

Board of Directors

Agenda and papers of a meeting to be held

2.30pm – 5pm
Thursday 29th April 2010

Board Room,
Tavistock Centre,
120 Belsize Lane,
London, NW3 5BA

Board of Directors
2.30pm– 5.00pm, Thursday 29th April 2010

Agenda

Preliminaries

- 1. Chair's opening remarks**
Ms Angela Greatley, Trust Chair
- 2. Apologies for absence**
- 3. Minutes of the previous meeting** *(Minutes attached)*
For approval
- 4. Matters arising**

Reports & Finance

- 5. Chair and Non-Executive Directors' Report** *For noting*
- 6. Chief Executive's Report** *(Report attached)*
Dr Matthew Patrick, Chief Executive *For noting*
- 7. Finance & Performance Report** *(Report attached)*
Mr Simon Young, Director of Finance
- 8. Quarter 4 Governance Declaration** *(Declaration attached)*
(Link to all outcomes)
Ms Pat Key, Director of Corporate Governance & Facilities *For approval*

Corporate Governance

- 9. Corporate Governance Report** *(Report attached)*
Miss Louise Carney, Trust Secretary *For approval*
- 10. Care Quality Commission Reports** *For discussion / approval*
 - a. Care Quality Commission Compliance 2009/10** *(Report attached)*
Ms Pat Key, Director of Corporate Governance & Facilities *For approval*
 - b. Care Quality Commission Reporting 2010/11** *(Report attached)*
Dr Matthew Patrick, Chief Executive *For approval*
- 11. Standing Financial Instructions** *(Report attached)*
Miss Louise Carney, Trust Secretary *For approval*
- 12. Scheme of Delegation of Power** *(Report attached)*
Miss Louise Carney, Trust Secretary *For approval*

Quality & Development

13. Clinical Quality, Safety, and Governance

Dr Matthew Patrick, Chief Executive

*(Report attached)
For discussion &
approval*

Conclusion

14. Any other business

15. Notice of future meetings

Thursday 13th May : Board of Governors
Tuesday 25th May: Board of Directors
Tuesday 8th June: Directors' Conference (Outcomes)
Tuesday 29th June: Board of Directors
Tuesday 27th July: Board of Directors
Thursday 9th September : Board of Governors
Tuesday 21st September: Directors' Conference (Research)
Tuesday 28th September: Board of Directors
Tuesday 26th October: Board of Directors
Tuesday 30th November: Board of Directors
Thursday 9th December : Board of Governors

Meetings of the Board of Directors are from 2.30pm until 5.30pm, and are held in the Board Room. Meetings of the Board of Governors are from 2pm until 5pm, and are held in the Lecture Theatre. Directors' Conferences are from 12.30pm until 5pm.

Board of Directors Part I

Meeting Minutes, 2.30pm – 5pm, Tuesday 30th March 2010

Present:			
Mr Martin Bostock Non-Executive Director	Ms Angela Greatley Trust Chair	Mr Altaf Kara Non-Executive Director	Ms Joyce Moseley Non-Executive Director
Dr Matthew Patrick Chief Executive	Ms Emma Satyamurti Non-Executive Director	Mr Richard Strang Non-Executive Director	Mr Simon Young Director of Finance
In Attendance:			
Miss Louise Carney Trust Secretary	Dr Caroline McKenna Associate Medical Director (representing Dr Senior)	Dr Andy Wiener Associate Clinical Director, Camden CAMHS (item 12)	
Apologies:			
Ms Trudy Klauber Dean	Ms Louise Lyon Trust Clinical Director	Dr Rob Senior Medical Director	

Actions

AP	Item	Action to be taken	By
1	3	Miss Carney to amend minutes	Immed
2	4	Miss Carney and Dr Patrick to review scheduling of topics for Directors' Conferences	May 10
3	7c	Future Capital Budgets to be put in context of 3 – 5 year planning	Mar 11
4	8	Dr Patrick and Miss Carney to consider whether matters for the Board of Directors can be delegated down to Committees	Jun 10
5	8	Mr Strang and Miss Carney to review Audit Committee Terms of Reference	Jun 10
6	10	Tavistock Clinic Foundation to report to Board of Directors with brief of work	Jun 10
7	11	Paper on re-structuring of Trust Committees to be presented to Board of Directors	Apr 10
8	11	Drs McKenna, Patrick, and Senior to consider whether a further report on Mid-Staffordshire is necessary	Jun 10

Actions **Agenda item**

Future Agendas

1. Chair's opening remarks

Ms Greatley welcomed everyone to the meeting, including Dr Caroline McKenna, who was representing Dr Rob Senior (but under the Trust's Constitution did not have Dr Senior's voting rights), and Dr Mary Burd (Governor, Public: Camden) who was observing the meeting.

2. Apologies for absence

As above.

3. Minutes of the previous meeting

AP1 The minutes were approved subject to minor amendments.

It was agreed to have a future discussion outside of a formal Board meeting on Agenda for Change.

4. Matters Arising

Action Paragraph 2 (CQC Final Declaration) and Action Paragraph 6 (Health & Safety Guidance)

AP2 Miss Carney noted that the next available Directors Conferences without topics scheduled were June and September 2011. Miss Carney and Dr Patrick to review scheduling of topics.

Outstanding Action Table

Miss Carney noted that, subject to the approval of the Annual Schedule of items to be discussed by the Board, to be considered under the Corporate Governance Report, the completion deadlines for some of the items on the outstanding action table may be moved.

5. Trust Chair's and Non-Executive Directors' Reports

Ms Angela Greatley, Trust Chair

Ms Greatley reported that Board members had met over lunch prior to the meeting and had discussed various issues facing the Trust within the context of the North Central Sector and the wider NHS environment.

Mr Martin Bostock, Non-Executive Director

Mr Bostock reported that he had joined the Trust's Sustainability, Health and Environmental Development (SHED) Unit (formerly known as the Green Group). The Unit were working towards an environmental campaign that would be launched on 17th June 2010.

Mr Richard Strang, Non-Executive Director

Mr Strang had attended the launch of the Open Your Mind campaign on behalf of Angela Greatley. Mr Strang suggested there may be some scope for the Trust to provide training to NHS trusts for implementing this campaign.

6. Chief Executive's Report

The Board of Directors formally recorded their shock and sadness over the death of Nicholas Selbie, former Trust Chair, and sent their best wishes to Mr Selbie's family.

Dr Patrick thanked Mr Bostock for his contribution to the Directors' Conference on marketing.

Dr Patrick noted that the results of the annual staff survey had been received by the Trust, and looked very positive. The Survey would be presented to the Board once the results had been analysed.

7. Finance & Performance

7a. Finance & Performance Report

Mr Young noted that the Trust remained ahead of Plan, but that prudent provisions may need to be made at the end of the year.

The Portman Clinic remained well under budget on expenditure. This was partly off-set by its income projection, and some funding of one-off consultancy work. Also, the unplanned gaps in staffing had reduced the time available to develop new projects.

The Children's Workforce Development income affected the cashflow statement, with receipts and payments both almost £500k higher than plan for this reason.

Clinical income was underachieving by £72k.

The Tavistock Consultancy Service was rated green on its own, but Trust-wide consultancy overall was rated amber.

Ms Moseley queried the implications of having a Financial Risk Rating of 4, rather than 3. Dr Patrick noted that either would be satisfactory.

It was noted that the reference cost indices are not particularly relevant to mental health. The Trust's costs are 87% of the national average; and allowing for the market forces factor, only 75%.

Dr Patrick noted that the Trust was being prudent in its income predictions. Ms Satyamurti noted that there must be a visible benefit for such prudence. Any surplus will be available to bid for. Mr Young noted that the Trust had run an organised bidding process for £240k additional non-recurrent expenditure, which had worked well.

7b. Annual Plan – Budget 2010/11

Mr Young noted that the Trust's aim was to make substantial productivity improvements. This would either be through providing more for the same money, or providing the same with less money. There is a national savings target of 3.5%. It was noted that the requirements of all Service Lines were proportionate.

The Budget aims for a surplus of £150k.

It was noted that the Budget contained, as usual, elements of volatile income. It was noted, however, that the Trust had every expectation that this income would be secured. The Trust believes the Budget to be entirely achievable.

The Trust was carrying over a significant amount of money to complete some projects.

Mr Bostock noted that income was increased, but so were productivity savings requirements. Mr Bostock queried why the EBITDA was not increased. Mr Young explained that since costs are increasing due to pay rises and other inflation, while income is not being uplifted except for increased activity, the productivity savings are needed simply in order to maintain the previous level of EBITDA and surplus.

Mr Strang noted that there were significant areas where the Trust should be concerned about hitting Budget targets, for instance the Monroe Family Assessment Service. Dr Patrick noted that income projection in these areas was conservative. It was also noted that some shortfalls would be compensated from others within service lines. Mr Strang queried whether it was fair to produce a Budget based on this. Dr Patrick noted the importance of setting realistic targets for benchmarking, and the importance of services having serious targets to aim towards. Mr Strang noted the difference between forecasts and targets, and suggested that a Budget should be a forecast.

Mr Kara noted that the Trust's efficiency targets included pay costs and therefore built in inflation. Mr Young noted that the Trust's main cost pressure is inflation, and it is therefore important to build this in.

Mr Kara noted that the Trust was expressing productivity improvements through additional income, and queried whether the Executive team was happy with this. It was noted that the Trust was confident that the budgeted areas of growth were possible in the current climate. Dr Patrick had spoken with all Directors responsible for new income, most of which was already secure, and all Directors confirmed they were confident going forwards with these projections.

Ms Moseley queried whether the Trust was making savings by not filling vacant posts. Dr Patrick noted that departments try to plan for any vacancies. Mr Young noted that the Trust was aiming for a higher percentage utilisation from staff, rather than a reduction in staff.

The Budget was approved.

7c. Capital Budget 2010/11

Four projects had been listed. The only item that would return to the Board of Directors for approval was the roof project. The roof project was not for approval at this stage, but a budget was being allocated to it.

Ms Moseley queried the absence of the project to create another entrance to the building for students. It was noted that this requires further work before coming to the Board of Directors, and was not provided for in this Capital Budget.

It was noted that RiO was funded through the Budget, not the Capital Budget, and there were no costs of software since this is funded nationally.

AP3 It was agreed that future Capital Budgets be put in context of 3 – 5 year planning.

The Capital budget was approved.

8. Corporate Governance Report

Board of Directors' Annual Schedule 2010/11

The Board queried whether the Schedule contained everything the Board needs to know. Miss Carney noted that it contained all regular items, and that both the Schedule and the Board agendas remained fluid and items could be added at any time. Miss Carney noted that all Board papers should include references to finance, productivity, quality, equality, patient safety, and risk.

AP4 Mr Strang queried whether any items on the Schedule could be delegated down to Committees. Dr Patrick and Miss Carney to consider.

The Schedule was approved.

Monitor's Code of Governance

AP5 It was noted that Section F of Monitor's revised Code of Governance may have implications for the Audit Committee. Mr Strang and Miss Carney to review the Audit Committee's Terms of Reference

9. Committee Minutes

Noted.

c. Patient & Public Involvement Committee, February 2010

It was noted that the patient representative's experience with the Adult Department was unfortunate. Mr Bostock confirmed that this matter was being dealt with.

10. Tavistock Clinic Foundation Constitution Update

AP6 Dr Patrick noted that the new Constitution ensures that the Foundation is properly independent from the Trust. The Foundation will report to the Board of Directors with a full brief of the Foundation's work.

11. Francis Inquiry

Dr McKenna recommended reading some of the testimony in the Francis Inquiry. Miss Carney to send link to full report.

AP7 Dr McKenna noted that the Trust was currently considering the re-structuring of patient safety and governance committees. This would be presented to the Board of Directors for approval. Dr McKenna noted the importance of not being complacent about the things that the Trust does

well. All policies and processes must be reviewed on a regular basis.

Mr Bostock commented on the make-up of the Board of Directors at Mid-Staffordshire, and queried whether the Trust considered itself to be better connected due to the number of clinicians on the Board. It was noted that it was a very positive thing to have clinicians at Board level, although it was recognised that the Trust should not be complacent about this, and should ensure that all Directors are able to query any matter.

Dr McKenna noted that there was a great disconnection between the Board of Directors and staff at Mid-Staffordshire, but noted that this was not the case at this Trust.

Dr Patrick noted that the main challenge for trusts was how to create a genuinely patient centred organisation and how to foster a culture where everyone feels they can raise concerns. The Trust must ensure structures are in place to facilitate this, but must also ensure that this culture is fostered.

AP8 Drs McKenna, Patrick and Senior to consider whether a further report on Mid-Staffordshire is necessary.

12. Service Line Report – Camden CAMHS

Dr Wiener noted that Camden CAMHS is going well. The service is able to escalate cases quickly with support from Psychiatrists, and is a very risk-aware service. The service had developed a proforma for case discussions in response to the increasing amount of risk associated with its cases, and its increase in patients.

Dr Wiener was confident the service would be able to continue providing at a high quality despite cost reductions. Dr Wiener noted good relations with Commissioners, although noted that there was a high level of scrutiny from Commissioners.

Dr McKenna noted that the service had a higher Did Not Attend (DNA) rate than other services in the Trust. Dr Wiener noted that the Child Protection team's DNA rate was 25%. Dr Wiener explained that tolerating a high DNA rate could be a good thing for this particular service, as clients were not immediately removed from the service, although it was noted that the Trust does not get paid for DNAs. Ms Moseley supported Dr Wiener, noting that her organisation has received complaints from people about their having been removed from services due to DNAs.

The Board discussed the issue of outcomes, noting that Commissioners are extremely interested in this. Dr Wiener noted that there would be a big push towards outcome monitoring. 1.5% of contracts would be linked to CQuINS. Dr Wiener noted that the service has, until now, relied upon its administrative systems to provide outcome data, but this will not be sufficient. Dr Patrick noted that the main driver of outcome monitoring should not be to comply with Commissioners' requirements, but to be able

to evidence services so the Trust can ensure it is provide high quality services. Dr McKenna noted that the Trust will need to work to embed outcome monitoring in its work, and noted that families of the Camden CAMHS service are asked to attend their sessions 15 minutes early to complete outcome forms prior to each session.

13. Any other business

None.

14. Notice of future meetings

Noted.

Outstanding Action Part 1

No.	Due Date	Agenda Item	Action Required	Director / Manager	Originating Meeting
1	Apr-10	16. Research & Development Report	Ms Moseley to arrange meeting with Dr Kennedy	Joyce Moseley	Nov-09
2	Apr-10	12. Information Governance Policy	All Trust policies to have a mechanism for reviewing their implementation and compliance	Trust-wide	Nov-09
3	Apr-10	5. Trust Chair's and Non-Executive Directors' Reports	Dr Patrick to provide pictorial view of the Trust's Assurance Framework	Pat Key	Jan-10
4	Apr-10	12. Information Governance Policy	History of development of policies to be added to front page	Trust-wide	Nov-09
5	May-10	15. Constitutional Amendments	Dr Hodges to return to Board of Directors with a proposal on junior membership	Sally Hodges	Jun-08
6	May-10	12. Annual Risk Management Review Report 2008/09	Section on vulnerable adults to be included in future reports	Rob Senior / Pat Key	Apr-09
7	May-10	8. Workforce Statistics	Data audit on turnover data to be undertaken	Susan Thomas	May-09
8	May-10	11. Single Equalities Scheme	Equalities discussion paper to be considered at Equalities Training event	Julia Smith	Jan-10
9	May-10	7b. Complaints Report	Student Complaints to be presented annually to Board of Directors	Trudy Klauber	Jan-10
10	Jun-10	14. Committee Minutes	Ms Lyon to present report on honorary appointments to Board of Directors	Louise Lyon / Susan Thomas	Oct-09
11	Jun-10	12. Health & Safety Guidance	Briefing on Health and Safety systems to be presented at Board of Directors' Lunch	Pat Key	Oct-09
12	Jun-10	10. Committee Minutes	Clinical Audit and integrated governance to be discussed at Directors' Conference on Outcomes	Rob Senior	Jan-10
13	Jun-10	11. Single Equalities Scheme	Miss Smith to give consideration to the description of mental health as a disability	Julia Smith	Jan-10
14	Jun-10	9. Care Quality Commission Registration	Essential Standards to be presented to Board of Directors on quarterly basis, beginning June 2010	Pat Key	Jan-10
15	Jun-10	11. Annual Training Services Report	Miss Carney to schedule Board of Directors discussion on branding management in relation to training	Louise Carney	Feb-10
16	Jun-10	14. RiO Project Update	RiO Project to return to the Board of Directors	Julia Smith	Feb-10
17	Sep-10	12. Student Feedback Report	Ms Klauber to undertake cross-organisational benchmarking	Trudy Klauber	Sep-09

Outstanding Action Part 1

18	Oct-10	5. Trust Chair's and Non-Executive Directors' Reports	Miss Carney to arrange session on the responsibilities and operation of the Board of Directors for the next layer of Management	Louise Carney	Oct-09
19	Nov-10	17. Membership Report	Miss Carney to provide comparative data on membership of foundation trusts	Louise Carney	Nov-09
20	Jan-11	22. Contingency for IT Failure	Internal Auditors to be asked to review policy to confirm it meets the Trust's requirements	Simon Young	Jan-09
21	Mar-11	12. Annual Communications Report	Future reports to reflect links Communications Department has with other Departments	Sally Hodges	Feb-10
22	As appropriate	13. Estates Report	Ms Key to return to Board of Directors with a timetable for Gloucester House relocation	Pat Key	May-09
23	As appropriate	20. RiO Business Case	Future reports to contain glossary of abbreviations used in report	Julia Smith	Nov-09
24	As appropriate	13. Website Analysis	Communications Department to consider the objectives and priorities of the Trust's website, when data becomes available	Kathryn Tyler	Feb-10
25	As appropriate	6. Chief Executive's Report	Ms Moseley to update the Board of Directors on Catch 22's discussions with Big White Wall	Joyce Moseley	Feb-10

Board of Directors : April 2010

Item : 6

Title : Chief Executive's Report

Summary:

The report covers the following items:

1. Introduction
2. Annual Plan
3. Organisational Changes in London

For : Discussion

From : Chief Executive

Chief Executive's Report

1. Introduction

- 1.1 This will be a brief report given that Easter has fallen between the last Board of Directors meeting and this one. I myself have been away for two weeks and many external developments have slowed or paused given the closeness of the General Election. Having said this, for some areas of the Trust this has been a particularly busy month. Within the CAMHS Directorate, the implementation of the new Young Person's Drug and Alcohol Service in Barnet, led by Dr Sally Hodges, has taken up much time and energy.
- 1.2 The Finance Department have also been fully occupied with the preparation of our draft annual accounts which are being submitted to Monitor and the Auditors on 22nd April and which are in line with the Finance and Performance Report presented to the Board of Directors today. The Trust has ended the year in a strong position financially and we expect to retain our Financial Risk Rating of 4 for the fourth quarter. This is particularly important in that it represents a good platform for this year's budget and contributes to ensuring our liquidity (our ability to pay our bills) for this and future years.

2. Annual Plan

- 2.1 Another element of work that has continued over the past month is the further development of this year's Annual Plan. All Service Line Directors have been involved in the preparation of the Plan as it relates to their own spheres of activity. The text, drafted earlier, is now being edited, and financial projections for Years 2 and 3 being built. A draft of the Plan is due to be circulated to the Board of Directors at the end of April / beginning of May for individual comment. A paper will then go to the Board of Governors for the 13th May meeting. A final draft of the Plan will be circulated on the 17th / 18th May for further comment, followed by discussion and approval at the Board of Directors' meeting on the 25th May. The plan is due to be submitted to Monitor on Friday 28th of May.
- 2.2 As you may expect, a key issue within the Plan relates to the economic climate facing the public sector and resultant funding and market pressures. In relation to this it is of note that in a recent communication from Stephen Hay (see appendix), Monitor issued a set of revised downside predictions against which aspirant and existing FTs would be assessed. It is also of note that within these predictions the likely funding environment for mental health trusts is set out as worse than that for the acute sector. This is based on an

assessment of the historic reality that in times of economic difficulty funding for mental health is reduced beyond that of the acute sector. In more recent years this has related to the lack of a tariff for mental health services, while the acute sector is funded on the basis of payment by results. It is perhaps inevitable that block contracts will be viewed as easier to manage than a tariff based contracts.

- 2.3 A related and equally key element of the plan relates to productivity. As a Trust we are still working on the basis of a need to make 5% improvements in productivity in each of the next three years. This is a realistic assessment in line with the new Monitor downside scenarios, but may also need to be varied in relation to local economic circumstances (for example the budgetary position of the five PCTs that constitute the North Central Sector).

3. Organisational Changes in London

- 3.1 The past month has also seen the next step in the unfolding future of PCT provider arms. In the absence of a coordinated strategy, within London provider arms are moving in a number of differing directions. It is reported that eleven PCT boards have chosen to vertically integrate their community services with NHS acute provider trusts or foundation trusts. Seven have opted to vertically integrate with mental health trusts or mental health foundation trusts. The remaining group includes four provider arms aspiring to become a community foundation trust under the name Central London Community Healthcare (CLCH), two social enterprises and one permitted by the Department of Health to remain as a direct provider. Five PCTs - Camden, Greenwich, Haringey, Hounslow and Richmond - are still to submit their proposals.
- 3.2 Within the North Central Sector, of those declared Barnet are part of the CLCH alliance, Enfield are looking towards an aspirant mental health FT, and Islington are integrating with an acute Trust.
- 3.3 Alongside these developments other organisational changes are out for consultation. These include a recent paper setting out the proposal to explore a potential merger between Homerton University Hospital NHS Foundation Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust. The single organisation is intended to offer increased flexibility to respond to service changes that are currently being consulted on, to be more resilient financially and to enable all 3 hospitals to be part of a Foundation Trust. It seems likely that other similar developments within London will be seen following the election as organisations work to ensure that they in the best possible shape to

deliver on the quality agenda within health within a very
constrained financial environment.

Matthew Patrick
Chief Executive
21 April 2010

1 April 2010



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To: Foundation Trust Applicants
Foundation Trust Unit
Foundation Trust Network

Dear Colleague,

I am writing to advise you of some changes to Monitor's financial assumptions used in the assessment of applicant trusts and in risk rating foundation trust investments and transactions. Consistent with our approach last year, Monitor has reviewed its financial assumptions in light of the Government's 2009 Pre Budget Report and 2010 Budget, and the publication of the Department of Health's Operating Framework for 2010/11.

As a result we have concluded that we need to change the downside assumptions to ensure they reflect a realistic view of the risks in the system. This letter sets out these changes. These revisions will come into effect for all authorisations from 1 May 2010 onwards, and NHS FTs should have regard to these financial assumptions in their annual planning.

As you will be aware, our current assumptions for acute and mental health providers were put in place on 1 May 2009. These assumptions were based on implied efficiency assumptions as set out below.

