

## Board of Directors Part One

**Agenda and papers**  
of a meeting to be held in public

2.00pm–4.00pm  
Tuesday 27<sup>th</sup> Sept 2016

Lecture Theatre,  
Tavistock Centre,  
120 Belsize Lane,  
London, NW3 5BA



## BOARD OF DIRECTORS (PART 1)

Meeting in public  
Tuesday 27<sup>th</sup> Sept 2016, 14.00 – 16.00  
Lecture Theatre, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

### AGENDA

PRELIMINARIES				
1.	<b>Chair's Opening Remarks</b> Prof Paul Burstow, Trust Chair		Verbal	-
2.	<b>Apologies for absence and declarations of interest</b> Prof Paul Burstow, Trust Chair	To note	Verbal	-
3.	<b>Minutes of the previous meeting</b> Prof Paul Burstow, Trust Chair	To approve	Enc.	p.1
3a.	<b>Outstanding Actions</b> Prof Paul Burstow, Trust Chair	To note	Verbal	-
4.	<b>Matters arising</b> Prof Paul Burstow, Trust Chair	To note	Verbal	-
REPORTS & FINANCE				
5.	<b>Student Story – CYAF Complex Needs</b>	To discuss	Verbal	-
6.	<b>Service Line Report – Complex Needs, CYAF</b> Dr Rachel James, Associate Clinical Director	To discuss	Enc.	p.9
7.	<b>Trust Chair's and NEDs' Reports</b> Prof Paul Burstow, Trust Chair	To note	Verbal	-
8.	<b>Chief Executive's Report</b> Mr Paul Jenkins, Chief Executive	To note	Enc.	p.26
9.	<b>Public Affairs Strategy</b> Ms Laure Thomas, Director of Communications & Marketing	To discuss	Enc.	p.31
10.	<b>Quality Improvement Plan Update</b> Ms Louise Lyon, Director of Quality & Patient Experience	To note	Enc.	p.42
11.	<b>Finance and Performance Report</b> Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	Enc.	p.49
12.	<b>Training and Education Report</b> Mr Brian Rock, Director of Education and Training/Dean	To note	Enc.	p.58
13.	<b>Q1 CQSG Report</b> Dr Rob Senior, Medical Director	To note	Enc.	p.63
14.	<b>Responsible Officer's Revalidation Report</b> Dr Rob Senior, Medical Director	To note	Enc.	p.72

15.	<b>Standing Financial Instructions</b> Mr Simon Young, Deputy Chief Executive & Director of Finance	To approve	Enc.	p.76
16.	<b>Constitution Changes – board composition</b> Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.153
<b>CLOSE</b>				
17.	<b>Notice of Future Meetings</b> <ul style="list-style-type: none"> <li>• Tuesday 4<sup>th</sup> Oct 2016: Joint Boards Meeting, 12.30pm – 5.30pm</li> <li>• Wednesday 5<sup>th</sup> Oct 2016: AGM, 4.00pm – 7.00pm, Tavistock Centre</li> <li>• Tuesday 29<sup>th</sup> Nov 2016: Board Meeting, 2.00pm – 5.30pm</li> </ul>		Verbal	-

## Board of Directors Meeting Minutes (Part One)

### Tuesday 26<sup>th</sup> July 2016, 2.00 – 5.00pm

<b>Present:</b>			
Dr Ian McPherson NED & Vice Chair of Trust	Prof. Dinesh Bhugra NED	Mr David Holt NED	Dr Sally Hodges CYAF Director
Mr Paul Jenkins Chief Executive	Ms Lis Jones Nurse Director	Ms Louise Lyon Director of Q&PE and A&FS	Ms Edna Murphy NED
Mr Brian Rock Director of E&T/ Dean	Dr Rob Senior Medical Director	Mr Simon Young Deputy CEO & Director of Finance	
<b>Attendees:</b>			
Mr Gervase Campbell Trust Secretary (minutes)	Ms Camilla Nichols, Governor	Ms Claire Kent, Patient Story Lead (item 5)	Mr Michael Mercer, AFS Complex Needs Lead (item 6)
Mr Toby Avery, IMT Director (item 10)	Mr Freddie Peel, Dashboards Lead (item 13)	Ms Marion Shipman, AD of Quality and Governance (item 14)	
<b>Apologies:</b>			
Prof. Paul Burstow Trust Chair	Ms Jane Gizbert NED	Dr Julian Stern, Director of Adult and Forensic Services	

#### Actions

AP	Item	Action to be taken	Resp	By
1	3	Minor amendments to be made to the minutes	GC	Immd.
2	15	Change format of quarterly quality reports so that they focus on key issues and actions, with data provided as an appendix.	MS	Oct.
3	16	Clarification of turnover rates	CdS	Sept.

#### 1. Chair's Opening Remarks

Dr McPherson opened the meeting.

#### 2. Apologies for Absence and declarations of interest

Apologies as above.

#### 3. Minutes of the Previous Meeting

**AP1** The minutes were approved subject to minor amendments

#### 4. Matters Arising

Action points from previous meetings:

AP1 – (minutes) – completed

AP2 – (MCA timescales) – Dr Senior gave an update on the training completed, the planned audit, and future integration of training within the mandatory system. Completed.

#### 5. Service User Story – Complex Needs, Adult and Forensic Services

Ms M. explained that she had started coming to the Trust two years ago for

weekly sessions, following three years of family therapy that came after a period as an inpatient. She had initially been wary of group therapy, but had trusted the clinician, and found that it was beneficial. Parts of the process – no contact with members outside the meeting, minimal direction from the clinician during sessions – had been hard to adjust to. She would be leaving therapy this year and felt ready to do so, better equipped to face life now.

Dr Hodges asked if it would have helped to be given more information explaining the process at the start. Ms M thought it would have helped to have known how the clinician would facilitate the group discussions. A paragraph or two explaining that the approach here was different would be helpful.

Mr Holt asked whether therapy ended abruptly, or if a safety net was provided. Ms M explained that nothing had been put in place here, but her last provider had said she could phone for an appointment if she needed one, and knowing that was available had been comforting.

Dr McPherson thanked Ms M for speaking with the Board, and for expressing the positives and negatives so eloquently – it had allowed the directors to put themselves in her shoes and been very helpful.

## **6. Service Line Report – Psychoanalytical Clinical Portfolio**

Mr Mercer introduced the report by noting that there had been difficult times for the service over the past few years, with savings and reorganisations, but they had now reached a plateau and were ready to look for development opportunities. They had a vital and committed staff, but needed to re-establish a senior staff base to provide ideas and innovation in the future. Adult services formed a smaller part of the Trust now than in the past, and there was raised anxiety, often expressed through the relocation project. The period of reflection the chief executive had led prior to Dr Stern's appointment had been helpful. The standard of the core services remained good, with exceptional figures for patient satisfaction.

