

Board of Directors Part One

Agenda and papers of a meeting to be held

2pm – 4pm
Tuesday 28th February 2012

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

Board of Directors
2pm – 4pm, Tuesday 28th February 2012

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

For noting

Reports & Finance

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

Non-Executive Directors as appropriate

6. Chief Executive's Report

Dr Matthew Patrick, Chief Executive

*(Report attached)
For discussion*

7. Finance & Performance Report

Mr Simon Young, Director of Finance & Deputy CEO

*(Report attached)
For discussion*

**8. Clinical Quality, Safety & Governance Committee
Quarter Three Report**

Dr Rob Senior, Medical Director & Committee Chair

*(Report attached)
For discussion*

9. Charitable Fund Committee Annual Review 2010/11

Ms Angela Greatley, Trust Chair & Committee Chair

*(Report attached)
For approval*

Corporate Governance

10. Corporate Governance Report

Miss Louise Carney, Trust Board & Company Secretary

*(Report attached)
For noting*

11. Standing Financial Instructions

*Mr Simon Young, Director of Finance & Deputy CEO
Miss Louise Carney, Trust Board & Company Secretary*

*(Report attached)
For approval*

12. Trust Policies

a. Anti-Bribery Policy

Mr Simon Young, Director of Finance & Deputy CEO

(Policy attached)

For approval

13. Committee Reports & Minutes

Committee Chairs, as necessary

For noting

Quality & Development

14. Service Line Report – CAMHS Training

Ms Karen Tanner, Associate Dean, CAMHS

(Report attached)

For discussion

15. Quality Report Quarter Three Review

Ms Louise Lyon, Trust Director

*Ms Justine McCarthy Woods, Quality Report & Standards
Lead*

(Report attached)

For discussion

Conclusion

16. Any other business

17. Notice of future meetings

Wednesday 14th March 2012 : Directors Conference
Tuesday 27th March 2012 : Board of Directors
Tuesday 24th April 2012 : Board of Directors
Tuesday 29th May 2012 : Board of Directors
Wednesday 13th June 2012 : Directors Conference
Thursday 21st June 2012 : Board of Governors
Tuesday 26th June 2012 : Board of Directors
Tuesday 31st July 2012 : Board of Directors
Wednesday 12th September 2012 : Directors Conference, 10am – 5pm
Thursday 13th September 2012 : Board of Governors
Tuesday 25th September 2012 : Board of Directors
Tuesday 30th October 2012 : Board of Directors
Wednesday 21st November 2012 : Directors Conference
Tuesday 27th November 2012 : Board of Directors
Thursday 6th December 2012 : Board of Governors

Meetings of the Board of Directors from 2012 onwards will be from 2pm until 5pm, 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 12noon until 5pm, except where stated

Board of Directors

Meeting Minutes (Part One)

2pm – 3pm, Tuesday 31st January 2012

Present:			
Ms Angela Greatley Trust Chair	Mr Malcolm Allen (part) Dean	Mr Martin Bostock Snr Independent Director	Ms Lis Jones Nurse Director
Mr Altaf Kara Non-Executive Director	Ms Louise Lyon Trust Director	Ms Joyce Moseley Non-Executive Director	Dr Ian McPherson Non-Executive Director
Dr Matthew Patrick (part) Chief Executive	Dr Rob Senior Medical Director	Mr Richard Strang Deputy Trust Chair	Mr Simon Young Director of Finance
In Attendance:			
Miss Louise Carney Trust Secretary	Dr Rita Harris CAMHS Director	Prof. Alessandra Lemma UCLP (item 9)	Prof. Peter Fonagy UCLP (item 9)
Apologies:			
Dr Matthew Patrick (part) Chief Executive	Mr Malcolm Allen (part) Dean		

AP	Item	Action to be taken	Resp	By
1	5	Mr Allen to produce briefing for Board members on commissioning for education and training	MA	Feb 12
2	6	Prof. Briggs to give presentation on e-learning to Board lunch	SB	Jun 12
3	7	Mr Young to produce more detailed Finance & Performance Report	SY	Feb 12
4	7	Mr Young to present forecasting review for Board	SY	Mar 12
5	9	Profs. Fonagy and Lemma to present report on Programme workstream	UCLP	Mar 13

1. Trust Chair's Opening Remarks

Ms Greatley welcomed everyone to the meeting, including Dr Harris, who was taking part in the Board meeting.

2. Apologies for Absence

As above. Ms Greatley explained that Dr Patrick had been called away unexpectedly, but would join the meeting as soon as possible (Dr Patrick arrived for item 7). Mr Allan had been called into the Trust's Quality Assurance Audit run by the University of East London and would join the meeting as soon as possible (Mr Allan arrived for item 10).

3. Minutes of the Previous Meeting

Approved.

4. Matters Arising

None. The outstanding action table was noted.

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

Angela Greatley, Trust Chair

Ms Greatley noted that there were a number of changes regarding the commissioning for education and training resulting from the second stage Future Forum reports. **Malcolm Allen was producing a briefing for Board members, to be circulated via e-mail.**

AP1

Richard Strang, Deputy Trust Chair

Mr Strang notified the Board that he was acting as a Board advisor to the Devon Partnership Trust. This had been entered onto the Register of Directors' Interests.

Joyce Moseley, Non-Executive Director

Ms Moseley had attended a King's Fund event at which the Chief Executive of Croydon Council had given a presentation. Ms Moseley had circulated his presentation.

6. Chief Executive's Report

Mr Young spoke to this report. Mr Young reported that the Trust had had an unexpected visit from the Care Quality Commission on 20th January. The Trust was well-prepared for such a visit. The inspectors had been introduced to a patient, and had also visited the Day Unit and met some of the pupils. The Board thanked all staff involved in the inspection on the day and also all those staff who had ensured that the Trust was prepared for the inspection. The Trust was awaiting its final written report with feedback.

AP2 **The Board noted the launch of the Trust's e-learning unit, and asked that Prof. Briggs attend a Board lunch to give a presentation on the work of the unit.**

Ms Moseley requested more information about the impact changes to the Public Law Outline were having on the Trust. Dr Harris noted that the Outline was starting to have an adverse effect on the court system, and there was a great deal of case backlog. Dr Harris noted that there were some pilot programmes, and the Trust would try to join these. It was also noted that the system was worse in London, as the cap was higher outside of London, and that the Trust was still getting court report requests from outside of London. Dr Harris noted that she was wary of closing services and losing the valuable workforce skills that had been developed. Dr McPherson noted that the Outline would also have an impact on the Portman Clinic. The Board noted the importance of communicating the importance of the Trust's work to those with responsibility for funding, such as Government Ministers. Dr Harris noted the Trust was already doing this.

Board members congratulated Dr McPherson on his OBE.

7. Finance & Performance Report

Mr Young reminded the Board that he had e-mailed details of actions management was planning of taking to reduce the Trust's income deficit. Mr Young circulated an updated version of this action plan, which summarised the changes in the forecast between Mr Young's e-mail of 16th December and the January Board report, and highlighted the main areas of risk to the forecast. Mr Young noted the following:

- The forecast surplus in December was £164k, but was now £117k
- Income showed £47 adverse variance from the December forecast, which was mostly related to court report work
- Expenditure had been reviewed in all areas, but there was a £20k adverse variance in the Adolescent Department
- Overall, there was a £5k saving, but the forecast had not yet taken into account the effects of the vacancy freeze announced by Dr Patrick in January. In addition to this, there may also be some further small savings from a bank and agency staff review currently underway. There was also an opportunity to redeploy staff to cover maternity vacancies.

Mr Young noted that much work had been done in Haringey, the Gender Identity Development Service, and Tavistock Consulting, but there was still some way to go

- Haringey Referrals: Activity levels had not increased by enough in December. January figures were more promising, and Mr Young was waiting for further analysis
- GIDS: Activity levels had not increased by enough. Mr Young was waiting for further analysis
- Tavistock Consulting: Activity levels had not increased by enough. Mr Young feared that the final forecast would be lower than that shown

Management action continues to ensure the achievement of the actions, but Mr Young recognised that this would be tight.

Mr Strang noted that there had been more detail in the original version of the action plan e-mailed in December, and noted that he did not feel that he fully understood what action had been taken already and what was still to be done.

Mr Kara noted it would be helpful to be reminded of the threshold for dropping a Financial Risk Rating. Mr Young explained that there was approximately £80k margin for this.

Mr Strang noted that it would be helpful to know the expectation for capital expenditure for year-end. Mr Young expected expenditure to be largely on Plan, with the exception of the Day Unit relocation, which had not yet gone ahead. Mr Young was anticipating around £520k capital expenditure.

Dr Patrick outlined the four key areas of management activity:

- Cost: Management has implemented a vacancy freeze, and is undertaking a review of bank and agency staff expenditure across the Trust
- MFAS: Funding for court work for complex multi-disciplinary assessments has abruptly ceased. There are specific plans in place to address this
- Haringey under-performance: The Trust is engagement with commissioners and with the single points of entry. CAMHS and Adult clinicians have been located within Haringey to address this.
- Gender Identity Development Service: Ms Lyon is actively addressing this with GIDS clinicians
- Tavistock Consulting: Income for this is volatile, and management are working closely to ensure delivery

Board noted the report, but expressed their concerns in relation to the achievability of the action plan by the end of the year. **Mr Strang requested a more detailed report to the February Board meeting.**

AP3

AP4 **Mr Strang also requested a review of forecasting process, in particular outlining key indicators that the Board should focus on when reviewing forecasts.**

8. Quarterly Declarations

In-Year Governance Declaration

Approved

Finance Declaration

Approved

Quality Declaration

Approved

9. UCL Partners Mental Health and Wellbeing Programme

Profs. Fonagy and Lemma introduced themselves to the Board. Prof. Fonagy is Director of Mental Health & Wellbeing Programme at UCLP, and is Head of the

Research Department for Clinical Education and Health Psychology at University College London. Prof. Lemma is the Unit Director for the Trust's Psychological Therapies Development Unit, represents the Trust on the UCLP Executive, and is Clinical Lead of UCLP's Psychological Interventions Research Centre (PIRC).

Prof. Fonagy noted that Dr Patrick had been influential in shaping the UCLP Mental Health and Wellbeing Programme.

Ms Greatley noted that the population size that UCLP covered was vast and very diverse. Ms Greatley also noted her interest in the concept of "bench to bedside", which linked pure academic science research with healthcare work out in communities. Improving the speed of this link would be a substantial achievement.

Dr McPherson noted that one of the challenges facing the health system was the interface between clinical work and research, and queried whether there were ways to influence the next generation of clinicians to have more engaged view towards research. Prof. Lemma referred to concept of fellows to PIRC. Prof. Fonagy noted that Academic Health Science Systems will become responsible for much post-graduate medical education.

Mr Bostock noted that it would be a great help to all in the field of mental health to have properly researched common bases upon which to compare themselves.

Ms Moseley noted that implementation into the systems in which practitioners operate is often very difficult. Prof. Lemma recognised this issue and noted that projects were chosen very carefully.

Dr Patrick noted that Academic Health Science Systems marked a major development for healthcare, and it was very important for the Trust to be involved.

AP5 Ms Greatley requested that Profs. Fonagy and Lemma return and report on one workstream in more detail in a year's time.

10. Rio 2015 Outline Business Case

Dr Patrick noted that he chairs the London Group and RiO Community Board.

Dr Patrick explained that the current contract with RiO is provided through BT. Contract extension prices beyond were very high. One option would be for the Trust to contract directly with the software developer.

Ms Moseley queried how many trusts were signed up to RiO. Dr Patrick explained that all mental health trusts with the exception of South London and Maudsley

were signed up, as were the majority of acute trusts in London.

Mr Strang queried whether there would be a review of the performance of RiO.
Dr Patrick confirmed that there would be.

11. Any Other Business

None.

12. Notice of Future Meetings

Noted.

Outstanding Action Part 1

No.	Originating Meeting	Agenda Item	Action Required	Director / Manager	Due Date	Progress Update / Comment
2	Jan-12	5. Trust Chair and NEDs Reports	Mr Allen to produce briefing on commissioning for education and training	Malcolm Allen	Feb-12	This was e-mailed to Board members on 7th February 2012
3	Jan-12	7. Finance & Performance Report	Mr Young to produce more detailed Finance & Performance Report	Simon Young	Feb-12	This has been done
4	Jan-12	7. Finance & Performance Report	Mr Young to present forecasting review for Board	Simon Young	Mar-12	
1	Mar-11	8. Health & Social Care Bill Update: Governance in NHS Foundation Trusts	Miss Carney to investigate insurance policies for Directors	Louise Carney	As appropriate	Waiting for final version of Health & Social Care Bill
5	Jan-11	10. Estates & Facilities Report	Ms Key to investigate whether the Public Services Bill affects the NHS and FTs in particular	Pat Key	As appropriate	I think we will need advice from the SoS. We can't get guidance until after Royal Assent

Red denotes actions overdue

Amber denotes actions due this month

Board of Directors : February 2012

Item : 6

Title : Chief Executive's Report

Summary :

This paper covers the following items:

1. Introduction
2. Health and Social Care Bill
3. NHS Commissioning Board
4. Training and Education
5. And Finally...

For : Discussion

From : Chief Executive

Chief Executive Report

1. Introduction

- 1.1 Work within the Trust over the past month has continued to focus on finances to year end and on productivity and workforce planning for next year and the two years to follow that. A further update on these matters will be provided at our meeting.
- 1.2 In February I wrote to all staff to clarify the approach we would be taking. While directorate productivity plans may include some elements of new income, importantly they need to focus on how we reduce our costs over the coming years.
- 1.3 I have authorised our Productivity Programme Board to oversee the process to ensure that plans are implemented openly, consistently and fairly across the Trust. The Productivity Programme Board is chaired by Simon Young, with Louise Lyon, Rita Harris and Susan Thomas. Simon will, however, be reviewing the membership of the Board to ensure that it is fit for the work it has to lead. The Board reports directly to me and to the Management Committee. One key element of the work to be delivered will be a workforce plan.
- 1.4 The Productivity Programme Board and I will communicate with staff as regularly as possible so that, as far as possible, any changes are made in collaboration with the staff they affect. We will consider a full range of approaches including redeployment of staff into new areas of work, the structure and skill mix of our teams, the banding of staff within teams and indeed the number of staff working in the organisation.
- 1.5 Alongside this, our Plan continues to focus on delivery around priority areas for growth (for example e-learning); both in support of our mission to reach, help, teach and influence more people but also because it helps financially and offers flexibility for our existing staff.

2. Health and Social Care Bill

- 2.1 Outside of the Trust, much attention continues to focus on the passage of the Health and Social Care Bill through Parliament. In particular, over the past month more professional bodies have expressed a view that the Bill should be withdrawn, including the Royal College of General Practitioners and the Faculty of Public health.

- 2.2 The Bill is currently in its second reading in the House of Lords, and a number of further amendments have been supported there. The House of Lords can only vote on specific amendments to the Bill and not on the Bill in its entirety.
- 2.3 The Prime Minister, David Cameron, has come out strongly in support of the Health Minister, Andrew Lansley, and strongly in support of the need for the Bill to be passed. He has argued that without the reforms proposed, the health service is not sustainable. Critics have continued to argue that the Bill will do more harm than good, and that it will undermine the NHS's ability to deliver on the financial challenges that it faces while continuing to drive quality upwards.

3. NHS Commissioning Board

- 3.1 One important aspect of the Bill relates to the establishment of an NHS Commissioning Board. The proposed design for the NHS Commissioning Board was recently released.
- 3.2 Among the issues covered in the document were running costs, leadership structure, staffing levels, values and culture. It is proposed there will be an overall workforce of 3,500, comprised of 800 at the centre, 200 in the four sectors and 2,500 across the fifty local offices. The running costs budget has been set at £492m, with an expectation that additional resources will be available in 2013/14 to support transitional costs.
- 3.3 The planned structure comprises nine directorates. Aside from the Performance and Operations Directorate it has been proposed that 'there should be no more than five layers of management', giving something of a flavour for the size and complexity of the organisation and task.

4. Training and Education

- 4.1 Developments also continue in relation to the commissioning of Training and Education for the NHS workforce.
- 4.2 In early February Malcolm Allen and I met with Christine Outram, the new SRO (Senior Responsible Officer) for Health Education England (HEE). HEE is the body that will oversee the future commissioning of training and education.
- 4.3 In the first instance, HEE will oversee the establishment of Local Education and Training Boards (LETBs), which will be the bodies

most directly responsible for commissioning. LETBs will include representatives from provider organisations as well as previous commissioning structures.

- 4.4 In London it is likely that there will be three LETBs, roughly coterminous with the three Academic Health Science Centres (UCL Partners; Kings Healthcare Partners; and Imperial). It is also likely that the AHSCs will themselves take on a role in both the housing and administration of LETBs.
- 4.5 In relation to the Trust's training contract, this has been renewed for a further two year period. This provides important stability while commissioning arrangements are in transition. Beyond this, more specialist national commissions such as ours are likely to be housed within one of the London LETBs.

5. Any Finally...

- 5.1 Over the past month we have had two important external inspections. The first from the Care Quality Commission, and the second a Quality Assurance Agency Review for Educational Oversight audit (QAA REO) in relation to our training and education.
- 5.2 Both inspections went well. The CQC inspection was unannounced and staff had, therefore, to make themselves available at very short notice. The Trust is still waiting for formal feedback from the CQC.
- 5.3 The results of the QAA REO audit were excellent, with the highest available rating being achieved in relation to our academic standards and the quality of learning opportunities, and reliance in the accuracy and completeness of our public information.
- 5.4 These inspections require and enormous amount of dedicated preparation, time and effort, and congratulations are due to all involved.

Dr Matthew Patrick
Chief Executive Officer
February 2012

Board of Directors : February 2012

Item : 7

Title : Finance and Performance Report

Summary:

After ten months a surplus of £12k is reported (before restructuring costs). There are income shortfalls on Directorate Consultancy, Clinical and "other", offset by under spends in Clinical and Central Functions.

The forecast for the year is now a surplus of £72k (before restructuring costs), compared to the budgeted £150k. Actions are being taken to deliver this result. An adverse movement since the December forecast is due to difficulties securing income for consultancy; and additional expenditure in some areas, though this is offset by reductions elsewhere.

An update on service line reporting is provided separately.

The cash balance at 31 January was £2,210k, £638k above Plan. Cash will reduce as planned, but the balance is projected to remain satisfactory.

This report focuses on the following areas:

- Finance

For : Information.

From : Simon Young, Director of Finance

Finance & Performance Report

1. **External Assessments**

1.1 **Monitor**

- 1.1.1 The Monitor quarter 3 return was submitted at the end of January. It is expected that the Trust will retain its green Governance Rating and Financial Risk Rating of 3, in line with Plan.
- 1.1.2 The current forecast would retain the Financial Risk Rating of 3 at year-end.

2. **Finance**

2.1 **Income and Expenditure 2011/12**

- 2.1.1 After ten months, the Trust is reporting a surplus of £12k. In January there was a small deficit of £16k due to rising costs in DET and shortfalls in consultancy, Monroe and "other" income.
- 2.1.2 Due to the budgeted reserves being profiled into the final month the expenditure budget is understated at Month 10. Therefore Appendix A&B indicates a target surplus of £377k which reduces to £150k at year-end, as the budgeted reserves are released.
- 2.1.3 Income is £478k below budget, offset by expenditure being £92k below budget. Some of these variances are due to timing, but some significant variances are expected to continue in the remainder of the year: see 2.1.6 to 2.1.8 regarding the full year forecast.
- 2.1.4 Consultancy income is £211k under budget, with departmental consultancy under by £210k and Tavistock Consulting under target by £1k. Other income is £181k below target mainly due to under achieved productivity schemes in Adult £91k and Adolescent £41k. Clinical Income is £238k below target: this includes PHP income £68k below Plan, Adult productivity schemes £78k below Plan and Big White Wall £25k below. These main income sources and their variances are discussed in sections 3, 4 and 5 below.
- 2.1.5 The cumulative expenditure underspend of £92k includes lower child psychotherapy trainee numbers and the lower than planned staffing in GID. These have been offset by an over spend of £181k in CAMHS, of which £113k relates to the vacancy savings factor which was budgeted (in addition to the savings on specific posts) but has not been achieved. DET is also over spent by £170k due to course and conference costs, with visiting lecturer costs being higher than planned.
- 2.1.6 The forecasts for the year have again been fully reviewed. Clinical NPA income, Day Unit, Tavistock Consulting and departmental

consultancy have all decreased. There have been small increases in expected income from training fees and clinical projects.