Current Financial Assumptions:

	10/11	11/12	12/13	13/14
Assessor Case Implied efficiency requirement	3.5%	4%	4%	4%
Downside Case Implied efficiency requirement	4%	4.5%	4.5%	4.5%

Following the 2009 Pre Budget Report and the 2010 Budget and the publication of the Department of Health's Operating Framework for 2010/11, Monitor has decided to retain the implied efficiency assumptions as set out in the current assessor case. There will however be some changes to the cost and tariff inflation assumptions to reflect the latest information in the 2010/11 Operating Framework.

Assessor case:

	10/11	11/12	12/13	13/14	14/15
Implied efficiency requirement	3.5%	4%	4%	4%	4%

Monitor has decided to adopt revised downside cases for acute and mental health providers as follows:

Acute Provider Downside case:

	10/11	11/12	12/13	13/14	14/15
Implied efficiency requirement	4.5%	5.1%	4.8%	4.6%	4.5%

Mental Health Provider Downside Cases:

	10/11	11/12	12/13	13/14	14/15
Implied efficiency requirement	4.5% and 5%				

For acute providers, we have concluded that the level of risk and uncertainty in overall health care expenditure should continue to be reflected by a 0.5% differential between the assessor and downside case from 10/11 onwards as in prior years. However, an additional adjustment has been made to reflect additional risk on providers from this year relating to demand growth.

The 2010/11 Operating Framework introduced a new 'marginal non elective tariff' and gave commissioners the power (with appropriate checks and balances) to suspend tariff. This represents a new risk on acute providers relating to demand management. In considering the downside case we have taken this into account as well as the likely response in local health economies through time i.e. we expect acute providers and commissioners to work together in time to ensure that demand can be managed to affordable levels through for example minimising avoidable emergency non elective admissions. The cumulative effect of these factors is reflected in the incremental efficiency requirements above the 0.5% differential.

Mental health providers face a different set of risks to those in the acute sector. Historically during periods of financial pressure in the healthcare system, expenditure on mental health activity has fallen more rapidly than expenditure in other areas. To reflect this risk Monitor will assess trusts in this sector against two downside cases of 4.5% and 5% efficiency requirement in each year.

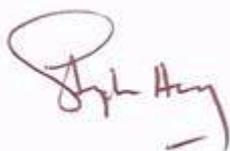
We recognise the scale of the productivity challenge that these efficiency requirements imply. However, it is important that the financial assumptions reflect the economic outlook and current policy framework. Monitor will continue to review these assumptions in light of any changes to either the economic outlook for the health sector or the policy framework. Whilst these assumptions reflect the risks facing the sector as a whole, we also recognise that providers in individual local health economies will face a specific individual set of circumstances, and we will continue to look at specific mitigations on a case-by-case basis.

Monitor will be writing separately to all applicant trusts shortly to provide more details of how the revised downside efficiency assumptions will be applied through the long term financial model. This letter will provide more details on the implied income inflation assumptions and costs pressures from unfunded activity growth.

This letter is being copied to SHA provider development leads for onward circulation to aspirant foundation trust applicants. The Foundation Trust Network should circulate this letter to their members.

Should you require any clarification on this letter please contact Richard Guest or Miranda Carter at the following email addresses: Richard.Guest@monitor-nhsft.gov.uk, Miranda.Carter@monitor-nhsft.gov.uk

Yours sincerely



Stephen Hay
Chief Operating Officer

CC: SHA Provider development leads

Board of Directors : April 2010

Item : 7

Title : Finance & Performance Report

Summary:

At the end of the 2009/10 financial year a surplus of £652k is reported, compared to the planned £151k. There has been a decrease in the surplus of £426k in month which is mainly due an increase in Central Functions and Clinical Directorates costs.

The cash balance at 31st March was £3,645k, £2,219k above Plan.

For : Discussion

From : Director of Finance

Finance and Performance Report

1. **External Assessments**

1.1 **Monitor**

1.1.1 For Quarter 3, Monitor gave the Trust a Financial Risk Rating of 4 and continued green ratings for governance and for mandatory services.

1.1.2 It is now expected that the actual financial risk rating for the full year may remain at 4, higher than Plan.

1.2 **The Care Quality Commission**

1.2.1 In the CQC annual health check 2008/09, the Trust was rated "Excellent" both for *quality of services* and for *management of financial resources*. The use of resources rating is based on Monitor's financial risk rating, where we achieved a 4. For 2009/10, the CQC rating on this category can be expected to be "Excellent" or "Good" depending on whether our FRR (see 1.1 above) is 4 or 3.

2. **Finance**

2.1 **Income and Expenditure 2009/10 (Appendices A and B)**

2.1.1 For the year, income is £127k above budget, and expenditure £312k below budget. The surplus is £510k above budget.

2.1.2 The cumulative income surplus of £127k against budget is mainly due to Training income £121k over achieved and Consultancy fees over achieved by £87k offset by an under achievement of £46k on Clinical income. Main income sources and their variances are discussed in sections 3, 4 and 5 below. £140k of research income has been deferred to 2010/11, to fund costs in that year including a post which has been vacant this year but will be filled.

2.1.3 The cumulative favourable variance on expenditure of £312k is mainly due to £217k in the Portman as a result of low staff numbers, Adult is £116k under budget primarily due to £121k for City & Hackney and £92k due to low numbers of Flexible Trainees.

2.1.4 As a result of the pay savings and a rates rebate Management authorised £240k additional non-recurrent expenditure on set-up costs, training and other investments in the Trust's facilities.

2.1.5 Interest income is below budget, due to the much lower rates available. However, the high cash balances held in the Government Banking Service have had the effect of reducing the dividend payable by some £100k.

2.2 **Cash Flow (Appendix C)**

2.2.1 The actual cash balance at 31st March was £3,643k, compared to the Plan of £1,424k. The income received above plan of £2,020k is due to income from general debtors which includes £670k from CWDC as

well as the over performance on the Day Unit. Also some income has been received in advance for 2010/11, and has been deferred.

- 2.2.2 Payments from the SHA for Training are also £670k above plan, partly due to additional payments received on behalf of students, hence the Students and sponsors under achievement. The under spend on salaries has been offset by the payments to CWDC partners.

	Cash Flow year-to-date		
	Actual £000	Plan £000	Variance £000
Opening cash balance	2,639	2,639	0
Operational income received			
NHS (excl SHA)	10,753	10,591	162
General debtors (incl LAs)	6,677	5,595	1,082
SHA for Training	11,161	10,484	677
Students and sponsors	2,185	2,338	(153)
Other	468	216	252
	<u>31,244</u>	<u>29,224</u>	<u>2,020</u>
Operational expenditure payments			
Salaries (net)	(13,407)	(13,610)	203
Tax, NI and Pension	(9,710)	(10,004)	294
Suppliers	(5,883)	(5,315)	(568)
	<u>(29,000)</u>	<u>(28,929)</u>	<u>(71)</u>
Capital Expenditure	(575)	(643)	68
Interest Income	20	20	0
Payments from provisions	(299)	(383)	84
PDC Dividend Payments	(386)	(504)	118
Closing cash balance	<u>3,643</u>	<u>1,424</u>	<u>2,219</u>

- 2.2.3 For 2010/11, a detailed cash forecast will be presented in May with the Annual Plan. Until then, it is noted that since we have a balanced income and expenditure budget, and since the opening balance is £2.2m higher than expected in the 2009 Plan, balances are forecast to remain satisfactory throughout the year. The increase over the 2009 Plan figures will reduce as deferred income is utilised

- 2.2.4 Clinical performance statistics will be provided in next months report.

3. **Training**

- 3.1 Income from university partners remains under negotiation, but we are near to agreement for the current academic year, and there has been no major variance from budget.
- 3.2 Training income is cumulatively over-achieving by £121k. This includes £153k on Fee Income and £82k on HEFCE Grant income which has been offset by £63k under achieved on Conferences.

4. **Patient Services**

4.1 **Activity and Income**

- 4.1.1 As previously reported, total contracted income for the year is in line

with budget. After twelve months, cost and volume activity is also in line. There are more significant variances, both positive and negative, in the other elements of clinical income, as shown in the table below.

	Budget £000	Actual £000	Variance %	Full year Variance	Comments
Contracts - base values	8,659	8,673	0.2%	13	
Cost and vol variances	22	10		-12	
NPAs	354	258	-27.2%	-96	
Projects and other	2,059	1,822		-	
Day Unit	955	1,149	20.3%	193	Treating more pupils than budgeted for
Monroe	810	676	-16.6%	-134	
FDAC	308	451	46.4%	-	Includes adjustment for last year. Income matched to costs, so variance is largely offset.
Court report	220	304	38.2%	84	
Total	13,388	13,342		48	

4.1.2 NPA (named patient agreements) income is £96k below budget, with £48k of this shortfall in the Portman.

4.1.3 Court report income was £84k above budget at year end mainly due to The Portman.

4.1.4 The Monroe income finished at £134k below budget.

5. Consultancy

5.1 TCS income was £131k in March, £66k above budget in month and £79k above cumulatively. The large in-month movement is due work done for CWDC.

5.2 Departmental consultancy income was £63k above budget this month and is £8k above at year end.

Simon Young
Director of Finance

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2009-2010

APPENDIX A

	Mar-10			CUMULATIVE		
	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S
INCOME						
1 CLINICAL	1,168	1,194	26	13,388	13,342	(46)
2 TRAINING	1,219	1,184	(35)	14,970	15,091	121
3 CONSULTANCY	104	233	129	1,119	1,206	87
4 RESEARCH	12	16	5	140	129	(11)
5 OTHER	39	64	25	556	531	(25)
TOTAL INCOME	2,542	2,691	149	30,172	30,299	127
OPERATING EXPENDITURE (EXCL. DEPRECIATION)						
6 CLINICAL DIRECTORATES	1,457	1,607	(150)	16,905	16,579	326
7 OTHER TRAINING COSTS	446	577	(132)	5,755	5,657	98
8 OTHER CONSULTANCY COSTS	47	93	(46)	567	605	(38)
9 CENTRAL FUNCTIONS	498	734	(236)	5,796	5,907	(111)
10 TOTAL RESERVES	0	0	0	0	0	0
TOTAL EXPENDITURE	2,448	3,012	(564)	29,023	28,747	276
EBITDA	93	(321)	(414)	1,150	1,552	402
ADD:-						
12 BANK INTEREST RECEIVED	2	2	0	20	18	2
LESS:-						
11 DEPRECIATION	43	132	(89)	515	563	(48)
13 FINANCE COSTS	0	0	0	0	0	0
14 DIVIDEND	42	(25)	67	504	355	149
RETAINED SURPLUS	10	(426)	(436)	151	652	505
EBITDA AS % OF INCOME	3.7%	-11.9%		3.8%	5.1%	

	Mar-10			CUMULATIVE		
	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S
INCOME						
NHS LONDON TRAINING CONTRACT	620	582	(38)	7,445	7,457	12
TRAINING FEES & OTHER ACA INC	370	384	14	4,776	4,835	59
POSTGRADUATE MED & DENT'L EDUC	5	5	0	64	64	0
JUNIOR MEDICAL STAFF	92	72	(20)	1,109	1,084	(24)
CHILD PSYCHOTHERAPY TRAINEES	131	140	9	1,576	1,650	74
R&D	12	16	5	140	129	(11)
CLINICAL INCOME	966	934	(32)	11,095	10,763	(332)
DAY UNIT	79	90	11	955	1,149	194
MONROE & FDAC	104	87	(17)	1,118	1,126	8
TCS INCOME	65	131	66	654	733	79
DEPT CONSULTANCY INCOME	39	102	63	465	473	8
COURT REPORT INCOME	18	82	64	220	304	84
EXCELLENCE AWARDS	13	10	(3)	157	142	(15)
RENTAL INCOME	0	0	0	41	40	(0)
OTHER INCOME	26	53	28	358	349	(10)
TOTAL INCOME	2,542	2,691	149	30,172	30,299	127
EXPENDITURE						
EDUCATION & TRAINING	279	416	(136)	3,754	3,783	(29)
PORTMAN CLINIC	132	139	(7)	1,583	1,366	217
ADULT DEPT	277	322	(44)	2,829	2,714	116
MEDNET	20	14	5	250	236	14
ADOLESCENT DEPT	126	158	(32)	1,409	1,404	5
ADOLESCENT PROJECTS	38	34	3	451	435	15
C & F CENTRAL	593	583	10	7,107	7,011	95
C&F PROJECTS	62	80	(19)	741	757	(16)
MONROE & FDAC	83	97	(14)	994	1,091	(96)
DAY UNIT	62	77	(14)	748	772	(24)
SPECIALIST SERVICES	59	72	(14)	713	678	35
COURT REPORT EXPENDITURE	7	31	(24)	80	116	(36)
TRUST BOARD	10	13	(3)	121	106	15
CHIEF EXECUTIVE OFFICE	27	41	(14)	319	391	(72)
PERFORMANCE & INFORMATICS	76	79	(2)	702	726	(24)
FINANCE & ICT	87	149	(62)	1,051	1,127	(75)
CENTRAL SERVICES DEPT	168	267	(99)	2,016	2,071	(55)
HUMAN RESOURCES	54	68	(14)	643	606	37
CLINICAL GOVERNANCE	22	25	(3)	250	232	18
TRUST DIRECTOR	8	19	(10)	175	164	11
PPI	15	18	(2)	212	192	20
SWP & R+D & PERU	37	33	4	394	358	36
R+D PROJECTS	0	0	(0)	0	1	(1)
PGMDE	10	17	(7)	125	106	19
NHS LONDON FUNDED CP TRAINEES	128	123	5	1,539	1,537	2
TAVISTOCK SESSIONAL CP TRAINEES	11	12	(2)	128	114	14
FLEXIBLE TRAINEE DOCTORS	17	10	7	208	116	92
TCS	45	90	(45)	537	569	(32)
DEPARTMENTAL CONSULTANCY	2	3	(1)	30	35	(6)
DEPRECIATION	43	132	(89)	515	563	(48)
PROJECTS CONTRIBUTION	(7)	(13)	6	(86)	(102)	16
IFRS HOLIDAY PAY PROV ADJ	0	36	(36)	0	36	(36)
CENTRAL RESERVES	0	0	0	0	0	0
TOTAL EXPENDITURE	2,491	3,144	(652)	29,538	29,310	227
OPERATING SURPLUS/(DEFICIT)	50	(453)	(503)	635	989	354
INTEREST RECEIVABLE	2	2	(0)	20	18	(2)
UNWINDING OF DISCOUNT ON PROVISION	0	0	0	0	0	0
DIVIDEND ON PDC	(42)	25	67	(504)	(355)	149
SURPLUS/(DEFICIT)	10	(426)	(437)	151	652	501

Appendix C

2009/10 Plan

	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	2,639	3,155	3,023	2,992	2,783	2,243	1,712	1,771	1,751	1,365	1,895	2,069	2,639
Operational income received													
NHS (excl SHA)	846	1,013	841	907	961	830	807	959	830	807	960	830	10,591
General debtors (incl LAs)	808	335	774	449	306	283	443	372	327	664	476	358	5,595
SHA for Training	860	901	860	860	902	860	859	901	860	860	901	860	10,484
Students and sponsors	300	150	150	100	0	200	500	200	0	550	188	0	2,338
Other	18	18	18	18	18	18	18	18	18	18	18	18	216
	2,832	2,417	2,643	2,334	2,187	2,191	2,627	2,450	2,035	2,899	2,543	2,066	29,224
Operational expenditure payments													
Salaries (net)	(1,109)	(1,160)	(1,134)	(1,134)	(1,134)	(1,135)	(1,134)	(1,134)	(1,134)	(1,134)	(1,134)	(1,134)	(13,610)
Tax, NI and Pension	(776)	(820)	(857)	(839)	(839)	(839)	(839)	(839)	(839)	(839)	(839)	(839)	(10,004)
Suppliers	(433)	(489)	(585)	(539)	(485)	(398)	(397)	(398)	(398)	(398)	(397)	(398)	(5,315)
	(2,318)	(2,469)	(2,576)	(2,512)	(2,458)	(2,372)	(2,370)	(2,371)	(2,371)	(2,371)	(2,370)	(2,371)	(28,929)
Capital Expenditure	0	(81)	0	(20)	0	(100)	(200)	(100)	(52)	0	0	(90)	(643)
Interest Income	2	1	2	2	1	2	2	1	2	2	1	2	20
Payments from provisions	0	0	(100)	(13)	(270)	0	0	0	0	0	0	0	(383)
PDC Dividend Payments	0	0	0	0	0	(252)	0	0	0	0	0	(252)	(504)
Closing cash balance	3,155	3,023	2,992	2,783	2,243	1,712	1,771	1,751	1,365	1,895	2,069	1,424	1,424

2009/10 Actual/Forecast

	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	2,639	3,069	2,930	2,752	3,112	3,090	2,295	3,135	3,032	3,204	3,507	4,191	2,639
Operational income received													
NHS (excl SHA)	703	873	713	1,600	632	575	1,229	693	1,146	462	1,324	803	10,753
General debtors (incl LAs)	898	544	395	233	606	289	525	411	204	1,076	933	563	6,677
SHA for Training	968	857	914	917	924	857	870	908	949	1,062	1,030	905	11,161
Students and sponsors	256	65	47	75	77	196	543	206	155	320	120	125	2,185
Other	23	19	45	33	18	45	28	29	37	87	27	77	468
	2,848	2,358	2,114	2,858	2,257	1,962	3,195	2,247	2,491	3,007	3,434	2,473	31,244
Operational expenditure payments													
Salaries (net)	(1,116)	(1,065)	(1,090)	(1,056)	(1,076)	(1,045)	(1,101)	(1,154)	(1,184)	(1,150)	(1,205)	(1,165)	(13,407)
Tax, NI and Pension	(776)	(815)	(794)	(808)	(785)	(784)	(785)	(804)	(809)	(844)	(840)	(866)	(9,710)
Suppliers	(527)	(540)	(405)	(426)	(345)	(705)	(185)	(321)	(299)	(672)	(699)	(759)	(5,883)
	(2,419)	(2,420)	(2,289)	(2,290)	(2,206)	(2,534)	(2,071)	(2,279)	(2,292)	(2,666)	(2,744)	(2,790)	(29,000)
Capital Expenditure	0	(78)	(4)	(80)	(74)	(13)	(148)	(73)	(30)	(38)	(5)	(32)	(575)
Interest Income	1	1	1	8	1	1	0	2	3	0	0	2	20
Payments from provisions	0	0	0	(136)	0	(18)	(136)	0	0	0	(1)	(8)	(299)
PDC Dividend Payments	0	0	0	0	0	(193)	0	0	0	0	0	(193)	(386)
Closing cash balance	3,069	2,930	2,752	3,112	3,090	2,295	3,135	3,032	3,204	3,507	4,191	3,643	3,643

Board of Directors : April 2010

Item : 8

Title : 2009/10 Monitor's Quarter 4 Governance Declaration

Summary:

The Trust has to make a quarterly declaration to Monitor to *"confirm compliance with its authorisation in relation to all targets and national core standards"*.

The Board of Directors must confirm that all targets have been met (after application of thresholds) over the period and that plans are in place to ensure that all known targets which will come into force will also be met. Only two targets could, in theory, apply: waiting times and booking (the Trust has its own waiting time targets, which are equivalent to the national targets). No new targets are to come into force that would apply to the Trust.

At the July 2007 meeting, it was agreed, on the advice of Monitor and NHS London, that waiting time and booking targets do not apply to the Trust because the Trust does not provide medical consultant led clinics. Therefore, no breaches have been reported.

The Board of Directors has agreed declarations of full compliance against CQC Core Standards to date. No lapses in compliance have been identified; the Board of Directors is asked to approve the 2009/10 quarter 4 declaration:

The Board confirms that all targets and national core standards have been met over the period (after application of thresholds) and that sufficient plans are in place to ensure that all known targets and national core standards that come into

force will also be met.

See separate paper setting out the basis on which the proposed declaration of compliance with the CQC's Essential Standards has been made.

For : Approval

From : Director of Corporate Governance and Facilities

Board of Directors : April 2010

Item : 9

Title : Corporate Governance Report

Summary :

The Board of Directors are asked to approve the sealing of the contract for the City & Hackney service.

For : Approval

From : Trust Secretary

Board of Directors : April 2010

Item : 10a

Title : Care Quality Commission Compliance 2009/10

Summary:

This paper presents the Trust's proposed declaration against the Care Quality Commission's national priority assessments for 2010/11 against the applicable Standards: Learning Disabilities; and Child and Adolescent Mental Health Care (details of the Trust's self-assessment are contained in the paper).

In addition, the Trust is required to report any failure to comply with Core Standards during the period November 2009 to March 2010. However, the Trust met all the Core Standards that apply to our services

For : Approval

From : Director of Corporate Governance & Facilities

Care Quality Commission Compliance 2009/10

1.0 Recap on position for 2009-10

The process for 2009-10 is in two parts: a full declaration against core standards for April-Oct 2009 (previously submitted); and a second declaration to confirm that there have been no breaches in complying with standards for the period Nov 2009- Mar 2010, or details of any breaches with associated action plan (see below).

In addition, the Trust is required to declare performance against national priorities in April 2010 for 2009-10.

The CQC will crosscheck declarations using all available evidence. It will not publish ratings for 2009-10; instead, from 1.4.10 continuous monitoring will come into force under the new scheme of regulation.

2.0 Assurance that core standards are met Nov 2009- March 2010

Boards are required to maintain assurance systems with regard to core standards, and they are required to inform the CQC of any significant lapses or gaps in assurance. Such systems must be able to generate data at any time of the year (not as an annual exercise as was the case with the HCC). At its meeting in November the Board agreed that the trust would continue to monitor compliance with core standards via the risk register.

Since Nov 2009, no lapse has been discovered and no new relevant risks have been added to the register.

In the table below, the areas of potential weakness provided to the Board in Nov 2009 have been updated; performance has not changed significantly:

Standard	Position at Month 7 Oct 2009	Position at year end Mar 2010	Position end Mar 2009
<i>C 11(b) All staff are required to attend Trust induction</i>	<i>92% for period April – Oct 2009</i>	<i>85% at year end</i>	<i>66% attendance</i>
<i>All staff are required to attend mandatory training (INSET)</i>	<i>97% of target staff has attended (245). Note we have reduced frequency to 2 yearly</i>	<i>97% of target staff has attended (245). Note we have reduced frequency to 2 yearly No change as there were no further INSET sessions in 2009-10</i>	<i>Not included in declaration</i>
<i>C2 Records of Level 3 child protection training should be kept</i>	<i>Detailed records are now kept. Training progress for level 3 Total staff requiring training = 295 Trained by 31.10.09 = 246 (85%)</i>	<i>97% trained at Level 1 (as part of INSET, see above) 94% trained at level 3 Current training focus on Level 2 training</i>	<i>No records kept</i>

As a result of this the Board is asked to approve a 'no change' report for year-end.