Prof. Bhugra noted that there had been no serious incidents in the past two years, para. 10. Mr Mercer explained that there had been two serious incidents in the past 10 years, and in each case lessons were learnt and changes made to how the services ran, especially in the integration of trainees and improved assessment and support system, which had reduced risk.

Mr Holt noted the number of patients seen for assessment, and the waits to start treatment, and asked how the service managed this. Mr Mercer noted that assessments themselves were extended, often 3 or more sessions in duration, and that during the wait for treatment there was care management, with a route for patients to contact the service if they needed to, and an automatic review after 6 months. Where a patient was judged high risk they were taken on immediately. Dr Senior added that it was an area of concern for the Trust, given the perception of increasingly risky populations, and so the Management Team would be looking to see if the Trust were tolerating risk it shouldn't, and to audit patients on the waiting list to see how the wait affected them. Dr Hodges asked about the people who want to use the service but cannot as

they do not fall in the catchment areas or are not funded by their CCG, and whether the Patient Choice agenda might effect this. Mr Mercer explained that the service was in favour of Patient Choice, but it had proved difficult to get funding agreed with CCGs. It felt as though recent developments in the area meant mechanisms were now available to make Choice meaningful, and this could lead to regaining some of the type of patients they used to see but who were no longer referred.

Mr Rock asked whether the impact of the education and training changes had settled in. Mr Mercer explained that they had been significant changes, but greater clarity and focus had emerged, and they were moving towards more collaborative work and building new relationships. They needed more resources to provide tutorials and supervision, and joint posts would be welcome.

Ms Murphy asked what the biggest challenge he currently faced was. Mr Mercer explained that it was finding and harnessing enough talent and putting it in the right places. He aspired to a vision of a group of senior staff with special projects, who were experienced and talented enough to be thought leaders, protecting tradition and producing innovation. Achieving this in the present competitive environment was the challenge.

Mr Jenkins commented that he and Julian Stern were keen to continue the work he had started with the Adult department, and were looking at opportunities to take it forward. He hoped that some of the developments in the STP might reduce barriers and help the service find better joined up pathways where our work complemented that of other organisations. He agreed that the time was right to reassess the Patient Choice agenda and see if more opportunities now existed to enable those who wanted to access our unique services to choose them.

The Board **noted** the report.

#### **7. Trust Chair and NEDs' Reports**

None.

#### **8. Chief Executive's Report**

Mr Jenkins introduced his report by noting the successful CQC Quality Summit which had been the forum for a useful discussion on where to go next and how to find a vision of 'outstanding' that fitted the Trust. The first step towards this had been the June Leadership Event, to which all the clinical team managers were invited, and the work would feed into the Quality Strategy in the Autumn.

He noted that staff were concerned over Brexit, and that the Trust had a large number of EU staff. There had been very positive feedback to his email communication on the issue, and a powerful Thinking Space event on the implications of leaving the EU. They would keep alert to developments, keep staff informed, and speak up for them. Prof. Bhugra commented that they needed to be prepared for the consequences, and should conduct scenario planning. Ms Murphy reported that her university had set up a dedicated Brexit

group to consider related issues, and suggested it might be helpful to keep Brexit as a standing item and keep communicating with staff.

The Board **noted** the report.

### **9. Q1 Trust Strategic Objectives Review**

Mr Jenkins noted that many of the objectives were RAG rated amber, but that they had made good progress in a number of areas. It was unlikely that they would be able to achieve the goal for Tavistock Consulting given the changes that had occurred there, and a significant review of the service was planned.

He commented that the structure the objectives provided was helpful, but they needed to retain flexibility as the environment changed, and so they would be reviewed substantially next quarter to identify those which were critical.

Mr Holt added that in the Committee they had considered progress against the objectives in detail, and what was presented here was a summary. He agreed that a review of the objectives was important to keeping them relevant for the management team's use. Ms Murphy added that if it became impossible to complete them all, it was for the Executive to say which were the most important. Dr Senior suggested that they were all essential, but the review was a useful tool for ensuring resources were applied correctly. Mr Young suggested that as currently stated the objectives had a clarity that made them easy to work with, and this should be protected.

The Board **noted** the report.

### **10. IMT Q1 Report and Care Notes Optimisation Update**

Mr Avery introduced the report, noting that IM&T was currently amber overall against the plan, and whilst a lot had been done in the past 6 months, they were behind in some areas, such as procurement for the new network.

The management team had agreed to replace the current email solution with Microsoft 365, a better system that would support secure emails and Skype for Business, a system that could be used for tele-medicine and which would be piloted by GIDS in the spring.

The current power supply was over stretched and there had been an outage recently, whose impact had demonstrated the poor network resilience. A new supply would be implemented in the main computer room in August, and then the room would be reconfigured to make it more reliable and safer.

He noted the unprecedented demand for informatics resources, which was leading to a lack of responsiveness from the team to managers' requests. He also noted the impact of operational issues on the Director's ability to do the necessary strategic work, and suggested that it would be important to support Mr Wyndham-Lewis in this area. Mr Holt pressed for details on how this could be done: Mr Avery suggested permission to say no to important, but non-essential, requests, and Mr Young agreed with this. Mr Jenkins added that they had

greater clarity about the core agenda and priorities now, which would make these hard decisions easier.

Mr Avery noted that they were on target for most of the Carenotes optimisation project and highlighted key points:

- They had developed a training plan for September's new students, and put in a bid for resources to deliver it.
- There were issues with the performance of the system that were proving difficult to pin down, but were due to connection issues at some sites, and to the system itself in other places. They were working with the supplier to identify and solve them.
- Data quality was improving, but more work was needed on standardising forms.

Dr McPherson commented that it was a complex interface between technology and culture change, and they needed strong leadership to ensure staff engage with the system and the informatics team.

Mr Jenkins and the Board thanked Mr Avery for his work at the Trust.

The Board **noted** the report.

### **11. Finance and Performance Report**

Mr Young reported that they were currently ahead of plan and he was confident they would stay within the control total for the year. There would be spending on various areas in the coming months, such as GIDS accommodation work, which would start next week.

Mr Holt noted that capital expenditure was below plan, p.42, and asked if they expected to be up to budget by the year end. Mr Young confirmed that it was largely a question of timing, for example a large part of the relocation project spending was design work that could not begin until a site was selected.

The Board **noted** the report.