2.1.7 These forecasts are shown in the Full Year columns of Appendix B.

2.1.8 There remain risks to some elements of the forecast. However, management action to secure the forecast income is continuing; and measures are being taken to make further savings, so that staff costs in some areas should be lower than the figures forecast here.

2.2 Cash Flow (Appendix C)

2.2.1 The actual cash balance at 31 January was £2,210k, £638k above the revised Plan of £1,572k. The balance rose in month by £200k, as payments to suppliers were lower than anticipated. Some further payments relating to the earlier redundancies are still outstanding which should bring the balance closer to Plan. The year-to-date receipts and payments are summarised in the table below.

	Cash Flow year-to-date		
	Actual £000	Plan £000	Variance £000
Opening cash balance	4,712	4,712	0
Operational income received			
NHS (excl SHA)	7,943	8,346	(403)
General debtors (incl LAs)	6,439	5,577	862
SHA for Training	9,759	9,199	560
Students and sponsors	1,841	2,400	(559)
Other	379	180	199
	<u>26,361</u>	<u>25,702</u>	<u>659</u>
Operational expenditure payments			
Salaries (net)	(12,803)	(12,903)	100
Tax, NI and Pension	(9,062)	(8,837)	(225)
Suppliers	(6,537)	(6,376)	(161)
	<u>(28,402)</u>	<u>(28,116)</u>	<u>(286)</u>
Capital Expenditure	(256)	(490)	234
Interest Income	8	8	0
Payments from provisions	(20)	(51)	31
PDC Dividend Payments	(193)	(193)	0
Closing cash balance	<u>2,210</u>	<u>1,572</u>	<u>638</u>

2.2.2 The forecast (Appendix C) shows that cash balances are expected to remain satisfactory for the rest of the year, with the balance on 31 March above Plan. At present, there are no significant revisions to the monthly forecasts for 2012/13, which also remain satisfactory.

2.3 Capital Expenditure

2.3.1 As reported last month, capital expenditure totalled £320k in the first nine months. The forecast for the year is £490k, £185k less than budget.

3. **Training**

3.1 Training income is now £164k above budget in total. Fee income is £251k above budget, offset by the a shortfall on Child Psychotherapy Trainees but this is due to slightly lower numbers, and is offset by lower costs.

4. **Patient Services**

4.1 **Activity and Income**

4.1.1 Total contracted income for the year is in line with budget. After ten months, there is a small adverse variance on cost and volume activity of £44k: this includes an under performance of £86k with one PCT. The Camden Adult service is currently over performing by 37% but the contract only allows for 2.5% to be paid. Part of the budgeted income for the year is dependent on meeting our CQUIN[†] targets agreed with commissioners and achievement is reviewed on a quarterly basis.

4.1.2 Variances in other elements of clinical income are tabulated below.

	Budget	Actual	Variance	Full year		Comments
	£000	£000	%	Variance based on y-t-d	Predicted variance	
Contracts - base values	7,930	7,892	-0.5%		-33	
Cost and vol variances	5	-44			-52	
NPAs	192	177	-7.9%	-18	-20	
Projects and other	1,895	1,907		-	54	Income matched to costs, so variance is largely offset.
Day Unit	879	880	0.1%	1	0	
Monroe	408	363	-11.0%	-55	-81	
FDAC 2nd phase	340	347	2.1%	8	50	Income matched to costs, so variance is largely offset.
Court report	237	124	-47.9%	-137	-110	
Total	11,886	11,647		-201	-198	

[†] Commissioning for Quality and Innovation

- 4.1.3 The income for named patient agreements (NPAs) was £177k after ten months, which is £15k below budget. The forecast for the year is now £20k below.
- 4.1.4 Court report income is budgeted at £285k for the year, of which £210k is for the Portman. After ten months, however, we are £114k below budget overall; the Portman is £79k below target and CAMHS are £35k below. Forecast for the year is £110k below budget.
- 4.1.5 Monroe income is below budget by £45k after ten months, with a shortfall of £24k in January due to difficulty in securing funding for cases. Income is likely to continue at the January level for the remainder of the financial year. The annual budget was reduced from £780k to £504k this year, with a corresponding reduction in staffing which has now taken place.
- 4.1.6 Day Unit is currently on target year-to-date. There are 12 pupils this term, against a budgeted target of 12.5. Income remains slightly above budget, due to the contractual arrangements.

5. **Consultancy**

- 5.1 Tavistock Consulting income was £13k below budget in January and is now slightly behind cumulatively: £487k, compared to the budget of £488k. The service is forecasting a shortfall of between £5k and £48k for the year; in this report, a shortfall of £20k has been allowed for. Expenditure is £39k above budget cumulatively, but is now running at a reduced level. A significant contract which was being delivered by an associate ended in October.
- 5.2 Departmental consultancy is £210k below budget after ten months. The majority of the shortfall is within CAMHS which is currently £188k below target, partly offset by additional income from conferences and other training activities.

Simon Young
Director of Finance
20 February 2012

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2011-12

APPENDIX A

	JANUARY 2012			CUMULATIVE			FULL YEAR 2011-12		
	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	REVISED BUDGET £000	FORECAST OUTTURN £000	BUDGET VARIANCE £000
INCOME									
1 CLINICAL	1,252	1,178	(73)	11,886	11,647	(238)	14,398	14,206	(192)
2 TRAINING	1,289	1,298	9	14,281	14,445	164	16,830	17,050	220
3 CONSULTANCY	108	68	(40)	1,114	903	(211)	1,361	1,072	(289)
4 RESEARCH	14	28	14	139	128	(11)	160	160	(0)
5 OTHER	66	57	(8)	637	455	(181)	768	536	(233)
TOTAL INCOME	2,728	2,630	(98)	28,057	27,579	(478)	33,516	33,024	(493)
OPERATING EXPENDITURE (EXCL. DEPRECIATION)									
6 CLINICAL DIRECTORATES	1,495	1,453	43	14,753	14,643	111	17,788	17,649	139
7 OTHER TRAINING COSTS	508	537	(29)	6,258	6,292	(33)	7,287	7,336	(49)
8 OTHER CONSULTANCY COSTS	49	41	8	484	533	(49)	582	621	(39)
9 CENTRAL FUNCTIONS	551	558	(7)	5,447	5,361	86	6,561	6,440	121
10 TOTAL RESERVES	0	0	0	0	0	0	264	0	264
TOTAL EXPENDITURE	2,603	2,589	14	26,943	26,828	115	32,482	32,046	436
EBITDA	125	41	(85)	1,113	751	(363)	1,034	978	(57)
ADD:-									
12 BANK INTEREST RECEIVED	1	1	0	9	8	1	11	10	(1)
LESS:-									
11 DEPRECIATION & AMORTISATION	42	47	(5)	424	447	(23)	509	529	20
13 FINANCE COSTS	0	0	0	0	0	0	0	0	0
14 DIVIDEND	32	11	22	322	300	22	386	386	0
SURPLUS BEFORE RESTRUCTURING COSTS	52	(16)	(67)	377	12	(365)	150	72	(78)
15 RESTRUCTURING COSTS	0	78	(78)	1,000	1,083	(83)	1,000	1,100	(100)
SURPLUS/(DEFICIT) AFTER RESTRUCTURING	52	(94)	(145)	(623)	(1,071)	(448)	(850)	(1,028)	(178)
EBITDA AS % OF INCOME	4.6%	1.5%		4.0%	2.7%		3.1%	3.0%	

THE TAVISTOCK AND PORTMAN NHS TRUST
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2011-12

APPENDIX B

	JANUARY 2012			CUMULATIVE			FULL YEAR 2011-12			
	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	REVISED BUDGET £000	FORECAST £000'S	REVISED BUDGET VARIANCE £000	
INCOME										
1	NHS LONDON TRAINING CONTRACT	605	604	(0)	6,045	6,053	8	7,254	7,262	8
2	TRAINING FEES & OTHER ACA INC	395	415	20	5,545	5,796	251	6,314	6,580	267
3	POSTGRADUATE MED & DENT'L EDUC	12	6	(6)	117	75	(43)	141	115	(26)
4	JUNIOR MEDICAL STAFF	81	93	12	805	913	108	966	1,098	132
5	CHILD PSYCHOTHERAPY TRAINEES	197	180	(17)	1,768	1,608	(160)	2,155	1,995	(160)
6	R&D	14	28	14	139	128	(11)	160	160	(0)
7	CLINICAL INCOME	1,051	1,025	(26)	9,944	9,816	(127)	12,054	12,002	(51)
8	DAY UNIT	88	81	(7)	879	880	1	1,055	1,055	(0)
9	MONROE	48	24	(24)	408	363	(45)	504	423	(81)
10	FDAC	42	38	(3)	417	463	47	500	550	50
11	TCS INCOME	47	34	(13)	488	487	(1)	613	593	(20)
12	DEPT CONSULTANCY INCOME	61	34	(27)	626	416	(210)	747	479	(269)
13	COURT REPORT INCOME	24	11	(13)	237	124	(114)	285	175	(110)
14	EXCELLENCE AWARDS	10	10	0	97	97	0	116	116	0
15	OTHER INCOME	56	48	(8)	540	359	(181)	652	420	(233)
TOTAL INCOME		2,728	2,630	(98)	28,057	27,579	(478)	33,516	33,024	(493)
EXPENDITURE										
16	EDUCATION & TRAINING	289	328	(39)	4,271	4,441	(170)	4,868	5,041	(173)
17	PORTMAN CLINIC	118	111	7	1,144	1,121	22	1,375	1,342	33
18	ADULT DEPT	241	249	(8)	2,556	2,538	17	3,051	3,038	13
19	MEDNET	21	18	3	205	178	28	246	219	28
20	ADOLESCENT DEPT	147	138	9	1,435	1,403	33	1,729	1,664	65
21	C & F CENTRAL	734	728	6	7,035	7,216	(181)	8,538	8,706	(168)
22	MONROE & FDAC	70	73	(3)	765	815	(50)	905	955	(50)
23	DAY UNIT	60	61	(1)	631	606	25	751	733	18
24	SPECIALIST SERVICES	98	75	23	912	725	187	1,108	941	167
25	COURT REPORT EXPENDITURE	7	0	7	71	40	31	85	51	34
26	TRUST BOARD & GOVERNORS	9	8	0	88	90	(2)	106	108	(2)
27	CHIEF EXECUTIVE OFFICE	26	23	3	259	257	2	311	308	2
28	PERFORMANCE & INFORMATICS	81	70	10	681	617	65	843	759	84
29	FINANCE & ICT	101	111	(10)	1,013	1,085	(72)	1,215	1,303	(88)
30	CENTRAL SERVICES DEPT	183	204	(20)	1,822	1,877	(55)	2,187	2,241	(55)
31	HUMAN RESOURCES	50	46	4	597	559	38	710	652	58
32	CLINICAL GOVERNANCE	38	31	7	370	325	45	446	388	58
33	TRUST DIRECTOR	34	38	(4)	326	316	10	395	385	10
34	PPI	14	15	(1)	144	133	11	173	163	10
35	SWP & R+D & PERU	22	22	0	220	193	26	264	237	26
37	PGMDE	5	3	2	52	38	14	63	44	19
38	NHS LONDON FUNDED CP TRAINEES	197	178	19	1,768	1,617	151	2,155	1,994	160
39	TAVISTOCK SESSIONAL CP TRAINEES	7	4	3	73	61	11	88	76	11
40	FLEXIBLE TRAINEE DOCTORS	9	23	(14)	95	134	(40)	113	181	(67)
41	TCS	44	35	9	437	476	(39)	525	555	(30)
42	DEPARTMENTAL CONSULTANCY	5	6	(1)	47	57	(9)	57	66	(9)
43	DEPRECIATION & AMORTISATION	42	47	(5)	424	447	(23)	509	529	(20)
44	PROJECTS CONTRIBUTION	(7)	(10)	3	(73)	(91)	18	(87)	(106)	18
45	IFRS HOLIDAY PAY PROV ADJ	0	0	0	0	(0)	0	0	(0)	0
46	CENTRAL RESERVES	0	0	0	0	0	0	264	0	264
TOTAL EXPENDITURE		2,645	2,636	9	27,367	27,275	92	32,991	32,575	416
OPERATING SURPLUS/(DEFICIT)		83	(6)	(89)	689	304	(385)	525	449	(77)
47	INTEREST RECEIVABLE	1	1	(0)	9	8	(1)	11	10	(1)
48	UNWINDING OF DISCOUNT ON PROVISION	0	0	0	0	0	0	0	0	0
49	DIVIDEND ON PDC	(32)	(11)	22	(322)	(300)	22	(386)	(386)	0
SURPLUS/(DEFICIT)		52	(16)	(68)	377	12	(365)	150	72	(78)
50	RESTRUCTURING COSTS	0	78	(78)	1,000	1,083	(83)	1,000	1,100	(100)
SURPLUS/(DEFICIT) AFTER RESTRUCTURING		52	(94)	(146)	(623)	(1,071)	(448)	(850)	(1,028)	(178)

Cash Flow 2011/12

Appendix C

2011/12 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	4,712	4,770	4,010	3,316	2,872	2,366	1,607	1,401	1,422	1,118	1,572	1,505	4,712
Operational income received													
NHS (excl SHA)	541	623	659	976	1,007	890	877	1,008	888	877	1,009	888	10,243
General debtors (incl LAs)	742	374	560	519	425	650	533	485	450	839	565	472	6,614
SHA for Training	914	934	914	914	933	914	914	934	914	914	934	914	11,047
Students and sponsors	300	150	150	100	0	200	650	250	100	500	100	100	2,600
Other	18	18	18	18	18	18	18	18	18	18	18	18	216
	2,515	2,099	2,301	2,527	2,383	2,672	2,992	2,695	2,370	3,148	2,626	2,392	30,720
Operational expenditure payments													
Salaries (net)	(1,209)	(1,210)	(1,209)	(1,210)	(1,209)	(1,710)	(1,661)	(1,162)	(1,161)	(1,162)	(1,161)	(1,161)	(15,225)
Tax, NI and Pension	(900)	(894)	(894)	(894)	(894)	(894)	(894)	(858)	(858)	(858)	(858)	(858)	(10,554)
Suppliers	(349)	(756)	(849)	(761)	(687)	(576)	(584)	(595)	(605)	(614)	(615)	(613)	(7,604)
	(2,458)	(2,860)	(2,952)	(2,865)	(2,790)	(3,180)	(3,139)	(2,615)	(2,624)	(2,634)	(2,634)	(2,632)	(33,383)
Capital Expenditure	0	0	0	(100)	(100)	(60)	(60)	(60)	(50)	(60)	(60)	(109)	(659)
Interest Income	1	1	1	0	1	1	1	1	1	0	1	1	10
Payments from provisions	0	0	(45)	(6)	0	0	0	0	0	0	0	0	(51)
PDC Dividend Payments	0	0	0	0	0	(193)	0	0	0	0	0	(193)	(386)
Closing cash balance	4,770	4,010	3,316	2,872	2,366	1,607	1,401	1,422	1,118	1,572	1,505	963	963

2011/12 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	4,712	3,376	3,516	2,536	2,445	2,208	2,132	2,316	3,499	1,957	2,210	1,993	4,712
Operational income received													
NHS (excl SHA)	691	725	341	871	603	1,568	1,185	1,355	9	595	1,009	888	9,840
General debtors (incl LAs)	618	238	279	691	724	350	593	2,160	182	604	565	472	7,476
SHA for Training	0	1,707	968	876	1,061	1,013	837	1,074	1,017	1,206	934	914	11,607
Students and sponsors	198	92	162	39	77	261	379	163	131	339	100	100	2,041
Other	4	22	30	68	47	40	90	14	20	44	18	18	415
	1,511	2,784	1,780	2,545	2,512	3,232	3,084	4,766	1,359	2,788	2,626	2,392	31,379
Operational expenditure payments													
Salaries (net)	(1,243)	(1,210)	(1,202)	(1,255)	(1,355)	(1,459)	(1,165)	(1,246)	(1,310)	(1,358)	(1,161)	(1,161)	(15,125)
Tax, NI and Pension	(900)	(917)	(926)	(906)	(902)	(896)	(930)	(869)	(901)	(915)	(858)	(858)	(10,779)
Suppliers	(705)	(497)	(542)	(463)	(469)	(709)	(777)	(1,433)	(679)	(263)	(765)	(613)	(7,915)
	(2,848)	(2,624)	(2,670)	(2,624)	(2,726)	(3,064)	(2,872)	(3,548)	(2,890)	(2,536)	(2,784)	(2,632)	(33,819)
Capital Expenditure	0	(21)	(91)	(13)	(23)	(51)	(29)	(16)	(12)	0	(60)	(121)	(437)
Interest Income	1	1	1	1	0	0	1	1	1	1	1	1	10
Payments from provisions	0	0	0	0	0	0	0	(20)	0	0	0	0	(20)
PDC Dividend Payments	0	0	0	0	0	(193)	0	0	0	0	0	(193)	(386)
Closing cash balance	3,376	3,516	2,536	2,445	2,208	2,132	2,316	3,499	1,957	2,210	1,993	1,439	1,439

Board of Directors : February 2012

Item : 8

Title : CQSG Report, Q3

Purpose:

The purpose of this report is to give an overview of performance of clinical quality, safety, and governance matters.

The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance, and where not, whether the Board of Directors is satisfied with the action plans that have been put in place.

This report is based on assurance scrutinised by the following Committees:

- Management Committee
- Clinical Quality, Safety, and Governance Committee

The assurance to these committees was based on evidence scrutinised by the work stream leads.

This report focuses on the following areas:

- Quality
- Patient / User Experience
- Patient / User Safety
- Risk
- Finance
- Productivity
- Communications

For : Discussion

From : Rob Senior, CQSG Chair

CQSG Report, Q3

1. Introduction

- 1.1 The overview summary of areas already considered by the CQSG is set out in Appendix 1. RAG ratings are not weighted – a red rating may not necessarily imperil the Trust, and a green rating does not confirm there is no work to be done. The Board of Directors is reminded that ratings are not given in the same way as for the Risk Register.
- 1.2 The focus in this narrative is on areas of concern and interest of which the board should pay particular attention; it is not simply a repetition of red and amber related elements.

2. Findings

- 2.1 Appendix 1 sets out the detail by reporting line, the main concussions are:

2.2 Corporate Governance and Risk

- 2.2.1 The workforce RAG rating has shown great improvement due to improvements in systems; it is not green as the externally imposed 95% target for IG training has not been reached and remains a challenge; however, if the same threshold was applied to this as to other mandatory training targets there would be no problem.
- 2.2.2 The CAB line is rated red due to late reporting rather than poor performance. The Trust was not affected by any of the alerts in question.

2.3 Clinical Outcomes

- 2.3.1 The MC has commissioned a group to deliver a new system (see also 2.5.1, 2.7.3)
- 2.3.2 Contracts are at long-term risk if progress is not made

2.4 Clinical Audit

2.4.1 This needs to be invigorated; new requirements on doctors to undertake audit is helpful.

2.5 Patient Safety and Clinical Risk

2.5.1 The investigation into a former patient's suicide is unlikely to have any implications for the Trust.

2.5.2 The court case relating to libel is yet to be committed to trial.

2.5.3 Safeguarding systems are being developed in line with plans.

2.6 Quality Reports

2.6.1 It is not possible to produce robust CQUIN data pending developments in clinical information management.

2.6.2 The arrival of final guidance on quality reporting from Monitor / DH well into Q4 is unhelpful

2.7 Patient and public involvement

2.7.1 Work to date remains on track; outstanding action to be completed by end of Q4.

2.7.2 A new communications group is to be established to support work on social media.

2.7.3 Although the new leaflets are expected to be produced after the deadline, they will be ready by the end of Q4.

2.8 Information Governance

2.8.1 Robust plans are in place to meet training requirements; these were accepted by the CQSG.

2.8.2 The management of information asset owners is being monitored by the Management Committee.

2.8.3 Implementing the clinical information management system proposals (being developed) will generate the information

management assurance required, though this will not be in place before the end of Q4.