2.3 Performance national priorities and existing commitments

The CQC set the following performance indicators for the Trust for 2009/10:

- **Best practice relating to service access for patients with learning difficulties** (*self assessment against standard set, see report below*)
- **CAMHS service assessment** (*self declaration against standard set, see report below*)
- **Mental Health Minimum Data Set (MHMDS)** externally gathered
- **NHS staff satisfaction survey** (externally gathered)

The Board is asked to approve the declared scores based on the information provided:

Performance Assessment 2009/10

Access to healthcare for people with a learning disability

Rationale

The Independent Inquiry into Access to Healthcare for People with learning Disabilities recommended performance indicators for assessment of compliance with the Human Rights Act 1998 and the Disability Discrimination Act 1995. These ensure that equity of access for people with learning disabilities as human rights in the NHS, and that 'reasonable adjustments' are made in the delivery of services to reduce health inequalities.

Indicator

Note: *This indicator will not be included in the scored assessment for 2009/10. However, trusts will be expected to collect the information and report on it separately and we will publish this along side the results of the review to ensure visibility.*

The scoring guide for question 1, 3-6 is as follows:

- (1) = Protocols/mechanisms are not in place.
- (2) = Protocols/mechanisms are in place but have not yet been implemented.
- (3) = Protocols/mechanisms are in place but are only partially implemented.
- (4) = Protocols/mechanisms are in place and are fully implemented.

Scoring guide for question 2 is as follows:

1. Accessible information not provided

2. Accessible information provided for one of the criteria
3. Accessible information provided for two of the criteria
4. Accessible information provided for all three of the criteria.

Criteria for Assess to healthcare for people with a learning disability	Score (1-4)	Evidence	Assurance
1. Does the trust have a mechanism in place to identify and flag patients with learning disabilities* and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?	3	<ul style="list-style-type: none"> ○ We operate a specialist LD service for both adults and children, and receive direct referrals to the service , referrals will contain some LD information ○ Learning Disability information is collected routinely for all CAMHS patients from Nov 09, this is as part of the assessment process conducted by clinicians with patients and parent/carer ○ We receive direct referrals to the LCDS service where LD information is provided as part of the referral, we reassess this at the assessment phase of contact for all patients accepted for assessment ○ The LCDS runs a twice-monthly clinical workshop, which is open to all clinical staff in the Trust. The workshop offers the opportunity to examine and explore issues pertinent to patients who have learning/ complex disability 	<ul style="list-style-type: none"> ○ Referral administrators can confirm that direct referrals to the services are received and reviewed by clinical teams ○ Case note review would show that LD information is recorded when relevant ○ Referral letters and assessment documentation within the patient record ○ Contact Maxine Dennis and Lynda Miller re raising LD issues in adult and adolescent services respectively. ○ Elisa Reyes-Simpson can provide details of the Nov 2009 conference ○ Elisa Reyes Simpson can provide details of clinical workshops

		<ul style="list-style-type: none"> ○ LCDS offer consultation to clinicians from all directorates ○ MOSAIC team presented their work to the Child & Family directorate 	<ul style="list-style-type: none"> ○ Nancy Sheppard can provide details of MOSIAC team presentations ○ Ellisa Reyes Simpson can provide confirmation of advisory service to clinicians
<p>2. In accordance with the Disability Equality Duty of the Disability Discrimination Act (2005), does the trust provide readily available and comprehensible information** (jointly designed and agreed with people with learning disabilities, representative local bodies and/or local advocacy organisations) to patients with learning disabilities about the following criteria:</p> <ul style="list-style-type: none"> • treatment options (including health promotion) • complaints procedures, and • appointments 	<p style="text-align: center;">4</p>	<ul style="list-style-type: none"> ○ The Trust commissioned some advisory work from People First to help us improve our literature and other arrangements for patients with LD, because of this work new documents have been produced and there is an ongoing piece of work arising from the consultation with the reception and front of house staff, see attached documents. <div style="display: flex; justify-content: space-around; align-items: flex-start;"> <div style="text-align: center;">  Complaints leaflet.doc </div> <div style="text-align: center;">  Information for Patients.doc </div> </div> <div style="text-align: center; margin-top: 10px;">  Tavistock leaflet.doc </div>	<ul style="list-style-type: none"> ○ To include more information on the website. Consult Sally Hodges <div style="display: flex; justify-content: space-around; align-items: flex-start;"> <div style="text-align: center;">  recommendations from consultation2.doc </div> <div style="text-align: center;">  Response from Estates Team.doc </div> </div>

<p>3. Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities, including the provision of information regarding learning disabilities, relevant legislation*** and carers' rights?</p>	<p>3</p>	<ul style="list-style-type: none"> ○ Learning Disabilities team have agreed mechanisms to support families, it is integral to the way that the service is delivered. 	<ul style="list-style-type: none"> ○ A review of records will show this to be the way that the service operates. The trust does not have a written procedure describing how this is to be carried out in practice as this will be according to the specific needs of the patient
<p>4. Does the trust have protocols in place to routinely include training on learning disability awareness, relevant legislation***, human rights, communication techniques for working with people with learning disabilities and person centred approaches in their staff development and/or induction programmes for all staff?</p>	<p>3</p>	<ul style="list-style-type: none"> ○ Mandatory inset training days (every staff member has to attend at least one every 2 years) includes Disability Awareness Training including presentation about vulnerable Adults by a member of the Learning Disability Team ○ During the Induction Day presentation, Elisa Reyes-Simpson makes a presentation, not solely as a member of LCDS, but as the Trust Advisor on Vulnerable Adults ○ Training for team managers, on annual basis, on Disability Awareness ○ Regular one-to-one consultations for front-line staff from senior Learning Disability team members regarding specific L D patients as necessary 	<ul style="list-style-type: none"> ○ INSET and Clinical Audit INDUCTION programmes ○ Elisa Reyes Simpson can provide details of other training conducted throughout the year ○ The Mandatory training matrix included Vulnerable Adults training and this includes persons with a LD, within the staff training policy (most up to date policy attached) <div style="display: flex; justify-content: space-around; align-items: flex-start;"> <div style="text-align: center;">  Staff training Policy March 2010.doc </div> <div style="text-align: center;">  vulnerable adults July 2008 final.doc </div> </div> <div style="text-align: center; margin-top: 20px;">  vulnerable adults July 2008 final.doc </div>

<p>5. Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers within Trust Boards, local groups and other relevant forums, which seek to incorporate their views and interests in the planning and development of health services?</p>	<p>2</p>	<ul style="list-style-type: none"> ○ The Trust invites all patients (Including LD patients) to be members of the trust ○ in 2009-10 there was no LD representative on the PPI committee but as a result of the People First project there will be a representative from April 2010 ○ we have a voluntary sector rep as a Trust Governor 	<ul style="list-style-type: none"> ○ Application to Trust membership available to all (but currently we do not have information written in a simple format in relation to membership) ○ We will have a Peoples First rep on the PPI committee from April 2010
<p>6. Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? (1-4)</p>	<p>3</p>	<ul style="list-style-type: none"> ○ The LD have a team meeting weekly during which cases are audited and reviewed, it is core to the way the department works ○ The Trust seeks feedback from patients including patients with LD and these are reported in our annual PPI report which is available via the trust website 	<ul style="list-style-type: none"> ○ Elisa Reyes Simpson an provide details of the Friday clinical meetings ○ PPI information on Trust website: http://128.86.238.87/sites/default/files/PPI%20recent%20activity.pdf ○ http://128.86.238.87/Patient%20and%20public/involvement-strategy

Definitions

* *Learning disabilities (Valuing People, 2001) include the presence of:*

1. *A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;*
2. *A reduced ability to cope independently (impaired social functioning);*
3. *which started before adulthood, with a lasting effect on development.*

***As described in the Mental Capacity Act (2007), organisations should take 'all practicable steps' to present information in a way that is appropriate to the person's circumstances.*

****To include the Mental Capacity Act (2007), the Disability Discrimination Act (1995) and the Carers Act (1995)*

Data source and period

Care Quality Commission special data collection (as at 31st March 2010)

CQC National Priorities Performance assessment 2009/10

Child and adolescent mental health services (CAMHS)

Rationale

Mental health problems in children are associated with educational failure, family disruption, disability, offending and antisocial behaviour, placing demands on social services, schools and the youth justice system. Untreated mental health problems create distress not only in the children and young people but also for their families and carers, continuing into adult life and affecting the next generation. The National Service Framework for Children, Young People and Maternity Services set out the standards and milestones for improvement in child and adolescent mental health services, including year on year improvements in access.

Indicator

Trusts will be assessed on their responses to the following six questions. For each question, a response of 1 to 4 is required depending upon the extent to which plans and protocols are in place and are fully implemented for all aspects of each question. The scoring guide for each question is as follows:

- (1) = Protocols/mechanisms are not in place.*
- (2) = Protocols/mechanisms are in place but have not yet been implemented.*
- (3) = Protocols/mechanisms are in place but are only partially implemented.*
- (4) = Protocols/mechanisms are in place and are fully implemented.*

Overall Indicator

The responses to the six questions will be combined to give an overall indicator score.

Data source and period

Care Quality Commission special data collection (as at March 31st 2010)

Criteria for CAMHS special data collection	Score (1-4)	Evidence	Assurance
<p>1. Does the trust have identifiable protocols and mechanisms for accessing the views of children and young people in contact with child and adolescent mental health services as part of service reviews</p>	<p>3/4</p>	<p>Named lead: Sally Hodges Lead for PPI and Associate Director C&F</p> <p>Mechanisms and staff support in place:</p> <p>Children's Survey (annual each February) Report</p> <p>PPI Annual Report</p> <p>Adolescent Department text survey</p>	<p>All three surveys are discussed in the monthly PPI committee which reports to the Board</p> <p>Annual Report for PPI , which is received by the Board includes achievements and forward plans</p>  <p>Annual Report 2008-2009.pub</p>
<p>2. Does the trust have identifiable protocols and mechanisms to collect routine individual outcome measures for children and young people in contact with child and adolescent mental health services and to make use of the information to inform service development</p>	<p>3/4</p>	<p>Named Lead: Dr C McKenna Associate Medical Director</p> <p>Mechanisms and staff support for process in place:</p> <p>Collection of routine individual outcome measures for children and young people has been collected in the department for several years.</p>	<p>Outcome Monitoring is a standing agenda item at the monthly Clinical Governance Committee Meeting and the monthly Clinical Services Management Committee Meeting.</p> <p>Training on the use of the expanded protocol is being provided to staff.</p> <p>An Associate Medical Director has taken the lead for Outcome Monitoring and will be attending the</p>

		<p>However, in a current pilot project the range of measures used has been expanded to fulfil the requirements of CORC (CAMHS Outcome Research Consortium) i.e. to use an agreed common set of measures to evaluate routinely outcomes from at least three key perspectives – the child/young person, the parent/carer and the clinician as well as measuring service satisfaction.</p> <p>All processes including significant additional IT support are now in place for the expanded range of measures to be implemented across all service lines from 1 April 2010.</p>	<p>CORC Members Forum from April 2010.</p> <p>Improvement plan shown here:</p>  <p>Quality Improvement Plan2.doc</p>
<p>3. Does the trust have shared protocols in place with commissioners to ensure that children and young people in contact with mental health services are cared for in environments which are appropriate for their age and level of maturity (ensuring compliance with the Age Appropriate Environment Amendment within the Mental Health Act 2007) and offer adequate child protection</p>	<p>4</p>	<p><i>The change in legislation applies to inpatient settings only therefore is not relevant to the trust.</i></p> <p><i>We are 'fully compliant' as it is not applicable to the Trust</i></p> <p><i>n.a</i></p>	
<p>4. Does the trust have protocols in</p>	<p>4</p>	<p>There is the joint protocol, with Camden and</p>	<p>Monitoring of compliance is via monthly Tier 4</p>

<p>place (and an audit process for monitoring compliance with the protocol) for the transition of young people from child and adolescent mental health services to adult mental health services</p>		<p>Islington Foundation NHSFT, which is managed by them. Our Psychiatrists are on the district rota for out of hours mental health cover for children and adolescents.</p>  <p>CAMHS-Adult Transition Protocol Ja</p>	<p>monitoring group that tracks all admissions of under 18s, which ensures that no young people are admitted to adult psychiatric wards</p> <p>We submitted the findings of an SUI involving a near 18 year old to the Commissioners for consideration</p>  <p>Final Investigation report HB.doc</p>
<p>5. Has the trust established partnerships and protocols for information sharing, support and early intervention across the range of multi-agency services to ensure that children and young people in contact with mental health services receive care based on joint working and evidence based practice</p>	<p>4</p>	<p>Named Lead : Rita Harris CAMHS Director</p> <ol style="list-style-type: none"> 1. We are an integral part of Camden’s Children and Young people’s partnership planning structures. 2. CAMHS are jointly planned and commissioned in all major contract areas and we are integral to these processes. 3. There are CAMHS reference groups for joint planning, and monitoring of CAMHS in all major contract areas. 4. We are part of Camden’s integrated working steering group and have established outreach service in partnership with CSF 5. Referrals to CAMHS come via single points of entry and on e-caf 	<ol style="list-style-type: none"> 1. The CAMHS Director is a member of the CAMHS joint commissioning group that meets quarterly. 2. The CAMHS Director and associate Clinical Director are members of the CAMS and Emotional well being reference groups. 3. The Camden Team leaders are members of Camden’s integrated working steering group. 4. The associate clinical Director Chairs the Joint intake/Single point of Entry meeting to ensure clear and consistent referral pathways 5. . All outreach services are reviewed regularly with the relevant commissioner and CAMHS Manager.
<p>6. Does the trust have protocols in</p>	<p>4</p>	<p>Trust Lead for Learning Disabilities Elisa</p>	<ol style="list-style-type: none"> 1. There are regular service and contract

<p>place to ensure the range of services provided reflect the specific needs related to the circumstances of the child, particularly where associated with the presence of a learning disability</p>		<p>Reyes- Simpson</p> <ol style="list-style-type: none"> 1. We employ and second CAMHS staff into an integrated service run for disabled children, young people and their families. 2. The Trust also provides a specialist psychotherapeutic service for those with Learning and Complex Disabilities across the age range. 3. We have recently commissioned a review by People First, the learning disability advocacy group to look at all our services and literature to ensure it is disability user friendly 4. The trust has effective procedures in place for management of children with learning disabilities either by appropriate allocation at intake or by access to advisers/ service once a patient has been accepted. 	<p>monitoring meetings with the CAMHS commissioner and service managers.</p> <ol style="list-style-type: none"> 2. Disability review has been considered by the PPI committee which reports to the board 3. Feedback from People First (also see CQC Special Data Collection on Learning Disability for full details)
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Board of Directors : April 2010

Item : 10b

Title : Care Quality Commission Reporting 2010/11

Summary:

The report provides information on the ongoing monitoring of Essential Standards for 2010/11.

For : Approval

From : Director of Corporate Governance & Facilities

Care Quality Commission Reporting 2010/11

1. As reported in January 2010, unlike the annual declaration against Core Standards, all registered providers will be expected to keep an ongoing check on compliance with all Essential Standards, and could be subject to an inspection and/or request for compliance evidence at any time. The CQC have indicated that each regulated body will have an inspection of some or all of its business each year, performed by the local assessor.
2. In order to be fully prepared for this it is intended that a rolling check of compliance and data gathering against compliance is established with quarterly reports to the relevant Committee, and an 'exception' report will be presented to the Board of Directors quarterly. This will be tied into the cycle for review of the Assurance Framework and Risk Registers.
3. An Assurance Map reporting format has been developed with assistance from our internal auditors and an 'unpopulated' version is shown at Appendix A of this report.
4. Any compliance that is found to be 'at risk' will be added to the Risk Register and a detailed action plan developed and then monitored by the appropriate Committee. It is proposed that as the Trust becomes fully familiar with the new Standards, the Board of Directors will receive a fully updated Assurance Map for the first two quarters of 2010/11, and then subject to approval by the Board of Directors, it is proposed that the updated map is presented to the Audit Committee and the Board of Directors receives a summary 'exception' report.
5. All evidence will be stored centrally on 'Performance Accelerator', the new governance software currently being implemented, which will also be used to store and update the Risk Register and evidence of compliance with NHSLA standards.

Pat Key
Director of Corporate Governance and Facilities
April 2010

Tavistock and Portman Foundation NHS Trust CQC Essential Standards of Quality and Safety - Assurance Map												
Reg	Outcome no	Subject	Director Lead	Standards for Better Health cross reference	Links to NHSLA standard	Monitoring committee /group	Key Trust assurances	Key external assurances (including internal audit)	Any issues raised by CQC Quality & Risk Profile (QRP)	Comments	Rating at 31.3.10	
INVOLVEMENT AND INFORMATION												
R17	1	Respecting and involving people who use services		<u>Strong links:</u> C13a - Dignity & Respect C16 - Accessible Information <u>Some Links:</u> C 7e - Discrimination C17 - PPI C18 - Choice & equity C23 - Public Health Cycle								
R18	2	Consent to care and treatment		<u>Strong Link:</u> C13b - Consent <u>Some Links:</u> C12 - Research Governance								
R21	3	Fees etc.	this does not apply to the Trust as we do not offer private care									
PERSONALISED CARE, TREATMENT AND SUPPORT												
R9	4	Care and welfare of people who use services		<u>Strong links:</u> C5a - NICE technology appraisal & nationally agreed guidance <u>Some links:</u> C1a - Incidents - reporting & learning C1b - Patient Safety communications C3 - NICE interventional procedures C7a&c - Clinical & corporate governance C23 - Public Health cycle C24 - Emergency	3.1 secure environment							
R14	5	Meeting nutritional needs	not relevant to the Trust									

Reg	Outcome no	Subject	Director Lead	Standards for Better Health cross reference	Links to NHSLA standard	Monitoring committee /group	Key Trust assurances	Key external assurances (including internal audit)	Any issues raised by CQC Quality & Risk Profile (QRP)	Comments	Rating at 31.3.10
R24	6	Cooperating with other providers		<u>Strong links:</u> C6 - Partnership working <u>Some Links:</u> C13c - confidentiality of patient information C22a&c - Public Health partnerships C24 - Emergency preparedness	4.10 transfer and discharge						
SAFEGUARDING AND SAFETY											
R11	7	Safeguarding vulnerable service users		<u>Strong links:</u> C2 - safeguarding children	3.3 safeguard adults						
R12	8	Cleanliness and infection control		<u>Strong links:</u> C4a - Infection control C4c - Decontamination C21 - Element 2: Environment	4.9.infection control						
R13	9	Management of medicines		<u>Strong links:</u> C4d - Medicines Management <u>Some Links:</u> C1a - Incidents - reporting & learning C1b - Patient Safety communications C12 - Research Governance	4.6 meds management						
R15	10	Safety and suitability of premises		<u>Strong links:</u> C20a - Safe, secure environment C20b - Privacy & Dignity <u>Some Links</u> C1a - Incidents- reporting & learning. C1b - Patient safety communications C4e - Clinical waste C21 - Clean, well designed environment	3.1 secure environment						

Reg	Outcome no	Subject	Director Lead	Standards for Better Health cross reference	Links to NHSLA standard	Monitoring committee /group	Key Trust assurances	Key external assurances (including internal audit)	Any issues raised by CQC Quality & Risk Profile (QRP)	Comments	Rating at 31.3.10
R16	11	Safety, availability and suitability of equipment		<p><u>Strong links:</u> C4b - Safe use of medical devices</p> <p><u>Some links:</u> C1a - Incidents- reporting & learning. C1b - Patient safety communications C21 - Clean, well designed environment</p>							
SUITABILITY OF STAFFING											
R21	12	Requirements relating to workers		<p>C10a - Employment checks C10b - professional codes of conduct C11a - Recruitment, training, & skill mix, C11b - Mandatory training C11c - Professional Development</p>	1.9 prof reg. 1.10 employment checks						
R22	13	Staffing		C11a - Recruitment, training, & skill mix,	2.1, 2.2, 2.3 induction 2.4 clin supervision						
R23	14	Supporting workers		<p>C5b - Clinical supervision C5c - updating clinical skills & techniques C8b, Personal development C11b - Mandatory training C11c - Professional Development C20a - safe, secure environment</p>	2.4 clin supervision 2.5 risk management training						
QUALITY AND MANAGEMENT											

Reg	Outcome no	Subject	Director Lead	Standards for Better Health cross reference	Links to NHSLA standard	Monitoring committee /group	Key Trust assurances	Key external assurances (including internal audit)	Any issues raised by CQC Quality & Risk Profile (QRP)	Comments	Rating at 31.3.10
R11	15	Statement of Purpose		New		N/A			N/A		
R8	16	Assessing and monitoring the quality of service provision		Strong links: C1a - Incident reporting & learning C5d - Clinical audit & review C7a&c - Clinical & Corporate Governance Some links: C8a - Whistle blowing C14a - Complaints response C17 - Patient & public involvement C23 - Public health cycle	5.2 incident reporting 5.3 concerns 5.8 NICE 5.9 NSF's 1.7 External reviews						
R19	17	Complaints		#VALUE!	5.3 complaints						
R20	21	Records		Strong links: C9 - Records Management C13c - Confidentiality of patient information	1.8 health records 4.4 health records standards						

Board of Directors : April 2010

Item : 11

Title : Standing Financial Instructions

Summary:

This paper highlights the changes that have been made to Standing Financial Instructions.

In addition to the changes listed, minor typographical and grammatical errors have been amended. All references have been updated.

The Instructions are included at Appendix 1, for reference, with tracked changes.

The revised Instructions were approved by the Management Committee on 22nd April, and are presented to the Board of Directors for approval. Following approval, the Instructions will be published on the Trust's Intranet.

For : Approval

From : Trust Secretary

Review of Standing Financial Instructions

- 1 Paragraph 1.2, Terminology has been extended so that it is congruent with the related paragraph in the Trust's Constitution.
- 2 Paragraph 2.1 has been extended so that it reflects the full breadth of the Audit Committee's duties.
- 3 Paragraph 2.4 has been extended to ensure it reflects the full breadth of Internal Audit's functions.
- 4 Paragraph 2.4.4.1 has been updated in line with the *Government Internal Audit Standards* document.
- 5 Paragraph 3.2.1.3 has been added to reflect the level of information that is included in each budget.
- 6 Paragraph 5.3.1.4 has been amended so it is in line with the Trust's *Operating Cash Management Policy*.
- 7 Paragraph 6.2.5 has been amended to make it clear that responsibility for ensuring the Trust has procedures in place to ensure compliance with the Private Patient Cap lies with the Director of Finance.
- 8 Paragraph 8.1.2 has been amended to make it clear that the Remuneration Committee does not provide advice to the Board of Directors, but has delegated responsibility to make decisions itself.
- 9 Paragraph 8.1.3 has been amended as above, and also makes it clear that the Board of Directors remains responsible for the decisions of its Committees.
- 10 Paragraph 8.1.4, which stated that the Chief Executive would present proposals on changes in the remuneration and conditions of service of those employees not covered by the Remuneration Committee to the Board of Directors, has been removed, as those staff not covered by the Remuneration Committee are covered by arrangements, such as Agenda for Change, and Medical Salaries. Paragraph 8.1.5 and 8.1.6 have become paragraph 8.1.4 and 8.1.5 respectively.
- 11 Paragraph 9.2.8 no longer makes reference to *Concode*, as the Department of Health notes that this has been superceded by other developments in procurement regulations. The Trust is still required to comply with all other applicable policy and guidance.