### **12. Training and Education Report**

Mr Rock introduced his report, noting that the QAA report would be published shortly and they had met all the expectations. He reported that they had made good progress on student loans and now the majority of their courses would be eligible.

They had received more than 700 applications for courses, and the recruitment team had done excellent work using data to focus their activity. Mr Holt asked how many applications had been made but not accepted, and Mr Rock explained that it was around 100-150, but that they were much further ahead than last year, and the team was following up on these, and on incomplete applications. Ms Murphy added that in education August was the busy month, and they would see then whether they had reached a different clientele this year, or engaged the same group more effectively and earlier.

The Board **noted** the report.

### **13. Q1 Dashboards**

Mr Jenkins noted that they were still working on the dashboards, but already they were proving useful in making key performance issues evident. He drew attention to the year on year increase in patient numbers, and to the safety position, with a reduction in incidents at the Gloucester House Day Unit, a decrease in safeguarding alerts overall, and an increase in adult alerts thanks to improved training and management.

Waiting times were of increasing importance to the Trust, and were an issue in services that had seen a large increase in demand, with GIDS and City and Hackney accounting for almost all of the 18 weeks waits. Further analysis had shown a reduction in the 15-18 week waits, which was an indicator of a downward trend, but this was an area that needed continued attention and management of our existing resources.

The Board discussed the dashboards, agreeing that trend and target information should be included in the future, and that they should guide the agendas of future meetings. Mr Jenkins suggested the Board's focus should be on the fall in incidents and waiting times. It was agreed that dashboards should be pushed down to team level, but acknowledged that this would require additional resources, and Mr Jenkins commented that this was an area they were considering investing in.

The Board **noted** the report

### **14. Q1 Quality Report**

Ms Lyon introduced the report, and opened a discussion on whether the data as presented was as useful as it could be. Mr Holt and Mr Young suggested that it was too detailed, and needed to focus on areas that had already been flagged, such as waiting times. Prof. Bhugra added that it should include details of actions that were planned or had been taken to address areas of concern. The directors agreed that a longer narrative report focussing on key issues and actions, with the data included as an appendix, would be more helpful. Mr Jenkins added that as the dashboards matured they would look to integrating the reports to enable more focus on strategic issues whilst also providing more benefit to commissioners.

**AP2**

Dr McPherson acknowledged the work that had gone into the report, and welcomed a different focus for future quarters.

The Board **noted** the report.

### **15. Q1 Governance Statements**

Mr Young presented the report, explained the financial elements and confirmed

that targets were being met and were forecast to continue to be met throughout the year. He recommended approving the statements.

The Board **approved** the statements

#### **16. Q1 HR Report**

Mr Holt noted that the turnover rate was 20%, which seemed high, reinforcing the debates the board had previously had on retention and risks associated with Brexit. It was agreed that they should seek clarification on the rate and whether it included trainees on fixed contracts.

AP3

The Board discussed Safer Recruitment training, and Dr Senior explained that there had been difficulty getting accurate data on whether we were reaching the target of a trained person on every panel, and so this was shown as red until the HR Director could provide assurance.

The Board **noted** the report.

#### **17. Equalities WRES Report**

Dr McPherson commented that the report had been discussed in detail at the Equalities Committee, and it was an important issue that deserved an extended discussion at a future meeting so that they could review whether the measures that had been taken were having a positive effect.

Ms Lyon commented that the Chair and CEO had held a helpful meeting with BME staff in the Trust, and points raised by them had been included in the action plan presented here. Mr Jenkins added that a second meeting was scheduled for September, and as well as being a helpful forum and a way to focus attention, it was also helpful in providing accountability.

The Board **noted** the report and action plan, and approved publication.

#### **18. Register of Interests**

Dr McPherson reminded directors that although the register was presented annually, directors were responsible for updating it with any changes to their circumstances as they occurred.

The Board **approved** the register.

#### **19. Sustainability and Transformation Plan (STP) Update**

Mr Jenkins explained that this paper was provided by North Central London to all the Trusts in the sector, for the public domain.

The Board **noted** the report.

#### **20. Any Other Business**

The Board noted its future meetings.

Part one of the meeting closed at 17.00

## Board of Directors : September 2016

**Item : 6**

**Title :** Children, Young Adults and Families (CYAF) Complex Needs Service Line Report

**Purpose:**

The purpose of this report is to give an update on the performance and issues facing the Complex Needs Service.

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 Team, September 2016

**This report focuses on the following areas:**

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

**For :** Discussion

**From :** Associate Clinical Director for Complex Needs service line, Rachel James

## CYAF Complex Needs Service Line Report

### Executive Summary

#### 1. Introduction

- 1.1 This service line consists of a range of complex needs clinical services in CYAF, including the Family Mental Health Team, the Lifespan Team, the Adolescent and Young Adults (AYA) Service. It does not include services that fall under the Camden contract, FDAC, the Westminster Family Contact Contract, the Fostering, Adoption and Kinship Care team, or First Step.
- 1.2 Rachel James was appointed Associate Clinical Director of the complex needs service line on 1<sup>st</sup> April 2016, following Sally Hodges' appointment to the CYAF Director role.
- 1.3 The work of the service line is complex and involves negotiation with a large number of commissioners, including health, local authority and public health commissioning. A significant issue for the service line is that commissioners keep changing, so relationship management is difficult.

#### 2. Areas of Risk and/or Concern

- 2.1 Reputational: the Lifespan team has an 11 month waiting list, which means that we do not meet waiting time KPIs. Despite the waiting list, the team is currently over-performing, so additional resources are going to be required to enable waiting times to be reduced. Negotiations are taking place with commissioners, specifically Haringey, to explore possibilities.
- 2.2 Financial: clinical services within the service line have a greater expenditure than income. Historically, there was a higher income from the national training contract, which partly supported the service to employ staff who can both train and provide a clinical service, and who tend to be on higher bandings. The potential cut to this contract places increased financial pressure on the clinical service. These clinical services provide an additional training function, and further productivity work is scheduled to ensure that the budgets represent the work that is undertaken. There are significant efficiency savings predicted across the CYAF Directorate for 2017/18.

Staff are increasingly anxious that the ongoing reduction in specialism through cost savings will erode the specialist nature of the services and impact on capacity to provide services that are different enough from local services to warrant their commissioning.

- 2.3 Conflicting priorities: the service is subject to comply with CAMHS sustainability and transformation plans using the vision document of 'Future in Mind' as a blueprint developed in partnership with a range of CCGs including Haringey, Barnet, Enfield and Islington. This is likely to

provide a challenge across the clinical services as they are required to focus on:

- being a 'Thrive-like' service
- reducing our wait times to 8 weeks for at least 80 % of our referrals
- ensuring our services are compliant with CYP IPT principles of outcome monitoring, user involvement, shared decision making and routine use of evidence based treatments.