3. Conclusion

- 3.1 This report gives a comprehensive overview and summary of CQSG's findings: good progress has been made in many areas but outcome monitoring systems are to be comprehensively overhauled, elements of IG in relation to quality management have not been started due to late decisions on ownership, and there is a need to ensure that elements of PPI are held in the most appropriate work streams.

Jonathan McKee
Governance Manager
21.2.12

Corporate Governance and Risk Work stream						
Task	Q1	Q2	Q3	Q4	Action plan for amber and red risks	Predicted position for year end
To maintain CQC registration without qualification	G	A	G			
To maintain a green governance rating with Monitor	G	A	G			
To maintain a highly effective workforce	R	A	A		See IG report, line 112.	
Estates and Facilities infrastructure improvements and CQC and NHSLA compliance	A	A	G			
Managing responses to recommendations and requirements of external bodies	G	G	G			
Maintain compliance with current NHSLA rating	G	G	G			
Non-clinical incident reports	G	G	G			
Specific case reports (serious	G	G	G			

incidents / SUIs)						
Central alert broadcast advice	A	G	R		Management has been reviewed and position rectified.	
Operational Risk Register	G	G	G			
Relocation of Day Unit	A	A	A		Project plan has been agreed with steering group.	
CGR IG compliance	A	A	A		Awaiting data from one directorate.	

Clinical Outcomes Work Stream						
Task	Q1	Q2	Q3	Q4	Action plan for amber and red risks	Predicted position for year end
Development of outcome monitoring	A	R	A		Detailed action plans to address immediate needs for 2011/12 were put in place	
Outcome monitoring procedure compliance	A	A	A		A new system will be in place in 2012/13; in the meantime developmental work is on-going.	
RiO migration and outcome reporting	A	R			Due to improving systems and processes; this line has been replaced with the following two.	
Effective clinical governance and quality management in place for CAMHS			A		New CAMHS working group established, will report in Q4.	
Effective clinical governance and quality management in place for SAMHS			A		New group to be established and support given.	
Patient Reported Outcome Measures	A	A	A		Plans to increase return rates and manage data better are in place.	
Outcome monitoring of specific populations	G	G	G			

Clinical Audit work stream						
Task	Q1	Q2	Q3	Q4	Action plan for amber and red risks	Predicted position for year end
Development of Clinical Audit Process and Clinical Audit Annual plan	A	A	R		Plan to increase capacity to manage audit to be implemented in Q4 to reflect new GMC guidelines. Plan for 2012/13 to be presented to CQSG in Q1.	
NICE compliance	G	G	A		Recently issued guidelines need to be implemented in Q4	
Confidential inquiries	G	G	G			
Completion of annual case note audit	G	G	G			
CA IG compliance	G	G	G			

Patient Safety and Clinical Risk Work stream						
Task	Q1	Q2	Q3	Q4	Action plan for amber and red risks	Predicted position for year end
Clinical incidents	G	G	G			
Specific case reports (serious incidents / SUIs)	G	G	A		Investigation relating to former patient's suicide underway	
Hospital acquired infection	G	G	G			
New Clinical claims	G	G	A		Libel proceedings have been brought against the Trust; the claim is being defended.	
Complaints responses	G	G	G			
Serious complains update	G	G	G			
PSCR NHSLA compliance	G	G	G			
PSCR CQC compliance	G	G	G			
Central Alert Broadcast advice	G	G	G			
Supervision of clinicians	G	G	G			
Revalidation	G	G	G			
PSCR risk review	G	G	G			
Safeguarding children	A	R	A		New system in place; effectiveness to be audited in Q4.	

Safeguarding adults	A	A	A		New adult lead funding secured; need to make appointment.	
---------------------	---	---	---	--	---	--

Quality work stream						
Task	Q1	Q2	Q3	Q4	Action plan for amber and red risks	Predicted position for year end
Quality report section of the AR is produced to a high standard	G	G	G			
Arrangements to deliver CQUIN are fit for purpose	A	A	R		A new system will be in place in 2012/13; in the meantime developmental work is on-going.	
That data to be collected has been agreed	G	G	G			
That data quality procedure is implemented	A	A	G			
That QR components of the AR are submitted on time and in the correct format	G	G	G			
That QR requirements of IG9 are completed	A	R	R		Audit scheduled for Q4; available data will be used to provide assurance.	

PPI work stream						
Task	Q1	Q2	Q3	Q4	Action plan for amber and red risks	Predicted position for year end
Providing assurance that the trust adheres to all PPI related policies and procedures	G	G	G			
Providing a forum of PPI related matters	A	G	G			
Discussing the findings of the 2010/11 patient survey	A	G	G			
Ensuring that the action plan developed to address the finding of the patient survey is implemented	A	G	G			
Ensuring the involvement of patients in service improvement	A	G	G			
To improve the patient experience of diverse groups	A	G	G			
To hold 3 meetings with stakeholders	A	G	G			
To increase membership by 10%	A	G	G			

To develop a BME engagement strategy	A	G	G			
To hold 3 patient forums	A	G	G			
To increase presence in social media	A	G	A		Assurance to be provided by a new working group.	
To promote choice through information provision and produce 5 leaflets on modalities	A	G	A		Additional consultation on patient-friendly wording being undertaken.	
To work with QR lead to develop quality culture and patient centred services	A	G	G			
That PPI IG requirements are completed	A	G	G			

Information Governance Work Stream						
Task	Q1	Q2	Q3	Q4	Action plan for amber and red risks	Predicted position for year end
101 Governance Overview		G	G			
105 Policy overview		R	G			
110 Contractor compliance		G	G			
111 Employee contract compliance		G	G			
112 IG training		R	R		Prospective application of sanctions has generated activity.	
200 Data protection compliance		R	G			
201 Confidentiality compliance		G	G			
202 & 203 Consent compliance		G	G			
205 Access request compliance		R	G			
206 Confidentiality audit compliance		R	A		This is scheduled for Q4.	

207 Sharing protocol compliance		R	G			
209 processing outside UK		G	G			
210 New systems compliance		G	G			
300 Information security skills compliance		R	R		SIRO is monitoring activity.	
301 Risk assessment of IAs		R	R		SIRO is monitoring activity.	
302 Incident Reports		G	G			
303 Registration Authority compliance		R	G			
304 RA monitoring compliance		R	G			
305 access control compliance		R	R		SIRO is monitoring activity.	
307 Risk management		R	R		SIRO is monitoring activity.	
308 Transfer compliance		R	R		SIRO is monitoring activity.	
309 Business continuity assurance		R	R		SIRO is monitoring activity.	
310 Disruption preparation assurance		R	R		SIRO is monitoring activity.	
311 Protection of IAs		R	G			

313 Network assurance		R	R	Final elements to be completed in Q4	
314 Teleworking assurance		R	G		
323 Protection of IA assurance		R	R	SIRO is monitoring activity.	
324 Pseudonymisation assurance		R	R	Informatics Manager to	
400 IG skills and experience assurance		R	R	SIRO is monitoring activity.	
401 NHS number assurance		G	G		
402 Accuracy of data input		R	G		
404 Audit assurance		G	G		
406 Monitoring paper records assurance		G	G		
501 Data definitions compliance assurance		R	G		
502 External data feedback reports		R	R	A new system will be in place in 2012/13; in the meantime developmental work is on-going. A monitoring system is already in place.	
504 Benchmark reports		R	R	A new system will be in place in 2012/13; in the meantime developmental work is on-going. A monitoring system is already in place.	

506 Service user data accuracy validation		R	R		A new system will be in place in 2012/13; in the meantime developmental work is on-going.	
507 Data completeness validation		R	R		A new system will be in place in 2012/13; in the meantime developmental work is on-going.	
508 Clinical data input validation						
514 Clinical coding audit validation						
516 Clinical coding training programme assurance						
601 Corporate record management assurance		G	G			
603 FOI compliance assurance		G	G			
604 Records lifecycle management assurance		A	A		Awaiting data from one directorate.	

Board of Directors : February 2012

Item : 9

Title : Charitable Fund Committee Annual Review 2010/11

Purpose:

This report covers the activity of the Charitable Fund Committee over the financial year 2010/11.

The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance that the Committee is carrying out its duties, and where not, whether the Board of Directors is satisfied with the action plans that have been put in place.

This report focuses on the following areas:

(delete where not applicable)

- Quality
- Risk
- Finance

For : Approval

From : Angela Greatley, Trust Chair

Charitable Fund Committee Annual Review 2010/11

1. Introduction

- 1.1 The Charitable Fund Committee (the Committee) was established by a Declaration of Trust on 4th September 1995 to contain all the funds held on trust by the Tavistock and Portman NHS Trust. Its objects cover *any charitable purpose of purposes relating to the National Health Service wholly or mainly for the services provided by the Tavistock and Portman Clinics.*
- 1.2 This report forms the annual review of the work and functioning of the Committee. This is to ensure that the Committee is operating at its maximum effectiveness and to make any recommendations for changes considered necessary, to the Board of Directors.

2. Membership and Meeting Frequency

- 2.1 The membership of the Committee is the Trust Chair (or another Non-Executive Director), who is the chair of the Committee, the Chief Executive, and the Director of Finance. The current members of the Committee are Angela Greatley, Trust Chair, Matthew Patrick, Chief Executive, and Simon Young, Director of Finance.
- 2.2 The Committee met once in 2010/11. Due to the limited nature of the funds, the Committee has been, in recent years, in the practice of meeting once annually.

Table 1: Committee Attendance in 2010/11

Members	Oct 10
A. Greatley	P
M. Patrick	P
S. Young	P

3. Committee Duties¹

- 3.1 *“To agree and recommend to the Board of Directors a strategic policy for utilising the assets of the Fund in pursuit of its stated purposes and to review that policy at least every three years.”*

3.1.1 The Committee reviewed its strategic approach to the Charitable Fund in October 2010, and agreed that more

¹ These duties are as listed in the Charitable Fund Committee Terms of Reference, November 2010, Paragraph 8.

active fundraising would not be undertaken, as it would require the commitment of resources that the Trust does not have at its disposal. The Committee agreed that the Tavistock Clinic Foundation should be the more active of the Trust's two charitable organisations.

3.2 *"To consider and approve any proposals for expenditure above £20,000 from the Fund, except where these relate to external grants awarded for specific purposes."*

3.2.1 There were no proposals for expenditure above £20,000 from the Fund in 2010/11.

3.3 *"To agree and recommend to the Board of Directors an investment policy for the Fund and to review that policy at least every three years."*

3.3.1 The Committee reviewed its investment policy in October 2010, and agreed that it was appropriate to hold monies in the Fund in readily accessible bank accounts.

3.4 *"To review the financial statements of the Fund annually and more frequently if appropriate."*

3.4.1 The financial statements were reviewed once as part of the consideration of the Annual Report and Accounts in October 2010.

4. Reporting to the Board of Directors

4.1 Draft minutes from the Committee meeting were submitted to the Board of Directors on 26th October 2010. The Annual Report and Accounts of the Charitable Fund were presented to the Board of Directors by the Committee Chair for approval on 26th October 2010, prior to their submission to the Charities Commission.

4.2 The Committee Chair will draw attention to any issues that require executive attention by the Board of Directors or the Audit Committee. There were no such issues in 2010/11.

5. Review of Performance

5.1 The Committee met on 23rd November 2011, and reviewed its performance. The Committee feels that it meets with appropriate frequency and has completed all of its duties adequately. No input was sought from outside sources in writing the review.

6. Terms of Reference

- 6.1 The Committee proposed several amendments to the Terms of Reference, bringing them in line with *Standing Financial Instructions*. These were approved by the Board of Directors and issued in November 2010.
- 6.2 The Terms of Reference, with tracked changes are attached at Appendix A.

Angela Greatley
Committee Chair
January 2012

Charitable Fund Committee Terms of Reference

Ratified by:	Board of Directors
Date ratified:	30th June 2009
Name of originator/author:	Nicholas Selbie <u>Angela Greatley</u> , Committee Chair
Name of responsible committee/individual:	Charitable Fund Committee / Nicholas Selbie , Committee Chair
Date issued:	July 2007; June 2009
Review date:	June 2010 <u>October 2011</u>

Charitable Fund Committee Terms of Reference

1. Constitution

[1.1 The Tavistock and Portman Charitable Fund was established by a Declaration of Trust dated 4 September 1995, to contain all the funds held on trust by the Tavistock and Portman NHS Trust. Its objects cover any charitable purpose or purposes relating to the National Health Service wholly or mainly for the services provided by the Tavistock and Portman Clinics.](#)

~~1.1.2~~ The Board of Directors hereby resolves to establish a Committee to be known as the Charitable Fund Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference.

2. Membership

2.1 The Committee will be appointed from amongst the Executive and Non-Executive Directors of the Trust. The following will be members of the Committee:

2.1.1 Trust Chair, or another Non-Executive Director (Committee Chair)

2.1.2 Chief Executive

2.1.3 Director of Finance

2.2 At the discretion of the Committee Chair, other persons (Trust managers and staff, and other interested persons) may be invited to attend and participate in Committee meetings. However, only members have the authority to vote and determine decisions on behalf of the Committee.

3. Quorum

3.1 This shall be a minimum of one Executive Director and one Non-Executive Director.

4. Frequency of meetings

4.1 The Committee will meet once annually, to fulfil the duties set out in section 8 of these *Terms of Reference*, and additionally on an ad hoc basis, as required.

5. Agenda & Papers

- 5.1 Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.
- 5.2 Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.

6. Minutes of the Meeting

- 6.1 The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.
- 6.2 Approved minutes will be forwarded to the Board of Directors for noting.

7. Authority

- 7.1 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised to obtain outside legal advice or other professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

8. Duties

- 8.1 To agree and recommend to the Board of Directors a strategic policy for utilising the assets of the Fund in pursuit of its stated purposes ([see 1.1](#)) and to review that policy at least every three years.
- 8.2 To consider and approve any proposals for expenditure above £20,000 from the Fund, except where these relate to external grants awarded for specific purposes.
- 8.3 To agree and recommend to the Board of Directors an investment policy for the Fund and to review that policy at least every three years.
- 8.4 To review the financial statements of the Fund annually and more frequently if appropriate.

- 8.5 To ensure that regular reports are made to the Board of Directors with regards to, inter alia, the receipt of funds, investments, and the disposition of resources.
- 8.6 To prepare an annual trustee's report for adoption by the Board of Directors.
- 8.7 To ensure that required returns are submitted to the Charity Commission on time.
- 8.8 To appoint an suitable Auditor or independent examiner, in accordance with Charity Commission requirements.
- 8.9 To identify all costs directly incurred in the administration of charitable funds and, in agreement with the Board of Directors, charge such costs to the appropriate charitable fund.
- 8.10 To ensure appropriate administration of the Trust's charitable funds in compliance with the Declaration of Trust and appropriate legislation.
- 8.11 To 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.
- 8.12 To ~~ensure that produce~~ detailed codes of procedure ~~are produced~~ covering every aspect of the financial management of funds held on trust, for the guidance of Directors and employees.
- 8.13 To periodically review the funds in existence and 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.
- 8.14 To provide guidance to officers of the Trust as to how to proceed with regards to donations, legacies and bequests, and trading income.
- 8.15 To advise the Trust on any fundraising activity.
- 8.16 To ensure that appropriate banking services are available to the Trust as corporate trustee.

9. Other Matters

- 9.1 At least once a year the Committee will review its own performance, constitution and terms of reference to ensure that it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board of Directors for approval.

10. Sources of Information

10.1 The Committee will receive and consider the accounts of the Fund supplied by the Finance Department and regular reports from any research or other projects which the Committee has agreed to ~~funded by the Fund.~~

11. Reporting

11.1 The minutes of the Committee, once approved by the Committee, will be submitted to the Board of Directors for noting. The Committee Chair shall draw the attention of the Audit Committee or the Board of Directors to any issues in the minutes that require disclosure or executive action.

11.2 The Committee Chair shall attend the Annual General Meeting (AGM) prepared to respond to any Member's questions on the Committee's activities.

12. Support

12.1 The Committee will be supported by a Secretary from the Trust Secretary's team.

Board of Directors : February 2012

Item : 10

Title : Corporate Governance Report

Purpose:

The purpose of this report is to present the Board of Directors with an update on various matters of corporate governance, and of events in the wider healthcare arena.

This report focuses on the following areas:

(delete where not applicable)

- Quality
- Patient / User Experience
- Patient / User Safety
- Equality
- Risk
- Finance
- Productivity
- Communications

For : Noting

From : Louise Carney, Trust Board and Company Secretary

Corporate Governance Report

1. Register of Directors' Interests

- 1.1 The updated Register of Directors' Interests is attached at Appendix A, for information. Declarations for 2012/13 will be collected in April.

2. Information Governance Training

- 2.1 The Board of Directors is 91% compliant with Information Governance training. Directors are reminded that completion of IG training is mandatory and must be completed by the end of February.

3. Dates for 2012

- 3.1 Dates for 2012 are attached at Appendix B. There are further dates for joint Boards meetings, and various committees that will follow in due course. Directors are advised to refer to the events programme that accompanies the bimestrial Governor Update.

4. Board of Governors Election 2012

- 4.1 The Trust Secretary's office is currently planning the process for the upcoming elections to the Board of Governors, consulting with the PPI Committee and existing Governors. This planning includes background material for prospective Governors, outlining what is expected from Governors, time commitments, what the Trust gets from its Governors, what Governors get from the Trust, publicity considerations, how to get a Governing body that is representative of the community we serve, proceeding time for elections (extended) and induction for new Governors. This will be circulated to the Board of Directors for information and comment in due course.

5. Annual General Meeting

- 5.1 This year's Annual General Meeting will be held on Wednesday 10th December. This coincides with World Mental Health Day. Provisional discussions include holding a wider public event at an external location, in conjunction with community groups and other mental

health organisations, promoting the work of all the organisations involved, and promoting mental well-being. This will be a much larger event than the Trust has previously run, and will start in the afternoon, continuing until the AGM in the evening. Full plans will be presented to the Board of Directors and the Board of Governors in due course.

6. Consultation on Draft Standards for NHS Boards

6.1 In July 2011, Sir David Nicholson, Chief Executive of the NHS, asked the Council for Healthcare Regulatory Excellence to develop a set of high-level standards for Executive and Non-Executive NHS Board members. This request arose from the Government's commitment in the Command Paper *Enabling Excellence – Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers*. The standards build on work already done by the National Leadership Council and are consistent with the Nolan Principles on Public Life and other regulatory frameworks that apply to professional working in the NHS. They cover three domains:

6.1.1 Technical competence and ability to carry out the job

6.1.2 Personal behaviours and accountability

6.1.3 Business practices, including financial probity.

6.2 These standards are now out for public consultation until 10th April 2012, and are attached at Appendix C.

7. Monitor Updates

7.1 Monitor has published *NHS foundation trusts: review of six months to 30th September 2011*. There were 138 foundation trusts at this date. Monitor's report is based on the data submitted by FTs on a quarterly basis.

7.2 Below are the Quarter Two statistics on foundation trusts. Categories into which the Trust fits are highlighted in red.

Table 1: NHS Foundation Trust Statistics at 30th September 2011¹

Type of FTs		
Total	138	
Acute	78	56%
Mental Health	41	30%

¹ As at February 2011, there were 141 Foundation Trusts

Specialist	17	12%
Ambulance	2	1%
FTs by Strategic Health Authority²		
North West	28	74%
South West	17	65%
Yorkshire & The Humber	16	42%
London	16	73%
East of England	15	58%
West Midlands	13	48%
North East	10	91%
South Central	9	53%
South East Coast	7	54%
East Midlands	7	47%
Governance Risk Ratings		
Green	56	41%
Amber-Green	34	25%
Amber-Red	31	22%
Red	17	12%
Financial Risk Ratings		
5 (lowest risk)	11	8%
4	46	33%
3	67	49%
2	8	6%
1	6	4%
FTs in significant breach of terms of authorisation		
Total	13	9%
Combined actual net surplus Q3		
Total	£164m	
EBITDA margin		
Total	6.0%	

7.3 Monitor reported the following key findings:

- 7.3.1 The average FRR has remained consistent from Quarter One at 3.3, which is slightly ahead of plan (3.2);
- 7.3.2 FTs have delivered £567m in cost improvement plans (CIPs); this is 9% behind plan compared with slippage of 11% in the second quarter of 2010/11;
- 7.3.3 Aggregate EBITDA margin of 6.0% is marginally ahead of plan (5.9%) but reflects a reduction from 2010/11;
- 7.3.4 14 FTs are reporting an FRR of 1 or 2, a decrease from 15 at Quarter One 2011/12;
- 7.3.5 31 FTs reported a GRR of amber-red (compared to 42 at Quarter One). This reduction is largely due to a reduction in the number of FTs breaching targets overall;

² Percentages are of foundation trusts out of potential foundation trusts in each Health Authority

- 7.3.6 17 FTs reported a GRR of red (compared to 16 at Quarter One);
 - 7.3.7 34 FTs have declared a risk to their full year *C.difficile* target, although the overall number of cases of *C.difficile* has declined by an average of 23% since Quarter Two the previous year;
 - 7.3.8 The number of FTs with outstanding CQC compliance concerns or actions is currently 35, a decrease from 37 at the time of publishing Quarter One 2011/12 results.
- 7.4 Monitor's document can be found at:
www.monitor-nhsft.gov.uk/home/news-events-and-publications/our-publications/browse-category/reports-nhs-foundation-trusts/nhs.

