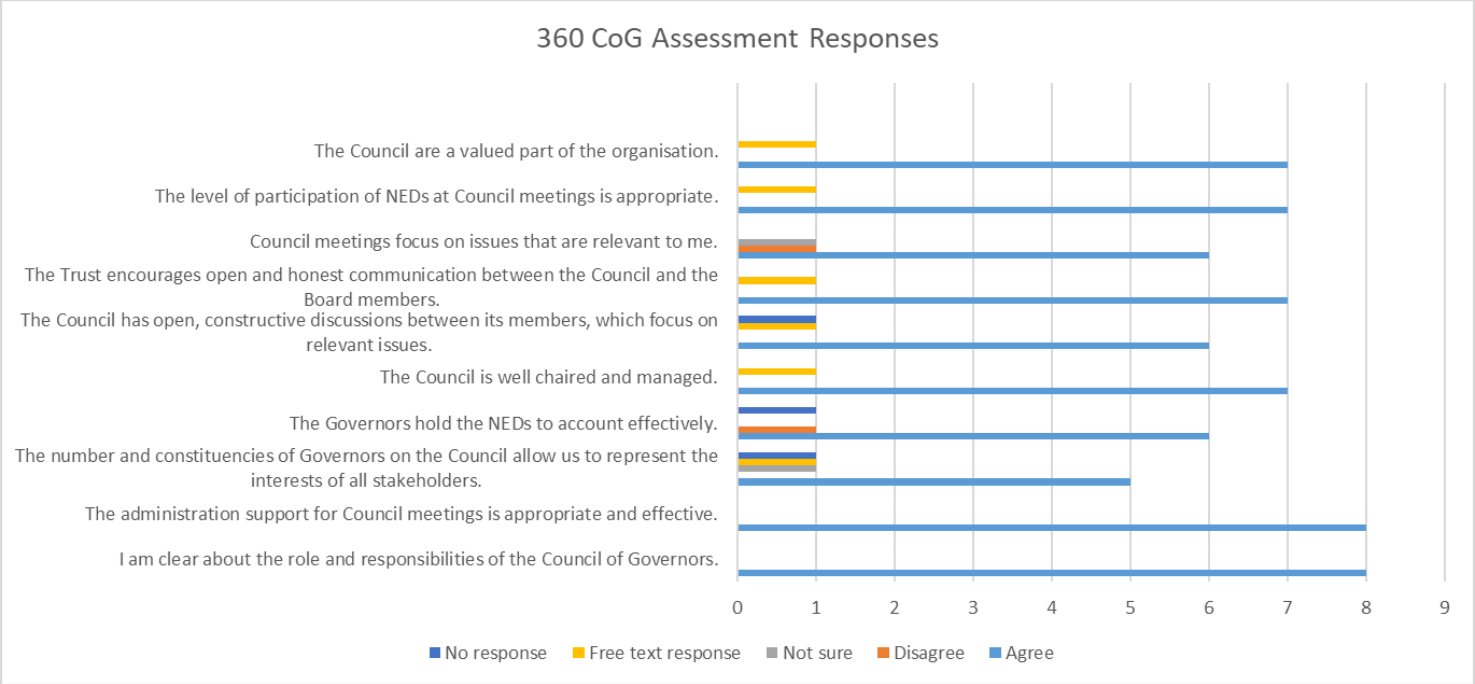


Free text responses

I am clear about my role and responsibilities as a Governor.	New in role
The number and constituencies of Governors on the Council allow us to represent the interests of all stakeholders.	In my opinion more staff governors would be beneficial
	Representation of children or children services could be improved
I receive sufficient high-quality information about Trust activities to enable me to hold the NEDs to account.	We know about the issues with IPR. But I feel like the only actual feedback I get on NED performance is from the Chair, making it difficult to form my own opinion.
The level of participation of NEDs at Council meetings is appropriate.	Could be better. I appreciate there have been some unforeseen circumstances recently.
	Last meeting, I didn't feel that some NEDs were that engaged
	At times NED attendance has been low. It is appreciated if they are able to attend regularly. The Joint sessions have helped build relationships between the COG and the NEDs
I am properly engaged in the strategic direction of the Trust.	Does anyone know what the strategic direction is?