2.4 Data Quality: The implementation of Carenotes has been particularly challenging for staff in the clinical teams as they have negotiated the transition from paper to electronic systems. The transition to Carenotes had an impact on our capacity to robustly report on activity and outcomes.

### 3. Proposed Action Plan

3.1 To manage the reputational and financial risks, a directorate-wide productivity working group has been set up with team managers and heads of discipline to develop productivity plans in partnership with staff across the CYAF Directorate. In light of this being a challenging time for staff, regular engagement meetings have been set up to elicit feedback and invite creative ideas for savings and growth.

3.2 We have adopted a centralised project management approach across the CYAF Directorate to ensure consistency across the three CAMHS transformation areas described above. This approach will ensure consistency across teams and service lines, and increase the completeness and accuracy of data. Staff engagement and training events have already been scheduled to help staff increase engagement through enhanced understanding and progress in these areas.

3.3 In light of the CCGs reviewing their CAMHS provision for the sustainability and transformation plans, focussing on relationships with the commissioners and being responsive to local drivers is critical.

Rachel James  
Associate Clinical Director

## Main Report

### 4. Overview of the Service

The Complex Needs service line was reconfigured following Sally Hodges appointment to the CYAF Clinical Director role, and now consists of three clinical teams:

- The Lifespan Team
- The Family Mental Health Team
- The Adolescent and Young Adult Service (AYAS) (2 teams)

This service line does the majority of work on our main contracts in CAMHS (excluding Camden) such as Haringey, Barnet, Islington, Enfield as well as other smaller contracts, and as such the service has just over 14 commissioners potentially interested in its work.

The services are mostly based in the main Tavistock Centre, although outreach services are present in Haringey.

#### 4.1 The Lifespan Team

The Lifespan Team is a multidisciplinary CAMHS team with 3.5 WTE. The team is managed by Sarah Helps. The team works with children, adults and families where there is a neurodevelopmental concern, such as autism, learning disability or brain injury. Commissioners have increasingly requested Autism spectrum condition assessments and therapeutic work with children and adults and their families as psychotherapeutic services are often not available in borough. The team offer a range of therapeutic interventions including CBT, EMDR, RDI, family therapy, child and adult psychotherapy, consultation to professional networks and group work.

The Lifespan Team use the Trust standard CAMHS Outcome Measures for under 18s (The Children's Global Assessment Scale, The Strengths and Difficulties Questionnaire, The Goal Based Measure, and the Experience of Service Questionnaire). In addition, for children with a learning disability, they use the Sheffield Learning Disabilities Outcome Measure, which specifically assesses the parent's views of and ability to manage their child's difficulties. For adult service users, they replace the CGAS, SDQ and SLDOM with the CORE or CORE-LD outcome measure as appropriate.

The team's referral and DNA statistics, covering the period 01.04.15 – 31.03.16:

Referrals Accepted	148
First Appointments (total)	129
Subsequent Appointments (total)	2238
DNA's (first + sub)	82
DNA Rate (total)	4.0%
First appt to subsequent ratio	1 : 17

The following table summarises the ESQ data from Lifespan team over 2015-16:

Response	Q1 True %	Q2 True %	Q3 True %	Q4 True %
Listened to	97%	94%	88%	100%
Easy to talk	88%	94%	90%	97%
Treated well	94%	94%	90%	100%
Views and worries	97%	94%	88%	100%
Know how to help	75%	88%	88%	97%
Given enough explanation	69%	50%	50%	73%
Working together	91%	93%	80%	93%
Comfortable facilities	75%	81%	60%	88%
Convenient appointments	66%	75%	90%	69%
Convenient location	50%	69%	60%	75%
Recommend to friend	80%	94%	80%	93%
Options	80%	83%	100%	77%
Involved	90%	67%	83%	88%
Quickly Seen	100%	67%	67%	71%
Good help	94%	94%	90%	97%

An example of a positive comment about the service in the free text section which invites qualitative feedback from service users included:

"Things were explained in a way I could understand"

A suggestion for improvement regarding access to care was "time scales", although no further information was given regarding this.

#### 4.2 The Family Mental Health Team

The Family Mental Health Team is a multidisciplinary team that takes its referrals from across all our contracts, and works with generic CAMHS cases as well as more specialist work with parents with mental health difficulties. The team is managed by Sarah Wynick and has 4.2 WTE staff.

The team's referral and DNA statistics, covering the period 01.04.15 – 31.03.16:

Referrals Accepted	141
First Appointments (total)	196
Subsequent Appointments (total)	4222
DNA's (first + sub)	205
DNA Rate (total)	5.3%
First appt to subsequent ratio	1: 22

4.3 The table summarises the ESQ data from Family Mental Health team over 2015-16:

Response	Q1 True %	Q2 True %	Q3 True %	Q4 True %
Listened to	87%	93%	100%	100%
Easy to talk	87%	89%	100%	88%
Treated well	93%	95%	100%	97%
Views and worries	83%	92%	100%	100%
Know how to help	80%	94%	100%	80%
Given enough explanation	70%	61%	100%	77%
Working together	89%	92%	100%	88%
Comfortable facilities	75%	73%	83%	84%
Convenient appointments	73%	78%	75%	72%
Convenient location	70%	84%	83%	76%
Recommend to friend	77%	84%	100%	84%
Options	77%	80%	75%	96%
Involved	86%	85%	100%	92%
Quickly Seen	45%	82%	83%	75%
Good help	93%	89%	100%	97%

Responses in the free text section of the ESQ which invites qualitative feedback from service users included:

"The process of having a counsellor in the room and several others behind glass in another room watching is really intimidating especially for children."

"The people who talked to me were friendly and gave me good advice. Also I felt comfortable talking about my worries."

"Excellent therapist – very professional"

"They took on all my concerns and were very sympathetic. It provided me with time to reflect and really consider my concerns and work things out and I felt less isolated with my worries"

**A summary of the strengths collected from the relevant free text section of the completed ESQs:**

**Quality of care:** Service users reported feeling listened to, comfortable to talk, able to voice their feelings, taken seriously, and involved in their care. They also found the care to be personal and tailored to the children's needs and they found professionals to be kind and knowledgeable. Service users finally reported feeling happier, more independent, and noticing improvements in their life after treatment and they therefore felt grateful for the support received.