8. The Mid Staffordshire NHS Foundation Trust Public Inquiry

- 8.1 The public inquiry, chaired by Sir Robert Francis, QC, is charged with investigating the role of the commissioning, supervisory, and regulatory bodies in the monitoring of Mid Staffs. Its remit is to consider why serious problems at the hospital were not identified and acted upon sooner, and to identify important lessons to be learnt for the future of patient care. Hearings began on Monday 8th November 2010, and concluded on Thursday 1st December 2011. The inquiry has heard wide-ranging criticisms of the organisations who had responsibility for monitoring Mid Staffs.
- 8.2 At the concluding session, Sir Robert stated what he intends to cover in his final report. He confirmed that he would be visiting other NHS hospitals in order to learn about good practice in the NHS and provide him with some context in relation to NHS healthcare provision generally. He noted that much needed to be done to restore public confidence, protect patients and maintain appropriate standards. His final report will address those concerns and draw out lessons that must be learnt. The following were identified as some of the issues that will be included in his final report:
 - 8.2.1 Recruitment, standards, training and regulation of healthcare support workers, nurses, and senior managers;
 - 8.2.2 The exercise of the fitness to practice functions of professional regulatory bodies;
 - 8.2.3 The nature of standards set for the safety and quality of care, and which bodies should have the responsibility for setting

and enforcing them;

- 8.2.4 The interface between the regulation of governance, finance, quality, and safety standards;
 - 8.2.5 The use of commissioning to require and monitor safety and quality standards and methods of monitoring and enforcing those standards;
 - 8.2.6 The potential adverse consequence of structural reorganisations and the requirements for addressing these;
 - 8.2.7 The role of foundation trust governors and members, and other local public, patient and staff representatives, and the means of embedding the patient voice throughout the system
 - 8.2.8 The nature, scope and definition of a duty of candour and methods of enforcing it;
 - 8.2.9 The involvement of external agencies in the complaints process and the use of information from it;
 - 8.2.10 The obligations of disclosure to and obtaining of evidence by coroners;
 - 8.2.11 The development, collection, use, and sharing of information and data;
 - 8.2.12 The protection of whistle-blowers
- 8.3 More information and transcripts of hearings can be found on the inquiry's website www.midstaffpublicinquiry.com. A copy of the report from the first inquiry is available on loan from the Trust Secretary's office.

9. Appointment of a National Chief Coroner

- 9.1 A High Court judge will be appointed as the national Chief Coroner. The post was first established by the Labour Government in Coroners and Justices Act 2009, but in 2010, the current Government attempted to abolish the role via the Public Bodies Bill, which was rejected by the House of Lords. It was announced in November 2011 that this position would not be abolished, following opposition from groups including the Royal British Legion.
- 9.2 Coroners are independent judicial officers who hold office under the

Crown, but are appointed and paid by Local Authorities, who are responsible for providing the administrative staff and accommodation. A 2006 Constitutional Affairs Committee described the coronial system as lacking national direction, with “wide variations in regional practice”. The appointment of a national Chief Coroner provides national leadership.

9.3 The Chief Coroner will prepare an annual report to the Lord Chancellor on the operation of the coronial system. The report will include an assessment of the consistency of standards between coronial areas, a summary of the number of cases which have not been completed within a year and the reasons for delays and measures taken to avoid them. The Chief Coroner will also provide advice to the Lord Chancellor on the operation of the system. Of particular note for the healthcare section, the Chief Coroner is likely to consider the following:

9.3.1 Training for coroners

9.3.2 Communication with the bereaved

9.3.3 Disclosure to interested persons

9.3.4 Obtaining and paying for experts

9.3.5 When discretion should be exercised to call a jury

9.3.6 Standard case management procedure

9.3.7 The reported tendency towards “accidental death” verdicts rather than suicide

9.3.8 Review of medical records and SI reports

9.3.9 Liaising with the media

Louise Carney
Trust Board and Company Secretary
February 2012

Register of Directors' Interests 2011/12

Register of Directors' Interests 2011/12

1. Introduction

All existing Directors shall declare relevant and material interests forthwith and the Trust shall ensure that those interests are noted in the Register of Directors' Interests. Any Directors appointed subsequently shall declare their relevant and material interests on appointment.³

2. Interests

Interest	Name	Disclosure ⁴
Directorships, included non-executive directorships held in private companies or PLCs (with the exception of those directorships of dormant companies)	Mr Martin Bostock, Non-Executive Director	<ul style="list-style-type: none"> Director, Nelson Bostock Group Ltd., a wholly-owned subsidiary of Creston PLC
Ownership, part-ownership or directorships of private companies, businesses or consultancies likely or possibly seeking to do business with the National Health Service	Ms Lis Jones, Nurse Director	<ul style="list-style-type: none"> Lis Jones Associates, Consultancy
	Mr Altaf Kara, Non-Executive Director	<ul style="list-style-type: none"> Director, Ernst & Young (does not sit on Board of Directors) which offers advisory services to all NHS
Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the National Health Service	<i>No disclosures made</i>	

³ Tavistock & Portman NHS Foundation Trust, *Constitution, Election Rules, Standing Orders*, February 2010, Annex 5, 10.1

⁴ A lack of disclosure from any Director indicates a nil return on the Declaration of Interest

Interest	Name	Disclosure ⁴
<p>A position of authority in a charity or voluntary organisation in the field of health and social care</p>	<p>Ms Angela Greatley, Trust Chair</p>	<ul style="list-style-type: none"> • Board Member, "Headstrong" (Irish National Youth Mental Health Centre)
	<p>Ms Lis Jones, Nurse Director</p>	<ul style="list-style-type: none"> • Trustee, North London Hospice
	<p>Mr Altaf Kara, Non-Executive Director</p>	<ul style="list-style-type: none"> • Trustee of "Find the Time" Trust – charity promoting bone marrow donation – now dormant
	<p>Ms Louise Lyon, Trust Director</p>	<ul style="list-style-type: none"> • Chair, Tavistock Clinic Foundation (charity)
	<p>Ms Joyce Moseley, Non-Executive Director</p>	<ul style="list-style-type: none"> • Chief Executive, Catch22, a charity providing services to young people, some of whom may have mental health difficulties. There is a very slight chance (but unlikely) that Catch22 and the Trust could bid for the same contract • Trustee, Social Research Institute, Dartington
	<p>Dr Ian McPherson, Non-Executive Director</p>	<ul style="list-style-type: none"> • Chief Executive, Mental Health Providers Forum (Charity) • Director, Improving Health & Wellbeing UK CIC (Community Interest Company)
	<p>Mr Richard Strang, Non-Executive Director</p>	<ul style="list-style-type: none"> • Advisor to Devon Partnership NHS Trust Board

Interest	Name	Disclosure ⁴
<p>Any connection with a voluntary or other organisation contracting for National Health Service services or commissioning National Health Service services</p>	<p>Ms Joyce Moseley, Non-Executive Director</p>	<ul style="list-style-type: none"> • Chair of Board of Directors of HCT Group, a community social enterprise which runs the transport service for NHS organisations (St Thomas and Guys Hospital [sic])
<p>Any connection with an organisation entity or company considering entering into or having entered into a financial arrangement with the Trust including but not limited to lenders or banks</p>	<p><i>No disclosures made</i></p>	

Meetings 2012

Appendix B

Board of Directors	Directors' Conferences	Board of Governors	Audit Committee	Clinical Quality, Safety, & Governance Committee	Business Development & Investment Committee	PPI Committee	Management Committee 1	Management Committee 2 (Board papers)	Management Committee 3 (F&P)
Tues 31 st Jan 2pm – 5pm Board Room	-----	-----	Tues 24 th Jan 10am 12 noon Board Room	-----	-----	Tues 31 st Jan 12pm – 1pm Committee Room	Thurs 12 th Jan 11.30am – 1.30pm Board Room	Thurs 19 th Jan 11.30am – 1.30pm Committee Room	Thurs 26 th Jan 11.30am – 12.30pm Committee Room
Tues 28 th Feb 2pm – 5pm Board Room	-----	Thurs 2 nd Feb 2pm – 5pm Lecture Theatre	-----	Tues 21 st Feb 11am – 1pm Board Room	-----	Tues 28 th Feb 12pm – 1pm Committee Room	Thurs 9 th Feb 11.30am – 1.30pm Board Room	Thurs 16 th Feb 11.30am – 1.30pm Board Room	Thurs 23 rd Feb 11.30 - 12.30 Board Room
Tues 27 th Mar 2pm – 5pm Board Room	Wed 14 th March 12noon-5pm Board Room	-----	Mon 26 ^h Mar 10am - 12 noon Small Meeting Room	-----	-----	Tues 27 th Mar 12pm – 1pm Committee Room	Thurs 8 th Mar 11.30am – 1.30pm Committee Room	Thurs 15 th Mar 11.30am – 1.30pm Board Room	Thurs 22 nd Mar 11.30am – 1.30pm Committee Room
Tues 24 th Apr 2pm – 5pm Board Room	-----	-----	-----	-----	-----	Tues 24 th Apr 12pm – 1pm Committee Room	-----	Thurs 12 th Apr 11.30am – 1.30pm Board Room	Thurs 19 th Apr 11.30am – 1.30pm Board Room
Tues 29 th May 2pm – 5pm Board Room	-----	-----	Thurs 24 ^h May 10am - 12 noon Small Meeting Room	-----	Wed 16 th May 3pm – 5pm Board Room	Tues 29 th May 12pm – 1pm Committee Room	Thurs 3 rd May 11.30am – 1.30pm Board Room	Thurs 17 th May 11.30am – 1.30pm Board Room	Thurs 24 th May 11.30am – 12.30pm Board Room
Tues 26 th Jun 2pm – 5pm Board Room	Wed 13 th Jun 12noon-5pm Board Room	Thurs 21 st June 2pm – 5pm Lecture Theatre	-----	Tues 12 th June 11am – 1pm Board Room	-----	Tues 26 th Jun 12pm – 1pm Committee Room	Thurs 7 th Jun 11.30am – 1.30pm Board Room	Thurs 14 th Jun 11.30am – 1.30pm Board Room	Thurs 21 st Jun 11.30am – 12.30pm Board Room
Tues 31 st Jul 2pm – 5pm Board Room	-----	-----	-----	-----	-----	-----	Thurs 5 th Jul 11.30am – 1.30pm Board Room	Thurs 19 th Jul 11.30am – 1.30pm Board Room	Thurs 26 th Jul 11.30am – 12.30pm Board Room
-----	-----	-----	-----	-----	-----	-----	-----	-----	-----
Tues 25 th Sep 2pm – 5pm Board Room	Wed 12 th Sep 10am-5pm Lecture Theatre	Thurs 13 th Sep 2pm – 5pm Lecture Theatre	Wed 12 th Sept 10am - 12 noon Small Meeting Room	Tues 11 th Sept 11am – 1pm Board Room	Wed 19 th Sep 3pm – 5pm Board Room	Tues 25 th Sep 12pm – 1pm TBC	Thurs 6 th Sep 11.30am – 1.30pm Board Room	Thurs 13 th Sep 11.30am – 1.30pm Board Room	Thurs 20 th Sep 11.30am – 12.30pm Board Room
Tues 30 th Oct 2pm – 5pm Board Room	-----	-----	-----	-----	-----	Tues 30 th Oct 12pm - 1pm TBC	Thurs 4 th Oct 11.30am – 1.30pm Board Room	Thurs 18 th Oct 11.30am – 1.30pm Board Room	Thurs 25 th Oct 11.30am – 12.30pm Board Room
Tues 27 th Nov 2pm – 5pm Board Room	Wed 21 st Nov 12noon-5pm Board Room	-----	Wed 28 th Nov 10 am - 12 noon TBC	Tues 13 th Nov 11am – 1pm Board Room	Wed 14 th Nov 3pm – 5pm Board Room	Tues 27 th Nov 12pm - 1pm TBC	Thurs 8 th Nov 11.30am – 1.30pm Board Room	Thurs 15 th Nov 11.30am – 1.30pm Board Room	Thurs 22 nd Nov 11.30am – 12.30pm Board Room
-----	-----	Thurs 6 th Dec 2pm – 5pm Lecture Theatre	-----	-----	-----	-----	Thurs 6 th Dec 11.30am – 1.30pm Board Room	Thurs 13 th Dec 11.30am – 1.30pm Board Room	-----

Standards for members of NHS boards and governing bodies in England

Draft for consultation

January 2012

About CHRE

The Council for Healthcare Regulatory Excellence promotes the health and well-being of patients and the public in the regulation of health professionals. We scrutinise and oversee the work of the nine regulatory bodies¹ that set standards for training and conduct of health professionals.

We share good practice and knowledge with the regulatory bodies, conduct research and introduce new ideas about regulation to the sector. We monitor policy in the UK and Europe and advise the four UK government health departments on issues relating to the regulation of health professionals. We are an independent body accountable to the UK Parliament.

Our aims

CHRE aims to promote the health, safety and well-being of patients and other members of the public and to be a strong, independent voice for patients in the regulation of health professionals throughout the UK.

Our values and principles

Our values and principles act as a framework for our decision making. They are at the heart of who we are and how we would like to be seen by our stakeholders.

Our values are:

- Patient and public centred
- Independent
- Fair
- Transparent
- Proportionate
- Outcome focused

Our principles are:

- Proportionality
- Accountability
- Consistency
- Targeting
- Transparency
- Agility

Right-touch regulation

Right-touch regulation means always asking what risk we are trying to regulate, being proportionate and targeted in regulating that risk or finding ways other than regulation to promote good practice and high-quality healthcare. It is the minimum regulatory force required to achieve the desired result.

¹ General Chiropractic Council (GCC), General Dental Council (GDC), General Medical Council (GMC), General Optical Council (GOC), General Osteopathic Council (GOsC), General Pharmaceutical Council (GPhC), Health Professions Council (HPC), Nursing and Midwifery Council (NMC), Pharmaceutical Society of Northern Ireland (PSNI)

Contents

- 1. Background 4
- 2. Developing the Standards 5
- 3. About the Standards 6
- 4. About the consultation 7
- 5. Standards for members of NHS boards
and governing bodies in England 8
- 6. Consultation questions..... 11
- 7. How to respond 17
- 8. Our consultation process 18

1. Background

- 1.1 The Government made a commitment in February 2011 in *Enabling Excellence* to commission work to 'agree consistent standards of competence and behaviour for senior NHS leaders'.²
- 1.2 On 8 July 2011, Sir David Nicholson, Chief Executive of the NHS in England, announced that CHRE had been asked to develop a set of high-level ethical standards for executive and non-executive NHS Board members in England.
- 1.3 This consultation paper seeks your views on our draft Standards. These have been developed through review of existing standards and other relevant guidelines and through extensive discussion with key stakeholders across the healthcare sector. They are intended to be consistent with the Nolan Principles on Public Life³ and with existing regulatory frameworks applying to professionals and senior managers working in the NHS.
- 1.4 The application and implementation of these standards is beyond the scope of CHRE's commission and will be decided by the Department of Health with employers, patients, professionals and the public, as set out the Government's statement in *Enabling Excellence*.⁴

2 Department of Health. 2011. *Enabling Excellence*. The Stationery Office: London

3 http://www.public-standards.gov.uk/About/The_7_Principles.html

4 Department of Health. 2011. *Enabling Excellence*. The Stationery Office: London

2. Developing the Standards

Review of existing Standards

2.1 We have reviewed existing policy and standards in this area, and used this review to inform the development of this draft. In particular, we considered:

- *The Code of Conduct for NHS Managers*⁵
- *The Code of Conduct and Code of Accountability in the NHS*⁶
- *Standards of business conduct for NHS staff*⁷
- *Managing Public Money*⁸
- *Good Medical Practice*⁹
- Institute of Healthcare Management Code of Conduct¹⁰
- NHS Leadership Framework.¹¹

Stakeholder engagement

2.2 Around 30 individuals have contributed directly through either face-to-face or telephone discussions. These contributors included:

- Chief executives, non-executive directors and executive directors of NHS trusts and SHAs
- Health professionals
- Experts on leadership and management in health, and on inclusion and equality.

2.3 The NHS Confederation, NHS Employers, the Institute of Healthcare Management, and the National Leadership Council have all contributed and we have held discussions with two LINKs groups, in Lincolnshire and Greater Manchester.

5 Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005410. Accessed 03/11/11

6 Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4116281. Accessed 03/11/11

7 Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/HealthServiceGuidelines/DH_4017845. Accessed 03/11/11

8 Available at: http://www.hm-treasury.gov.uk/d/mpm_whole.pdf. Accessed 03/11/11

9 Available at: http://www.gmc-uk.org/guidance/good_medical_practice.asp. Accessed 03/11/11

10 Available at: https://www.ihm.org.uk/About_Us/code_of_conduct/. Accessed 03/11/11

11 Available at: <http://www.nhsleadership.org/> Accessed 23/11/11

3. About the Standards

- 3.1 The draft Standards that we are consulting on cover three distinct areas:
- Personal behaviours
 - Technical competence
 - Business practices.
- 3.2 They are intended to apply to members of boards and governing bodies in NHS organisations. This would include:
- Chief executives
 - Executive directors who sit on the board, such as medical, nursing, finance, and HR
 - Chairs and other non-executive directors
 - Members of governing bodies of Clinical Commissioning Groups.
- 3.3 These senior leadership roles can frequently require individuals to address dilemmas and difficult decisions. Their decisions must balance the potentially conflicting but legitimate needs of individuals, communities, the healthcare system and taxpayers. Our draft Standards aim to provide a framework to guide people's judgement in these circumstances, through a consistent application of values and principles to explain how these difficult decisions are taken.
- 3.4 The application and implementation of these Standards is not within the scope of this project. However, in our drafting, we considered that the Standards could apply to the boards or governing bodies of the following organisations:
- All existing, remaining and/or outgoing NHS Trusts
 - Clinical Commissioning Groups
 - NHS Foundation Trusts
 - The NHS Commissioning Board.
- 3.5 Therefore these draft Standards should be read alongside the proposals in development by the Department of Health for the governance of clinical commissioning groups.¹²

¹² Department of Health, 2011. *Towards Establishment: Creating Responsive and Accountable Clinical Commissioning Groups*.

4. About the consultation

- 4.1 This consultation will run for twelve weeks from 19 January 2012 until 10 April 2012.
- 4.2 We would like to hear from anyone with an interest in this work, including:
- Members of the public, patients, their families and carers,
 - NHS board members, managers, and staff at all levels
 - Health professionals
 - Individuals or organisations with an interest or expertise in leadership and management in the NHS or other comparable environments.
- 4.3 We are inviting responses on:
- The form and content of the draft Standards in section 5
 - The impact the Standards could have on different gender, age, ethnic or disability groups.
- 4.4 Following the consultation we will collate and analyse the responses on these questions, and use them to inform the second draft of the Standards and our overall advice. This second draft will then be subject to a peer review exercise before it is submitted to the Secretary of State for Health in May 2012.
- 4.5 The report on the consultation responses will be published at the end of May 2012 forming part of CHRE's advice to the Secretary of State for Health, alongside the final draft of the Standards.

5. Standards for members of NHS boards and governing bodies in England

- 5.1 All members of NHS boards and governing bodies should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities, such as the differences in role of executive and non-executive board members. To justify the trust that has been placed in them by patients and the public they must adhere to these standards of personal behaviour, technical competence and business practice.