	I think the strategic direction is still being developed.
As a member of the Council I feel a valued part of the organisation.	I am always impressed that SECAMb staff thank me for participating in a range of events and am always met with politeness and a willingness to discuss issues
The Council is informed of any issues that could cause public or media interest before they are a risk.	There is some room for improvement in the timing of this. We do not always get to hear of issues being raised in the local press
The Council receives training or has issues explained that support understanding of a topic.	Secamb staff are very supportive in explaining issues to COG members
Is there anything else you would like to tell us about the effectiveness of the Council?	There are still some governors who get too much into the operational detail rather than fulfilling our role of holding NEDs to account
	I think this is difficult to assess and would welcome the opportunity to explore our effectiveness with Governors from other NHS organisations
	Council must endeavour to be strategic and hold to account and not sink into the weeds and attempt to do the jobs which staff are employed to do

5. CoG 360 (stakeholder/colleague) results



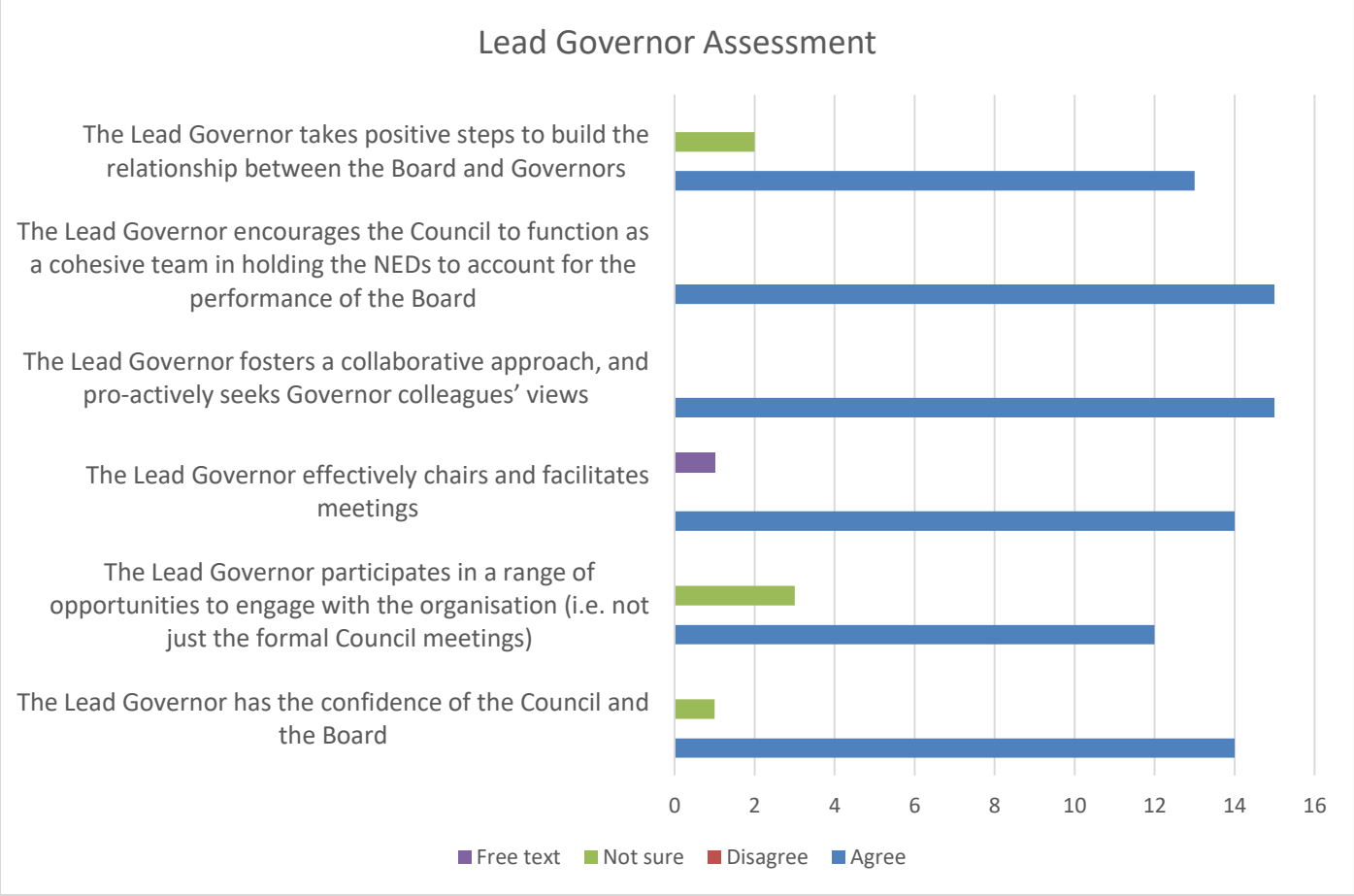
Free text responses:

The number and constituencies of Governors on the Council allow us to represent the interests of all stakeholders.	It's a tricky one to know whether this is true!
The Council is well chaired and managed.	Well managed but some inconsistencies in chairing style
The Council has open, constructive discussions between its members, which focus on relevant issues.	Better now than at any other time in last 5 years
The Trust encourages open and honest communication between the Council and	NEDs do and increasingly the wider Trust is more open and recognises the benefits of engaging with the Council early and in full

the Board members.	
The level of participation of NEDs at Council meetings is appropriate.	Those NEDs who attend contribute really well but more attendees would be welcome!
The Council are a valued part of the organisation.	I think we could make more of the Council - more strategic involvement in helping us understand the views of the public
Is there anything else you would like to tell us about the effectiveness of the Council?	It's improving and the level of challenge and questioning is becoming far more relevant, pertinent and strategic. Thanks to all Governors for their hard work!
	We need to draw on Members' knowledge and understanding of local issues as we move into the more uncertain world where the NHS and other partners are restructuring around ICSs and ICPs.
	I think that the council operates well because of the quality of the folk that we have on the council.
	The quality - rather than quantity - of Governors is all important

6. Lead Governor assessment

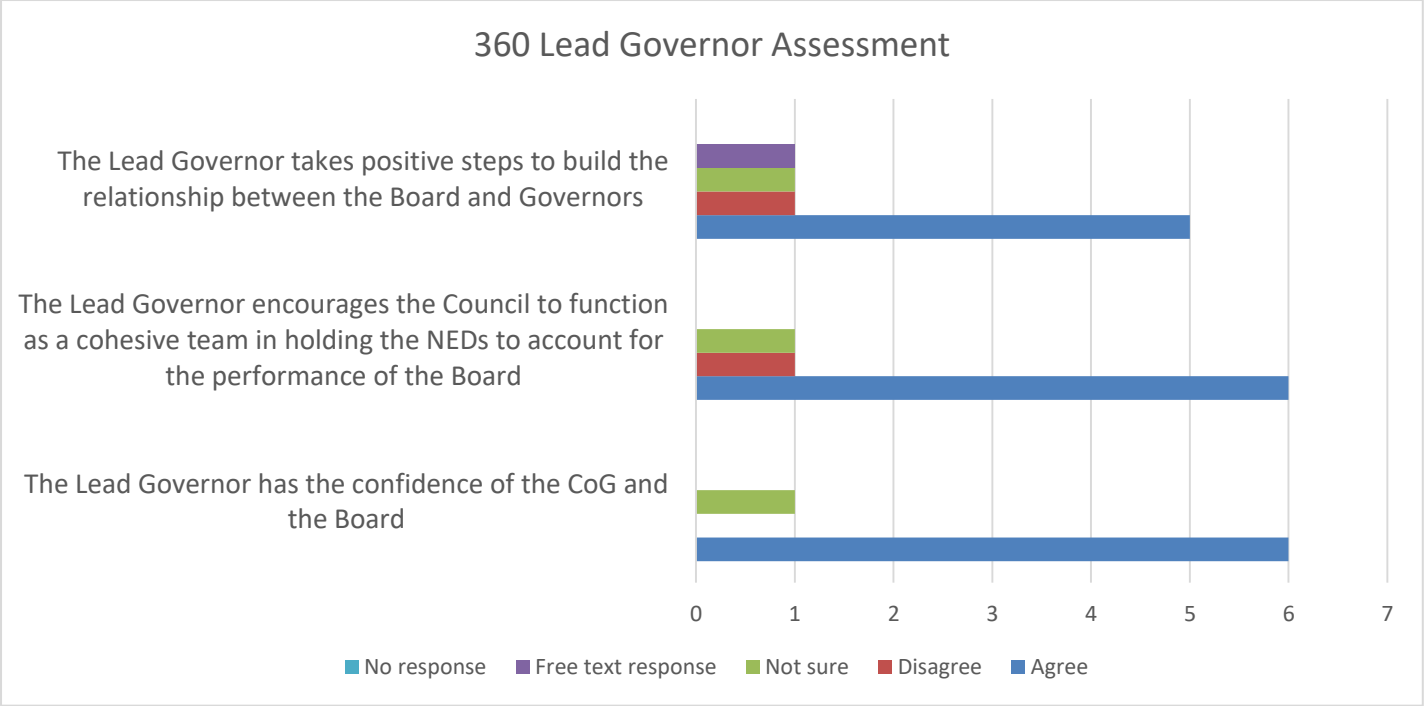
Self-assessment



Free text comments

The Lead Governor effectively chairs and facilitates meetings	Could sometimes keep us on track a bit more.