- 12 Paragraph 11.1.5 has been amended to remove the reference to the Business Development and Investment Committee, which does not have responsibility for reviewing capital projects.
- 13 Paragraph 16.9.1 has been added to make it clear that the Trust must appoint an Auditor or Independent Examiner, in accordance with Charity Commission requirements, to review its funds held on trust.
- 14 Paragraph 20.1 has been added to make it clear that all items covered by the Trust's *Policy on Gifts and Hospitality* are to be recorded in the Trust's *Register of Gifts and Hospitality*, which is held by the Trust Secretary.
- 15 Appendix 1, paragraph 4.2 has a footnote to define Part B services.
- 16 Appendix 1, paragraph 4.5 has been amended to note that the approved lists for capital and estates projects are held by the Royal Free Hospital, and that for other procurement, approved suppliers are those with whom PASA has negotiated contracts.
- 17 Appendix 1, paragraph 5.1.1 has been amended to ensure that at the time of issuing invitations to tender, the "originating department" notifies the Trust Secretary of the firms invited and the closing date, and agrees a reference number with the Trust Secretary.
- 18 Appendix 1, paragraph 5.3.7 has been amended to reflect the fact that the *Register of Tenders* is held by the Trust Secretary, not the Chief Executive, which is in line with the rest of SFIs, and reflects current practice.
- 19 Appendix 1, paragraph 5.5.3 has been amended to reflect the fact that unopened tenders are held by the Trust Secretary, not the Chief Executive, which is in line with the rest of SFIs, and reflects current practice.
- 20 Appendix 1, paragraph 5.6.2 has been amended to note that a copy of the outcome of the tender exercise, stating reasons as to why a tender was awarded to a particular individual / firm, should be retained with the *Register of Tenders*.
- 21 Appendix 1, paragraph 6.1.1 has been amended to increase the minimum threshold for quotations to £10,000 (the previous £5k threshold was set in 1998).

- 22 Appendix 1, paragraph 6.2.1 has been amended to ensure that copies of quotations are held on file and retained by the Supplies Officer.
- 23 Appendix 1, paragraph 6.2.2 has been amended to ensure that reasons for obtaining verbal and not written quotations for goods / services estimated to cost more than £5,000 are set out in a permanent record and held by the Supplies Officer.
- 24 Appendix 1, paragraph 6.2.4 has been amended to ensure that reasons for choosing one particular individual / firm over another are set out in a permanent record and held by the Supplies Officer.
- 25 Appendix 1, paragraph 6.3 has been added to provide for exceptions and instances where quotations need not be obtained (this paragraph was previously in Standing Orders (2003 ed.))
- 26 Appendix 1, paragraph 12.6 was removed from SFIs, as it was a superfluous paragraph, and was not logically placed.

Standing Financial Instructions

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Standing Financial Instructions

1 Introduction

1.1 General

1.1.1 These *Standing Financial Instructions (SFIs)* shall have effect as if incorporated in the *Board of Directors Standing Orders (BDSOs)*¹.

1.1.2 These *SFIs* detail the financial responsibilities, policies, and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency, and effectiveness.

1.1.3 These *SFIs* identify the financial responsibilities that apply to everyone working for the Trust and its constituent organisations. They do not provide detailed procedural advice. These *SFIs* should therefore be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

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1.1.4 Should any difficulties arise regarding the interpretation or application of any of these *SFIs*, the advice of the Director of Finance must be sought before acting. The user of these *SFIs* should also be familiar with, and comply with, the provisions of *BDSOs*. Note in particular [the SFI Appendix](#) and [BDSO 11](#).

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1.1.5 Officers of the Trust should note that *BDSOs*, *SFIs*, and the *Scheme of Delegation of Powers*, do not contain every legal obligation applicable to the Trust. The Trust and each officer of the Trust must comply with all requirements of legislation (which shall mean any statute, subordinate or secondary legislation, any enforceable community right within the meaning of [Section 2\(1\) of the European Community Act 1972](#) and any applicable judgment of a relevant court of law which is a binding precedent in England), and all guidance and directions binding on the Trust. Legislation, guidance and directions will impose requirements additional to *BDSOs*, *SFIs*, and the *Scheme of Delegation of Powers*. All such legislation and binding guidance and directions shall take precedence over *BDSOs*, *SFIs*, and the *Scheme of Delegation of Powers*, which shall be interpreted accordingly.

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1.1.6 Officers of the Trust should further note that they must disclose forthwith to the Chief Executive any material non-compliance with

¹ For *BDSOs*, see [Tavistock & Portman NHS Foundation Trust, Constitution, Election Rules, Standing Orders, February 2010](#)

BDSOs, SFIs, and the Scheme of Delegation of Powers of which they become aware.

1.1.7 Failure to comply with BDSOs, SFIs, and the Scheme of Delegation of Powers is a disciplinary matter that could result in dismissal.

1.2 Terminology

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning as in these instructions; and

1.2.1.1 "the Accounting Officer" is the person who, from time to time, discharges the functions specified in paragraph 25(5) of Schedule 7 to the National Health Service Act 2006;

1.2.1.2 "Chief Executive" shall mean the chief officer of the Trust;

1.2.1.3 "Board of Directors" shall mean the Trust Chair and Non-Executive Directors, appointed by the Board of Governors, and the Chief Executive and Executive Directors, appointed by the relevant committee of the Trust, whose responsibilities are set out in Board of Directors' Standing Orders;

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1.2.1.4 "Board of Governors" shall mean the Trust Chair and Governors, appointed and elected;

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1.2.1.5 "Budget" shall mean a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

1.2.1.6 "Budget Holder" shall mean the Director or employee with delegated authority to manage finances (income and/or expenditure) for a specific area of the organisation;

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1.2.1.7 "Director" shall mean a person appointed as a Director in accordance with the Membership and Procedure Regulations and includes the Trust Chair;

1.2.1.8 "Director of Finance" shall mean the chief finance officer of the Trust;

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1.2.1.9 "Funds held on trust" shall mean those funds that the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under

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section 47 of the *National Health Service Act 2006*. Such funds may or may not be charitable;

1.2.1.10 "Legal Adviser" shall mean the properly qualified person appointed by the Trust to provide legal advice;

1.2.1.11 "Nominated Officer" shall mean an officer charged with the responsibility for discharging specific tasks within BDSOs and SFIs;

1.2.1.12 "Officer", shall mean staff member referred to in 1.2.1.14;

1.2.1.13 "the Regulator" is Monitor, the Independent Regulator of NHS Foundation Trusts, established under Section 31 of the *National Health Service Act 2006*.; and

1.2.1.14 "Staff" shall mean all those employed on permanent contracts, all those appointed on fixed term contracts of more than a year, people who have been continuously employed for more than twelve months, honorary staff working more than 10 hours per week on average or earning more than £5,000 per annum, contractors (e.g. canteen staff), those employed by other organisations but working at the Trust (e.g. researchers, staff in service units);

1.2.1.15 "Terms of Authorisation" are the terms of authorisation issued by Monitor under Section 35 of the *National Health Service Act 2006*;

1.2.1.16 "the Trust", shall mean the Tavistock and Portman NHS Foundation Trust; and

1.2.1.17 "Trust Secretary" shall mean a person appointed by the Trust to monitor the Trust's compliance with the law, the Trust's Constitution, and observance of relevant guidance;

1.2.2 Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these *SFIs*, it shall be deemed to include such other Director or employees who have been duly authorised to represent them.

1.2.3 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3 Responsibilities and delegation

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¶
<#>"Legal Adviser" means the properly qualified person appointed by the Trust to provide legal advice; ¶
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<#>"Independent Regulator" is Monitor, the Independent Regulator of NHS Foundation Trusts, established under Section 31 of the *National Health Service Act 2006*. ¶
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1.3.1 The Board of Directors exercises financial supervision and control by:

1.3.1.1 formulating the financial strategy of the Trust;

1.3.1.2 requiring the submission and approval of budgets;

1.3.1.3 defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

1.3.1.4 defining specific responsibilities placed on Directors and employees as indicated in the *Scheme of Delegation of Powers*.

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1.3.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in *BDSO 11*.

1.3.3 The Board of Directors will delegate responsibility for the performance of its functions in accordance with the *Scheme of Delegation of Powers*.

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1.3.4 Within these *SFIs*, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors for ensuring that the Board of Directors meets its obligation to perform its functions with the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board of Directors for ensuring that its financial obligations and targets are met, and has overall responsibility for the Trust's system of internal control.

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1.3.5 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

1.3.6 It is a duty of the Chief Executive to ensure that existing Directors and employees and all new appointees are notified of and understand their responsibilities within these *SFIs*.

1.3.7 The Director of Finance is responsible for:

1.3.7.1 implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

1.3.7.2 maintaining an effective system of internal financial control, including ensuring that detailed financial procedures and systems incorporating the principles of

separation of duties and internal checks are prepared, documented and maintained to supplement these instructions; and

1.3.7.3 ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

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1.3.8 Without prejudice to the functions of Directors and employees of the Trust, the duties of the Director of Finance include:

1.3.8.1 the provision of financial advice to the Trust and its Directors and employees;

1.3.8.2 the design, implementation and supervision of systems of internal financial control; and

1.3.8.3 the preparation and maintenance of such accounts, certificates, estimates, records, and reports as the Trust may require for carrying out its statutory duties.

1.3.9 All Directors and employees, separately and collectively, are responsible for:

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1.3.9.1 the security of the property of the Trust;

1.3.9.2 avoiding loss;

1.3.9.3 exercising economy and efficiency in the use of resources; and

1.3.9.4 conforming to the requirements of *BDSOs*, *SFIs*, the *Scheme of Delegation of Powers*, and financial procedures.

1.3.10 Any contractor, or employee of a contractor, who is empowered by the Trust to commit the Trust to expenditure, or who is authorised to obtain income shall be covered by these *SFIs*. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.11 For any and all Directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which Directors and employees discharge their duties must be to the satisfaction of the Director of Finance.

2 Audit

2.1 Audit Committee

2.1.1 The Board of Directors shall formally establish an Audit Committee, in accordance with BDSO 5, with clearly defined terms of reference, which will provide an independent and objective view of integrated governance, risk management, and internal control by:

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2.1.1.1 overseeing Internal and External Audit services, and counter fraud services;

2.1.1.2 reviewing financial systems;

2.1.1.3 monitoring compliance with *BDSOs* and *SFIs*;

2.1.1.4 review the adequacy of all risk and control related disclosure statements;

2.1.1.5 review the adequacy of the Trust's assurance processes;

2.1.1.6 review the adequacy of Trust policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements;

2.1.1.7 other matters as set out in the Audit Committee's Terms of Reference.

2.1.2 Where the Audit Committee feel there is evidence of *ultra vires* transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board of Directors.

2.1.3 It is the responsibility of the Director of Finance to ensure an adequate Internal Audit service is provided, and the Audit Committee shall be involved in the selection and appointment (or re-appointment) of an Internal Audit service provider.

2.2 Fraud and corruption

2.2.1 The Chief Executive and the Director of Finance shall monitor and ensure compliance with the Regulator's directions on fraud and corruption and with all guidance issued by the Counter Fraud and Security Management Service (CFSMS) of the Department of Health.

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2.2.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the [NHS Counter Fraud and Corruption Manual](#).²

2.2.3 The Local Counter Fraud Specialist shall report to the Director of Finance and shall work with staff in the CFSMS in accordance with the [NHS Counter Fraud and Corruption Manual](#).

2.3 Director of Finance

2.3.1 The Director of Finance is responsible for:

2.3.1.1 ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

2.3.1.2 ensuring that the internal audit is adequate and meets the [requirements of the Audit Code for NHS Foundation Trusts](#)³;

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2.3.1.3 deciding at what stage to involve the police in cases of misappropriation and other irregularities; and

2.3.1.4 ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee. The report must cover:

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[2.3.1.4.1](#) a clear statement on the effectiveness of internal control;

[2.3.1.4.2](#) major internal control weaknesses discovered;

[2.3.1.4.3](#) progress on the implementation of [Internal Audit](#) recommendations;

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[2.3.1.4.4](#) progress against Plan over the previous year;

[2.3.1.4.5](#) strategic audit plan covering the coming three years; and

[2.3.1.4.6](#) a detailed plan for the coming year.

2.3.2 The Director of Finance or designated auditors are entitled, without necessarily giving prior notice, to require and receive:

² [NHS Counter Fraud Service, NHS Counter Fraud and Corruption Manual](#)

³ [Monitor, Audit Code for NHS Foundation Trusts, October 2007](#)

- 2.3.2.1 access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- 2.3.2.2 access at all reasonable times to any land, premises or employee of the Trust;
- 2.3.2.3 the production of any cash, stores or other property of the Trust under an employee's control; and
- 2.3.2.4 explanations concerning any matter under investigation.

2.4 Role of Internal Audit

2.4.1 Internal Audit will review, appraise and report upon:

- 2.4.1.1 the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
- 2.4.1.2 the adequacy and application of financial and other related management controls;
- 2.4.1.3 the suitability of financial and other related management data;
- 2.4.1.4 the extent to which the Trust's assets and interests are accounted for, and safeguarded from, loss of any kind, arising from:

2.4.1.4.1 waste, extravagance, and inefficient administration; and

2.4.1.4.2 poor value for money or other causes; and

2.4.1.5 any other risk management, control, and governance matters as outlined in the Internal Audit strategy.

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¶

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- 2.4.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property, or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.
- 2.4.3 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Trust Chair and Chief Executive of the Trust.

2.4.4 The *NHS Foundation Trust Accounting Officer Memorandum*⁴ provides that Internal Audit should accord with the objectives, standards and practices set out in the *Government Internal Audit Standards*⁵, which states that Internal Audit is an independent and objective appraisal service within an organisation:

2.4.4.1 Internal auditing is "an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes".⁶

2.4.5 Accordingly, the Head of Internal Audit shall be accountable to the Director of Finance, but also to the Chief Executive. The reporting system for Internal Audit shall be agreed between the Director of Finance, the Audit Committee, the Chief Executive and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting and relationships contained in the *Government Internal Audit Standards*⁷. The reporting system shall be reviewed at least every three years.

2.5 External Audit

2.5.1 The External Auditor is appointed by the Board of Governors on the recommendation of the Audit Committee.

2.5.2 In auditing the accounts, the Auditor must comply with any directions given by the Regulator as to the standards, procedures, and techniques to be adopted, in particular the *Audit Code for NHS Foundation Trusts*⁸.

3 Business Planning, Budgets, Budgetary Control and Monitoring

3.1 Preparation and approval of budgets

3.1.1 Prior to the start of the financial year, the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board of Directors. Such budgets will:

Deleted: <#>Internal audit primarily provides an independent and objective opinion to the Accountable Officer, the Board of Directors and the Audit Committee on risk management, control and governance, by measuring and evaluating their effectiveness in achieving the organisation's agreed objectives. In addition, internal audit's findings and recommendations are beneficial to line management in the audited areas. Risk management, control and governance comprise the policies, procedures and operations established to ensure the achievement of objectives, the appropriate assessment of risk, the reliability of internal and external reporting and accountability processes, compliance with applicable laws and regulations, and compliance with the behavioural and ethical standards set for the organisation.¶

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<#>Internal audit also provides an independent and objective consultancy services specifically to help line management improve the organisation's risk management, control and governance. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management put in place to ensure the achievement of the organisation's objectives, and through recommendations for improvement. Such consultancy work contributes to the opinion which internal audit provides on risk management, control and governance. ¶

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⁴ Monitor, *NHS Foundation Trust Accounting Officer Memorandum*, April 2008

⁵ HM Treasury, *Government Internal Audit Standards*, April 2009

⁶ *The Definition of Internal Auditing*, © 1999 Copyright by The Institute of Internal Auditors, in HM Treasury, *Government Internal Audit Standards*, April 2009, p.7

⁷ HM Treasury, *Government Internal Audit Standards*, April 2009

⁸ Monitor, *Audit Code for NHS Foundation Trusts*, October 2007

- 3.1.1.1 contain a statement of the significant assumptions on which they are based;
- 3.1.1.2 contain details of major changes in workload, delivery of services, or resources required;
- 3.1.1.3 be produced following discussion with appropriate Budget Holders;
- 3.1.1.4 be prepared within the limits of available funds; and
- 3.1.1.5 identify potential risks.

3.1.2 The Director of Finance shall monitor financial performance against budget and report to the Board of Directors.

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3.1.3 All Budget Holders will sign up to their allocated budgets at the beginning of each financial year.

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3.1.4 All Budget Holders must provide information as required by the Director of Finance to enable budgets to be compiled.

3.1.5 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to Budget Holders to help them successfully manage their budgets.

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3.2 Budgetary delegation

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

3.2.1.1 the amount of the budget;

3.2.1.2 the purpose(s) of each budget heading;

3.2.1.3 a detailed breakdown of the budget, including the staffing numbers at each grade (the establishment);

3.2.1.4 individual and group responsibilities;

3.2.1.5 authority to exercise virement;

3.2.1.6 achievement of planned levels of service; and

3.2.1.7 the provision of regular reports.

- 3.2.2 The Chief Executive and delegated Budget Holders must not exceed the budgetary total or virement limits set by the Board of Directors.
- 3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.
- 3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.3 Budgetary control and reporting

- 3.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

- 3.3.1.1 monthly financial reports to the Board of Directors in a form approved by them, containing:

- [3.3.1.1.1](#) income and expenditure to date, showing trends and forecasting year-end position;

- [3.3.1.1.2](#) (quarterly) capital project spend and projected outturn against Plan;

- [3.3.1.1.3](#) explanations of any material variances from Plan; and

- [3.3.1.1.4](#) details of any corrective action where necessary, and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

- 3.3.1.2 the issue of timely, accurate and comprehensible advice and financial reports to each Budget Holder, covering the areas for which they are responsible;

- 3.3.1.3 investigation and reporting of variances from financial, workload, and manpower budgets;

- 3.3.1.4 monitoring of management action to correct variances; and

- 3.3.1.5 arrangements for the authorisation of budget transfers.

- 3.3.2 Each Budget Holder is responsible for ensuring that:

- 3.3.2.1 any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board of Directors;
- 3.3.2.2 the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and
- 3.3.2.3 no permanent employees are appointed without the approval of the Chief Executive other than those provided for in the budgeted establishment as approved by the Board of Directors.

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Trust's Annual Plan and a balanced budget.

3.4 Capital expenditure

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure, ~~(the particular regulations relating to capital are contained in SFI 11).~~

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3.5 Financial reporting to the Regulator

3.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the Regulator.

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4 Annual Accounts and Reports

4.1 The Director of Finance, on behalf of the Trust, will:

4.1.1 prepare financial returns in accordance with the accounting policies and guidance given by the Regulator and the Treasury, the Trust's accounting policies, and International Financial Reporting Standards (IFRS);

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4.1.2 prepare and submit annual financial reports to Parliament with reports signed in accordance with current guidance; and

4.1.3 submit financial returns to the Regulator for each financial year in accordance with the timetable prescribed.

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4.2 The Trust's audited annual accounts must be presented to members of the Trust at the Annual General Meeting.

4.3 The Trust will publish an Annual Report, in accordance with guidelines on local accountability, and present it to the Board of Governors and to the Annual General Meeting of the Trust. The document will comply with the [NHS Foundation Trust Annual Reporting Manual](#)⁹ issued each year.

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5 Bank and Paymaster Accounts

5.1 General

5.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance [and/or](#) directions issued [by](#) the Department of Health.

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5.1.2 The Board of Directors shall approve the banking arrangements.

5.2 Bank and Paymaster accounts

5.2.1 The Director of Finance is responsible for:

- 5.2.1.1 bank accounts and Paymaster accounts;
- 5.2.1.2 establishing separate bank accounts for the Trust's Non-Exchequer funds;
- 5.2.1.3 ensuring payments made from bank or Paymaster accounts do not exceed the amount credited to the account except where arrangements have been made; and
- 5.2.1.4 reporting to the Board of Directors all arrangements made with the Trust's bankers for accounts to be overdrawn.

5.3 Banking procedures

5.3.1 The Director of Finance will prepare detailed instructions on the operation of bank and Paymaster accounts which must include:

- 5.3.1.1 the conditions under which each bank and Paymaster account is to be operated;
- 5.3.1.2 the limit to be applied to any overdraft;
- 5.3.1.3 those authorised to sign cheques or other orders drawn on the Trust's accounts;

⁹ Monitor, [NHS Foundation Trust Annual Reporting Manual 2009-10, April 2010](#)

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5.3.1.4 an [Operating Cash Management Policy](#), to be authorised by the Board [of Directors](#) and applied where money is to be invested [to ensure that a competitive return is obtained on surplus operating cash, while minimising risk and also avoiding disproportionate administration costs](#), (see [SFI 10.2.1](#)); and

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5.3.1.5 the signatory requirements for different payment amounts and types.

5.3.2 Note that the Board of Directors has reserved to itself the power to determine the list of posts whose holders shall be authorised signatories ([BDSO 11.7.2](#)). When new persons are appointed to these posts, the Director of Finance will implement the necessary changes without further reference to the Board of Directors.

5.3.3 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.4 Tendering and review

5.4.1 The Director of Finance will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

5.4.2 Competitive tenders should be sought at least every five years, with the exception of the [Government Banking Service](#). The results of the tendering exercise should be reported to the Board of Directors.

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6 Income, Fees, and Charges, and Security of Cash, Cheques, and other Negotiable Instruments

6.1 Income systems

6.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection, and coding of all monies due [to the Trust](#).

6.1.2 The Director of Finance is also responsible for ensuring the prompt banking of all monies received [by the Trust](#).

6.2 Fees and Charges

6.2.1 The Trust shall follow the Department of Health's advice in setting prices for service agreements within the NHS, and shall implement *Payment by Results*, [where applicable](#).

6.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges, other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

6.2.3 Under no circumstances ~~shall~~ the Trust accept cash payments worth more than £5,000.

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6.2.4 All employees must inform the Finance Directorate promptly of money due arising from transactions, which they initiate ~~and/or~~ deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.2.5 The ~~Director of Finance shall establish procedures to ensure that the~~ Trust ~~complies with the~~ [Private Patient Income Cap](#) required under the Terms of Authorisation.