Personal behaviours

- 5.2 As a Member I commit to:
- The values of the NHS Constitution in the treatment of staff, patients, their families and carers, and the community, and in the design and delivery of services for which I am responsible
 - Promoting equality and diversity in the treatment of staff, patients, their families and carers, and the community, and in the design and delivery of services for which I am responsible
 - Promoting human rights in the treatment of staff, patients, their families and carers, and the community, and in the design and delivery of services for which I am responsible.
- 5.3 I will apply the following values in my work and relationships with others:
- **Accountability:** I will take full responsibility for my work and for the work that I delegate, and for the performance of the staff and services for which I am responsible
 - **Honesty:** I will act with honesty and probity in all my actions, transactions, communications, behaviours and decision-making, including with respect to any personal, professional or financial interests that could influence my decisions as a board member
 - **Openness:** I will be as open as possible about the reasoning, reasons and processes underpinning my actions, transactions, communications, behaviours and decision-making and about any conflicts of interest
 - **Respect:** I will show respect to all patients, their families and carers, and to the wider community, staff and colleagues, in my actions, transactions, communications, behaviours and decision-making
 - **Professionalism:** I will take responsibility for ensuring that I have the relevant knowledge and skills to perform as a board member, and that I am in a position to identify and fill any gaps in my knowledge and skills and will participate constructively in appraisal of myself and others
 - **Integrity:** I will apply these values consistently in all my actions, transactions, communications, behaviours and decision-making, and will always raise concerns if I see harmful behaviour or misconduct by others.

Technical competence

5.4 As a Member, for myself and my organisation, I will seek:

- To make sound decisions individually and corporately
- Excellence in the safety and quality of care
- Long term financial sustainability and value for money.

5.5 I will do this through:

- Demonstrating the skills and competencies necessary to fulfil my role and by engaging in training and continuing professional development
- Working collaboratively and constructively with others
- Ensuring performance is measured and risk is evaluated and managed
- Making effective use of evidence
- Maintaining my focus on the safety of patients, the quality of care and patient experience
- Understanding the health needs of the population I serve
- Looking for the impact of decisions on services we provide and those provided by others and on the people who use them
- Seeking the expertise and views of service users, their families, carers, the community, and staff
- Communicating clearly, consistently and honestly with colleagues, staff, patients and the public.

Business practices

5.6 As a Member, for myself and my organisation I will seek:

- To demonstrate honesty, probity and integrity in our conduct, decisions and financial and commercial relationships
- To manage public money wisely and to seek best value in the interests of the people and community I serve
- To be transparent in decision-making and be ready to be held publicly to account.

5.7 I will do this through:

- Having a clear understanding of the business and financial aspects of my organisation's work and of the business, financial and legal contexts in which it operates
- Declaring any personal, professional or financial interests and ensuring that they do not interfere with my actions, transactions, communications, behaviours or decision-making, removing myself from decision-making when they might be perceived to do so
- Being open about the evidence, reasoning and reasons behind decisions about budget and resource allocation, and contract allocation in particular

- Careful stewardship of public money, always acting with probity, honesty and restraint
- Ensuring that the contracts and commercial relationships my organisation enters into are legal and well-founded, that they are properly monitored, that the terms of the contract are adhered to and that I fulfil my responsibilities within it
- Building and maintaining effective partnerships with relevant stakeholders, including healthcare partners, the independent sector and patient and public representative groups
- Ensuring that patients and their families have clear information about the choices available to them so that they can make decisions on their own behalf
- Taking appropriate action to raise concerns if I perceive that my organisation or my colleagues are engaging in any harmful behaviour or misconduct.

6. Consultation questions

We welcome your views and comments on these proposed standards. In your responses to the questions below, please use the paragraph numbers in the draft Standards when referring to specific parts of the document.

The Standards

1. Are the Standards easy to read and understand?
 Yes No

If no, how can we improve them?

If no , how can we improve them?

2. Are there any areas in addition to personal behaviours, technical competence and business practices that you think should be covered in these Standards?
 Yes No

If yes, which additional areas should be covered?

If yes , which additional areas should be covered?

3. Are there any aspects of the Standards that you feel could result in differential treatment of or impact on groups or individuals based on their:

	Yes
Age	<input type="checkbox"/>
Gender	<input type="checkbox"/>
Ethnicity	<input type="checkbox"/>
Disability	<input type="checkbox"/>

If yes to any of the above, please explain why and what could be done to change this.

--

4. Is any part of the Standards in conflict with any existing standards frameworks that apply to all or some Members of NHS boards and governing bodies?
 Yes No

If yes, please explain.

5. Do you think these Standards will help guide Members' judgements when making difficult decisions about conflicting needs?
 Yes No

Please explain.

6. With reference to question 5, would more detailed guidance be useful?
 Yes No

Please explain.

7. Would these Standards be equally useful to Executive and Non-executive Board Members?

Yes No

If no, please explain.

--

8. Would separate standards for Non-executive Board Members be needed in certain areas?

Yes No

If yes, please explain.

--

9. Please add any other comments you have on the draft Standards or their development, or on the consultation process itself?

--

On personal behaviours

10. Does this section cover all the aspects of personal behaviours that should be expected of Members of NHS board and governing bodies?

Yes No

If no, what changes should we make?

--

11. Do you have any other comments on this section?

--

On technical competence

12. Does this section cover all the aspects of technical competence that should be expected of Members of NHS board and governing bodies?

Yes No

If no, what changes do you think we should make?

--

13. Do you have any other comments on this section?

--

On business practices

14. Does this section cover all the aspects of business practice that should be expected of Members of NHS board and governing bodies?

Yes No

If no , what changes do you think we should make?
--

--

15. Do you have any other comments on this section?

--

About you:

Name:	
Contact address including postcode:	
Organisation representing (if appropriate):	
Email:	

Are you responding as:

an NHS board member:	<input type="checkbox"/> Yes <input type="checkbox"/> No
a member of clinical commissioning group:	<input type="checkbox"/> Yes <input type="checkbox"/> No

a patient or member of the public:	<input type="checkbox"/> Yes <input type="checkbox"/> No
a registered health professional:	<input type="checkbox"/> Yes <input type="checkbox"/> No
a person with a professional interest in leadership and management in the NHS:	<input type="checkbox"/> Yes <input type="checkbox"/> No
other NHS employee (<i>please specify below</i>):	<input type="checkbox"/> Yes <input type="checkbox"/> No
other (<i>please specify below</i>):	<input type="checkbox"/> Yes <input type="checkbox"/> No

Would you like the information you provide to be treated as confidential?

Yes No

If yes, please give your reasons for this? (*this may help us keep your information confidential in the event of a Freedom of Information request*):

7. How to respond

7.1 You can respond to this consultation either by:

- Completing and returning the consultation questionnaire and returning it by email to policy@chre.org.uk, or by post to:

Policy Team
CHRE
157-197 Buckingham Palace Road
London
SW1W 9SP

- Completing our online questionnaire here:
<http://www.chre.org.uk/satellite/413/>

7.2 If you have any queries, or require an accessible version of this document, please contact CHRE on 020 7389 8030 or by email at policy@chre.org.uk.

Confidentiality of information

7.3 We will manage the information you provide in response to this consultation in accordance with our information security policies.

7.4 Any information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA) the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

7.5 If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential.

7.6 If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality will be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on CHRE.

7.7 CHRE will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

8. Our consultation process

8.1 This consultation follows the 'Government Code of Practice'. In particular, we aim to:

- Consult formally at a stage where there is scope to influence the policy outcome
- Consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible
- Be clear about the consultation process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals
- Ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach
- Keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process
- Analyse responses carefully and give clear feedback to participants following the consultation
- Ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

8.2 This consultation will last 12 weeks and the costs of the proposals are excluded from the scope as the method of implementation is outside of the scope of the commission.

8.3 If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact CHRE's Consultations Coordinator:

Rachael De Souza
External Relations Manager
Council for Healthcare Regulatory Excellence
157-197 Buckingham Palace Road
London SW1W 9SP

Tel: 020 7389 8030
Fax: 020 7389 8040

rachael.desouza@chre.org.uk

Please do not send consultation responses to this address but to the address above.

Council for Healthcare Regulatory Excellence
157-197 Buckingham Palace Road
London
SW1W 9SP
Telephone: **020 7389 8030**
Fax: **020 7389 8040**
Email: **info@chre.org.uk**
Web: **www.chre.org.uk**

© CHRE [January 2012]



Board of Directors : February 2012

Item : 11

Title : Standing Financial Instructions

Purpose:

The purpose of this report is to present proposed changes to Standing Financial Instructions. This report highlights the major changes that have been made. In addition to the changes listed in the report, all financial thresholds have been subject to review, and where necessary, amendment, and all references have been updated.

The Instructions are included, for reference, with tracked changes.

This report has been reviewed by the following Committees:

- Management Committee, 16th February 2012

This report focuses on the following areas:

(delete where not applicable)

- Quality
- Risk
- Finance

For : Approval

From : Simon Young, Director of Finance
Louise Carney, Trust Board & Company Secretary

Standing Financial Instructions

1. Introduction

- 1.1 Standing Financial Instructions (SFIs) have been thoroughly reviewed by the Director of Finance and the Trust Board and Company Secretary, with additional input from the Counter Fraud and Security Management Service.
- 1.2 Changes to SFIs are outlined below. The Board is required to approve these changes before publication.

2. Amendments to Standing Financial Instructions

2.1 Terminology

- 2.1.1 **Paragraph 1.2.1.14** describes who is referred to by the term “staff”. This has been updated to include all those employed by the Trust, rather than its original restricted reference to staff on a certain type of contract, with contracts of a certain length, or earning more than a certain amount per annum.

2.2 Internal Audit Services

- 2.2.1 **Paragraph 2.1.3** has been updated to note that there should be a competitive appointment process for internal audit every five years

2.3 Fraud and Corruption

- 2.3.1 **Paragraph 2.2.2** has been added to keep Local Counter Fraud Specialist arrangements in line with those for Internal Auditors.
- 2.3.2 **Paragraph 2.2.3** has been added at the recommendation of the Trust’s Local Counter Fraud Specialist, to include a reference to the Bribery Act 2010.

2.4 Annual Report & Accounts

- 2.4.1 **Paragraphs 4.2 and 4.3** have been updated to note that the Trust is required to present its Report and Accounts to the Board of Governors at a general meeting rather than at the AGM, although our practice of presenting an overview of the Report and Accounts at the AGM is not likely to change.

- 2.4.2 **Paragraph 4.3** has been added for clarity, although this is already Trust practice
- 2.5 Funded Establishment
 - 2.5.1 **Paragraph 8.2** has been added, and **paragraph 8.3** has been amended, for clarity
- 2.6 Non-Pay Expenditure – Limits on Expenditure
 - 2.6.1 **Paragraphs 9.3.1 and 9.3.2** have been added, for clarity. These paragraphs contain explicit reference to obtaining quotes and tenders and the financial thresholds for these requirements, in the event that people do not refer to Appendix A.
 - 2.6.2 **Paragraph 9.3.3** has been added at the recommendation of CFSMS, to require all requisitions over £60k to be authorised.
 - 2.6.3 **Appendix C** has been included to provide a standard format for authorising such requisitions.
- 2.7 Stores and Receipt of Goods
 - 2.7.1 **Paragraph 12.2** has been amended to note that overall responsibility for control of stores of goods is delegated to departments rather than the Chief Executive, as the Trust no longer has central goods stores.
 - 2.7.2 **Paragraph 12.4** has been removed, as it refers to central goods stores.
- 2.8 Formal Competitive Tendering – Exceptions and instances where formal tendering need not be applied
 - 2.8.1 **Appendix A, Paragraph 4.3.5** has been amended to note that the standard format for documenting and recording waivers to tendering is at Appendix B.
 - 2.8.2 **Appendix B** has been included to provide a standard format for waiving tender requirements.
 - 2.8.3 **Appendix A, Paragraph 4.5** was amended to reflect the fact that PASA no longer exists.
- 2.9 Contracting and Tendering Procedure – Specification and Terms & Conditions

2.9.1 **Appendix A, Paragraph 5.2** was added at the recommendation of CFSMS, to require that for all projects expected to cost over £60k managers consult the Director of Finance on the selection process.

2.10 Contracting and Tendering Procedure – Acceptance of Formal Tenders

2.10.1 **Appendix A, Paragraph 5.7.1** was added at the recommendation of CFSMS, to require that for all projects expected to cost over £60k there be a selection panel for reviewing and accepting tenders

2.10.2 **Appendix D** has been included to provide a standard format for accepting tenders.

2.10.3 **Appendix A, Paragraph 5.7.4** has been added to note that the Tender Acceptance Form should be sent to the Trust Secretary to be retained with the Register of Interests.

2.10.4 **Appendix A, Paragraph 5.7.9** has been amended to make it clear that copies of tenders should be retained by the originating department.

2.11 Contracting and Tendering Procedure – Completion Reviews

2.11.1 **Appendix A, Paragraphs 5.8.1 to 5.8.2** have been added at the recommendation of CFSMS, to require all projects costing over £100k to be reviewed at completion.

2.11.2 **Appendix E** has been included to provide a standard format for completion reviews.

2.11.3 **Appendix A, Paragraph 5.8.3** has been added to note that the completion reviews should be sent to the Trust Secretary to be retained with the Register of Interests.

Simon Young, Director of Finance
Louise Carney, Trust Board & Company Secretary
February 2012

Standing Financial Instructions

Ratified by:	Board of Directors
Date ratified:	30th November 2010 <u>28th February 2012</u>
Name of originator / author:	Simon Young, Director of Finance Louise Carney, Trust Secretary
Name of responsible committee / individual:	Audit Committee / Richard Strang
Date issued:	December 2010 <u>February 2012</u>
Review date:	March 2010 <u>November 2012</u>

Contents

1. Introduction	4
2. Audit	9
3. Business Planning, Budgets, Budgetary Control, and Monitoring	12
4. Annual Accounts and Reports	15
5. Bank and Paymaster Accounts	16
6. Income, Fees and Charges, and Security of Cash, Cheques and other Negotiable Instruments	17
7. Contracting for the Provision of Services	19
8. Terms of Service and Payment of Directors and Employees	20
9. Non-Pay Expenditure	23
10. External Borrowing and Investments	28
11. Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets	30
12. Stores and Receipt of Goods	34
13. Disposals and Condemnations, Losses and Special Payments	35
14. Information Technology	36
15. Patients' Property	38
16. Funds Held on Trust	38
17. Retention of Documents	44
18. Risk Management & Insurance	44
19. Consultation	45
20. Gifts & Hospitality	46
Appendix A : Tendering & Contracting Procedure	47
1. Duty to comply with <i>Board of Directors' Standing Orders (BDSOs)</i> , <i>Standing Financial Instructions (SFIs)</i> and the <i>Scheme</i>	47

of Delegation of Powers

2. Legislation and Guidance Governing Public Procurement	47
3. Capital Investment	47
4. Formal Competitive Tendering	47
5. Contracting / Tendering Procedure	51
6. Quotations: Competitive and Non-Competitive	57
7. Authorisation of Tenders and Competitive Quotations	58
8. Private Finance for Capital Procurement	58
9. Compliance Requirements for all Contracts	59
10. Personnel and Agency or Temporary Staff Contracts	59
11. Disposals	59
12. In-House Services	60
<u>Appendix B: Authority to Waive Competitive Tender Requirements</u>	<u>63</u>
<u>Appendix C: Authorisation of Requisitions over £60,000</u>	<u>65</u>
<u>Appendix D: Tender Acceptance Form</u>	<u>72</u>
<u>Appendix E: Completion Review Form</u>	<u>76</u>

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.
- 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 A* and *BDSO 11*.
- 1.1.5 Officers of the Trust should note that *BDSOs*, *SFIs*, and the *Scheme of Delegation of Powers*², 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.

¹ For *BDSOs*, see Tavistock & Portman NHS Foundation Trust, *Constitution, Election Rules, Standing Orders*, February 2010

² [Tavistock & Portman NHS Foundation Trust, *Scheme of Delegation of Powers*, October 2011](#)

- 1.1.6 Officers of the Trust should further note that they must disclose forthwith to the Chief Executive any material non-compliance with *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*;
 - 1.2.1.4 “Board of Governors” shall mean the Trust Chair and Governors, appointed and elected;
 - 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;
 - 1.2.1.7 “Director” shall mean a person appointed as a Director in accordance with the [National Health Service Trusts \(Membership and Procedure\) Regulations 1990](#), and includes the Trust Chair;
 - 1.2.1.8 “Director of Finance” shall mean the chief finance officer of the Trust;

- 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 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 with responsibility for a specific area of work;
- 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 by the Trust, regardless of grade, working hours, or type of contract~~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, including~~ contractors (e.g. canteen staff), and 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~~the~~ 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

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*.

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*.

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.

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;
- 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:
- 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~~ Terms of ~~reference~~ Reference, which will provide an independent and objective view of integrated governance, risk management, and internal control by:

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;

~~2.1.1.6~~

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. There should be a

competitive process for the appointment of Internal Auditors every five years.

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.

2.2.2 It is the responsibility of the Director of Finance to ensure an adequate counter fraud service is provided, and the Audit Committee shall be involved in the selection and appointment (or re-appointment) of a Local Counter Fraud Specialist as specified by the NHS Counter Fraud and Corruption Manual.³ There should be a competitive process for the appointment of a Local Counter Fraud Specialist every five years.

~~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*.

2.2.3 Under the Bribery Act 2010, bribery is defined as "inducement for an action which is illegal, unethical, or a breach of trust. Inducements can take the form of gifts, loans, fees, rewards, or other privileges." Corruption is broadly defined as the offering or the acceptance of inducements, gifts or favours, payments, or benefits in kind which may influence the improper action of any person. Corruption does not always result in a loss. The corrupt person may not benefit directly from their deeds; however, they may be unreasonably using their position to give some advantage to another. To demonstrate that the Trust has in place sufficient and adequate procedures and to show openness and transparency, all staff are required to comply with the requirements of Standing Financial Instructions. For a more detailed explanation, see the Trust's Anti-Bribery and the Trust's Counter-Fraud Policy.

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

³ NHS Counter Fraud Service, *NHS Counter Fraud and Corruption Manual*

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*⁴;

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:

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;

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:

2.3.2.1 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

⁴ Monitor, *Audit Code for NHS Foundation Trusts*, ~~October 2007~~ March 2011

- 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.
- 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*⁵ provides that Internal Audit should accord with the objectives, standards and practices set out in the *Government Internal Audit Standards*⁶, 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

⁵ Monitor, *NHS Foundation Trust Accounting Officer Memorandum*, April 2008

⁶ HM Treasury, *Government Internal Audit Standards*, April 2009

the effectiveness of risk management, control and governance processes”⁷.

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*⁸. 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*⁹.

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:

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

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

⁸ HM Treasury, *Government Internal Audit Standards*, April 2009

⁹ Monitor, *Audit Code for NHS Foundation Trusts*, ~~October 2007~~ March 2011

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

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.

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*);

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.

4.2 ~~The Director of Finance is responsible for ensuring that~~ The Trust's audited annual accounts must be presented to ~~members of the Trust at the Annual General Meeting~~ the Board of Governors at a general meeting of the Board of Governors.

4.3 The ~~Trust Chief Executive~~ will publish an Annual Report, in accordance with guidelines on local accountability, and present it to the Board of Governors ~~at a general meeting of the Board of Governors and to the Annual General Meeting of the Trust. The document will comply with the NHS Foundation Trust Annual Reporting Manual⁴⁰ issued each year.~~

⁴⁰ ~~Monitor, NHS Foundation Trust Annual Reporting Manual 2009-10, April 2010~~

4.4 The Trust Secretary is responsible for ensuring copies of the audited accounts and report are made available for inspection by members of the public free of charge at all reasonable times.

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.

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;

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

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.

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**.
 - 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.
- 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 procedures¹¹.
 - 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

¹¹ 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~~ Terms of ~~reference~~ Reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.
- 8.1.2 The ~~terms~~ Terms of ~~reference~~ Reference will include delegated authority to take decisions on the remuneration and terms of service of the Chief Executive and other Executive Directors.
- 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.
- 8.1.4 Employees of the Trust will only be paid in accordance with their contracts of employment. Additional payments are forbidden.
- 8.1.5 The Trust will remunerate the Trust Chair and Non-Executive Directors in accordance with the decisions of the Board of Governors.