**A summary of the "improvements" from the relevant free text section of the completed ESQs:**

**Understanding the care:** Service users would appreciate receiving more feedback on their progress, more understanding of the nature of their difficulties, and more information around the setting of their first meeting, particularly when it involves meeting a team.

**Continuity of care:** Changing clinicians, particularly from first assessment to the treatment, was felt to be difficult for some children. There was a suggestion to have a check in period after the treatment ends, particularly when this occurs during the exam period, to reduce the risk of relapse.

#### 4.4 The Adolescent and Young Adult Service

This service consists of two clinical teams; Central and East/North-West team, Camden/North-West Team, and overall has a combined WTE of 6.15 sessions. From January 2015 the service has been part of the CYAF, after moving from the Complex Needs Adults service line. This has enabled the service to be more in line with external direction of travel for CAMHS, i.e. more flexible services across the child-adult transition. The service has an overall lead, Justine McCarthy Woods, who also leads one of the teams. The service specialises in analytically informed work with adolescents, young adults and their families. The service takes referrals from a wide range of areas, and has established a self-referral pathway for some services, including the YPCS (Young People's Consultation Service), for Camden and Barnet. The service offers individual therapy, family therapy and group therapy, along with parent work. The AYA service is particularly concerned about the increased levels of complexity and risk with the adolescents and young adults referred and how best to manage this from an outpatient psychotherapy service perspective. Commissioners think well of the service, its flexibility with age range and quality and the service is currently working on objectives around growth and increased presence. For example, by arranging recently for Dr Jacqueline Cornish, National Clinical Director for Children, Young People and Transition to Adulthood, NHS England to come to the Tavistock Centre to meet with Paul Jenkins, Chief Executive and key staff from the AYA service; with the service establishing contact with managers from Student Support & Well-being Services at local universities, in addition to the relevant adult commissioners concerned with student mental health and well-being, and with the work undertaken to market the 4-session Parent

Consultation Service, as a way of generating additional income for the directorate.

Prior to the service joining the service line (from January 2015), AYAS were in the adult service line previously for two years and prior to this they functioned as an independent directorate. They have been through many changes and have had significant cuts to their staff group, through productivity and movement in to the generic CAMHS service in Camden, and within the last year the staff group in the service has decreased from a combined 7.1 WTE to 6.15 WTE. The service is highly valued by commissioners and is considered to be one of the trust's 'USPs', which has been reflected with the increase in NPAs for referrals not covered by the existing contracts.

The team's referral and DNA statistics, covering the period 01.04.15 – 31.03.16:

Data for all AYA teams	
Referrals Accepted	285
First Appointments (total)	256
Subsequent Appointments (total)	6737
DNA's (first + sub)	724
DNA Rate (total)	13.1%
First appt to subsequent ratio	1 : 26

The table below summarises the ESQ data AYA over 2015-16:

Response	Q1 True %	Q2 True %	Q3 True %	Q4 True %
Listened to	99%	93%	97%	94%
Easy to talk	80%	76%	71%	76%
Treated well	99%	97%	97%	95%
Views and worries	98%	96%	94%	91%
Know how to help	79%	81%	71%	74%
Given enough explanation	77%	67%	78%	67%
Working together	89%	90%	91%	86%
Comfortable facilities	88%	93%	94%	93%
Convenient appointments	89%	87%	92%	84%
Convenient location	82%	82%	72%	74%
Recommend to friend	92%	86%	91%	89%
Options	89%	84%	87%	83%
Involved	92%	83%	90%	83%
Quickly Seen	79%	67%	73%	82%
Good help	95%	91%	92%	93%

**4.5 A summary of the strengths collected from the relevant free text section of the completed ESQs:**

The care was considered to be excellent, professional, well integrated and helpful. Service users felt that it was easy to talk freely without being judged and felt listened to, taken seriously, cared for, safe, and involved in the decision making process. Additionally, service users reported having made progress in their lives as a result of the therapy and having received useful tools for coping.

Therapists were often individually named and appreciated for being sensitive, understanding, competent, welcoming, insightful, non-judgemental and very helpful.

**4.6 A summary of suggested improvements collected from the relevant free text section of the completed ESQs:**

Service users reported that they would like to have more information on the types of therapy offered, more choice in their therapy, more knowledge on how treatment endings are addressed and when they will occur, and more opportunities to monitor their progress. Service users also reported that they would like to receive a care plan stating clear goals and ways of achieving them.

Service users found the waiting time to access treatment to be too long

**5. Clinical Services and Activity Data**

Family mental Health, AYAS and Lifespan are all over-performing at present. For 2016/17, the current position for AYA and Lifespan at Month 4 is as follows:

	Contract Value - Baseline	YTD Target	YTD Actual	Total Variance	Total % Variance
AYA	£525,563	£183,947	£224,136	£40,189	21.8%
Lifespan	£276,500	£96,775	£127,214	£30,439	31.5%

Data is not currently available for the Family Mental Health Team due to the complexity of contracting arrangements.

We will need to work with all teams to reduce the overall team performance as part of the productivity programme. This will enable staff to allocate time to income generation.

As a result of block contracts, it is difficult to decline referrals. In addition, we need to keep in mind relationships with external providers who potentially see our contracts as a threat to their income.

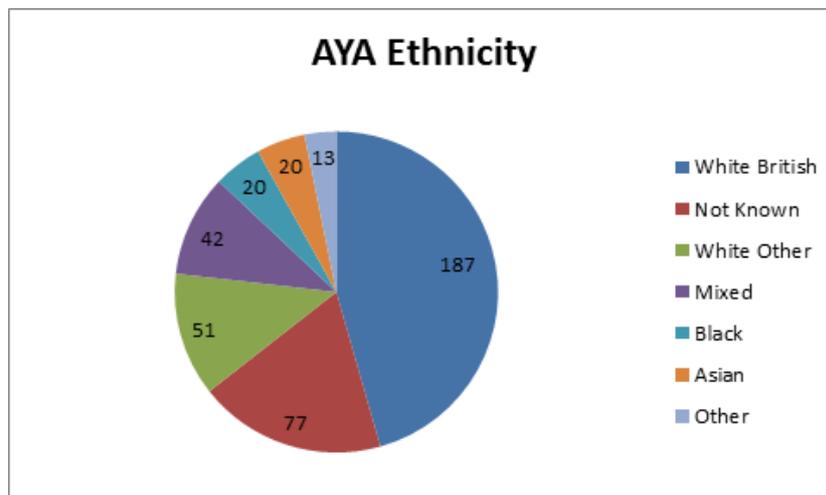
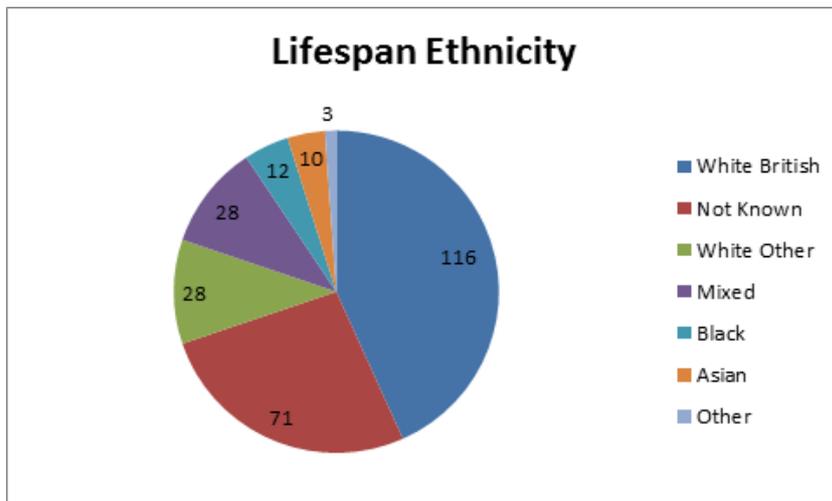
**5.1 Waiting times as evidenced by reports**