360 feedback

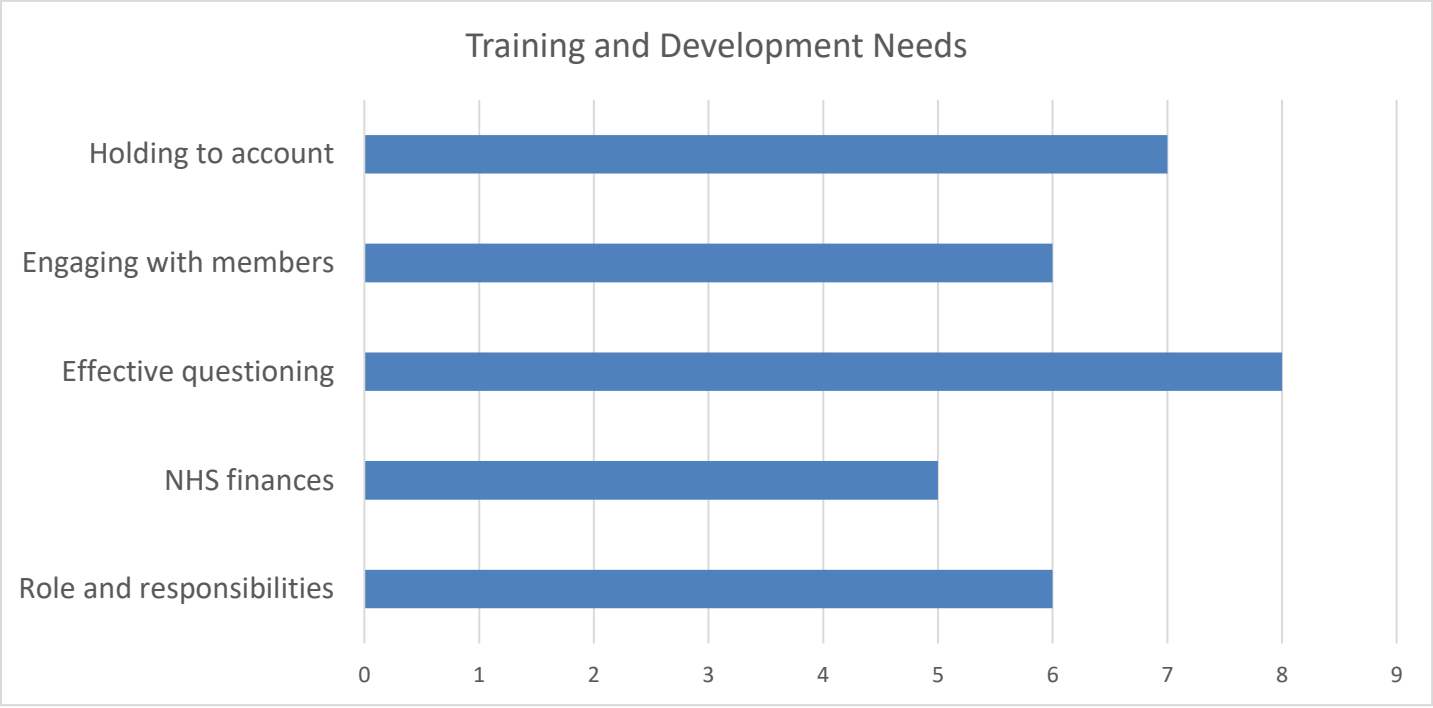


Free text comments

The Lead Governor takes positive steps to build the relationship between the Board and Governors	Best to date

7. Training and development requirements

7.1. There were not a huge number of responses from the 15 respondents, but they are set out below. In general, some people seemed to want training in all or a number of areas, while others felt they required none at all.



8. Overview

8.1. It is for Governors to interpret the feedback but it is also vital for the Trust to take note and assure itself the Council is operating effectively.

8.2. The GDC suggested a number of observations and key areas for discussion.

8.3. Overall, the Council is operating effectively.

8.4. The Lead Governor role is working, and Felicity is doing a good job (thank you Felicity!).

8.5. Some Governors have identified issues in relation to:
- 8.5.1. Timely advice of potential media attention and public interest stories;
- 8.5.2. Attendance of NEDs at Council meetings;
- 8.5.3. Knowledge of the strategic direction of the Trust (perhaps unsurprising as a new strategy is currently under development);
- 8.5.4. Some Governors getting into too much detail at Council

8.6. NEDs/stakeholders clearly feel that the Council's operation and impact is on an improving trajectory.

8.7. Some Governors feel they could benefit from training across the piste and this should be followed up to identify who and what.

9. Recommendations

9.1. The Council is asked to:
- 9.1.1. Review the data above and come to the meeting prepared to comment on your interpretation of the results;
- 9.1.2. Consider any recommendations for improvement that should be made.

Izzy Allen, Assistant Company Secretary