8.2 Funded establishment

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

~~8.2.18.2.2~~ Where external funding is obtained for a new service or post, the budget will be revised.

~~8.2.28.2.3~~ Except as in 8.2.2, tThe 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;

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.

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~~7.2~~ 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.

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 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 A*)

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.

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 generated by the Trust's e-procurement system.
- 9.2.2 Orders will be issued based on an electronic requisition authorised by a Budget Holder on the e-procurement system.
- 9.2.3 Under no circumstances should a requisition number be quoted to a supplier as authority for a purchase.
- 9.2.4 The Trust's Procurement Officer shall maintain on the e-procurement system a catalogue of items usually needing to be purchased for the Trust's activities. The catalogue will hold details of range available, the suppliers to be used, and the current agreed prices.
- 9.2.5 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 Procurement Officer shall be sought where an item is not available from the Trust catalogue. 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 A*, which requires competitive tenders or quotations to be obtained where the expected cost exceeds certain thresholds.
- 9.2.6 The Director of Finance will:
- 9.2.6.1 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*¹²;
 - 9.2.6.2 be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:
 - 9.2.6.2.1 A list of Directors and employees (including specimens of their signatures) authorised to certify invoices;

¹² See <http://www.payontime.co.uk/>

9.2.6.2.2 Certification that:

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

9.2.6.2.2.2 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;

9.2.6.2.2.3 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;

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

9.2.6.2.2.5 the account is arithmetically correct; and

9.2.6.2.2.6 the account is in order for payment;

9.2.6.2.3 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

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

- 9.2.6.3 be responsible for ensuring that payment for goods and services is only made once the goods and services have been received (except as below).
- 9.2.7 Pre-payments are only permitted where exceptional circumstances apply. In such instances:
 - 9.2.7.1 pre-payments are only permitted where the financial advantages outweigh the disadvantages and the intention is not to circumvent cash limits;
 - 9.2.7.2 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;
 - 9.2.7.3 the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and
 - 9.2.7.4 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.
- 9.2.8 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:
 - 9.2.8.1 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;
 - 9.2.8.2 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;
 - 9.2.8.3 where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;
 - 9.2.8.4 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:

- 9.2.8.4.1 isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars; and
 - 9.2.8.4.2 conventional hospitality, such as lunches in the course of working visits¹³;
 - 9.2.8.5 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;
 - 9.2.8.6 all goods, services, or works are ordered on an official order except purchases from petty cash;
 - 9.2.8.7 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”;
 - 9.2.8.8 orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
 - 9.2.8.9 goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;
 - 9.2.8.10 changes to the list of Directors ~~and~~ employees authorised to certify invoices are notified to the Director of Finance;
 - 9.2.8.11 purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and
 - 9.2.8.12 petty cash records are maintained in a form as determined by the Director of Finance.
- 9.2.9 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 *Estatecode*¹⁴ and all other applicable policy and guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.

¹³ 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

9.2.10 Leases

9.2.10.1 *SFI 9.2.1, 9.2.2, 9.2.3 and 9.2.5, above, apply to leases as to any other purchase contracts. When determining whether tendering or quotations are required in accordance with SFI 9.2.5, the expected value of the lease across the whole term will be used in respect of the thresholds set out in ~~the~~ SFI Appendix A.*

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

9.3 Limits of expenditure

9.3.1 *For works, goods, or services with estimated expenditure over £10,000 but not exceeding £60,000, competitive quotations are required (see SFI Appendix A, Paragraph 6).*

9.3.2 *For works, goods, or services with estimated expenditure over £60,000, formal tendering is required (see SFI Appendix A, Paragraph 4).*

9.2.119.3.3 *Requisitions for works, goods, or services with estimated expenditure over £60,000 should be authorised in a standard format and countersigned by the Chief Executive or the Director of Finance prior to the order being placed on the e-procurement system. A copy of the authorisation form should be retained by the originating officer and the Procurement Officer (see SFI Appendix C).*

9.39.4 Bankruptcy clauses in contracts

9.3.19.4.1 Trust contracts are to explicitly state that the Trust is to be made aware of any bankruptcy of any customer or supplier.

9.3.29.4.2 The Director of Finance should make every effort to apprise himself of any formal insolvency arrangement applied to any customer or supplier.

9.3.39.4.3 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.

9.3.49.4.4 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.
- 10.1.3 The Director of Finance must prepare procedural instructions concerning applications for PDC, loans, or overdrafts.
- 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*.
- 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.

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.

¹⁵ Monitor, *Prudential Borrowing Code (PBC) for NHS Foundation Trusts*, April 2009

¹⁶ Monitor, *Managing Operating Cash in NHS Foundation Trusts*, December 2005

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 (unless the approved cash flow forecast indicates that this is not required). 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.

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:
- 11.1.4.1.1 an option appraisal of potential benefits, compared with known costs to determine the 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.
- 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 A, 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*.

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

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

¹⁹ Op. cit.

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.

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;

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

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 – to be known as the *Fixed Asset Register* – 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.

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;

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

- 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*).
- 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*.
- 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.
- 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;

²¹ Monitor, *NHS Foundation Trust Annual Reporting Manual* ~~2009-10~~2010/11, ~~April 2010~~March 2011

- 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.
- 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 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 Departmental stores of stationery etc. should be kept at the minimum level necessary to support efficient working. Facilities 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.~~
- 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~~ officer. Wherever practicable, stocks should be marked as health service property.

²² See HM Treasury, *Managing Public Money*, Annex 4.10 "Losses and Write Offs", and Annex 4.13 "Special Payments", February 2010

~~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~~12.4 Stocktaking arrangements shall be agreed with the Director of Finance.

~~12.6~~12.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

~~12.7~~12.6 The designated ~~manager-officer~~ 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 A, paragraph 11*.

~~12.8~~12.7 For any goods supplied via the NHS central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the 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 A, paragraph 11*, shall be complied with in all disposals.

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.

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 Policy²⁴ to be approved by the Board of Directors, which sets out the action to be taken both by persons 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.
- 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:
- 13.2.3.1 the Board of Directors; and
- 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.

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

²⁵ Department of Health, *HSC 1999/062: Countering Fraud in the NHS notification of possible disciplinary, civil or criminal proceedings*, March 1999

- 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.
- 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:
 - 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*;
 - 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.
 - 14.1.5 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.

- 14.1.6 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.
- 14.1.7 Where another organisation provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.
- 14.2 Where computer systems have an impact on corporate financial systems, the Director of Finance shall satisfy himself that:
- 14.2.1 systems acquisition, development, and maintenance are in line with the Trust's policies;
- 14.2.2 data produced for use with financial systems is adequate, accurate, complete, and timely, and that a management (audit) trail exists;
- 14.2.3 Finance Directorate staff have access to such data; and
- 14.2.4 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.
- 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.

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 propriety.
- 16.1.2 *BDSO 1.4.1* and *BDSO 4.1-21.4.2* 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.
- 16.1.3 The Trust shall establish a Charitable Fund Committee with clearly defined terms Terms of reference 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
- 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.

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~~ the Trust 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~~ the Trust'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*).

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;

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

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:

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;

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.

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

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.

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~~ Annual trustee's ~~Trustee's report~~ Report for adoption by the Board of Directors, and shall submit the required returns to the Charity Commission.

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.

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

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.

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

²⁷ *Ibid.*

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

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*²⁸.

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

²⁸ [Monitor, NHS Foundation Trust Annual Reporting Manual 2009-10, April 2010 Op. cit.](#)

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
- 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*²⁹, a copy of which is available on the Trust's Intranet.
- 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.

²⁹ Tavistock & Portman NHS Foundation Trust, *Policy on Gifts and Hospitality*, January 1996

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*

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*³⁰.

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*.

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*³¹ in respect of capital investment and estate and property transactions.

4. Formal Competitive Tendering

4.1 General applicability

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

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;

³⁰ See Tavistock & Portman NHS Foundation Trust, *Constitution, Election Rules, Standing Orders*, February 2010, Tavistock & Portman NHS Foundation Trust, *Standing Financial Instructions*, ~~April 2010~~ **November 2010**, and Tavistock & Portman NHS Foundation Trust, *Scheme of Delegation of Powers*, ~~April 2010~~ **October 2011**

³¹ ~~Monitor, *Protection of Assets Guidance for NHS Foundation Trusts*, October 2004~~ Op. cit.

- 4.1.1.3 the design, construction, and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and
- 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 Services³²)

- 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 A, paragraph 2*.

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 A, 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 A, paragraph 2* and where the Trust is entitled to access such framework agreement; and
 - 4.3.1.3 where under *SFI 13*, in the case of disposal of assets, formal tendering procedures are not required.
- 4.3.2 Subject to the duties at *SFI Appendix A, paragraph 2* (and to obtaining appropriate advice from the Trust's procurement department and where considered necessary external professional

³² 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

advice), formal tendering procedures may be waived in the following circumstances:

- 4.3.2.1 where the requirement is covered by an existing contract;
- 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 A, 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 ([see SFI Appendix B](#)) and in the *Register 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 their next](#) meetings.

4.4 Fair, transparent and adequate competition

- 4.4.1 Except where the exceptions set out at *SFI Appendix A, 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.

- 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 A, 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 [listed by the Government Procurement Service, or providers for specialised services with a professional recommendation](#)~~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 A, paragraph 5.8*). A copy of this waiver shall be kept with the *Register of Tenders* (see *SFI Appendix A, paragraph 5.3.7*).

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

- 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.

5.2 Specifications and Terms and Conditions

- 5.2.1 For all projects expected to cost over £60,000, managers must consult the Director of Finance on the selection process at an early stage, and certainly before issuing invitations to tender.

- 5.2.2 If advice is obtained before drawing up a specification, this process must not result in undue advantage to one or more potential suppliers.

5.2.15.2.3 Every invitation to 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.

5.2.25.2.4 Every invitation to tender for building or engineering works (except for maintenance work, when *Estatecode*³³ 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 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.

5.3 Receipt and safe custody of tenders

5.3.1 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.

5.3.2 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.

5.4 Opening tenders and *Register of Tenders*

5.4.1 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 A*, paragraph 5.3.7).

³³ Op. cit

- 5.4.2 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*.
- 5.4.3 The “originating department” will be taken to mean the department sponsoring or commissioning the tender.
- 5.4.4 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-officer~~ from the Finance Directorate from serving as one of the two senior ~~managers-officers~~ to open tenders.
- 5.4.5 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.
- 5.4.6 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.
- 5.4.7 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:
- 5.4.7.1 The subject of the tendering exercise, and the reference number;
 - 5.4.7.2 the name of all firms / individuals invited;
 - 5.4.7.3 the names of all firms / individuals from which tenders have been received;
 - 5.4.7.4 for those who do not tender, a note of any reason given;
 - 5.4.7.5 the latest date and time for receipt;
 - 5.4.7.6 the date the tenders were opened;
 - 5.4.7.7 the persons present at the opening;
 - 5.4.7.8 the price shown on each tender;

- 5.4.7.9 against each tendered sum, the signatures of two of those present at the opening;
 - 5.4.7.10 a note where price alterations have been made on the tender;
 - 5.4.7.11 which tender is to be accepted; and
 - 5.4.7.12 a summary of the number of organisations invited to tender and the number actually tendering.
- 5.4.8 Each entry to the *Register of Tenders* shall be signed by those present.
- 5.4.9 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.
- 5.4.10 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 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.

5.5 Admissibility of Tenders

- 5.5.1 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.
- 5.5.2 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.

5.6 Late tenders

- 5.6.1 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.

5.6.2 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.

5.6.3 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.

5.7 Acceptance of formal tenders

5.7.1 All tenders shall be reviewed by a selection panel, consisting of two people, one of whom should not be from the originating department.

5.7.2 The selection of tenders should be recorded using the form at Appendix D.

~~5.6.4~~

~~5.6.5~~

~~5.6.6~~ 5.7.3 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.

~~5.6.7~~ 5.7.4 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 by the Selection Panel in a standard form and sent to the Trust Secretary, where it will be 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*.

~~5.6.8~~ 5.7.5 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:

~~5.6.8.1~~ 5.7.5.1 experience and qualifications of team members;

~~5.6.8.2~~ 5.7.5.2 understanding of client's needs;

~~5.6.8.3~~ 5.7.5.3 feasibility and credibility of proposed approach; and

~~5.6.8.4~~ 5.7.5.4 ability to complete the project on time.

5.6.95.7.6 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.

5.6.105.7.7 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.

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

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

5.6.11.25.7.8.2 the best value for money.

5.6.125.7.9 All tenders should be treated as confidential and should be retained for inspection by the originating department.

5.8 Completion Reviews

5.8.1 All projects / goods costing over £100k shall be reviewed within three months of completion, considering the following:

5.8.1.1 Have the requirements of the specification been met;

5.8.1.2 Was the project / goods delivered within the timescale; and

5.8.1.3 Was the project / goods delivered within the tendered price.

5.8.2 The review shall be carried out by a panel of at least two, one of whom shall be nominated by the Chief Executive or the Director of Finance and shall not be from the originating department, and shall report to the Chief Executive.

5.8.3 The review shall be documented in a standard form at Appendix E and sent to the Trust Secretary, where it will be retained with the *Register of Tenders*.

5.75.9 Tender reports to the Board of Directors

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

5.85.10 Lists of approved firms

5.8.15.10.1 Responsibility for maintaining list

5.8.1.15.10.1.1 ~~An officer manager~~ or an 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 A, 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.

5.8.1.25.10.1.2 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.

5.8.1.35.10.1.3 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.

5.8.1.45.10.1.4 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~~ officer 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.

~~5.8.25.10.2~~ Building and engineering construction works

~~5.8.2.15.10.2.1~~ Where permitted under *SFI Appendix A, 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 A, 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*³⁴ guidance.

~~5.8.35.10.3~~ Financial standing and technical competence of contractors

~~5.8.3.15.10.3.1~~ 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~~ clinical Governance ~~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 A, 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).

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 Procurement Officer.

³⁴ Op. cit

- 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 Procurement** Officer.
 - 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 Procurement** 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 Procurement** 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.

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.

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:

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 Trusts*³⁵;

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 A*, paragraph 2.

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.

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

³⁵ Op. cit

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.

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;

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

12.2.3 Evaluation Team, comprising normally a specialist officer, ~~a the supplies Procurement 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.

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.

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 A, paragraph 2*.

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.

Appendix B

Authority to Waive Competitive Tender and Competitive Quotations Requirements

1. The Trust's requirements for competitive tendering and seeking competitive quotations are set out in *SFI Appendix A*.
2. *SFI Appendix A, paragraph 4.3.2* sets out the exceptional circumstances in which formal tendering procedures need not be applied. *SFI Appendix A, paragraph 6.3.1* sets out the exceptional circumstances in which competitive quotations need not be obtained.
3. If any of these circumstances are considered to apply, they must be recorded on this form, which must be signed by the Director of Finance and the Chief Executive before any order or contract is signed or any commitment is made on behalf of the Trust.
4. This form must then be sent to the Trust Secretary if authority to waive a tender has been given or to the Procurement Officer if authority to waive a competitive quotation has been given. Details in the case of tenders must be recorded in the *Register of Tenders*, and reported to the next Audit Committee.

Works, goods, or services to be purchased or contracted:
Length of proposed contract <i>(if applicable):</i>
Value of purchase or contract: <i>(show annual and total value, if applicable)</i>

Proposed supplier:								
Reason why competitive tendering is not considered practicable: <i>(Refer to SFI Appendix A, paragraph 4.3.2)</i>								
Proposed by:								
<table style="width: 100%; border: none;"> <tr> <td style="border-bottom: 1px solid black; width: 70%;"></td> <td style="border-bottom: 1px solid black; width: 30%; text-align: center; color: #ccc;">DD/MM/YYYY</td> </tr> <tr> <td>Director / Manager responsible for project</td> <td style="text-align: center;">Date</td> </tr> </table>		DD/MM/YYYY	Director / Manager responsible for project	Date				
	DD/MM/YYYY							
Director / Manager responsible for project	Date							
Approved by:								
<table style="width: 100%; border: none;"> <tr> <td style="border-bottom: 1px solid black; width: 70%;"></td> <td style="border-bottom: 1px solid black; width: 30%; text-align: center; color: #ccc;">DD/MM/YYYY</td> </tr> <tr> <td>Director of Finance</td> <td style="text-align: center;">Date</td> </tr> </table> <table style="width: 100%; border: none;"> <tr> <td style="border-bottom: 1px solid black; width: 70%;"></td> <td style="border-bottom: 1px solid black; width: 30%; text-align: center; color: #ccc;">DD/MM/YYYY</td> </tr> <tr> <td>Chief Executive</td> <td style="text-align: center;">Date</td> </tr> </table>		DD/MM/YYYY	Director of Finance	Date		DD/MM/YYYY	Chief Executive	Date
	DD/MM/YYYY							
Director of Finance	Date							
	DD/MM/YYYY							
Chief Executive	Date							
Recorded in the <i>Register of Tenders</i> by:								
<table style="width: 100%; border: none;"> <tr> <td style="border-bottom: 1px solid black; width: 70%;"></td> <td style="border-bottom: 1px solid black; width: 30%; text-align: center; color: #ccc;">DD/MM/YYYY</td> </tr> </table>		DD/MM/YYYY						
	DD/MM/YYYY							

Trust Secretary

Date

Appendix C

Authorisation of Requisitions over £60,000

1. The Trust's requirements for non-pay expenditure are set out in *SFI Paragraph 9*.
2. *SFI Appendix 9.3* requires all requisitions for works, goods, or services with estimated expenditure over £60,000 to be authorised on this form and counter-signed by the Chief Executive or Director of Finance prior to the requisition being placed on the e-procurement system.
3. A copy of this form must then be sent to the Procurement Officer and a copy retained by the originating department.

Works, goods, or services to be purchased or contracted:
Length of proposed contract <i>(if applicable):</i>
Value of purchase or contract: <i>(show annual and total value, if applicable)</i>
Proposed supplier:

Proposed by:	
<hr/>	<hr/>
Director / Manager responsible for project	DD/MM/YYYY Date
Approved by:	
<hr/>	<hr/>
Director of Finance	DD/MM/YYYY Date
<hr/>	<hr/>
Chief Executive	DD/MM/YYYY Date
Received by:	
<hr/>	<hr/>
Procurement Officer	DD/MM/YYYY Date

Appendix D

Tender Acceptance Form

1. The Trust's requirements for accepting tenders are set out in *SFI Appendix A, Paragraph 5.7*. All tenders shall be reviewed by a Selection Panel of at least two people, one of whom should not be from the originating department.
2. The Selection Panel shall accept the most economically advantageous tender, unless there are good and sufficient reasons to the contrary. The factors taken into account in selecting a tenderer must be clearer recorded.
3. This form must be sent to the Trust Secretary to be recorded in the Register of Tenders.

Works, goods, or services to be purchased or contracted:

--

Length of proposed contract (if applicable):

--

Value of purchase or contract: (show annual and total value, if applicable)

--

Summary of Tenders

Organisation 1

Tendered Sum	
Experience and qualification	

of team members	
Understanding of client needs	
Feasibility and credibility of proposed approach	
Ability to complete project on time	
Organisation 2	
Tendered Sum	
Experience and qualification of team members	
Understanding of client needs	
Feasibility and credibility of proposed approach	
Ability to complete project on time	
Organisation 3	
Tendered Sum	
Experience and qualification of team members	
Understanding of client needs	
Feasibility and credibility of proposed approach	
Ability to complete project on time	
Organisation 4	
Tendered Sum	
Experience and qualification	

of team members	
Understanding of client needs	
Feasibility and credibility of proposed approach	
Ability to complete project on time	

Accepted Tender

Name of Organisation

Reasons for accepting tender

I confirm that the accepted tender represents the best value for money

Name & Job Title

DD/MM/YYYY

Date

Name & Job Title

DD/MM/YYYY

Date

I confirm that the accepted tender will not commit the Trust to expenditure in excess of that which has been allocated

Name & Job Title

DD/MM/YYYY

Date

Name & Job Title

DD/MM/YYYY

Date

Recorded in the *Register of Tenders* by:

Trust Secretary	DD/MM/YYYY Date
-----------------	--------------------

Appendix E

Completion Review Form

1. The Trust's requirements for completion reviews are set out in *SFI Appendix A, Paragraph 5.8*. All projects / goods costing over £100k shall be reviewed within three months of completion.
2. The review shall be carried out by a Completion Review Panel of at least two people, one of whom shall be nominated by the Chief Executive or Director of Finance and should not be from the originating department, and shall report to the Chief Executive.
3. This form must be sent to the Trust Secretary to be retained with the Register of Tenders.