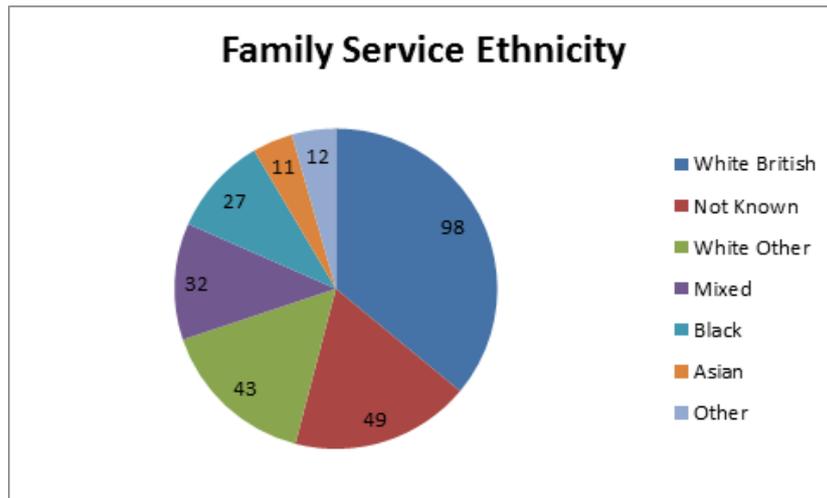
The data overleaf is from the financial year starting 1<sup>st</sup> April 2015 to 31<sup>st</sup> March 2016:

Mean waiting times in weeks				
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Lifespan	5.2	7.6	7.6	7.5
FMHT	4.1	6.4	6.9	5.5
AYA	6.6	4.6	4.8	6.0

## 5.2 Ethnicity as compared to local population and national figures

The self-defined ethnicity groupings of cases across the complex needs service line for 2015/16 are shown in the charts overleaf. Given the complexity of contracting arrangements across the service line, it is not currently possible to compare the data with local population figures as there are 14 different contracts that the service line covers. Going forward, the CYAF Directorate are exploring data analysis/business intelligence tools to enable greater benchmarking of local populations.





5.3 Other performance indicators as required, e.g. quality of data collection in CAMHS to include recording SEN, Disability and LAC status.

All teams are currently being trained in the use of the “Current View” form, which is a clinician rated measure used at the initial assessment and at times when the situation changes. It will significantly improve the quality of data collection across the whole of the CYAF Directorate as it records clinical problems, complexity factors and contextual factors, all of which can improve during the course of treatment. The data will be collected from 1<sup>st</sup> October 2016 across all teams in CYAF and collated both locally and nationally to report on reliable change and recovery rates, taking into account relevant contextual and other factors including SEN, Disability and LAC status.

6. Financial Situation

The service line budget for 2015/16 was just over £3.2 million. As can be seen on Table Two overleaf, the service line had a deficit of £450,850 for 2015/16, which is a reduction of the deficit in 2014/15 of £500,535. This was achieved despite a reduction in the allocation of training income of £137k. The reduced deficit compared to 2014/15 therefore reflects efficiency savings across the service line. The efficiencies made within the service line are not sustainable given the high level of over-performance by the clinical teams. A directorate-wide productivity working group has been set up with team managers and heads of discipline to develop productivity plans in partnership with staff across the CYAF Directorate.

Complex Needs

	Budget 2015-16	Actual 2015-16
<b>INCOME</b>		
C&F Central (incl VIPP, Coram & nurse emotional school)	48,134	26,553
RNOH Contract	93,870	93,870
CAMHS NPA	20,727	79,909
Court report income & F&A	0	-669
ADOS training	20,000	24,775
First Step	356,226	357,796
Barnet YP D&A Service	238,689	238,704
NRHS	67,486	67,486
Brent CP	51,526	51,526
Hertfordshire County Council ASD	25,759	25,759
QK/Pimlico school (ending 15/16)	10,912	-3,697
Child & Family SLAs	1,885,765	1,931,323
<u>Allocation of Trust central income:</u>		
Training	374,804	374,804
Buildings	14,495	10,195
<b>Total Income</b>	<b>3,208,394</b>	<b>3,278,334</b>
<b>OPERATING EXPENDITURE (EXCL. DEPRECIATION)</b>		
Management - Central mgt (incl VIPP)	-189,397	-155,328
Family Mental Health	-411,149	-512,689
Life Span	-361,552	-238,299
RNOH	-87,188	-86,203
ADOS	-5,000	0
CP Brent	-78,890	-34,688
NRHS	-62,970	-59,652
Barnet YP D&A Service	-183,169	-188,311
Fostering & Adoption	-373,692	-305,805
First Step	-316,355	-324,607
Adolescent & young people	-736,539	-691,049
QK/Pimlico school (ending 15/16)	-19,938	-9,624
CAMHS Complex Needs Mgmt	-174,274	-118,607
Buildings	-454,118	-569,092
<b>Total expenditure</b>	<b>-3,454,232</b>	<b>-3,293,954</b>
<b>CONTRIBUTION</b>	<b>-245,839</b>	<b>-15,620</b>
<b>CENTRAL FUNCTIONS</b>		
Income	33,724	62,895
Expenditure	-492,218	-498,125
<b>Deficit</b>	<b>-704,333</b>	<b>-450,850</b>

**Table Two:** A table showing the CAMHS Complex Needs budget and actual income and expenditure for 2015-16

We are in the process of analysing the current figures to better reflect the actual composition of the service line.