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6.3 Debt recovery

6.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income not received should be dealt with in accordance with losses procedures.¹⁰

6.3.3 Overpayments to employees, suppliers or other creditors should be detected (or preferably prevented) and recovery initiated.

6.4 Security of cash, cheques and other negotiable instruments

6.4.1 The Director of Finance is responsible for:

6.4.1.1 approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

6.4.1.2 ordering and securely controlling any such stationery;

6.4.1.3 the provision of adequate facilities and systems for employees whose duties include collecting and holding

¹⁰ See HM Treasury, [Managing Public Money, Annex 4.10 "Losses and Write Offs", and Annex 4.13 "Special Payments", February 2010](#)

cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

- 6.4.1.4 prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.
- 6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques.
- 6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.
- 6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7 Contracting for Provision of Services

- 7.1 The Board of Directors shall regularly review, and shall at all times maintain and ensure, the capacity and capability of the Trust to provide the mandatory goods and services referred to in the Terms of Authorisation and related Schedules.
- 7.2 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable contracts with Primary Care Trusts and other commissioners for the provision of NHS services.
- 7.3 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services, whether clinical or non-clinical, the responsible officer should ensure that an appropriate contract is present and signed by both parties.
- 7.4 All contracts shall be legally binding, shall comply with best costing practice and shall be so devised as to manage contractual risk, in so far as is reasonably achievable in the circumstances of each contract, whilst optimising the Trust's opportunity to generate income.
- 7.5 In carrying out these functions, the Chief Executive should take into account the advice of Directors regarding:
 - 7.5.1 costing and pricing of services and/or goods;

- 7.5.2 payment terms and conditions;
 - 7.5.3 billing systems and cash flow management;
 - 7.5.4 the contract negotiating process and timetable;
 - 7.5.5 the provision of contract data;
 - 7.5.6 contract monitoring arrangements;
 - 7.5.7 amendments to contracts; and
 - 7.5.8 any other matters relating to contracts of a legal or non-financial nature.
- 7.6 The Director of Finance shall produce regular reports detailing actual and forecast service activity income with a detailed assessment of the impact of the variable elements of income.

8 Terms of Service and Payment of Directors and Employees

8.1 Remuneration and terms of service

8.1.1 In accordance with *BDSOs*, the Board of Directors shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

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8.1.2 The terms of reference will include delegated authority to take decisions on the remuneration and terms of service of the Chief Executive and other Executive Directors.

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8.1.3 The Committee shall report in writing to the Board of Directors the basis for its decisions. The Board of Directors shall remain accountable for decisions on the remuneration and terms of service of Executive Directors.

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8.1.4 Employees of the Trust will only be paid in accordance with their contracts of employment. Additional payments are forbidden.

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8.1.5 The Trust will remunerate the Trust Chair and Non-Executive Directors in accordance with the decisions of the Board of Governors.

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8.2 Funded establishment

8.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

8.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive.

8.3 Staff appointments

8.3.1 No Director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration unless:

8.3.1.1 authorised to do so by the Chief Executive;

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8.3.1.2 within the limit of his approved budget and funded establishment; and

8.3.1.3 within the Trust's approved paycales and procedures.

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8.3.2 The Board of Directors will approve procedures presented by the Chief Executive for any changes in the determination of commencing pay rates, condition of service, etc, for employees.

8.4 Processing of payroll

8.4.1 The Director of Finance is responsible for arranging the provision of an appropriate payroll service. Together with the service provider, the Director of Finance is responsible for:

8.4.1.1 specifying timetables for submission of properly authorised time records and other notifications;

8.4.1.2 the final determination of pay;

8.4.1.3 making payment on agreed dates; and

8.4.1.4 agreeing method of payment.

8.4.2 Together with the service provider, the Director of Finance will issue instructions regarding:

8.4.2.1 verification and documentation of data;

8.4.2.2 the timetable for receipt and preparation of payroll data and the payment of employees;

8.4.2.3 maintenance of subsidiary records for pension contributions, income tax, social security, and other authorised deductions from pay;

[8.4.2.4](#) security and confidentiality of payroll information;

[8.4.2.5](#) checks to be applied to completed payroll before and after payment;

[8.4.2.6](#) authority to release payroll data under the provisions of the *Data Protection Act 1998*;

[8.4.2.7](#) methods of payment available to various categories of employee;

[8.4.2.8](#) procedures for payment by cheque, bank credit, or cash to employees;

[8.4.2.9](#) procedures for the recall of cheques and bank credits;

[8.4.2.10](#) pay advances and their recovery;

[8.4.2.11](#) maintenance of regular and independent reconciliation of pay control accounts;

[8.4.2.12](#) separation of duties of preparing records and handling cash; and

[8.4.2.13](#) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

[8.4.3](#) Appropriately nominated managers have delegated responsibility for:

[8.4.3.1](#) submitting time records, and other notifications in accordance with agreed timetables;

[8.4.3.2](#) completing time records and other notifications in accordance with the instructions of the Director of Finance and in the form prescribed by the Director of Finance; and

[8.4.3.3](#) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination, or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Human Resources [Directorate](#) must be informed immediately.

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[8.4.4](#) Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate [contracted](#) terms and conditions, adequate internal

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controls, and audit review procedures, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.5 Contracts of employment

8.5.1 The Board of Directors shall delegate responsibility to a manager for:

8.5.1.1 ensuring that all employees are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment legislation; and

8.5.1.2 dealing with variations to, or termination of, contracts of employment.

8.6 Overtime and expenses

8.6.1 Overtime and expenses claims must be filed within six months. Claims filed after that period will not be paid.

9 Non-Pay Expenditure (see also *SFI Appendix*)

9.1 Delegation of authority

9.1.1 The Board of Directors will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to Budget Holders.

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9.1.2 The Chief Executive and the Director of Finance will set out:

9.1.2.1 the list of managers who are authorised to place requisitions for the supply of goods and services; and

9.1.2.2 the maximum level of each requisition and the system for authorisation above that level.

9.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

9.2 Choice, requisitioning, ordering, receipt and payment for goods and services

9.2.1 Official orders must:

9.2.1.1 be consecutively numbered;

9.2.1.2 be in a form approved by the Director of Finance;

- 9.2.1.3 state the Trust's terms and conditions of trade; and
- 9.2.1.4 only be issued to, and used by, those duly authorised by the Chief Executive.
- 9.2.2 Orders will normally be issued based on a requisition signed by a Budget Holder and sent to the Supplies Officer. Budget Holders do not have authority to commit the Trust to a purchase directly, except as follows:
 - 9.2.2.1 library books and services (see *Scheme of Delegation of Powers 3(d)*); Deleted: , section
 - 9.2.2.2 travel arrangements;
 - 9.2.2.3 hotel bookings; and
 - 9.2.2.4 catering and flowers (up to a maximum of £500). Deleted: 2
- 9.2.3 Under no circumstances should a requisition number be quoted to a supplier as authority for a purchase.
- 9.2.4 The requisitioner, in choosing the item to be supplied (or the service to be performed), shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Supplies Officer shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted. Officers must comply with the *SFI Appendix*, which requires competitive tenders or quotations to be obtained where the expected cost exceeds certain thresholds. Deleted: below,
- 9.2.5 The Director of Finance will:
 - 9.2.5.1 be responsible for the prompt payment of all properly authorised accounts and claims, in accordance with contract terms and with the *Better Payment Practice Code*¹¹;
 - 9.2.5.2 be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:
 - 9.2.5.2.1 A list of Directors and employees (including specimens of their signatures) authorised to certify invoices; Deleted: /

¹¹ See <http://www.payontime.co.uk/>

9.2.5.2.2 Certification that:

9.2.5.2.2.1 goods have been duly received, examined, and are in accordance with specification, and the prices are correct;

9.2.5.2.2.2 work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

9.2.5.2.2.3 in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price, and the charges for the use of vehicles, plant, and machinery have been examined;

9.2.5.2.2.4 where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

9.2.5.2.2.5 the account is arithmetically correct; and

9.2.5.2.2.6 the account is in order for payment;

9.2.5.2.3 a timetable and system for submission to the Director of Finance of accounts for payment (provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment); and

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9.2.5.2.4 instructions to employees regarding the handling and payment of accounts within the Finance Directorate;

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9.2.5.3 be responsible for ensuring that payment for goods and services is only made once the goods and services have been received (except as below).

9.2.6 Pre-payments are only permitted where exceptional circumstances apply. In such instances:

9.2.6.1 pre-payments are only permitted where the financial advantages outweigh the disadvantages and the intention is not to circumvent cash limits;

9.2.6.2 the appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the pre-payment agreement unable to meet his commitments;

9.2.6.3 the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and

9.2.6.4 the Budget Holder is responsible for ensuring that all items due under a pre-payment contract are received, and he must immediately inform the appropriate Director or Chief Executive if problems are encountered.

9.2.7 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

9.2.7.1 all contracts, leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

9.2.7.2 contracts above specified thresholds are advertised and awarded in accordance with European Union and World Trade Organisation rules on public procurement and comply with legislation and Government guidance on competitive procurement;

9.2.7.3 where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;

9.2.7.4 no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Directors or employees, other than:

[9.2.7.4.1](#) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars; and

9.2.7.4.2 conventional hospitality, such as lunches in the course of working visits¹²;

9.2.7.5 no requisition or order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

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9.2.7.6 all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;

9.2.7.7 verbal orders must only be issued very exceptionally – by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed subsequently by an official order and clearly marked "Confirmation Order";

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9.2.7.8 orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

9.2.7.9 goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

9.2.7.10 changes to the list of Directors / employees authorised to certify invoices are notified to the Director of Finance;

9.2.7.11 purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and

9.2.7.12 petty cash records are maintained in a form as determined by the Director of Finance.

9.2.8 The Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within Estatecode¹⁴ and all other applicable policy and guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.

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9.2.9 Leases

¹² See also [Department of Health, Health Service Guideline \(93\)5: Standards of business conduct for NHS staff](#), January 1993, for guidance on standards of business conduct for NHS staff,

¹⁴ [Department of Health, Estatecode, January 2003](#)

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Deleted: Ibid.

9.2.9.1 [SFI 9.2.1, 9.2.2, 9.2.3 and 9.2.4](#), above, apply to leases as to any other purchase contracts. When determining whether tendering or quotations are required in accordance with [SFI 9.2.4](#), the expected value of the lease across the whole term will be used in respect of the thresholds set out in [the SFI Appendix](#).

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9.2.9.2 Any leases above a five-year commitment will require the explicit approval of the Director of Finance.

9.3 Bankruptcy clauses in contracts

[9.3.1](#) Trust contracts are to explicitly state that the Trust is to be made aware of any bankruptcy of any customer or supplier.

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[9.3.2](#) The Director of Finance should make every effort to apprise himself of any formal insolvency arrangement applied to any customer or supplier.

[9.3.3](#) When a formal insolvency arrangement is discovered, all payments should be ceased pending confirmation of the exact legal status of the insolvency arrangement, and subsequent payments must be made to the correct person.

[9.3.4](#) When a formal insolvency arrangement is discovered, a statement should be prepared showing amounts due to and from the Trust. Any claim must be lodged by the Trust with the correct party without delay.

[10](#) External Borrowing and Investments

10.1 External borrowing

10.1.1 The Director of Finance will advise the Board of Directors concerning the Trust's ability to pay interest on, and repay the Public Dividend Capital (PDC) and any loans or overdrafts. The Director of Finance is also responsible for reporting periodically to the Board of Directors concerning the PDC and all loans and overdrafts.

10.1.2 Any application for an [additional PDC or for a loan or overdraft](#), may only be made by the Director of Finance or by an employee so delegated by him.

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10.1.3 The Director of Finance must prepare procedural instructions concerning applications for [PDC, loans, or overdrafts](#).

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10.1.4 All short-term borrowings should be kept to the minimum period possible, consistent with the overall cash flow position. Any short-term borrowing requirement must be authorised [in accordance with the Trust's Operating Cash Management Policy](#),

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10.1.5 All long-term borrowing must be consistent with the plans outlined in the current Annual Plan.

10.1.6 The Director of Finance must ensure compliance with the [Prudential Borrowing Code \(PBC\) for NHS Foundation Trusts](#)¹⁵ set by the Regulator to limit the amount of borrowing for NHS [foundation trusts](#). The PBC will determine the prudential borrowing limit beyond which the Trust must not borrow. The limit is imposed by the Regulator in the Terms of Authorisation. The Regulator will review the limit.

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10.2 Investments

10.2.1 Temporary cash surpluses must be held only in such public or private sector investments as specified in the [Trust's Operating Cash Management Policy](#) authorised by the Board of Directors in accordance with the Regulator's guidance [Managing Operating Cash in NHS Foundation Trusts](#)¹⁶.

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10.2.2 The Director of Finance is responsible for advising the Board of Directors on investments, and shall report periodically to the Board of Directors concerning the performance of investments held.

10.2.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

10.3 Working Capital Facility

10.3.1 The Board of Directors will ensure that funds are available for short-term cash flow management by negotiating an irrevocable working capital facility with a commercial bank. The value of this facility shall be set by the Board of Directors and shall not exceed the limit set in the Trust's Terms of Authorisation.

¹⁵ Monitor, [Prudential Borrowing Code \(PBC\) for NHS Foundation Trusts, April 2009](#)

¹⁶ Monitor, [Managing Operating Cash in NHS Foundation Trusts](#), December 2005

11 Capital Investment, Private Financing, Fixed Asset Registers, and Security of Assets

11.1 Capital investment

11.1.1 The Board of Directors shall approve a programme of building, engineering and design schemes known as the capital programme, as part of the budgetary process.

11.1.2 Where a requirement for a capital scheme not already in the approved programme arises during the course of the year, approval for its commencement shall be in accordance with the *BDSOs* and *Scheme of Delegation of Powers*, and a report shall be made to the next meeting of the Board of Directors, showing the impact of the new scheme on the capital programme and the revenue consequences.

11.1.3 The Chief Executive:

11.1.3.1 shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

11.1.3.2 is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

11.1.3.3 shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

11.1.4 For every capital expenditure proposal, the Chief Executive shall ensure:

11.1.4.1 that a business case is produced, in line with the guidance contained within the Regulator's *Protection of Assets Guidance for NHS Foundation Trusts*¹⁷ and the Department of Health's *Capital Investment Manual*¹⁸, and in a level of detail appropriate to the value of the project, setting out:

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11.1.4.1.1 an option appraisal of potential benefits, compared with known costs to determine the

¹⁷ Monitor, *Protection of Assets Guidance for NHS Foundation Trusts*, October 2004

¹⁸ Department of Health, *Capital Investment Manual*, June 1994

option with the highest ratio of benefits to costs;

[11.1.4.1.2](#) appropriate project management and control arrangements; and

[11.1.4.1.3](#) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

11.1.5 ~~The approval of a capital programme shall not constitute approval for expenditure on any scheme.~~

Deleted: For projects with a value over £200,000, the business case shall be considered by the Business Development and Investment Committee and approved by the Board of Directors before any commitments are made.

11.1.6 The Chief Executive shall issue to the manager responsible for any scheme:

11.1.6.1 specific authority to commit expenditure – officers must comply with the *SFI Appendix*, below, which requires competitive tenders or quotations to be obtained where the expected cost exceeds certain thresholds;

11.1.6.2 authority to proceed to tender; and

11.1.6.3 approval to accept a successful tender.

11.1.7 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with *Estatecode*¹⁹ guidance and *BDSOs*.

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11.1.8 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

11.1.9 The Director of Finance shall ~~report regularly to the Board of Directors on expenditure and commitment against authorised expenditure.~~

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11.2 Private finance

11.2.1 When the Trust proposes to use finance which is to be provided by the private sector and therefore other than through its own funds and/or borrowing, the following procedures shall apply:

11.2.1.1 the Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector;

¹⁹ [Op. cit.](#)

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11.2.1.2 the Trust must seek all applicable approvals and comply with the requirements of all guidance by the Regulator, including *Risk Evaluation for Investment Decisions by NHS Foundation Trusts*²⁰; and

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11.2.1.3 the proposal must be specifically agreed by the Board of Directors.

11.3 Asset registers

11.3.1 The Chief Executive is responsible for the maintenance of a register of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the *Fixed Asset Register* to be conducted once a year.

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11.3.2 The Trust shall maintain a *Fixed Asset Register* recording fixed assets. The minimum data set to be held within this Register shall be as specified in the Trust's accounts policies.

11.3.3 Additions to the *Fixed Asset Register* must be clearly identified to an appropriate Budget Holder and be validated by reference to:

11.3.3.1 properly authorised and approved agreements, architect's certificates, supplier's invoices, and other documentary evidence in respect of purchases from third parties;

11.3.3.2 stores, requisitions, and wages records for own materials and labour, including appropriate overheads; and

11.3.3.3 lease agreements in respect of assets held under a finance lease and capitalised.

11.3.4 Where capital assets are sold, scrapped, lost, or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate) (see also *SFI 13*).

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11.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed asset accounts in ledgers against balances on the *Fixed Asset Register*.

²⁰ Monitor, *Risk Evaluation for Investment Decisions by NHS Foundation Trusts*, February 2006

11.3.6 The process for revaluing assets periodically must be approved by the Audit Committee and by the Board of Directors and must comply with the [NHS Foundation Trust Annual Reporting Manual](#)²¹.

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11.3.7 The value of each asset shall be depreciated using methods and rates as specified in the Trust's accounts policies.

11.4 Security of assets

11.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

11.4.2 Asset control procedures (including fixed assets, other equipment as appropriate, cash, cheques and negotiable instruments, and including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

11.4.2.1 recording managerial responsibility for each asset;

11.4.2.2 identification of additions and disposals;

11.4.2.3 identification of all repairs and maintenance expenses;

11.4.2.4 physical security of assets;

11.4.2.5 periodic verification of the existence of, condition of, and title to, assets recorded;

11.4.2.6 identification and reporting of all costs associated with the retention of an asset; and

11.4.2.7 reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

11.4.3 All discrepancies revealed by verification of physical assets to the [Fixed Asset Register](#) shall be notified to the Director of Finance.

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11.4.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with these *SFIs*.

11.4.5 Any damage to the Trust's premises, vehicles, and equipment, or any loss of equipment, stores, or supplies must be reported by Directors

²¹ [Monitor, NHS Foundation Trust Annual Reporting Manual 2009-10, April 2010](#).

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and employees in accordance with the procedure for reporting losses²² (see also [SFI 13](#)).

11.4.6 Where practical, assets should be marked as Trust property.

12 Stores and Receipt of Goods

12.1 Both central and departmental stores should be kept to a minimum. Central stores will be subjected to annual stock take, and valued at the lower of cost and net replacement value; obsolete or excess stock shall be valued at net realisable value.

12.2 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated to departmental employees and stores managers / keepers, subject to such delegation being entered in a record available to the Director of Finance.

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12.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager. Wherever practicable, stocks should be marked as health service property.

12.4 The Director of Finance shall set out procedures and systems to regulate the stores, including records for receipt of goods, issues, and returns to stores, and losses.

12.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

12.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

12.7 The designated manager shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items, and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also [SFI 13](#)). Procedures for the disposal of obsolete stock shall follow [SFI 13.1](#) and [SFI Appendix, paragraph 11](#).

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12.8 For any goods supplied via the NHS central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the

²² See HM Treasury, [Managing Public Money, Annex 4.10 "Losses and Write Offs", and Annex 4.13 "Special Payments", February 2010](#)

store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance who shall satisfy himself that the goods have been received before accepting the recharge.

13 Disposals and Condemnations, Losses and Special Payments

13.1 Disposals and condemnations

13.1.1 ~~SFI Appendix, paragraph 11~~, shall be complied with in all disposals.

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13.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine, and advise the Director of Finance, of the estimated market value of the item, taking account of professional advice where appropriate.

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13.1.3 All unserviceable articles shall be:

13.1.3.1 condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;

13.1.3.2 recorded by the Condemning Officer in a form approved by the Director of Finance, which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance; and

13.1.3.3 the Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use, and shall report any such evidence to the Director of Finance who will take the appropriate action.

13.2 Losses and special payments

13.2.1 The Director of Finance must prepare procedural instructions on the recording of, and accounting for, condemnations, losses, and special payments. These procedures shall follow Department of Health guidance – [Finance Directorate Letter \(98\)2: Amendments to losses and special payments guidance](#)²³ – which also lays down the limits of authority delegated to the Trust. The Director of Finance must also prepare a [Counter Fraud Policy](#)²⁴ to be approved by the Board of Directors, which sets out the action to be taken both by persons

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²³ [HM Treasury, Managing Public Money, Annex 4.10 "Losses and Write Offs", and Annex 4.13 "Special Payments", February 2010](#)

²⁴ [See Tavistock & Portman NHS Foundation Trust, Counter Fraud Policy, December 2005](#)

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detecting a suspected fraud and by those persons responsible for investigating it.

13.2.2 Any employee discovering or suspecting a loss of any kind must either immediately inform their Head of Department, who must immediately inform the Director of Finance or the Chair of the Audit Committee. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. If the case involves suspicion of fraud, then the Fraud Response Plan must be followed and the Counter Fraud and Security Management Service (CFSMS) of the Department of Health must be informed in accordance with [the Department of Health's Managing Public Money](#)²⁵.

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13.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

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13.2.3.1 the Board of Directors; and

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13.2.3.2 the External Auditor.

13.2.4 Within limits delegated to it by the Department of Health, the Board of Directors shall approve the writing-off of losses.

13.2.5 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

13.2.6 For any loss, the Director of Finance, with the Director of Corporate Governance and Facilities should consider whether any insurance claim can be made.

13.2.7 The Director of Finance shall maintain a [Register of Losses and Special Payments](#) in which write-off action is recorded, and shall send reports periodically to the Department of Health if required.

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13.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

14 Information Technology

14.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

²⁵ Department of Health, [HSC 1999/062: Countering Fraud in the NHS notification of possible disciplinary, civil or criminal proceedings](#), March 1999

14.1.1 devise and implement any necessary procedures to ensure adequate protection of the Trust's data, programs, and computer hardware for which he is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft, or damage, having due regard for the *Data Protection Act 1998*;

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14.1.2 ensure that adequate controls exist over data entry, processing, storage, transmission, and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

14.1.3 ensure that adequate controls exist, such that the computer operation is separated from development, maintenance, and amendment; and

14.1.4 ensure that an adequate management (audit) trail exists through the computerised system, and that such computer audit reviews as he may consider necessary are being carried out.

14.2 The Director of Finance shall satisfy himself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

14.3 The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission, and storage. The contract should also ensure rights of access for audit purposes.

14.4 Where another organisation provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

14.5 Where computer systems have an impact on corporate financial systems, the Director of Finance shall satisfy himself that:

14.5.1 systems acquisition, development, and maintenance are in line with the Trust's policies;

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14.5.2 data produced for use with financial systems is adequate, accurate, complete, and timely, and that a management (audit) trail exists;

14.5.3 Finance Directorate staff have access to such data; and

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[14.5.4](#) such computer audit reviews as are considered necessary are carried out.