Have the requirements of the specification been met

--

Was the project / goods delivered within the agreed timescale

--

Was the project / goods delivered within the tendered sum

--

Reviewed by:

<hr/> Name & Job Title	<hr/> DD/MM/YYYY Date

<hr/>	DD/MM/YYYY
Name & Job Title	Date
Recorded in the <i>Register of Tenders</i> by:	
<hr/>	DD/MM/YYYY
Trust Secretary	Date

Board of Directors : February 2012

Item : 12

Title : Anti-Bribery Policy and Procedure

Purpose:

This new policy has been drawn up in compliance with the Bribery Act 2010 which is now in force. It brings together and strengthens previous Trust procedures.

It has been drafted with the assistance of the Trust's Local Counter-Fraud Service.

This report has been reviewed by the Management Committee, 16th February 2012

This report focuses on the following areas:

(delete where not applicable)

- Risk
- Finance

For : Approval

From : Simon Young, Director of Finance

Anti-Bribery Policy and Procedure

Version:	1
Bodies consulted:	RSM Tenon, Local Counter Fraud Service
Approved by:	
Date Approved:	
Name of originator/author:	Simon Young, Jonathan McKee
Lead Director:	Director of Finance
Date issued:	
Review date:	

Contents

1	Introduction	4
2	Purpose	4
3	Scope.....	5
4	Definitions	5
5	Procedure.....	5
6	Roles and Responsibilities.....	8
7	Training.....	12
8	Monitoring Effectiveness.....	12
9	Additional Information	13
10	Related Policies	13
	Appendix A: Summary of the Bribery Act 2010	14
	Appendix B : Equality Impact Assessment.....	15

Anti-Bribery Policy

1 Introduction

- 1.1 This document sets out the Tavistock & Portman NHS Foundation Trust's (the Trust) policy and procedure on dealing with bribery or suspected bribery.
- 1.2 The Bribery Act 2010 introduces a new, clearer regime for tackling bribery that will apply to all organisations based or operating in the UK. It covers all sorts of bribery, the offering and receiving of a bribe, directly or indirectly, whether or not it involves a public official, in the UK or abroad.
- 1.3 Bribery is a criminal offence can be punished with imprisonment of up to 10 years or unlimited fines. If any employee was accused of bribery, the Trust's reputation might be damaged considerably, and subsequent enforcement action would be time-consuming and hinder the Trust from focusing on its core service delivery.

2 Purpose

- 2.1 This policy relates to all forms of bribery and is intended to provide direction and help to employees who may identify suspected bribery. The overall aims of this policy are to:
 - improve the knowledge and understanding of everyone in the Trust, irrespective of their position, about the risk of bribery within the organisation
 - assist in promoting a climate of openness and a culture and environment where staff feel able to raise concerns sensibly and responsibly
 - set out the Trust's responsibilities in terms of the deterrence, prevention, detection and investigation of bribery and corruption
 - ensure the appropriate sanctions are considered following an investigation, which may include any or all of the following:
 - Criminal prosecution
 - civil prosecution
 - internal / external disciplinary action (incl. professional / regulatory bodies)

3 Scope

This policy applies to all employees of the Trust, regardless of position held, as well as consultants, vendors, contractors, and/or any other parties who have a business relationship with the Trust. It will be brought to the attention of all employees and form part of the induction process for new staff. It is incumbent on all of the above to report any concerns they may have concerning bribery.

4 Definitions

Definitions for bribery and corruption vary. Some common definitions are:

Bribery - "Inducement for an action which is illegal, unethical or a breach of trust. Inducements can take the form of gifts, loans, fees, rewards or other advantages". Appendix A is a summary of the Bribery Act 2010. It is a common law offence of corruption to bribe the holder of a public office and it is similarly an offence for the office holder to accept a bribe.

Corruption - This can be broadly defined as the offering or acceptance of inducements, gifts, favours, payment or benefit-in-kind which may influence the action of any person. Corruption does not always result in a loss. The corrupt person may not benefit directly from their deeds; however, they may be unreasonably using their position to give some advantage to another.

5 Procedure

5.1 General

- 5.1.1 The Trust is committed to the rigorous investigation of any such allegations and to taking appropriate action against wrong doers, including possible criminal prosecution.
- 5.1.2 The Trust procures goods and services ethically and transparently with the quality, price and value for money determining the successful supplier/contractor, not by receiving (or offering) improper benefits. The Trust will not engage in any form of bribery, either in the UK nor

abroad. The Trust and all employees, independent of their grade and position, shall at all times comply with the Bribery Act 2010 and with this policy.

- 5.1.3 The Trust employees will not request or receive a bribe from anybody, nor imply that such an act might be considered. An employee must not agree to receive or accept a financial or other advantage from a former, current or future client, business partner, contractor or supplier or any other person as an incentive or reward to perform improperly their function or activities.
- 5.1.4 Employees will not pay a bribe to anybody. They will not offer, promise, reward in any way or give a financial or other advantage to any person in order to induce that person to perform his/her function or activities improperly. This provision includes creating the appearance of an effort to improperly influence another person.
- 5.1.5 All employees should be aware that bribery will normally, dependent upon the circumstances of the case, be regarded as gross misconduct thus warranting summary dismissal without previous warnings. However, no such action will be taken before a proper investigation and a disciplinary hearing have taken place. Such actions may be in addition to the possibility of criminal prosecution.
- 5.1.6 The Trust has procedures in place that reduce the likelihood of bribery occurring. These include Standing Orders, Standing Financial Instructions, documented procedures, a system of internal control (including Internal and External Audit) and a system of risk assessment. In addition, the Trust seeks to ensure that a comprehensive anti-bribery culture exists throughout the Trust via the appointment of a *Senior Compliance Officer* and Local Counter Fraud Specialist.

5.2 Facilitation payments

- 5.2.1 Facilitation payments are small payments made to secure or expedite the performance of a routine action by a government official or agency (e.g. issuing licenses or permits, installation of a telephone line, processing goods through customs, etc.) to which the payer (or the company) has legal or other entitlement.
- 5.2.2 Facilitation payments are prohibited under the Bribery Act like any other form of bribe. They shall not be given by the Trust or by Trust employees in the UK or any other country.

5.3 Political & charitable contributions

- 5.3.1 The Trust does not make any contributions to politicians, political parties or election campaigns.
- 5.3.2 The Trust may make charitable donations. However, these payments shall not be provided to any organisation upon the suggestion of any person of the public or private sector in order to induce that person to perform improperly the function or activities which he or she is expected to perform in good faith, impartially or in a position of trust or to reward that person for the improper performance of such function or activities.
- 5.3.3 Any donations and contributions must be ethical and transparent. The recipient's identity and planned use of the donation must be clear, and the reason and purpose for the donation must be justifiable and documented. All charitable donations will be publicly disclosed.
- 5.4.4 Donations to individuals and for-profit organisations and donations paid to private accounts are incompatible with THE Trust's ethical standards and are prohibited.

5.4 Sponsoring

- 5.4.1 Sponsoring means any contribution in money or in kind by THE TRUST towards an event organised by a third party in return for the opportunity raise the Trust's profile. All sponsoring contributions must be transparent, pursuant to a written agreement, for legitimate business purposes, and proportionate to the consideration offered by the event host. They may not be made towards events organised by individuals or organisations that have goals incompatible with THE Trust's ethical standards or that would damage the Trust's reputation. All sponsorships will be publicly disclosed.
- 5.4.2 Where commercial sponsorship is used to fund Trust training events, training materials and general meetings, the sponsorship must be transparent, pursuant to a written agreement, for legitimate business purposes, and proportionate to the occasion. Where meetings are sponsored by external sources, that fact must be disclosed in the papers relating to the meeting and in any published minutes/proceedings.
- 5.4.3 Where sponsorship links to the development of guidelines and advice, this should be carried out in consultation with the Senior Compliance Officer.

5.5 Raising concerns

- 5.5.1 The Trust wishes to encourage anyone having reasonable suspicions of bribery to report them. The Trust's policy, which will be rigorously enforced, is that no individual will suffer any detrimental treatment as a result of reporting reasonably held suspicions. The Public Interest Disclosure Act 1998 came into force in July 1999 and gives statutory protection, within defined parameters, to staff who make disclosures about a range of subjects, including bribery and corruption, which they believe to be happening within their employment at the Trust. Within this context, 'reasonably held' means suspicions other than those which are raised maliciously and are subsequently found to be groundless.
- 5.5.2 Any unfounded or malicious allegations will be subject to a full investigation and appropriate disciplinary action.
- 5.5.3 The Trust expects anyone having reasonable suspicions of bribery to report them to the Senior Compliance Officer and/or Local Counter Fraud Specialist who will then ensure that procedures are followed. Concerns can also be raised through THE Trust's whistleblowing policy.

6 Roles and Responsibilities

- 6.1.1 The Board of Directors (BD) has a duty to ensure that it provides a secure environment in which to work, and one where people are confident to raise concerns without worrying that it will reflect badly on them. This extends to ensuring that staff feel protected when carrying out their official duties and are not placed in a vulnerable position. If staff have concerns about any procedures or processes that they are asked to be involved in, THE TRUST has a duty to ensure that those concerns are listened to and addressed.
- 6.1.2 The Board and/or the Senior Compliance officer will be liable to be called to account for failing to prevent bribery. The Trust therefore has a duty to ensure employees receive adequate training and support in order to carry out their responsibilities.

6.2 Employees

- 6.2.1 For the purposes of this policy, 'Employees' include the Trust's staff, boards of directors and governors, volunteers, and trainees. It is expected that
- Non-Executive Directors and staff at all levels will lead by example in acting with the utmost integrity and ensuring adherence to all relevant regulations, policies and procedures.

- Employees must act in accordance with the Trust's Standards of Business Conduct, Gifts and Hospitality procedures and declare any interests
- Employees who are involved in receiving offers of sponsorship, funding or gifts from outside agencies also should comply with their own professional codes of practice. Professional staff must also make themselves aware of their own professional body codes of conduct e.g. Nursing and Midwifery Council, General Medical Council, professional, legal, accounting and other bodies.

6.3 Managers

6.3.1 Line managers at all levels have a responsibility to ensure that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively. The responsibility for the prevention and detection of bribery therefore primarily rests with managers but requires the co-operation of all employees.

6.3.2 As part of that responsibility, line managers must:

- Inform new staff (during their local induction) of the Trust policies available on the intranet, and of policies particularly key to their post
- ensure that all employees for whom they are accountable are made aware of the requirements of the policy
- assess the types of risk involved in the operations for which they are responsible
- ensure that adequate control measures are put in place to minimise the risks. This must include clear roles and responsibilities, supervisory checks, staff rotation (particularly in key posts), separation of duties wherever possible so that control of a key function is not invested in one individual, and regular reviews, reconciliations and test checks to ensure that control measures continue to operate effectively
- identify sensitive/at-risk posts
- ensure that controls are being complied with
- contribute to their Director's assessment of the risks and controls within their area, which feeds into the Trust's and the Accounting Officer's overall statements of accountability and internal control.

6.3.3 All instances of actual or suspected bribery, which come to the

attention of a manager, must be reported immediately. It is appreciated that some employees will initially raise concerns with their manager, however, in such cases managers must not attempt to investigate the allegation themselves, and they have the clear responsibility to refer the concerns to the Senior Compliance Office and/or the Local Counter Fraud Specialist as soon as possible.

6.4 Local Counter Fraud Specialist

6.4.1 The Directions to NHS Bodies on Counter Fraud Measures 2004 require the Trust to appoint and nominate a LCFS. The LCFS's role is to ensure that all cases of actual or suspected bribery and corruption are notified to the Director of Finance and reported accordingly.

6.4.2 The LCFS will regularly report to the Director of Finance on the progress of the investigation and when/if referral to the police is required.

6.4.3 The LCFS and the Director of Finance, in conjunction with the NHS Protect, will decide who will conduct the investigation and when/if referral to the police is required. Cases, where possible bribery/corruption is involved will usually be investigated by NHS Protect themselves (though the LCFS may assist), otherwise the investigation will normally be undertaken by the Trust's own LCFS directly.

6.4.4 The LCFS will:

- Ensure that the Director of Finance is kept apprised of all referrals/cases.
- Investigate all cases of bribery, as per 7.4.3 above.
- In consultation with the Director of Finance and NHS Protect, will report any case to the Police as agreed.
- Report any case and the outcome of the investigation to NHS Protect and Director of Finance, and provide required reports to NHS Protect.
- Ensure that other relevant parties are informed where necessary e.g. Human Resources will be informed where an employee is a suspect.
- Ensure that the Trust's incident and losses reporting systems are followed.
- Ensure that any system weaknesses identified as part of the investigation are followed up with management or Internal

Audit.

- 6.4.4 The LCFS in consultation with the Director of Finance will review the strategic objectives contained within the assurance framework to determine any potential bribery risks. Where risks are identified these will be included on the Trust's risk register so the risk can be proactively addressed.

6.5 Senior Compliance Officer

- 6.5.1 The Director of Finance is the Senior Compliance Officer responsible for implementing this policy, providing guidance and training, monitoring compliance and sanctioning violation of the policy. The Senior Compliance Officer will review annually the suitability, adequacy and effectiveness of the Trust's anti-bribery arrangements and implement improvements as and when appropriate.
- 6.5.2 The Senior Compliance Officer directly reports to the Chief Executive. Once a year, the Senior Compliance Officer reports the results of the reviews to the Board.
- 6.5.3 Any incident or suspicion that comes to attention of the Senior Compliance Officer will be passed immediately to the LCFS.

6.6 Director of Finance

- 6.6.1 The Director of Finance, in conjunction with the Chief Executive, monitors and ensures compliance with Secretary of State Directions regarding fraud and corruption or Clause 43 and Schedule 13 of the Standard NHS Contract for Acute Services.
- 6.6.2 The Director of Finance, in consultation with NHS Protect and the LCFS, will decide whether there is sufficient cause to conduct an investigation, and whether the Police and External Audit need to be informed.
- 6.6.3 The Director of Finance or the LCFS will consult and take advice from the Director of HR if a member of staff is to be interviewed or disciplined. The Director of Finance or LCFS will not conduct a disciplinary investigation, but the employee may be the subject of a separate investigation by HR.
- 6.6.4 The Director of Finance will, depending on the outcome of investigations (whether on an interim/ on-going or a concluding basis) and/or the potential significance of suspicions that have been raised, inform the Chair of THE TRUST and the Chair of the Audit Committee of cases, as may be deemed appropriate or necessary.

6.7 Internal and external audit

6.7.1 Any incident or suspicion that comes to Internal or External Audit's attention will be passed immediately to the LCFS.

6.8 Human Resources

6.8.1 Human Resources will liaise closely with managers and the LCFS, from the outset, where an employee is suspected of being involved in bribery or corruption. The Human Resources Department shall advise those involved in the investigation in matters of employment law and in other procedural matters, such as disciplinary and complaints procedures. Close liaison between the LCFS and HR will be essential to ensure that any parallel sanctions (that is, criminal and disciplinary) are applied effectively and in a coordinated manner.

6.8.2 Human Resources will take steps at the recruitment stage to establish, as far as possible, the previous record of potential employees as well as the veracity of required qualifications and memberships of professional bodies, in terms of their propriety and integrity. In this regard, temporary and fixed term contract employees are treated in the same manner as permanent employees.

6.9 Information Technology Manager

6.9.1 The IT Manager will contact the LCFS immediately in all cases where there is suspicion that IT is being used to facilitate bribery, eg inappropriate internet/intranet, e-mail, telephones and PDAs. Human Resources will be informed if there is a suspicion that an employee is involved.

7 Training

The Trust will provide anti-bribery training to employees on a regular basis to make them aware of our Anti-Bribery Policy and guidelines, in particular of possible types of bribery, the risks of engaging in bribery activity, and how employees may report suspicion of bribery.

8 Monitoring Effectiveness

The Chief Executive and Director of Finance will monitor and ensure compliance with this policy.

Compliance with the Anti-Bribery Policy and these guidelines will be

monitored regularly. Three Departments/Areas/Sites within the Trust will be contacted randomly after 6 months from the ratification date of this policy to identify:

A	The policy location
B	Awareness and level of understanding of the policy.
C	Any implementation of the policy.

9 Additional Information

Any abuse or non-compliance with this policy or procedures will be subject to a full investigation and appropriate disciplinary action.

This policy will be subject to regular review.

10 Related Policies

- Gifts & Hospitality Procedure
- Standing Orders
- Standing Financial Instructions
- Fraud and corruption policy
- The Raising concerns and whistleblowing procedure
- Disciplinary policy
- Codes of Conduct

Appendix A: Summary of the Bribery Act 2010

The following business practices constitute criminal offences under the Bribery Act 2010 and are therefore prohibited:

Offences of bribing another person

Case 1 is where a THE TRUST employee offers, promises or gives a financial or other advantage to another person *and* intends the advantage (i) to induce that or another person to perform improperly a relevant function or activity, *or* (ii) to reward that or another person for the improper performance of such a function or activity.

Case 2 is where a THE TRUST employee offers, promises or gives a financial or other advantage to another person *and* knows or believes that the acceptance of the advantage would itself constitute the improper performance of a relevant function or activity by that person.

The bribery must relate to (i) a function of a public nature, (ii) an activity connected with a business, (iii) an activity performed in the course of a person's employment, *or* (iv) an activity performed by or on behalf of a body of persons (whether corporate or unincorporated). The person performing the function or activity must be expected to perform it in good faith, impartially or in a position of trust. It does not matter whether the function or activity is performed inside or outside the UK, whether the other person(s) involved is/are in the public or private sector and whether the advantage is offered, promised or given directly by the TRUST employee or through a third party, e.g. an agent or other intermediary.

Offences relating to being bribed

Case 3 is where a THE TRUST employee requests, agrees to receive or accepts a financial or other advantage intending that, in consequence, a relevant function or activity should be performed improperly (whether by him-/herself or another person).

Case 4 is where a THE TRUST employee requests, agrees to receive or accepts a financial or other advantage, *and* the request, agreement or acceptance itself constitutes the improper performance by him-/herself of a relevant function or activity.

Case 5 is where a THE TRUST employee requests, agrees to receive or accepts a financial or other advantage as a reward for the improper performance (whether by him-/herself or another person) of a relevant function or activity.

Case 6 is where, in anticipation of or in consequence of a THE TRUST employee requesting, agreeing to receive or accepting a financial or other advantage, a relevant function or activity is performed improperly (i) by that THE TRUST employee, *or* (ii) by another person

at his/her request or with his/her assent or acquiescence.

Again, the bribery must relate to (i) a function of a public nature, (ii) an activity connected with a business, (iii) an activity performed in the course of a person's employment, or (iv) an activity performed by or on behalf of a body of persons (whether corporate or unincorporated). The person performing the function or activity must be expected to perform it in good faith, impartially or in a position of trust.

It does not matter whether the function or activity is performed inside or outside the UK, whether the other person(s) involved is/are in the public or private sector, whether the TRUST employee requests, agrees to receive or accepts the advantage directly or through a third party, e.g. an agent or other intermediary, and whether the advantage is for the benefit of a THE TRUST employee or another person.

In Cases 4 to 6, it does *not* matter whether the TRUST employee knows or believes that the performance of the function or activity is improper.

Bribery of foreign public officials

Case 7 is where a THE TRUST employee bribes a foreign public official and intends (i) to influence that official in his/her capacity as a foreign public official *and* (ii) to obtain or retain a business or an advantage in the conduct of business. A foreign public official is someone who holds a legislative, administrative or judicial position of any kind or exercises a public function of a country outside the UK, or is an official or agent of a public international organisation.

The following paragraph will apply if any part of the organisation is considered as a 'commercial' one.