## 7. Clinical Quality and Outcome Data

All staff access regular high quality supervision and this is embedded in the culture of the trust. All clinical staff have access to a range of training, supervisory and case discussion opportunities for reflection and continuing professional development. All team managers are members of the Clinical Governance and Quality Committee which meets on a monthly basis and is chaired by the Governance Lead, Caroline McKenna. This group looks at quality across all domains including outcomes and user involvement as well as audit, safety and clinical record keeping.

The service line has recently applied to join the Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT) London Collaborative. This will enable us to fully embed the CYP-IAPT principles of service user participation, evidence based practice and clinically meaningful feedback and outcomes consistently across the clinical teams.

Due to the reconfigure of the service line, data warehouse reporting structures do not, as yet, allow the level of detail required for team level improvements over time for the complex needs service line. A plan is in place to rectify this in the next quarter.

## 8. Feedback from Service Users: Complaints and PPI

- 8.1 A total of six formal complaints were received in the period 0/04/15 to 31/3/16. Three complaints (50%) were not upheld, two were upheld, and one was upheld in part. The main theme within the complaints, upheld either fully or in part, was around communication. The teams developed action plans as a consequence of the learning from the complaints.
- 8.2 There were no formal complaints in the previous year's complex needs report to the Board. The increase in complaints within the service line is standard across the organisation. The process for the central management of complaints has been further embedded within clinical teams, which may account for an increase in the number of complaints being formally recorded across the Trust. It is likely that the increase in complaints over the past year is due to a more open and transparent complaints process, alongside the Trust-wide promotion of a more open culture that promotes staff and service users raising issues.
- 8.3 We do not have a formal mechanism for logging compliments, particularly as the majority of these are verbal. However the data from the experience of service questionnaire gives a good range of feedback and where available this has been included in the individual sections above.
- 8.4 There are a number of creative and innovative initiatives aimed at involving patients in services and service Development. Examples include ongoing monthly Pizza groups available for all young people across services where they give feedback on service delivery and make suggestions for improvements, and the Trust Artist in Residence who has

been working with children across CYAF service lines to produce various pieces which can be seen displayed across the trust sites.

- 8.5 The CYAF department has a parent volunteer from the Lifespan service who is helping to establish a regular parent reference group, for parents of children receiving treatment in CYAF to come together and be able to seek peer to peer support.
- 8.6 The PPI coordinators are running regular trainings for young people of all ages and services to learn how to become members of our interview panels. The team tries to have a patient or parent of a patient on as many clinical interview posts as possible, and a number of these volunteers are from the complex needs service line. The young people are finding this a valuable learning experience and have been enjoying the responsibility of being a part of the trusts staff recruitment process for the day.
- 8.7 Over the past year the involvement team has been working closely with the Data Quality team to look as thematic analysis of the Patient 'Experience of Service' questionnaire. This has led to positive changes for the CYAF Directorate, introducing a more detailed introduction letter to the trust, making patient areas more welcoming and painted 'warmer' colours, wider access to drinking water and the opportunity to be involved in more groups. Young people from CYAF are communicating independently to set up a 'thinking space' and a writing group.

## **9. Serious Untoward Incidents, Incidents and Safety Issues**

- 9.1 Data to date on safety issues and Serious Untoward Incidents (SUIs) have been reported separately to the Board, but are summarised as follows.

There were two Serious Untoward Incidents in Quarter 3 of 2015/16. One SUI involved a suicide of a young person previously known to the Family Mental Health Team, and the other involved a serious overdose of a young person in AYA.

There were 28 incidents across the service line in 2015/16. All incidents were followed up with actions disseminated for learning.

- 9.2 How have issues been dealt with

Following the first SUI, senior professionals liaised with the professional networks. T&P conducted an internal SI Investigation and these were shared in a report to the Board of Directors.

Louise Lyon is continuing to liaise with voluntary sector organisations regarding the second SUI, with a view to developing a policy for governance arrangements when working with third parties with whom we are not in a formal partnership.

### 9.3 Action to be taken

In addition to the actions described above, all trainees and clinicians attend regular mandatory Risk Assessments Skills Update training. Risk Assessment and risk management plans must be completed at the patient's initial appointment and these should be updated if there is any significant change in risk.

### 9.4 What has been learnt

Lessons learnt included that where there are ongoing concerns about self-harm or suicidality, risk must be assessed and documented at each patient contact. High risk young people should not be seen by trainees at an outreach clinic unless senior clinician support is immediately and consistently available at the same clinic. The importance of information sharing between all involved clinicians and regularly with the network around the young person is highlighted by the above incidents as well as the importance of keeping an open dialogue, especially where a young person is reluctant to engage.

## 10. Clinical Governance and Audit

10.1 Team managers are all members of the directorate Clinical Governance and Quality committee, where governance, record keeping and audit are discussed. The generic teams all participated in the recent waiting times and DNA audits as well as the annual case note audit. All the action plans from these audits are fed through to the teams through this committee and the committee reviews the work done as a result of action planning. Several teams have run team based audits, which are also reported on through this committee. For example, the AYAS recently carried out an audit on the accessibility of the service for service users. Each team has a NICE champion in order to ensure that evidence based treatment is embedded in the services.

## 11. Staffing and HR issues

### 11.1 Information about members, grades, and disciplines

There are no significant staffing, discipline, management or HR issues within the complex needs service line at present. However, we are entering a period of reviewing staffing structures in line with the required productivity savings previously described. All staff are up to date with mandatory training and all staff receive an annual performance appraisal.

### 11.2 'Staff Statements'

11.3 Statement from a member of staff in the Adolescent and Young Adult Service, Geraldine Crehan.

"I started my new post in November 2015; for four sessions I work as a clinician in AYAS and for five sessions as Course Lead for M7 (MA in Working with Children, Young People and Families: a Psychoanalytic Approach). Before this post, I worked as a child and adolescent psychotherapist in Guildford CAMHS, the Fostering, Adoption and Kinship Care Team (Tavistock) and at Wandsworth CAMHS. I was drawn to applying for this post because I wanted to work in a specialist service focused on working psychoanalytically with adolescents and young adults. The depth of clinical thinking taking place within this service is notable and in many ways forward looking, given the slow recognition within the NHS that the challenges of adolescence continue well into the early twenties.

Before I arrived, the service experienced significant loss as some very senior and talented child psychotherapists/psychoanalysts retired and resigned. Due to shrinking budgets some of these clinicians were not replaced and other posts were recruited to at lower bands. My sense is that the service is continuing to adjust to this loss of expertise. I think that a recent and helpful development has been the articulation of a clearer remit/identity for the teams as a psychoanalytic psychotherapy service.