[15](#) Patients' Property

15.1 The Trust has a responsibility to provide safe custody for any money and other personal property (hereafter referred to as "[property](#)") in the possession of unconscious or confused patients, or found in the possession of patients dying on Trust premises. Such property must be recorded and kept in a locked safe. If it is returned to a person other than the patient, a receipt shall be obtained.

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15.2 In any case, where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the [Administration of Estates \(Small Payments\) Act 1965](#)), the production of Probate or Letters of Administration shall be required before any of the property is released.

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[16](#) Funds Held on Trust

16.1 Introduction

16.1.1 The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for funding derived from Exchequer funds, and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence, and property.

16.1.2 [BDSO 1.4.1](#), and [BDSO 4.1.2](#) identify the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately, and full recognition given to the accountability to the Charity Commission for charitable funds held on trust.

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16.1.3 The Trust shall establish a Charitable Fund Committee with clearly defined terms of reference which:

16.1.3.1 shall ensure that the Trust's charitable funds are managed appropriately with regard to the [Declaration of Trust](#) and appropriate legislation, and

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16.1.3.2 have primary responsibility to the Board of Directors for ensuring that these *SFIs* are applied, and where

appropriate, closely liaise with the Board of Directors' legal adviser.

16.1.4 *SFI 16* shall be interpreted and applied in conjunction with the rest of these *SFIs*, subject to modifications contained herein.

16.2 Administration of the charitable funds

16.2.1 The Charitable Fund Committee will arrange for the proper administration of charitable funds in accordance with their respective terms of trust, and ensure that accounting records are kept in a way that identifies separately the different categories of fund between unrestricted funds, restricted funds, and endowment funds, and complies with charities legislation.

16.2.2 The Charitable Fund Committee will produce detailed codes of procedure covering every aspect of the financial management of funds held on trust, for the guidance of Directors and employees.

16.2.3 The Charitable Fund Committee shall periodically review the funds in existence, and shall make recommendations to the Board of Directors regarding the potential for rationalisation of such funds as permitted by the declarations of trust and charities legislation.

16.2.4 The Charitable Fund Committee may recommend that additional funds be established where this is consistent with [the Trust's](#) policy for ensuring the safe and appropriate management of funds, e.g. designation for specific wards or departments, or the creation of restricted funds to meet the restricted purpose of a donation.

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16.3 Income

16.3.1 In respect of donations, the Charitable Fund Committee shall:

16.3.1.1 provide guidelines to officers of this body as to how to proceed when offered funds. These to include:

[16.3.1.1.1](#) the identification of the donor's intentions;

[16.3.1.1.2](#) where possible, the avoidance of new restricted purpose funds;

[16.3.1.1.3](#) the avoidance of impossible, undesirable, or administratively difficult objects;

[16.3.1.1.4](#) sources of immediate further advice; and

[16.3.1.1.5](#) treatment of offers for personal gifts; and

16.3.1.2 provide secure and appropriate receipting arrangements which shall indicate that the funds have been accepted directly into this body's charitable funds, and that the donor's intentions have been noted and accepted.

16.3.2 In respect of legacies and bequests, the Charitable Fund Committee shall:

16.3.2.1 provide guidelines to officers of the Trust regarding the receipt of funds and/or other assets from Executors;

16.3.2.2 where necessary, obtain grant of probate, or make application for grant of letters of administration, where the Trust is the beneficiary;

16.3.2.3 be empowered, on behalf of the Trust, to negotiate arrangements regarding the administration of a Will with Executors, and to discharge them from their duty; and

16.3.2.4 be directly responsible for the appropriate treatment of all legacies and bequests.

16.3.3 In respect of trading income, the Charitable Fund Committee shall:

16.3.3.1 be primarily responsible, along with other designated officers, for any trading undertaken by the Trust as corporate trustee; and

16.3.3.2 be primarily responsible for the appropriate treatment of all funds received from this source.

16.3.4 In respect of investment income, the Charitable Fund Committee shall be responsible for the appropriate treatment of all dividends, interest, and other receipts associated with funds held on trust by the Trust as corporate trustee (see [SFI 16.5](#)).

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16.4 Fund raising

16.4.1 The Charitable Fund Committee shall:

16.4.1.1 in respect of legacies and bequests, provide guidelines to officers of the Trust covering any approach regarding the wording of Wills;

16.4.1.2 after taking appropriate legal and tax advice, deal with all arrangements for fund raising by and/or on behalf of

this body, and ensure compliance with all statutes and regulations;

16.4.1.3 be empowered to liaise with other organisations or persons raising funds for this body, and provide them with an adequate discharge. The Chief Executive (acting under the instructions of the Charitable Fund Committee) shall be the only officer empowered to give approval for such fund raising subject to the overriding direction of the Board of Directors;

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16.4.1.4 be responsible for alerting the Board of Directors to any irregularities regarding the use of the Trust's name or its registration numbers; and

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16.4.1.5 be required to advise the Board of Directors on the financial implications of any proposal for fund raising activities which the Trust, as corporate trustee, may initiate, sponsor, or approve.

16.4.2 The Trust's policy on fund raising is that:

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16.4.2.1 all those involved in fund raising, whether members of the public or NHS staff, are clear about the implications of their activities, and have agreed them with the Trust before they commence any appeal to the public, including the action to be taken should the appeal target not be reached;

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16.4.2.2 that the public are not misled about any aspect of an appeal; and

16.4.2.3 that any appeal with which the Trust is in any way associated is conducted in conformity with all applicable standards.

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16.5 Investment management

16.5.1 The Charitable Fund Committee shall be responsible for all aspects of the management of the investment of charitable funds. The issues on which it shall be required to provide advice to the Board of Directors shall include:

16.5.1.1 the formulation of investment policy within the powers of the Trust under statute and within its governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;

- 16.5.1.2 the appointment of advisers and funds managers. The Charitable Fund Committee will agree the terms of such appointments and the written agreements shall be signed by the Chief Executive;
 - 16.5.1.3 the use of Trust assets, which shall be appropriately authorised in writing;
 - 16.5.1.4 the review of the performance of fund managers and advisers; and
 - 16.5.1.5 the reporting of investment performance
- 16.5.2 All share and stock certificates and property deeds belonging to the Trust in its capacity as corporate trustee shall be deposited either with bankers / investment advisers or their nominee, or in a safe, or a compartment within a safe, to which only the Charitable Fund Committee, or its nominated officer, will have access.

16.6 Use of funds

- 16.6.1 Authorisation of expenditure from charitable funds will be laid down in [BDSO 11](#).
- 16.6.2 The exercise of the Trust's discretion in the application of charitable funds shall be managed by the Charitable Fund Committee. In doing so, it shall be aware of the following:
 - 16.6.2.1 the objects of the charitable funds;
 - 16.6.2.2 the availability of liquid funds;
 - 16.6.2.3 the powers of delegation available to commit resources as detailed in [BDSO 11](#);
 - 16.6.2.4 the avoidance of use of Exchequer funds to discharge charitable fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the trustee Exchequer funds shall be discharged by charitable funds at the earliest possible time;
 - 16.6.2.5 that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the body and any reserved policy;

16.6.2.6 the definitions of “charitable purposes”, as determined by the Charity Commission and relevant legislation and case law; and

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16.6.2.7 any restrictions on spending capital.

16.7 Banking services

16.7.1 The Charitable Fund Committee, with the approval of, the Board of Directors, shall ensure that appropriate banking services are available to the Trust as corporate trustee.

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16.7.2 The Trust as corporate trustee shall approve the bank accounts to be used for charitable funds.

16.8 Reporting

16.8.1 The Charitable Fund Committee shall ensure that regular reports are made to the Board of Directors with regard to, *inter alia*, the receipt of funds, investments, and the disposition of resources.

16.8.2 The Charitable Fund Committee shall prepare annual accounts in the required manner that shall be submitted to the Board of Directors within agreed timescales.

16.8.3 The Charitable Fund Committee shall prepare an annual trustee’s report for adoption by the Board of Directors, and shall submit, the required returns to the Charity Commission.

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16.9 Accounting and audit

16.9.1 The Charitable Fund Committee shall appoint a suitable Auditor or Independent Examiner, in accordance with Charity Commission requirements.

16.9.2 The Charitable Fund Committee shall maintain all financial records to enable the production of reports as above and to the satisfaction of Internal Audit and the Auditor or Independent Examiner.

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16.9.3 The Charitable Fund Committee shall liaise with the Auditor or Independent Examiner and provide them with all necessary information.

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16.10 Administration costs

16.10.1 The Charitable Fund Committee shall identify all costs directly incurred in the administration of charitable funds and, in

agreement with the Board of Directors, shall charge such costs to the appropriate charitable fund.

17 Retention of Documents

17.1 The Director of Corporate Governance and Facilities shall be responsible for maintaining archives for all documents required to be retained under the direction contained in *Health Service Circular 1999/053: For the record – managing records in NHS Trusts and health authorities*²⁶.

17.2 The documents held in archives shall be capable of retrieval by authorised persons.

17.3 Documents held under *Health Service Circular 1999/053: For the record – managing records in NHS Trusts and health authorities*²⁷ shall only be destroyed at the express instigation of the Chief Executive. Records shall be maintained of documents so destroyed.

18 Risk Management and Insurance

18.1 The Chief Executive shall ensure that the Trust has a programme of risk management that will be approved and monitored by the Board of Directors.

18.2 The programme of risk management shall include:

18.2.1 a process for identifying and quantifying risks and potential liabilities;

18.2.2 engendering among all levels of staff a positive attitude towards the control of risk;

18.2.3 management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

18.2.4 contingency plans to offset the impact of adverse events;

18.2.5 audit arrangements including internal audit, clinical audit, and health and safety review; and

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Retention of Documents¶

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<#>The Director of Corporate Governance and Facilities shall be responsible for maintaining archives for all documents required to be retained under the direction contained in *HSC 1999/053*²⁸.¶

<#>The documents held in archives shall be capable of retrieval by authorised persons.¶

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<#>Documents held under *HSC1999/053*²⁹ shall only be destroyed at the express instigation of the Chief Executive. Records shall be maintained of documents so destroyed.¶

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²⁶ Department of Health, *HSC 1999/053: For the record – managing records in NHS Trusts and health authorities*, March 1999

²⁷ *Ibid.*

³⁰ *Monitor, NHS Foundation Trust Annual Reporting Manual 2009-10, April 2010*

18.2.6 arrangements to review the risk management programme.

18.3 The existence, integration and evaluation of the above elements will provide a basis to make a Statement of Internal Control within the Annual Accounts - as required by the *NHS Foundation Trust Annual Reporting Manual*³⁰.

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18.4 The Director of Finance, with the Director of Corporate Governance and Facilities, shall ensure that insurance and/or risk pooling arrangements exist in accordance with the risk management programme and in accordance with Department of Health guidance.

19 Consultation

19.1 The Trust should take into account the legal duties of consultation that are applicable to the Trust when considering any changes to service provision at an early stage and seek advice where necessary.

19.2 *Section 242 of the National Health Service Act 2006* sets out the Trust's duty, as respects health services for which it is responsible, that persons to whom those services are being, or may be, provided for, directly or through representatives, be included in and consulted on:

19.2.1 the planning of the provision of those services;

19.2.2 the development and consideration of proposals for changes in the way those services are provided; and

19.2.3 decisions to be made by that body affecting the operation of those services.

19.3 Regulation 4(1) of the *Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002* sets out that the Trust need to consult with the Overview and Scrutiny Committee of a Local Authority where:

19.3.1 the Trust proposes to make an application to the Regulator to vary the Terms of Authorisation; and

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19.3.2 that application, if successful, would result in a substantial variation of the provision by the Trust of protected goods or services in the area of that Local Authority.

20 Gifts & Hospitality

20.1 All staff are expected to be aware of the Trust's *Policy on Gifts and Hospitality*³¹, a copy of which is available on the Trust's Intranet.

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20.2 All items covered by the Trust's *Policy on Gifts and Hospitality* are to be recorded in the Trust's *Register of Gifts and Hospitality*, held by the Trust Secretary.

20.3 Commercial sponsorship to attend courses and conference is acceptable only where permission is obtained in advance, and provided the conference is relevant.

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³¹ Tavistock & Portman NHS Foundation Trust, *Policy on Gifts and Hospitality*, January 1996

Appendix I

Tendering and Contracting Procedure

1. Duty to **Comply** with *Board of Directors' Standing Orders (BDSOs)*, *Standing Financial Instructions (SFIs)*, and the *Scheme of Delegation of Powers*

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1.1 The procedure for making all contracts by, or on behalf of, the Trust shall comply with *BDSOs, SFIs, and the Scheme of Delegation of Powers*³².

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2. **Legislation and Guidance Governing Public Procurement**

2.1 The Trust shall comply with the *Public Contracts Regulations 2006*, and all relevant EC Directives. Such legislation shall be incorporated into the Trust's *BDSOs and SFIs*.

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3. **Capital Investment**

3.1 The Trust shall comply, as far as is practicable, with the requirements of guidance published on capital investment and *Protection of Assets Guidance for NHS Foundation Trusts*³³ in respect of capital investment and estate and property transactions.

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4. **Formal Competitive Tendering**

4.1 General applicability

4.1.1 Subject to *SFI Appendix, paragraph 4.3*, the Trust shall ensure that competitive tenders are invited for:

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4.1.1.1 the supply of goods, materials, and manufactured articles;

4.1.1.2 the rendering of services, including all forms of management consultancy services;

4.1.1.3 the design, construction, and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and

³² See *Tavistock & Portman NHS Foundation Trust, Constitution, Election Rules, Standing Orders, February 2010, Tavistock & Portman NHS Foundation Trust, Standing Financial Instructions, [date]*, and *Tavistock & Portman NHS Foundation Trust, Scheme of Delegation of Powers, [date]*

³³ Monitor, *Protection of Assets Guidance for NHS Foundation Trusts*, October 2004

4.1.1.4 the disposals of any tangible or intangible property (including equipment, land, and intellectual property).

4.2 Health Care Services (and other services outlined as Part B Services³⁴)

4.2.1 Where the Trust has a requirement to procure healthcare services (and/or other services classed as Part B Services for the purposes of the *Public Contracts Regulations 2006*) (whether by way of sub-contract or otherwise), the Trust shall consider its duties under the EU Treaty and whether such service requirement should be advertised.

4.2.2 Where the Trust considers that the circumstances require it to advertise for the supply of healthcare services (and/or other services classed as Part B Services for the purposes of the *Public Contracts Regulations 2006*), *BDSOs* and these *SFIs* shall apply, as far as they are applicable, to the tendering procedure, although at all times the Trust should consider its duties under [SFI Appendix, paragraph 2](#),

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4.3 Exceptions and instances where formal tendering need not be applied

4.3.1 Formal tendering procedures need not be applied where:

4.3.1.1 the estimated expenditure or income does not, or is not reasonably expected to, exceed £60,000 (excluding VAT) (such amount to be reviewed annually by the Board of Directors). [\(Note: for expenditure under £60,000, see SFI Appendix, paragraph 6.1\);](#)

4.3.1.2 the supply can be obtained under a framework agreement that has itself been procured in compliance with the duties set out at [SFI Appendix, paragraph 2](#) and where the Trust is entitled to access such framework agreement; and

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4.3.1.3 where under [SFI 13](#), in the case of disposal of assets, formal tendering procedures are not required.

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4.3.2 [Subject to the duties at SFI Appendix, paragraph 2](#) (and to obtaining appropriate advice from the Trust's procurement department and where considered necessary external professional advice), formal tendering procedures may be waived in the following circumstances:

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[4.3.2.1 where the requirement is covered by an existing contract;](#)

³⁴ See [The Public Contracts Regulations 2006, Schedule 3. Part B services are listed as: hotel and restaurant services; transport by rail; transport by water; supporting and auxiliary transport services; legal services; personnel placement and supply services; investigation and security services, other than armoured car services; education and vocational health services; health and social services; and recreational, cultural and sporting services; other services](#)

4.3.2.2 where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members, including the Trust;

4.3.2.3 in exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable, and the circumstances are detailed in the *Register of Tenders* (see *SFI Appendix, paragraph 4.3.5*); the reasons will normally be one of the following:

4.3.2.3.1 where the timescale genuinely precludes competitive tendering (failure to plan the work properly may not be regarded as a justification for a single tender);

4.3.2.3.2 where specialist expertise is required and can be demonstrated to be available from only one source;

4.3.2.3.3 when the requirement is essential to complete a project, and arises because of a recently completed assignment and engaging different consultants for the new task would be impracticable; and

4.3.2.3.4 for the provision of legal advice and services, providing that any legal firm or partnership commissioned by the Trust is regulated by the [Law Society for England and Wales](#) for the conduct of their business (or by the [General Council of the Bar](#) in relation to the obtaining of [Council's](#) opinion), and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

4.3.3 The Director of Finance will ensure that any fees paid [for conducting a tender process](#) are reasonable and within commonly accepted rates for the costing of such work.

4.3.4 The waiving of competitive tendering procedures should not be used to avoid competition, or for administrative convenience, or to award further work to a consultant [or other supplier](#) originally appointed through a competitive procedure.

4.3.5 Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons, should be documented and recorded in a standard format and in the *Register*

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<#>where the requirement is covered by an existing contract;¶
¶
<#>where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members, including the Trust;¶
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<#>where the timescale genuinely precludes competitive tendering. Failure to plan the work properly may not be regarded as a justification for a single tender;¶

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of *Tenders*, signed by the Director of Finance and the Chief Executive, and reported to the Audit Committee at the next meeting scheduled to review the waiver of requirements to competitively tender. The Audit Committee shall review such waivers at alternate meetings.

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4.4 Fair, transparent and adequate competition

4.4.1 Except where the exceptions set out at [SFI Appendix, paragraph 4.3](#) apply and permit the use of a single tender action, the Trust shall ensure that for all invitations to tender, whether regulated by the *Public Contracts Regulations 2006* or not, the tender process adopted is fair and transparent and is considered in a fair and transparent manner.

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4.4.2 Where a tender process is conducted the Trust shall, in order to assure that best value is obtained, invite tenders from a sufficient number of firms / individuals to provide fair and adequate competition as appropriate, and in no case less than two firms / individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required. The Trust should also ensure that careful consideration is given to whether or not firms invited to tender are likely to apply.

4.5 List of approved firms

4.5.1 Where the Trust is satisfied under its duties at [SFI Appendix, paragraph 2](#), that an open tender process is necessary, the Trust shall ensure that the firms / individuals invited to tender (and where appropriate, quote) are among those on approved lists. [For capital and estates projects, the approved lists are held by the Royal Free Hospital Projects Department. For other procurement, the approved suppliers are those with whom the NHS Purchasing and Supply Agency \(PASA\) have negotiated contracts.](#) Where, in the opinion of the Director of Finance, it is desirable to seek tenders from firms not on the approved lists in such circumstances, the reason shall be recorded in writing to the Chief Executive (see [SFI Appendix, paragraph 5.8](#)). A copy of this [waiver](#) shall be kept with the [Register of Tenders](#) (see [SFI Appendix, paragraph 5.3.7](#)).

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4.6 Items that subsequently breach thresholds after original approval

4.6.1 Items estimated to be below the limits set in these *SFIs* for which formal tendering procedures are not used that subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in the [Register of Tenders](#).

5. Contracting / Tendering Procedure

5.1 Invitation to tender

5.1.1 All invitations to tender shall state the date and time that is the latest time for the receipt of tenders. At the time of issuing invitations to tender, the "originating department" shall notify the Trust Secretary of the list of firms invited and the closing date, and shall agree the reference number.

5.1.2 All invitations to tender shall state that no tender will be accepted unless:

5.1.2.1 submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender", followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Trust Secretary. Submissions must show the reference number. This is to ensure that if multiple tender exercises occur at the same time, tenders do not get mixed up. The reference number will be the same for all tenders within one exercise; and

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5.1.2.2 that tender envelopes / packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

5.1.3 Every tender for goods, materials, services, or disposals shall contain and comprise appropriate terms and conditions regulating the conduct of the tender, shall contain appropriate terms and conditions on which the contract is to be awarded, and shall be substantively based to regulate the provision of the goods, materials, or services to be provided or in relation to the disposal.

5.1.4 Every tender for building or engineering works (except for maintenance work, when *Estatecode*³⁵ guidance shall be followed) shall contain terms and conditions on which the contract is to be awarded, that shall embody or be in the terms of the current edition of a suitable and recognised industry form of contract, including but not limited to, one of the Joint Contracts Tribunal Ltd. Standard Form of Building Contract, or the NEC standard forms of contract or Department of the Environment (GC/Wks) Standard forms of contract; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of

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³⁵ [Op. cit](#)

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Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents may be modified (in minor respects only), to cover special features of individual projects.

5.2 Receipt and safe custody of tenders

5.2.1 The Trust Secretary, or his nominated officer, will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

5.2.2 The date and time of receipt of each tender shall be endorsed by the Trust Secretary or his nominated officer on the tender envelope / package.

5.3 Opening tenders and *Register of Tenders*

5.3.1 As soon as practicable after the date and time stated as being the latest date and time for the receipt of tenders, every tender received shall be opened by two senior officers / managers designated by the Chief Executive. Such senior officers / managers should not be from the originating department. The Trust Secretary, on behalf of the Chief Executive, shall maintain a list of designated officers to open tenders. A copy of this list shall be kept with the *Register of Tenders* (see *SFI Appendix, paragraph 5.3.7*).

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5.3.2 A member of the Board of Directors will be required to be one of the two approved persons present for the opening of tenders estimated above £100,000 (excluding VAT). The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in *BDSO 11*.

5.3.3 The "originating department" will be taken to mean the department sponsoring or commissioning the tender.

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5.3.4 The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance or any approved senior manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

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5.3.5 All Executive Directors will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department. The Trust Secretary will count as a Director for the purposes of opening tenders.

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- 5.3.6 Every tender received shall be marked with the date of opening and initialled by those present at the opening on the page bearing the tendered price or prices.
- 5.3.7 A *Register of Tenders* shall be maintained by the Trust Secretary, or a person authorised by him, to show for each set of competitive tender invitations despatched:
- 5.3.7.1 The subject of the tendering exercise, and the reference number;
 - 5.3.7.2 the name of all firms / individuals invited;
 - 5.3.7.3 the names of all firms / individuals from which tenders have been received;
 - 5.3.7.4 for those who do not tender, a note of any reason given;
 - 5.3.7.5 the latest date and time for receipt;
 - 5.3.7.6 the date the tenders were opened;
 - 5.3.7.7 the persons present at the opening;
 - 5.3.7.8 the price shown on each tender;
 - 5.3.7.9 against each tendered sum, the signatures of two of those present at the opening;
 - 5.3.7.10 a note where price alterations have been made on the tender;
 - 5.3.7.11 which tender is to be accepted; and
 - 5.3.7.12 a summary of the number of organisations invited to tender and the number actually tendering.
- 5.3.8 Each entry to the *Register of Tenders* shall be signed by those present.
- 5.3.9 A note shall be made in the *Register of Tenders* if any one tender price has had so many alterations that it cannot be readily read or understood.
- 5.3.10 Incomplete tenders, i.e. those from which information necessary for evaluation of the tender is missing, and amended tenders, i.e. those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of

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other tenders may at the discretion of the Chief Executive or his nominated officer be rejected, provided that the terms and conditions applicable to such tender process permit such rejection. If a tender is incomplete, it shall be admitted only if the missing information can be obtained without prejudicing the competitive process.