Failure of commercial organisations to prevent bribery (applicable only to corporates and partnerships - included for information)

A corporate or partnership is guilty of a corporate bribery offence if an employee, agent, subsidiary or any other person acting on its behalf bribes another person intending to obtain or retain business or an advantage in the conduct of business for the corporate or partnership For a definition of bribery, please refer to Cases 1, 2 and 7 above.

It should be the policy of a corporate or partnership not to tolerate any bribery on its behalf, even if this might result in a loss of business for it. Criminal liability must be prevented at all times.

Appendix B : Equality Impact Assessment

1. Does this Procedure, function or service development impact affect patients, staff and/or the public?

YES

2. Is there reason to believe that the Procedure, function or service development could have an adverse impact on a particular group or groups?

NO

*3. If you answered **YES in section 2**, how have you reached that conclusion? (Please refer to the information you collected e.g., relevant research and reports, local monitoring data, results of consultations exercises, demographic data, professional knowledge and experience)*

4.. Based on the initial screening process, now rate the level of impact on equality groups of the Procedure, function or service development:

Negative / Adverse impact:

Low.....

(i.e. minimal risk of having, or does not have negative impact on equality)

Positive impact:

Low.....

(i.e. not likely to promote, or does not promote, equality of opportunity)

Date completed 10.2.12

Name Jonathan McKee

Job Title Governance Manager

Board of Directors : February 2012

Item : 14

Title : Service Line Report – CAMHS Training

Summary :

The purpose of this report is to provide the Board of Directors with an update and overview of the CAMHS Training Service Line, including:

- current activity
- management structure
- priorities
- challenges

This report has been reviewed by the following Committees:

- Management Committee 19th January 2012

This report focuses on the following areas:

- Quality
- Patient / User Experience
- Equality
- Risk
- Finance
- Productivity
- Communications

For : Discussion

From : Associate Dean CAMHS

Service Line Report - CAMHS Training

1. Overview of the Service

- 1.1 The CAMHS Training Service Line is responsible for seventeen MA and Professional Doctorate programmes. Four programmes are also delivered in associate centres in a range of geographical sites.
- 1.2 There is additionally an active and constantly evolving Continuous Personal and Professional Development (CPPD) portfolio and in 2011/12 the CAMHS Training Service Line will have delivered 41 CPPD programmes and 10 conferences, two of which were highly successful international events.
- 1.3 Consultancy is also located within the Service Line. Consultancy activity is under-performing because of diminishing demand and staff time has been redirected to focus on developing CPPD; given the Trust's model of teaching and learning there is often a blurred distinction between consultancy (which can include clinical supervision and consultation) and training and the redirection of activity is not problematic.

2. Management Structure

- 2.1 The Service Line is part of the CAMHS Directorate and is managed by the Associate Dean in close collaboration with the CAMHS Training Committee. The Training Committee consists of the Heads of Discipline, CAMHS Director, Assistant Director Education and Training, Librarian, Conference / Marketing Unit representative, Commercial Manager (Training), and the Training Consultant for Race and Equity Issues.
- 2.2 Regular agenda items include strategy for education and training of the whole children's workforce, income and expenditure, course and CPPD approvals and reviews, tenders and quality and enhancement of the service.
- 2.3 Service Redesign in the Directorate of Education and Training (DET) has led to the introduction of Cluster Training Leads (CL) who are responsible for a cluster of courses which have some connection, either via underpinning discipline or course topic.
- 2.4 In CAMHS, there are seven Cluster Leads replacing 17 Organising Tutors. The Cluster Leads have been appointed and the model will be operational from the end of January 2012. This group will meet monthly with the Associate Dean CAMHS.

- 2.5 It is anticipated that the model will be a more efficient way of managing our validated courses and provide an opportunity for a more consistent engagement with the developing expectations of course management: marketing, e-learning, resource and personnel management, identification of new market opportunities etc.
- 2.6 The link with the CAMHS Training Committee will be through the Associate Dean CAMHS but this relationship will be reviewed as to its efficacy during 2012.

3. Activity and Financial Position

CAMHS Training Net

Service Line Report - Month 10 2011-12

	Actuals	Budget	Variance
INCOME			
<u>DIRECT:</u>			
Middlesex University	87,500	87,495	5
Child Protection Camden GP Training		41,665	-41,665
CAMHS Cent CRB student inc	254		254
Hackney Training	6,000		6,000
CAMHS Central CPD Income	2,714		2,714
<u>TRAINING:</u>			
Junior Doctors	690,956	681,762	9,194
Child Psychotherapists	1,342,698	1,416,975	-74,277
National Contract	3,162,780	3,157,675	5,105
Course Fees	1,524,276	1,424,120	100,156
CPD	86,282	139,978	-53,696
LCCPD	36,695	38,586	-1,891
Conferences	152,247	49,996	102,251
HEFCE	409,318	420,556	-11,238
<u>CONSULTANCY</u>			
Consultancy	23,178	168,330	-145,152
<u>RESEARCH</u>			
Research	77,831	84,654	-6,823
<u>BUILDINGS</u>			
Buildings	10,998	20,260	-9,262
	7,613,726	7,732,051	-118,325
OPERATING EXPENDITURE (EXCL. DEPRECIATION) <u>CLINICAL DIRECTORATES</u>			

Training Net	-1,171,322	-1,136,874	-34,448
C&F Junior Doctors	-666,358	-657,570	-8,788
CAMHS Management & Research	-158,645	-153,510	-5,135
<u>OTHER TRAINING COSTS</u>			
Junior Doctors	-157,800	-127,006	-30,794
Child Psychotherapists	-1,121,574	-1,228,485	106,911
Visiting Lecturers	-742,418	-666,088	-76,330
Northern School	-24,667	-51,360	26,693
<u>RESEARCH</u>			
Research	-117,340	-133,426	16,086
<u>BUILDINGS</u>			
Buildings	-487,560	-480,706	-6,854
	-4,647,684	-4,635,025	-12,659
CONTRIBUTION	2,966,043	3,097,026	-130,983
<u>DET</u>			
Income	1,122,926	1,039,473	83,453
Expenditure	-2,026,423	-2,003,912	-22,511
<u>CENTRAL FUNCTIONS</u>			
Income	90,830	70,798	20,032
Expenditure	-703,869	-718,857	14,988
RETAINED SURPLUS	1,449,506	1,484,527	-35,021
SURPLUS as % of income	16%	17%	0%
CONTRIBUTION as % of income	39%	40%	-1%

- 3.1 Since reporting to the Management Committee the financial position for month 10 indicates that the service line is making a surplus but 35k less than budgeted.
- 3.2 Recruitment on validated programmes in 2011/12 has improved and is now 23 over target resulting in an improved fee income.
- 3.3 LCCPD income (NHS London commissioned) is forecast as £8k less than anticipated because there were fewer commissions by NHS Trusts.
- 3.4 The revised forecast for Trust CPPD and conferences is 51k above plan rather than 78k due to some courses being deferred to the next financial year to build recruitment levels. However this surplus reflects a strategy to divert resources from consultancy, which has been consistently failing to reach its target income, to areas where there is a demand for our service. Redirecting staff into more

profitable activity within the service line will be a key driver in 2012/13.

4. Update on New Developments

- 4.1 As reported previously, the CAMHS Directorate has integrated its clinical and training experience in services for schools, colleges and education to develop a Tavistock-education service.
- 4.2 Whilst we are continuing to stimulate business in mainstream local authority funded education the group is seeking also to generate new business in:
 - 4.2.1 academies
 - 4.2.2 private education
 - 4.2.3 special education
- 4.3 To date we have modest commissions in these new areas of activity, and we hope to build upon them as we simultaneously prospect as widely as possible.
- 4.4 Our integrated approach is also informing our strategy in the education and training and clinical services for child maltreatment. A portfolio of training and clinical services has been identified for marketing externally and promotional material and a dedicated web page are currently being developed by the Commercial Directorate.
- 4.5 The Trust, the Anna Freud Centre, and Yale University have developed a competency-based Infant Mental Health training for tiers 1 and 2 of the children's workforce (primary care and secondary community services). The modularised training is being launched at the end of January 2012. This has been a complex and intensive piece of work led by Ellie Kavner on behalf of the Directorate.
- 4.6 Since its inception there has been a considerable shift in the economic climate and recruitment has not been as buoyant as anticipated but the Commercial Unit are working closely with the Anna Freud Centre on a targeted and intensive marketing drive.
- 4.7 We also hope that once the course is running word of mouth, a longstanding source of recruitment for the Trust, will stimulate interest.
- 4.8 There is a readiness within the service line to engage with the development of e-learning.

- 4.9 The Associate Dean CAMHS has worked closing with the Associate Dean SAMHS to identify validated courses and CPPD that could partially or completely be delivered within an e-learning format.
- 4.10 This will be approached on a staged and planned basis, partly because we need to develop staff confidence and capability and cascade this down through the department as participation in e-learning becomes a live issue. There is also a capacity issue as not all staff have the immediate capacity to engage in new developments.
- 4.11 In 2011, the Trust augmented its support for students with the introduction of the Student Advice and Consultation Service. This supplementary provision is in recognition of the confidential issues impacting on the student's learning experience and performance which may require a more independent source of advice and support.
- 4.12 The service is run by members of the professional staff within the Trust and CAMHS teaching staff are playing a key role in the delivery of the service.

5. Teaching Quality

- 5.1 The quality of academic standards and learning opportunities of the Trust's validated courses is subject to the governance processes of the Quality Assurance Agency (QAA) in Higher Education. In the Spring term the Trust will be participating in the following academic audits:
- 5.1.1 January (2 days): The Review of Education Oversight by the QAA on behalf of the UKBA. This is required in order to achieve 'highly trusted status' in respect of the recruitment of overseas students
- 5.1.2 February (2 days): University of East London Academic Review. The review every 6 years of all aspects of our academic provision by our major university partner
- 5.1.3 March (2 days): Institutional Audit by Essex University
- 5.2 The preparation process is led by the Associate Dean CAMHS, the Chair of the Research Degrees Committee (Andrew Cooper), and the Manager Quality Assurance and Academic Governance Unit (Louis Taussig).
- 5.3 An assessment of areas of potential vulnerability was undertaken and this has informed the preparation strategy.

- 5.4 The assessment led a number of developments including the current revision of the DET pages on the website, the introduction of peer review of teaching, and the development of an integrated and an updated DET Handbook.
- 5.5 All Trust teaching staff and DET are actively involved in this process, plus students and employers; not surprisingly the term will be demanding of resources and energy.

6. Complaints, Compliments and Feedback

- 6.1 The Board will be aware from Trust-wide Education and Training reports that our trainings receive a very high positive rating: 93% of students provided a positive response (excellent or good) on the quality of teaching and 87% reported that their expectations of the course and the Tavistock and Portman NHS Foundation Trust had been met.
- 6.2 Within the CAMHS Directorate there have been nine student complaints requiring investigation by the Associate Dean, all of which have been resolved at this stage and not progressed further. The Dean made an annual report with details of complaints earlier in the year.

7. Future challenges

- 7.1 A key challenge will be to maintain and increase income in a climate of financial restraint within organisations and by individuals. This has implications for recruitment to Trust validated programmes, CPPD and conferences and consequently income revenue.
- 7.2 Whilst the management of the Service Line, and staff generally, aims to respond swiftly to new opportunities and external changes, the structure of the Trust can inhibit decisive and fast engagement.
- 7.3 The Trust has internally audited and prepared for the series of academic reviews taking place this term and we are aware of potential areas of weakness, for example the systems for managing the governance and accuracy of public information. However, we must be prepared for unforeseen outcomes which may have resource implications.

Karen Tanner
Associate Dean, CAMHS
January 2012

Board of Directors : February 2012

Item : 15

Title : Quality Report Quarter Three Review

Summary:

This report provides a summary of the 2011/12 Quality Priorities progress update included in the Quarter Three CQSG reports.

The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance, and where not, whether the Board of Directors is satisfied with the action plans that have been put in place.

This report has been reviewed by the following Committees:

- Management Committee, 16th February 2012

This report focuses on the following areas:

(delete where not applicable)

- Quality
- Patient / User Experience
- Patient / User Safety

For : Noting

From : Louise Lyon, Trust Director
Justine McCarthy Woods, Quality Standards & Reports
Lead

Quarterly Report 2011-12: Quality Priorities Progress Update - Q3 February 2012

Priority	Target	Priority Lead	Monitoring Processes	Evidence Required	Start Date	Achievement Date	Progress	% Progress for 2011/12				RAG Status	Actions for Next Quarter
								25%	50%	75%	100%		
Outcome Monitoring	CAMHS (Child and Adolescent Mental Health Service): 1. To achieve a return rate of 60% for the Goal-based Measure for Time 1 and Time 2 (for those patients who completed the GBM at Time 1).	Caroline McKenna	<ul style="list-style-type: none"> • OM tracking system • Monitoring of progress by the OM Lead • Quarterly progress report • Quarterly review by the CQSG Committee and Board of Directors 	<ul style="list-style-type: none"> • OM analysis of the % return rate for Time 1 and Time 2 per quarter 	1st July 2011	31st January 2012	This target was not achieved at Q3 end. An action plan is in place to rectify this by end of Q4.					Amber	The availability from February 2012 of a "missing data " report for each team means that the outcome data needed to secure the CQUIN target can be identified and actioned on a case by case/clinician by clinician basis. Data will remain incomplete until non Tavistock based services are linked to RiO. It is expected that these services will be integrated by end of February 2012.
	Adult Department: 2. To achieve a return rate of 60% for the CORE for Time 1 and Time 2 (for those patients who completed the CORE at Time 1).				1st April 2011	31st January 2012	The target was not achieved in Q3.					Amber	Action plan requested February 16th 2012.
Access to Clinical Services and Health Care Information for Patients and Public	1. To increase the number of leaflets about specific treatment modalities from 0 to at least 5 leaflets	Sally Hodges	<ul style="list-style-type: none"> • PPI Lead to initiate and oversee the process for developing these leaflets • Monitoring of progress by PPI Lead • Feedback from patients and members on the accessibility of this information • Quarterly progress report • Quarterly review by the CQSG Committee and Board of Directors 	<ul style="list-style-type: none"> • Copies of the leaflets 	1st April 2011	31st January 2012	The PPI Lead presented this proposal to the Management Committee in July 2011. The Management Committee agreed to provide the clinical content of the modality leaflets for the PPI Committee in November 2011. One leaflet was reviewed by the PPI Committee in November 2011 and the other four to be reviewed by the PPI Committee on 31st January 2012.					Green	A first draft has been completed for all of the 5 leaflets. Three have been approved and will be on the website by the end of February 2012. The 2nd version of the remaining 2 leaflets will be drafted, approved and uploaded onto the internet as soon as possible.
	2. To ensure that links to this information are clearly accessible through the website			<ul style="list-style-type: none"> • Evidence of feedback received from patients and members • Evidence of how feedback was obtained and when 	1st April 2011	31st January 2012						Green	

Priority	Target	Priority Lead	Monitoring Processes	Evidence Required	Start Date	Achievement Date	Progress	% Progress for 2011/12				RAG Status	Actions for Next Quarter
								25%	50%	75%	100%		
Patient and Public Involvement	1. To have held at least 3 stakeholder quality meetings	Sally Hodges	<ul style="list-style-type: none"> • Maintain minutes from the stakeholder quality meetings • Maintain monthly records of the number of members • Patient and Member feedback • Monitoring of progress by PPI Lead • Quarterly progress report • Quarterly review by the CQSG Committee and Board of Directors 	• Minutes from the stakeholder meetings	1st April 2011	31st January 2012	A stakeholder meeting was held in September 2011 and a second has been arranged for January 2012. A third meeting involving the Clinical Director, Quality Lead, PPI Lead and some of the Governors has been scheduled for 15th February to discuss the Q1 & Q2 Quality Report.					Green	This reporting topic is expected to complete in February 2012.
	2. To increase the membership numbers by 10%			• Number of members per month	1st April 2011	31st January 2012	Membership as of April 2011 was 6234, equating to a 14.68% rise in membership since April 2010 when the membership was 5436.					Green	Achieved, exact figures to be supplied.
	3. To develop a clear strategy around BME engagement			• Documentation of the BME engagement strategy	1st April 2011	31st January 2012	The PPI team attended the Bangladeshi Community Mental Health Forum in September 2011 and are working with Voluntary Action Camden to become more involved with local organisations to promote awareness of our services to BME communities. The BME engagement strategy was discussed at the November 2010 Equalities committee, and amended and supported at the January 2011 Equalities committee. The strategy goals include providing appropriate evidence of compliance with the 2010 Equalities Act, public events at the Tavistock Centre promoting discussion on BME Engagement, a Trust presence at community mental health events in Camden Borough, and a Trust steering group to develop further goals for closer BME community involvement.					Green	Achieved.
	4. To trial a patient forum and to hold at least 3 patient information / discussion groups			• Minutes from the patient information / discussion groups	1st April 2011	31st January 2012	A series of discussions open to patients, Trust members and the general public have been organised. Two have been held – one in July 2011 and a second in November 2011, with two more planned for February 2012 and May 2012.					Green	This reporting topic is expected to complete in February 2012.

Priority	Target	Priority Lead	Monitoring Processes	Evidence Required	Start Date	Achievement Date	Progress	% Progress for 2011/12				RAG Status	Actions for Next Quarter
								25%	50%	75%	100%		
	5. To increase our presence on at least one of the social media websites			<ul style="list-style-type: none"> Links to our presence on the social media websites 	1st April 2011	31st January 2012	The Communications Committee has disbanded. The Barnet Young People's Drug and Alcohol Service has a Facebook page and the CEO has his own Twitter account and is working closely with the Communications team to generate content for this.					Amber	The social media strategy is being developed and will be written, reviewed and approved at the end of March 2012. Following which, actions from the strategy will commence and a social media policy will be written and implemented.
Maintaining a High Quality Effective Workforce	1. For 75% or more of Trust staff to have attended the mandatory training/INSET day once every 2 years, as required	Susan Thomas	<ul style="list-style-type: none"> Staff database in order to keep track of new starters and leavers Attendance records for the mandatory training, INSET day and trust-wide induction Completion records for the local inductions Monitoring of progress by HR Director Quarterly progress report Quarterly review by the CQSG Committee and Board of Directors 	<ul style="list-style-type: none"> Number of staff in the Trust Number and % of staff who attended mandatory training/ INSET day per quarter 	1st April 2011	31st March 2012	<p>82% of staff who are required to attend have attended within the last 2 years. There are 2 INSET days held each year, with the next one scheduled for May 2012.</p> <p>To improve compliance, Directors and heads of discipline are informed of which staff must attend. These staff will then be targeted prior to the session and Directors will have responsibility for ensuring that the required staff attend. Sanctions will be applied to staff that fail to attend INSET within the two year time-line.</p>					Green	Action plan to continue as planned and the Corporate Governance and Risk group will continue to monitor progress.
	2. For 75% or more staff joining the Trust to have attended Trust-wide Induction				<ul style="list-style-type: none"> Number of staff in the Trust Number and % of staff who attended Trust-wide Induction 	1st April 2011	31st March 2012	<p>81% of staff who are required to attend the Trust-wide induction have attended. Six of the nine staff that have not been inducted started working after the last Trust-Wide Induction took place on 29 November 2011. So only three staff failed to attend and one of these is on maternity leave.</p> <p>Induction takes place four times in each academic year, with the next induction scheduled for February 2012.</p> <p>All staff who fail to attend induction on date of invitation are notified of the next induction date and their line manager informed of their non-attendance. The Chief Executive will be notified of any staff member who fails to attend induction on a second occasion. Sanctions will be applied to staff that fail to attend Induction on the second occasion they are invited.</p>					

Priority	Target	Priority Lead	Monitoring Processes	Evidence Required	Start Date	Achievement Date	Progress	% Progress for 2011/12				RAG Status	Actions for Next Quarter
								25%	50%	75%	100%		
	3. For 75% or more staff joining the Trust to have completed their Local Induction			<ul style="list-style-type: none"> Number of staff in the Trust Number and % of staff who have returned local induction completion forms 	1st April 2011	31st March 2012	91% of staff who are required to complete a local induction have done so. Forms are now being given to staff when they sign on with HR. Managers are chased up at regular intervals to ensure that forms are returned, non responders will be escalated to the relevant Director and then the Chief Executive of the Trust if forms are still not received. Sanctions will be applied to staff that fail to complete local Induction within two months of starting work.					Green	