5.4 Admissibility of Tenders

5.4.1 If for any reason the designated officers are of the opinion that the tenders received are not competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

5.4.2 Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust. If they are of the opinion that this cannot be done, no contract shall be awarded.

5.5 Late tenders

5.5.1 Tenders received after the due date and time, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his nominated officer decides that there are exceptional circumstances, for example, if a tender was despatched in good time but was delayed through no fault of the tenderer.

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5.5.2 Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Trust Secretary or his nominated officer or if the process of evaluation has not started.

5.5.3 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Trust Secretary.

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5.6 Acceptance of formal tenders

5.6.1 Any discussions with a tenderer, which are deemed necessary to clarify technical aspects of his tender before the award of a contract, will not disqualify the tender.

5.6.2 The Trust shall accept the most economically advantageous tender unless there are good and sufficient reasons to the contrary. Such

reasons shall be set out in either the contract file, or other appropriate record. [A copy shall be given to the Trust Secretary and retained with the Register of Tenders.](#)

5.6.3 It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

5.6.3.1 experience and qualifications of team members;

5.6.3.2 understanding of client's needs;

5.6.3.3 feasibility and credibility of proposed approach; and

5.6.3.4 ability to complete the project on time.

5.6.4 The factors taken into account in selecting a tenderer must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest priced tender (if payment is to be made by the Trust) or the highest [priced tender](#) (if payment is to be received by the Trust) clearly stated.

5.6.5 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these [SFIs](#) except with the authorisation of the Chief Executive.

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5.6.6 The use of these procedures must demonstrate that the award of the contract was:

5.6.6.1 not in excess of the going market rate / price current at the time the contract was awarded; and

5.6.6.2 the best value for money.

5.6.7 All tenders should be treated as confidential and should be retained for inspection.

5.7 Tender reports to the Board of Directors

5.7.1 Reports to the Board of Directors will be made on an exceptional circumstance basis only.

5.8 Lists of approved firms

5.8.1 Responsibility for maintaining list

5.8.1.1 A manager or external contractor nominated by the Chief Executive shall, on behalf of the Trust, maintain lists of approved firms from whom, where permitted under [SFI Appendix, paragraph 4.5](#), tenders and quotations may be invited. Where such an approved list is used it must be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical competence and financial stability the Trust is satisfied.

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5.8.1.2 A firm will only be included on an approved list of tenderers if it complies with current VAT registration and insurance, and has a track record of doing so.

5.8.1.3 Where a firm is included on an approved list of tenderers, the Trust shall, as a condition for inclusion, ensure that it is satisfied that when engaging, training, promoting, or dismissing employees, or in any conditions of employment, that such firm shall not discriminate against any person because of colour, race, ethnic or national origins, religion or belief, age, disability, marital status, or sex, and will comply with all relevant legislation including, but not limited to, the provisions of the *Equal Pay Act 1970 (Amendment) Regulations 2004*, the *Sex Discrimination Act 1975 (Amendment) Regulations 2008*, the *Disability Discrimination Act 2005*, the *Employment Equality (Age) Regulations 2006*, the *Race Relations (Amendment) Act 2008*, and any amending and/or related legislation or binding guidance.

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5.8.1.4 Where a firm is included on an approved list of tenderers, the Trust shall ensure that it is satisfied that such firm conforms with the requirements of the [Management of Health & Safety at Work \(Amendment\) Regulations 2006](#), the *Regulatory Reform (Fire Safety) Order 2005*, and any amending and/or other related legislation concerned with fire, the health, safety, and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. As part of any process to identify or review firms for an approved list, firms must provide to the appropriate manager a copy of its health and safety policy, risk assessments, safe systems at work, together with any licences for other statutory authorities or approvals and evidence of the safety of plant and equipment, when requested.

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5.8.2 Building and engineering construction works

5.8.2.1 Where permitted under [SFI Appendix, paragraph 4.5](#), invitations to tender shall be made only to firms included on the approved list of tenderers, compiled in accordance with [SFI Appendix, paragraph 5.8](#), or on the separate maintenance list compiled by an accredited body certified as such by the Director of Finance, or a list compiled in accordance with [Estatecode](#)³⁶ guidance.

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5.8.3 Financial standing and technical competence of contractors

5.8.3.1 The Director of Finance may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for Clinical Governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

6. Quotations: Competitive and Non-Competitive

6.1 General position on quotations

6.1.1 Subject to [SFI Appendix, paragraph 4.3](#), quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £10,000 (excluding VAT) but not exceed £60,000 (excluding VAT).

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6.2 Competitive quotations

6.2.1 Quotations should be obtained from at least three firms / individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust. [Copies of the quotations must be held on file by the Supplies Officer.](#)

6.2.2 All quotations for any requirement estimated to cost greater than £10,000 (excluding VAT) should be in writing, unless the Chief Executive or his nominated officer determines that it is impractical to do so, in which case quotations may be obtained verbally. Confirmation of verbal quotations should be obtained as soon as possible and the reasons why a verbal quotation was obtained should be set out in a permanent record [held by the Supplies Officer.](#)

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³⁶ [Op. cit](#)

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6.2.3 All quotations should be treated as confidential and should be retained for inspection.

6.2.4 The Chief Executive or his nominated officer should evaluate the quotation and select the quote that gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record [held by the Supplies Officer](#).

6.3 Exceptions and instances where quotations need not be obtained

6.3.1 Quotations need not be obtained where:

6.3.1.1 Where the requirement is ordered under existing contracts, and does not extend those contracts; or

6.3.1.2 In exceptional circumstances where competition is considered impracticable, in which case the reasons will be set down in writing and approved by the Director of Finance and Chief Executive. A note of this will be sent to the Supplies Officer with the requisition.

6.4 Financial limits of quotations

6.4.1 No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these *SFIs* or the relevant delegation under *BDSO 11* except with the authorisation of either the Chief Executive or Director of Finance.

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Quotations to be within financial limits

7. Authorisation of Tenders and Competitive Quotations

7.1 Providing all the conditions and circumstances set out in these *SFIs* have been fully complied with, formal authorisation and awarding of a contract may be decided by the staff to the value of the contract as set out in the [Scheme of Delegation of Powers](#).

7.2 Formal authorisation must be put in writing. In the case of authorisation by the Board of Directors, this shall be recorded in their minutes.

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8. Private Finance for Capital Procurement (see overlap with SFI [11](#))

8.1 When the Board of Directors proposes, or is required, to use finance provided by the private sector, the following should apply:

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8.1.1 the Chief Executive shall demonstrate that the use of private finance represents value for money as against a public sector comparator, and genuinely transfers significant risk to the private sector;

8.1.2 the Trust must seek all applicable approvals and the requirements of all guidance by the Regulator including Risk Evaluation for Investment Decisions by NHS Foundation Trusts³⁷;

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8.1.3 the proposal must be specifically agreed by the Board of Directors; and

8.1.4 the selection of a contractor / finance company must be based on competitive tendering or quotations compliant with the duties set out at SFI Appendix, paragraph 2;

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9. Compliance Requirements for all Contracts

9.1 The Board of Directors may only enter into contracts on behalf of the Trust within the statutory powers of the Trust.

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10. Personnel and Agency or Temporary Staff Contracts

10.1 The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

11. Disposals

11.1 Competitive tendering or quotation procedures shall not apply to the disposal of:

11.1.1 any matter in respect of which best value can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

11.1.2 obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust; and

11.1.3 items with an estimated sale value of less than £2,000, this figure to be reviewed on a periodic basis.

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³⁷ [Op. cit](#)

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12. In-House Services

12.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be benchmarked or market tested by competitive tendering.

12.2 In all cases where the Board of Directors determines that in-house services should be subject to competitive tendering, the following groups shall be set up:

12.2.1 Specification Group, comprising the Chief Executive or nominated officer(s), and a relevant specialist in that field;

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12.2.2 In-House Tender Group, comprising a nominee of the Chief Executive and technical support; and

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12.2.3 Evaluation Team, comprising normally a specialist officer, a supplies officer and the Director of Finance or his nominated representative. For services having a likely annual expenditure exceeding £100,000, a Non-Executive Director should be a member of the Evaluation Team.

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12.3 All groups should work independently of each other. Individual officers may be a member of more than one group, but no member of the In-House Tender Group may participate in the Evaluation Team.

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12.4 The Evaluation Team shall make recommendations to the Board of Directors following any benchmarking process or a market testing exercise carried out pursuant to SFI Appendix, paragraph 2,

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12.5 The Chief Executive shall nominate an officer to oversee any market testing or benchmarking exercise, including an in house bid on behalf of the Trust.

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<#>These SFIs shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.¶
¶

Board of Directors : April 2010

Item : 12

Title : Scheme of Delegation of Powers

Summary:

This paper highlights the changes that have been made to Scheme of Delegation of Powers.

In addition to the changes listed, minor typographical and grammatical errors have been amended. Financial limits have been amended in line with *Standing Financial Instructions*. All references are in the process of being updated. The Board are assured that all references will be correct at the time of publication on the Trust's Intranet.

The Scheme is included at Appendix 1, for reference.

The Scheme was approved by the Management Committee on 22nd April, and is presented to the Board of Directors for final approval. Following approval, the Scheme will be published on the Trust's Intranet.

For : Approval

From : Trust Secretary

Review of Scheme of Delegation of Powers

- 1 Delegated matter 3(c) – Retaining documents to evidence that competitive quotations have been obtained – removed, as this is covered under delegated matter 5(e)
- 2 Delegated matter 5(a) – Obtaining 2 written quotations for goods / services from £5,000 to £9,999 – removed, as delegated matter 5(b) states financial thresholds for quotations.
- 3 Delegated matter 5(d) – opening tenders and quotations – amended to make clear who has authority for opening tenders.
- 4 Delegated matter 5(e) – retaining records – expanded to highlight responsibility for the holding of different records.
- 5 Delegated matter 7(a) – new training courses – Authority delegated to Dean has been removed, as *Standing Financial Instructions* make it explicit that the Director of Finance has responsibility for reviewing the level of all fees and charges (SFI 6.2.2).
- 6 Previously delegated matter 14 – receiving hospitality – removed as does not relate to delegated authority.
- 7 Delegated matter 14 – ensuring that Internal and External Audit and Local Counter Fraud Service recommendations are implemented – Local Counter Fraud Service added.
- 8 Delegated matter 18 – borrowing – previously listed at end of Scheme, but was illogically placed. Now listed along with other financial matters.
- 9 Delegated matter 32 – review of Trust’s compliance with the Data Protection Act – Senior Information Risk Owner now also has delegated authority.
- 10 Delegated matter 46 – the review and keeping of the *Assurance Framework and Risk Register* – has been split into Strategic and Operational, to reflect the delegated authority for the different Registers.

Scheme of Delegation of Powers 2010

Delegated Matter	Reference documents and notes		Chief Executive	Director of Finance	Medical Director	Trust Clinical Director	Dean	Nurse Director	Dir of HR & Organisational Development	Dir of Service Development & Strategy	Dir of Corporate Governance & Facilities	Trust Secretary	Clinical Director	PPI & Communications Lead	Head of IM&T	Line / Dept Manager	Librarian	Supplies Officer	Budget holder	Petty Cash Holder	Other
1. Management of Budgets	Responsibility of keeping expenditure within budgets	SFI 3																			
2. Maintenance / Operation of Bank Accounts		SFI 5																			
3. Non Pay Revenue and Capital Expenditure / Requisitioning / Ordering / Payment of Goods & Services	a) Requisitions	SFI 9																			
	b) Purchase Orders issued based on a requisition.																				
	c) Purchase Orders not covered by a requisition	Note: these are only permitted for stock items. The Supplies Officer is responsible for the storage and issue of these items, and therefore instigates the purchase of additional stock																			
	c) Orders for Library books and services.																				
4. Capital Schemes	a) Selection of architects, quantity surveyors, consultant engineer and other professional advisors, within EU regulations	SFI 11 & SFI Appendix 5.8.2																			Estates Officer
	b) Financial monitoring and reporting on all capital scheme expenditure																				
5. Quotation and Tendering Procedures (see also 3(e) above)	a) Obtaining 3 written quotations on the basis of a written specification for goods / services from £5,000 to £59,999	SFI Appendix 6																			Other Originating Officer
	b) Obtaining at least 3 written competitive tenders for goods/services above £60,000																				
	c) Waiving of the requirements to obtain quotations or tenders subject to SFIs																				
	d) Opening Tenders and Quotations																				
	e) Retaining records																				
	(i) Retaining the Register of Interests																				
(ii) Retaining details records of each tender																					
(iii) Retaining records of competitive quotations obtained																					Originating Department Originating Department
6. Contracts for NHS Clinical Services	a) Setting prices	SFI 7																			
	b) Signing agreements																				
7. Setting of Fees for Training courses, Consultancy work and other services	a) New training courses	SFI 6.2																			
	b) Annual review of fees for all courses																				Management Committee
	c) Daily fee rates (range) to be charged for all consultancy work																				Director Tavistock Consultancy Service
	d) Approval of fees for other services including the Tavistock Children's Day Unit and the Monroe Family Assessment Service																				Unit Directors

Scheme of Delegation of Powers 2010

Delegated Matter	Reference documents and notes		Chief Executive	Director of Finance	Medical Director	Trust Clinical Director	Dean	Nurse Director	Dir of HR & Organisational Development	Dir of Service Development & Strategy	Dir of Corporate Governance & Facilities	Trust Secretary	Clinical Director	PPI & Communications Lead	Head of IM&T	Line / Dept Manager	Librarian	Supplies Officer	Budget holder	Petty Cash Holder	Other	
8. Expenditure of Charitable Funds	a) From grants received for specific purposes (e.g. research grants; donations for specific services)	SFI 16 & Charitable Fund Committee Terms of Reference																				
	b) From staff earnings funds																					
	c) From all other funds:																					
	(i) Up to £20,000																					
	(ii) Above £20,000																					
9. Agreements/Licences	a) Letting of premises to outside organisations	SFI 6.2.3																				
	b) Approval of rents to be paid	SFI 9.2.6.1 (to be based on professional assessment and subject to competitive tendering requirements)																				
10. Condemning & Disposal - items which are obsolete, obsolescent, redundant, irreparable or which cannot be repaired cost effectively	a) with current / estimated purchase new price under £200	SFI 13 & SFI Appendix 11																				
	b) with current purchase new price over £200 but expected sale value and current book value (where applicable) both under £1,000																					
	c) with expected sale value or current book value (where applicable) both over £1,000																					
	d) with expected sale value or current book value (where applicable) both over £5,000	Note: Subject also to competitive quotations or tendering																				
11. Losses, Write-offs & Compensation	a) Losses due to theft, fraud, overpayment & others Up to £50,000	FDL(98)02 and SFIs Section 13.2																				
	b) Fruitless Payments (including abandoned Capital Schemes) Up to £50,000																					
	c) Bad Debts and Claims Abandoned up to £50,000																					
	d) Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use, up to £50,000																					
	e) Compensation payments made under legal obligation (no limit)																					
	f) Extra Contractual payments to contractors, up to £50,000																					
	g) Ex-gratia payments to patients and staff for loss of personal effects																					
	(i) Less than £100																					
	(ii) Between £100 and £50,000																					
	h) Ex-gratia payments for clinical negligence up to £50,000 (including plaintiff's costs) for negotiated settlements following legal advice and in compliance with guidance																					
i) Ex-gratia payments for personal injury claims involving negligence, up to £50,000 (including plaintiff's costs), where legal advice has been obtained and guidance applied																						

Scheme of Delegation of Powers 2010

Delegated Matter		Reference documents and notes	Chief Executive	Director of Finance	Medical Director	Trust Clinical Director	Dean	Nurse Director	Dir of HR & Organisational Development	Dir of Service Development & Strategy	Dir of Corporate Governance & Facilities	Trust Secretary	Clinical Director	PPI & Communications Lead	Head of IM&T	Line / Dept Manager	Librarian	Supplies Officer	Budget holder	Petty Cash Holder	Other	
	j) Other ex-gratia payments, up to £50,000 (but note that the Trust has no delegated authority to make any payments in cases of maladministration where there was no financial loss by the claimant)																					
12. Reporting of Incidents to the Police	a) Where a fraud is suspected	SFI 13.2.2 and the Trust's Counter Fraud Policy																				
	b) Violence, theft or any other offence or suspicion																					
13. Petty Cash Disbursements <i>Note.</i> Items which cannot be covered from petty cash floats are to be submitted as cheque requests (e.g. for long distance patient fares) or invoices approved for payment)	a) Expenditure up to £50	SFI 9.2.6.11-12																				
	b) Expenditure above £50 and up to £100 per item																					
14. Ensuring that Internal and External Audit recommendations are implemented		SFI 2																				
15. Maintenance & Update of Trust Financial Procedures		SFI 1.3.7																				
16. Investment of Funds	a) The Trust's Exchequer funds.	SFI 10.2 & Trust's Operating Cash Management Policy																				
	b) Charitable funds	SFI 16 and Charitable Fund Committee Terms of Reference																				
17. Application to the Department of Health for Advance of Public Dividend Capital		SFI 10.1 & Trust's Operating Cash Management Policy																				
18. Borrowing		SFI 10.1 & Trust's Operating Cash Management Policy																				
19. Human Resources & Pay	a) Authority to fill funded post on the establishment with permanent staff.	Trust's Policy and Procedure for Recruitment & Selection, February 2009																				
	b) Authority to appoint staff to post on the formal establishment.	Trust's Policy and Procedure for Recruitment & Selection, February 2009																				
	c) Additional Increments -The granting of additional increments to staff within budget	Agenda for Change Conditions of Service																				
	d) Grading and other remuneration matters -All requests shall be dealt with in accordance with Trust Procedure:	Trust regrading procedure																				
	i) Staff listed in "Duties (1)" of the Remuneration Committee Terms of Reference	SFI 8.1 & Remuneration Committee Terms of Reference																				
	ii) All other staff																					
e) Establishments																						

Scheme of Delegation of Powers 2010

Delegated Matter	Reference documents and notes	Chief Executive	Director of Finance	Medical Director	Trust Clinical Director	Dean	Nurse Director	Dir of HR & Organisational Development	Dir of Service Development & Strategy	Dir of Corporate Governance & Facilities	Trust Secretary	Clinical Director	PPI & Communications Lead	Head of IM&T	Line / Dept Manager	Librarian	Supplies Officer	Budget holder	Petty Cash Holder	Other
i) Additional staff to the agreed establishment with specifically allocated finance.																				
ii) Additional staff to the agreed establishment without specifically allocated finance.																				
f) Pay																				
i) Authority to complete standing data forms affecting pay, new starters, variations and leavers																				HR Officer
ii) Authority to authorise overtime																				
iii) Authority to authorise travel & subsistence expenses																				
iv) Approval of Performance Related Pay Assessment																				
g) Leave																				
i) Approval of annual leave	NHS Terms and Conditions of Service Handbook and other relevant terms and conditions of service																			
ii) Annual leave - approval of carry forward (up to 5 days or in the case of Ancillary & Maintenance staff as defined in their initial conditions of service).																				
iii) Annual leave - approval of carry over in excess of 5 days.																				
iv) Compassionate leave																				
v) Special leave arrangements																				
vi) Leave without pay																				
vii) Time off in lieu (to be documented)																				
viii) Maternity Leave - paid and unpaid																				HR Officer
h) <u>Sickness Absence</u>	Trust Sickness Absence & Rehabilitation Policy & Procedure																			
i) Extension of sick pay on half pay up to three months																				
ii) Return to work part-time on full pay to assist recovery																				
iii) Extension of sickness absence on full pay																				
l) <u>Study Leave</u>																				
i) Medical staff study leave																				
ii) All other study leave																				
j) <u>Removal Expenses and House Purchase, etc</u> - Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview) up to £2,000	Trust Staff Relocation Policy, November 2004																			
k) <u>Grievance Procedure</u> - All grievances cases must be dealt with strictly in accordance with the Grievance Procedure	Trust Grievance Policy & Procedure, October 2004																			
l) <u>Authorised Mobile Phone Users</u> - Requests for new posts to be authorised as mobile telephone users																				

Scheme of Delegation of Powers 2010

Delegated Matter	Reference documents and notes	Chief Executive	Director of Finance	Medical Director	Trust Clinical Director	Dean	Nurse Director	Dir of HR & Organisational Development	Dir of Service Development & Strategy	Dir of Corporate Governance & Facilities	Trust Secretary	Clinical Director	PPI & Communications Lead	Head of IM&T	Line / Dept Manager	Librarian	Supplies Officer	Budget holder	Petty Cash Holder	Other
m) Renewal of Fixed Term Contract																				
n) Staff Retirement Policy - Authorisation of extensions of contract beyond retirement age	Staff Retirement Procedure, October 2009																			
o) Redundancy																				CEO & Remuneration Committee for senior staff
p) Ill Health Retirement - Decision to pursue retirement on the grounds of ill-health																				
q) Dismissal	Disciplinary Procedures																			Dismissing Officer Management Committee
20. Authorisation of Sponsorship deals																				
21. Authorisation of Research Projects																				Director of Research & Development
22. Authorisation of Clinical Trials																				Director of Research & Development
23. Insurance Policies and Risk Management	SFI 18																			
24. Patients & Relatives Complaints	a) Overall responsibility for ensuring that all complaints are dealt with effectively																			Complaints Manager
	b) Responsibility for ensuring complaints relating to a department are investigated thoroughly.																			Dept Director
	c) Management of the legal aspects of complaints																			
25. Relationship with the media																				
26. Patient Services	Variation of clinic sessions																			
27. Facilities for staff not employed by the Trust to gain practical experience	Professional Recognition, Honorary Contracts, & Insurance of Medical Staff.																			
	Work experience students																			
28. Review of fire precautions																				
29. Review of all statutory compliance with legislation on health and safety																				
30. Review of Medicines Inspectorate Regulations																				
31. Review of compliance with environmental regulations																				
32. Review of Trust's compliance with the Data Protection Act																				Information Governance Lead & Senior Information Risk Owner
33. Review the Trust's compliance with the Access to Records Act																				
34. Membership management and governor elections	Trust's Constitution																			
35. The keeping of registers for the Declaration of Interests, the register of members and the Declaration of Independence	Trust's Constitution, Annex 5																			

Scheme of Delegation of Powers 2010

Delegated Matter	Reference documents and notes	Chief Executive	Director of Finance	Medical Director	Trust Clinical Director	Dean	Nurse Director	Dir of HR & Organisational Development	Dir of Service Development & Strategy	Dir of Corporate Governance & Facilities	Trust Secretary	Clinical Director	PPI & Communications Lead	Head of IM&T	Line / Dept Manager	Librarian	Supplies Officer	Budget holder	Petty Cash Holder	Other	
36. Attestation of sealings in accordance with Standing Orders		BDSO 8																			Or Officers nominated by CEO and FD
37. The keeping of a register of sealings, and reporting to the Board of Directors		BDSO 8																			
38. The keeping of the <i>Gifts and Hospitality Register</i>		SFI 20																			
39. Information Governance		SFI 17																			Head of Informatics & Caldicott Guardian
40. Clinical Governance																					
41. Review of the Trust's compliance with Monitor's <i>Code of Governance</i>		Monitor's Code of Governance																			
42. Review of the Trust's compliance with Monitor's <i>Compliance Framework</i>	Financial matters	Compliance Framework																			
	Governance declaration																				
	Membership matters																				
43. Review of the Trust's compliance with the <i>Codes of Conduct for the Board of Directors and the Board of Governors</i>		Board of Directors' Code of Conduct & Board of Governors' Code of Conduct																			
44. Patient and Public Involvement		Patient & Public Involvement Committee Terms of Reference																			PPI lead
45. Risk		Compliance Framework																			
46. The review and keeping of the <i>Assurance Framework and Risk Register</i>	a) Strategic Risk Register	Compliance Framework																			
	b) Operational Risk Register	Compliance Framework																			

Board of Directors : April 2010

Item : 13

Title : Clinical Quality, Safety, and Governance

Summary:

This paper makes proposals for an integrated system of development, delivery, and assurance, and is presented to the Board of Directors for approval.

For : Approval

From : Chief Executive

Clinical Quality, Safety, and Governance

Proposal for an integrated system of development, delivery and assurance

1. Introduction

- 1.1 The Tavistock and Portman NHS Foundation Trust (TPFT) is a specialist provider of clinical services, training and education. Our values and future are tied to the high quality of all of our services, and to their distinctive nature. As a small FT, our management and infrastructure cost are proportionately higher than those within larger organisations. We continue to increase investment in the areas of quality, safety and governance, however, as they are so tied to our mission and to that of the NHS.
- 1.2 The Trust has an excellent record in these areas. We have always performed well in relation to external assessments (whether they be by CHI, HCC or now CQC and NHSLA¹); we experience and report very few Serious Untoward Incidents (SUIs) each year; and we have a national and international reputation for the quality of our work. This does not, however, mean that there is no room for further improvement. In addition, the need to evidence our work, and the need to assure ourselves that potential risks are effectively managed, increase year on year.

2. The Case for Change

- 2.1 The NHS context within which we operate has changed; a number of factors have contributed to this over the past 12 months:
 - 2.1.1 the tragic death of Baby Peter shone a spotlight on issues of child protection;
 - 2.1.2 the enquiry into Mid Staffordshire Foundation Trust (Mid-Staffs) drew sharp attention to issues of patient safety, service quality and Board assurance;
 - 2.1.3 the creation of the CQC, together with a regime of more frequent inspection coupled with increasing reporting requirements;

¹ Commission for Health Improvement; Healthcare Commission; Care Quality Commission; National Health Service Litigation Authority.

- 2.1.4 *High Quality Care for All* (the outcome of Lord Darzi's review) and in particular the focus on clinical quality and safety that it encompasses;
 - 2.1.5 the development of patient experience as a key indicator of quality (see also *Our Health, Our Care, Our Say*);
 - 2.1.6 the embedding of the quality agenda into both contracting (e.g. Commissioning for Quality and Innovation (QUIN) and Quality Standards) and governance (in the form of Quality Accounts);
 - 2.1.7 and lastly (or perhaps foremost) our own ambition to provide services of the very highest quality and safety, and our need to be able to evidence and communicate these features effectively, persuasively and convincingly.
- 2.2 Providing assurance that the risks relating to quality and safety are being managed and that the annual plan can be delivered and future planning informed will become an increasingly onerous challenge under current arrangements.
- 2.3 These developments have led the executive to review our resourcing of key areas, and to develop this proposal for a system of integrated development, delivery and governance that will ensure that we deliver on these key agendas and provide assurance to the Board of Directors that we are doing so.

3. Work to Date

- 3.1 Developing robust governance arrangements was a key work stream in the preparation to becoming an FT and much useful development was undertaken as a result; however, as the Francis Report (2010) makes clear, relying on the development of governance systems to achieve FT status will not in itself generate assurance arrangements that stand up to scrutiny in an increasingly challenging regulatory regime.
- 3.2 Our present system of management and Board assurance in these areas comprises the following:
- 3.2.1 A Risk Management Committee covering both clinical and non-clinical risk, chaired by the CEO;
 - 3.2.2 A Clinical Governance Committee chaired by the Medical Director;

- 3.2.3 A Patient & Public Involvement Committee chaired by the PPI Lead.
- 3.3 These three Committees all report to the Board of Directors. The Audit Committee, also a Committee of the Board of Directors, provides further assurance in relation to our governance processes. We believe, however, that the connectedness between these Committees and the work that they oversee could be improved. In addition, resource constraints have meant that work within each workstream has not progressed as quickly as we have wished it to. In particular, we are concerned that our PPI activity needs a higher profile in supporting the development of a stronger public and patient 'voice'.
- 3.4 Lastly, we are concerned to ensure that Governors are enabled to make a genuine contribution in these areas. Specifically they have a potential role in the building up of Quality Accounts as well as working with the Board of Directors to comment on all aspects of quality.
- 3.5 Details of our present system of assurance are provided in Appendix 1, together with a model for best practice in figure 2. Principles of Good Governance are set out in Appendix 2.
- 3.6 Over the past 12 months we have begun to address some of the issues through increased resourcing in the form of:
- 3.6.1 Two new Assistant Medical Directors;
 - 3.6.2 A new Child Protection Lead (non-medical), with increased dedicated time available for this work;
 - 3.6.3 An additional session to the Trust Clinical Director for her work on Quality;
 - 3.6.4 An increase in the banding of the Executive Assistant to the Medical Director.
- 3.7 We now believe that the next step should involve a review of how these resources are made use of, and how our structures are brought together in a manner that maximises their potential.

4. Proposal

- 4.1 The proposed system has two aims:

- 4.1.1 First, to develop and deliver the Trust's Clinical Quality, Safety and Governance agenda;
 - 4.1.2 Second, to ensure that sufficient assurance is provided to both Boards around this work.
- 4.2 In order to achieve this, the system has the following features (represented graphically in Appendix 3):
- 4.2.1 The system will operate based on clear individual responsibility for specified domains of work, with clear lines of accountability and reporting;
 - 4.2.2 Accountable individuals may be supported and advised by work groups or committees that they chair;
 - 4.2.3 Overarching responsibility for clinical quality, safety and governance will remain held by the CEO;
 - 4.2.4 The Medical Director will chair a new Clinical Quality, Safety and Governance Committee (CQSGC). The Committee will replace the Clinical Governance Committee and will lead and oversee a number of workstreams falling under its remit. The Committee will also receive and review assurance from these workstreams, reporting to the Board of Directors. This committee will have Non-Executive Director and Governor representation and the CEO will be a member of the Committee;
 - 4.2.5 Responsibility for workstreams will be delegated to named Directors who shall report to the CQSGC;
 - 4.2.6 The Risk Management Committee will be replaced by a Corporate Governance and Risk Committee (chaired by the Director of Corporate Governance) and a Patient Safety and Clinical Risk Committee (Chaired by the Medical Director). Both Chairs will sit on the CQSGC and will report to the CQSGC on their workstreams as they pertain to the work of that Committee;
 - 4.2.7 Clinical Quality and Effectiveness will report to the CQSGC from Clinical Outcomes and Clinical Audit workstreams, responsibility for which will be held by the two Associate Medical Directors. The Associate Medical Directors are accountable to the Medical Director who chairs the CQSGC;

- 4.2.8 The Trust's PPI Lead will continue to hold responsibility for Patient Experience and will be a member of the CQSGC, reporting on activity relating to the remit of that Committee;
 - 4.2.9 Responsibility for Quality Accounts will be held by a Quality Accounts Lead (to be appointed), accountable to the Trust Clinical Director. The Quality Accounts Lead will be a member of the CQSGC;
 - 4.2.10 The Trust Director will also sit on the CQSGC, representing the professional link with the Trust Clinics Committee, and will assume responsibility for professional engagement and accountability (in line with the Francis Report recommendations).
- 4.3 Key elements of the work undertaken within workstreams will also report to the Management Committee in advance of reporting elsewhere. For example:
- 4.3.1 SUIs;
 - 4.3.2 PPI;
 - 4.3.3 Complaints;
 - 4.3.4 CQC reporting / compliance;
 - 4.3.5 NHSLA compliance;
 - 4.3.6 Patient surveys;
 - 4.3.7 Compliance with contractual requirements and progress on CQUINS and Quality Accounts.
- 4.4 Individuals holding responsibility for key work streams will also be asked to report on their work to the Management Committee.

5. Benefits

- 5.1 We believe that the proposed system will yield the following:
- 5.1.1 The system is clinically focussed and clinically led;
 - 5.1.2 The approach will generate quality assurance and will stand up to robust challenge from external assessors;

- 5.1.3 The executive has a clear mandate and can focus its efforts on the development and delivery of high quality services;
- 5.1.4 The Board of Directors should have increased capacity to consider strategy;
- 5.1.5 The structure will allow organisational leaders to work in partnership with senior managers to deliver a whole systems product;
- 5.1.6 The Trust will be able to retain its excellent quality rating and work towards higher NHSLA ratings;
- 5.1.7 Better NHSLA rating will reduce costs, and increase reputation for risk management;
- 5.1.8 Non-Executive Directors will not be pulled out of role or their contribution diluted;
- 5.1.9 Governors will have a clear role in relation to quality and safety;
- 5.1.10 Outcome results will inform the annual business planning process at the optimum point in the year so planning can be more effective;
- 5.1.11 Other areas, such as the NHS Constitution, Information Governance etc., can be included without any change to the system.

6. Capacity and capability

- 6.1 Leadership is good and there exists the potential to adjust arrangements at this level to good effect. We have, in addition, already identified resources to appoint a Quality Accounts Lead.

7. Why 'no change' is not an option

- 7.1 The additional extra volume and extra tasks is likely to severely challenge existing systems if a no change option is adopted.
- 7.2 In particular, the attainment of NHSLA Level 2 and beyond is business-critical; without this the Trust is likely to lose its excellent rating.

- 7.3 Task performance at strategic level is split into clinical delivery and outcome reporting so tasks are not managed holistically. This is inefficient and undermines individual contributions to the collective effort.
- 7.4 As systems become increasingly focussed on the patient, and patients focus on their rights as consumers, governance between organisations needs to be examined where services are provided in partnership with other providers.
- 7.5 The Management Committee and both Boards need to ensure they are properly focused on the development and delivery of high quality services.

8. Conclusion

- 8.1 The case for change is very strong. The challenge is to develop a system that delivers quality of service and outcomes together with assurance and management of risk. The system needs to assist the Board of Directors in its corporate collective responsibility, whilst maintaining accountability to Members, the public, the regulators, and commissioners.
- 8.2 We believe that these proposals meet these challenges, and we commend them for your attention, comment and approval.

Dr Matthew Patrick
Chief Executive
21/04/2010

Appendix 1

Assurance

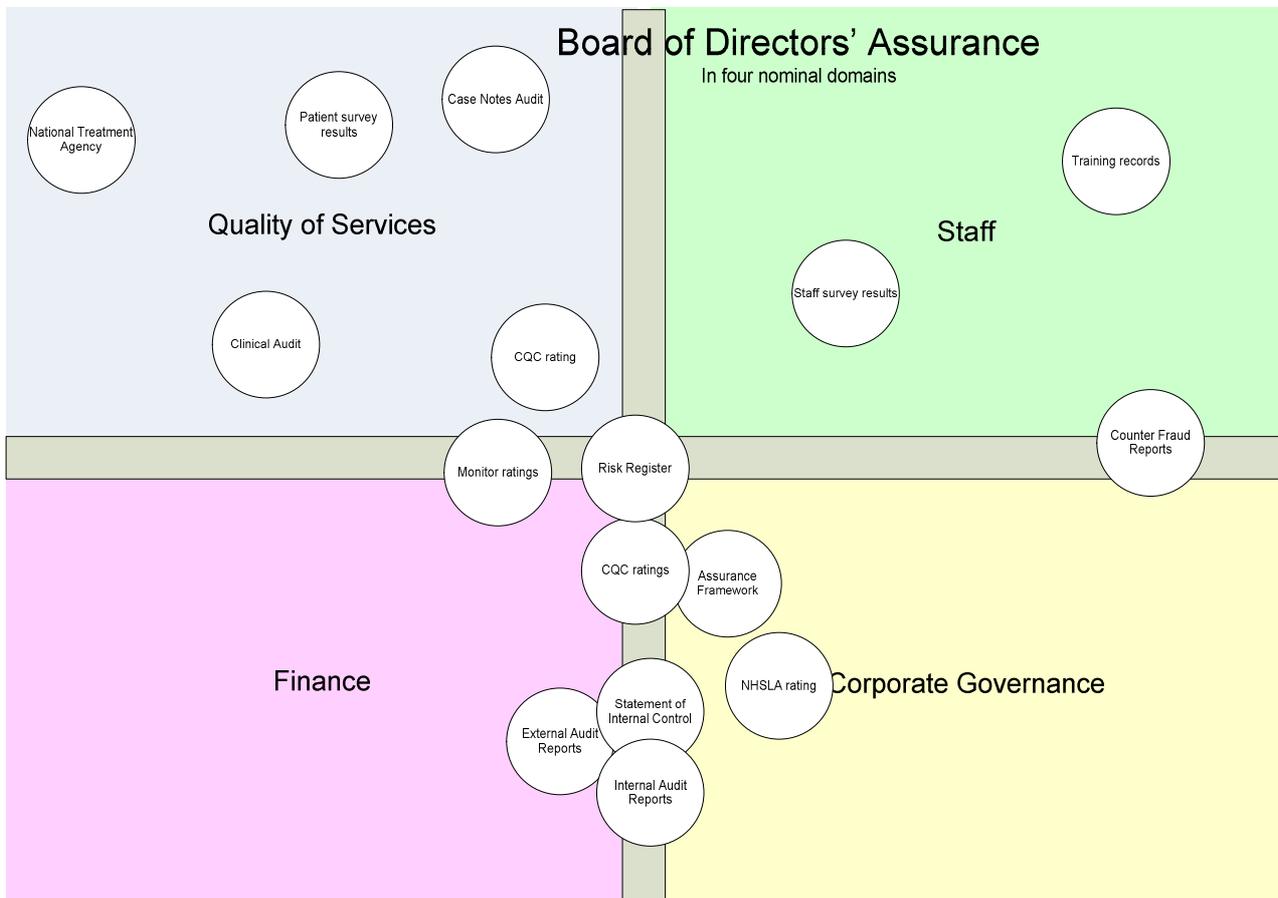


Fig 1: The provision of assurance in four domains

The illustration above shows a sample of the type of assurance that the Board of Directors and external assessors require in four nominal domains. Those items closest to the centre are of greatest importance (though their placing is subjective). At present, a number of the forms of assurance tend to be provided on an *ad hoc* basis with the concern that they be, as a consequence, insufficiently connected with service delivery. Such an approach:

- can be inefficient as there is much duplication
- puts too much separation between the provision of excellent services and the provision of assurance as distinct tasks, when they should be part of the same holistic task
- can lead to silo working across directorates, and may not address the complexity of governance between organisations inherent in a diverse and increasingly remote patient pathway across multiple providers

- can make it hard for the organisation and both Boards to have a comprehensive overview of quality outcomes rather than system outputs (a criticism in the Francis Report (2010))

Focus on excellence

A model for delivering assurance as business as usual

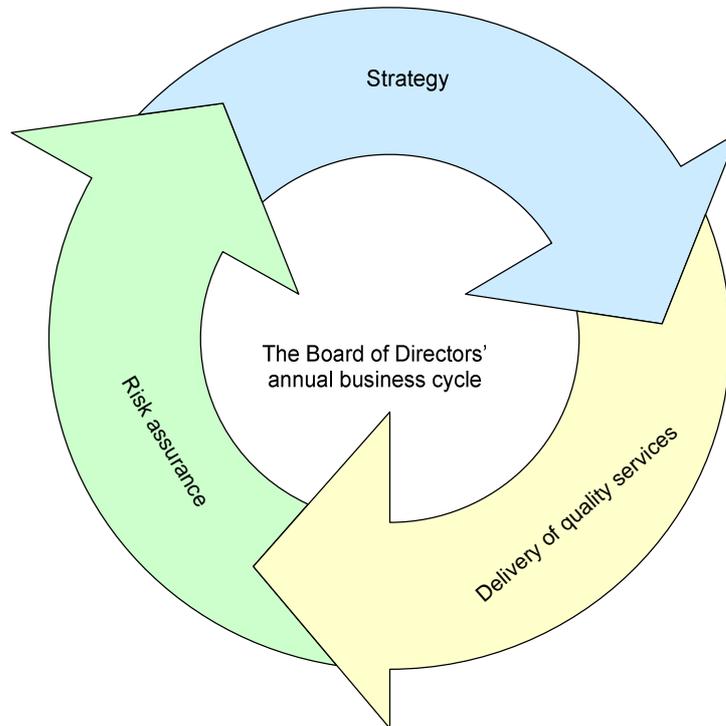


Fig 2: Assurance of outcomes informs business planning at strategic level

Appendix 2

Principles of Good Governance

The role of NHS boards has evolved. As an entity, the Board of Directors' job is to set the strategy of the Trust, to monitor progress against plan, and to scrutinise the assurance provided on the risks that challenge that strategy. It does this by delegating its authority through the executive (e.g. Standing Financial Instructions; Scheme of Delegation; setting policies etc), and holds the executive to account through the assurance it receives (e.g. through reports).

The Trust Board's business is managed in this way and gives maximum time to the strategic function of the board; however, the NHS has traditionally had a poor record on developing and implementing effective governance arrangements (as evidence by the number of high profile reviews conducted by the HCC/CQC and others in recent years (e.g. Maidstone, Mid Staff's, South London and St Georges' to name but a few). The diagram below sets out a model for the relationship between the Board and Management:

The Board of Directors

Task and role boundaries

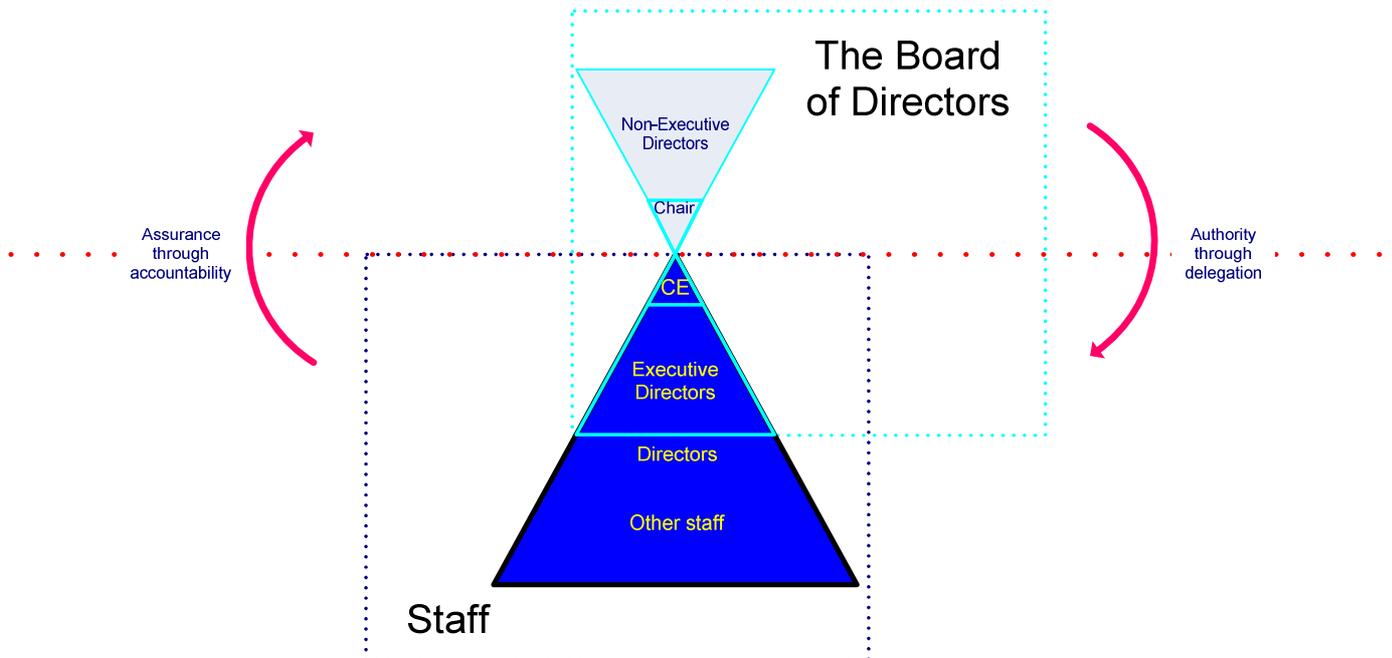


Fig 3: A model of corporate governance

This model is based on the approach taught by ICSA². The Trust's current governance model is based on this approach.

People and Committees

The Board of Directors' Committees are connected to the Board only; their function is to provide assurance directly to the Board, not to manage the work of the Trust. Individuals, not Committees, are accountable for the delivery of work. Terms of reference need to reflect this fact in the language used in the duties section.

No part of the Management Committee structure is connected to Board Committees, though individuals and groups within the Trust may be expected or commissioned by Board Committees to prepare reports. Board Committees (such as the proposed CQSGC) can also function to support the work of the executive through providing leadership and direction and coordination. In addition, Board Committees are a forum to scrutinise outcomes, advise senior staff how standards might be improved, and provide assurance to the Board on these matters.

Non-Executive Directors make an enormously valuable contribution to the work of the Trust, including within operational domains. This carries with it a risk, however, that they may be pulled out of role in a manner that makes the provision of assurance *by NEDs of NEDs'* work potentially very difficult.

Structure

Having noted the principle by which the board is run, the structure of the Board's Committees, and the organisation, follow logically. The illustration below (Appendix 3) focuses on those groups that deliver essential assurance, other groups that report to the Management Committee may be established or retained.

² The Institute of Chartered Secretaries and Administrators

Appendix 3: assurance for the Board of Directors

~delivering clinical quality, safety, and governance