Much of the work that is taking place is carried out by trainees and the more experienced staff spend a large proportion of their time supervising. Quite rightly, discussion and consideration of trainees work is prioritised; many of our cases are high risk and careful containment and crisis planning/management is of paramount importance. As a result, the work and supervision of qualified clinicians' gets much less time and this is more keenly felt as work with this age group is not usually accompanied by parent/family work. There is also pressure in the service to take on more and more work as concern increases about growing waiting lists. Balancing the demands of being a helpful team member and maintaining a sustainable workload is a difficult tension for many of us to manage.

An important learning experience for me on joining the team was being able to shadow the lead child psychotherapist as he supervised the trainee therapists. I had not experienced this level of extended induction before and it has been invaluable in developing the supervision I offer to the trainees that I am now responsible for.

To finish, I am happy to be a clinician in the AYA Service and I enjoy my work with patients and colleagues. My experience of the administration team is that they are highly efficient and helpful. Team discussions and psychotherapy discipline meetings are led in a mature and containing style which accommodates different perspectives and promotes enquiry – commitment and respect for patients is always central. The service is struggling to adjust to making difficult decisions about offering much shorter, time-limited treatment to some very distressed patients. What is available to patients (in terms of length of treatment) has changed during the months that I have been here. The team has been working hard with the reality of decreased resources and grappling with how best to manage patients' needs whilst also maintaining a helpful therapeutic framework where significant disturbance in mental health can be worked through effectively.

In its present form as a specialist service, I would confidently recommend this service to my family and friends.”

#### 11.4 Statement from a member of staff in the Lifespan Team, Nechama Polak.

Moving to the UK after studying and practicing Clinical Psychology in Holland, I was looking to find a job as a Clinical Psychologist in London. I was looking for a ‘way in’ to work in the NHS and be able to complete what was called back then the ‘Statement of Equivalence’ of the BPS, which was the conversion programme of Clinical Psychologists who graduated elsewhere, to UK recognition. I sent many CVs, but without success. By pure luck, a friend introduced me to the Head of Psychology at the Tavistock, who offered me to come and work on an honorary contract, gaining NHS work experience and UK accreditation. I am fully aware of the ethical and financial complication of different types of honorary contracts, but to me it was a lifesaver. I worked at the Tavistock for 2 years on an unpaid, honorary contract, completed the Statement of Equivalence and became BPS and HCPC registered. I am extremely grateful for this opportunity and feel very lucky to have gained all the experience and the support needed.

I got a fixed term job in the Child and Family Department, worked for different teams, which allowed me to eventually apply for a permanent position. I am currently working as a Specialist Clinical Psychologist in the Lifespan Service, combining my experience and passion for working with children and families, as well as adults, in different types of therapeutic interventions with assessment work. The client population of my team is a mixture of ‘typical ASD clients’ and clients where there ASD presentation has resulted as a consequence of trauma and complex history. As I am also an adult psychotherapist and an EMDR practitioner, I feel very privileged to be able to use different modalities of work with our clients.

In my 6 years at the Tavistock, the trust has gone through major changes; different phases of voluntary redundancy, changes in teams and team members, as well as changes in the way we work, audit and monitor our practice. Due to increasing work pressure, deadlines and administrative work, there is less time to think, research and discuss clients, formulations and care plans. I am fully aware that this is the situation everywhere, but am sometimes worried about the lack of ability to think. I would have liked to develop our adult services much more, as there is a clear gap in the market, however time pressures and other uncertainties make it quite difficult. I hope future changes and improvements will leave also space for thinking and research, as I see it as a crucial part of our work.

Despite all the challenges and the changes, since my first day at the Tavistock I have met many amazing clinicians /friends, who have always supported me and from who I have learned a lot. Working jointly with my colleagues, supervisors and trainees has been an endless pleasure.

Dr Rachel James  
Associate Clinical Director  
16<sup>th</sup> September 2016



## Board of Directors : September 2016

**Item :** 8

**Title :** Chief Executive's Report

**Summary:**

This report provides a summary of key issues affecting the Trust.

**For :** Discussion

**From :** Chief Executive

## Chief Executive's Report

### 1. Deputy Chief Executive and Director of Finance

- 1.1 Simon Young, our Deputy Chief Executive and Director of Finance will be retiring from the Trust at the end of September after 20 years' service. Over this time Simon has made an enormous contribution to the work of the Trust and I would like to record formally my appreciation of the role he has played. Simon's successor Terry Noys will be starting on 31<sup>st</sup> October.

### 2. Director of Nursing

- 2.1 After 6 years as Nurse Director at the Trust Lis Jones has also announced her intention to step down during the course of the autumn and her last Board meeting will be in October. Following interviews held in July we have appointed Chris Caldwell as her replacement. Chris is currently Dean of Healthcare Professions at Health Education England (North Central and East London). As well her strategic role in nursing issues at the Trust and leadership on physical health issues, Chris will work closely with Brian Rock in helping us explore opportunities to extend the reach of our training and educational work. Chris will be working three days a week at the Trust and will also be joining the Trust at the end of October

### 3. QAA

- 3.1 In 8<sup>th</sup> August the QAA (Quality Assurance Agency) published their report on the educational work of the Trust. This followed a visit from a QAA Inspection Team at the end of April. The overall judgement from the QAA was:

- The maintenance of the academic standards of awards offered on behalf of its degree-awarding bodies **meets** UK expectations.
- The quality of student learning opportunities **meets** UK expectations.
- The quality of the information about learning opportunities **meets** UK expectations.
- The enhancement of student learning opportunities **meets** UK expectations.

- 3.3 The QAA highlighted a number of areas of good practice and made four recommendations to be addressed in the year leading up to June 2017. An action plan is currently being finalised around these areas.

- 3.4 Their report represents a very good result for the Trust. The QAA have judged the higher education provision in the same way and to the same standards as any other university in the UK. What is notable is that this result has been achieved in spite of the variety and geographical spread of delivery partners which often present quality and consistency issues for institutions.

## 4 Finance

- 4.1 The Trust reported a surplus of £1,030k after August 2016 but the end year forecast has now fallen to £600k, £200k below our control total of £800k. A number of factors are driving this including the fact that expenditure in the GID service will be significantly higher in the second half of the year, with new staff now recruited to deliver the higher level of demand and activity. We have also needed to adjust downwards the forecast for training income to reflect the likely outcome on student recruitment.
- 4.2 The Management Team has reviewed the position and we remain confident that we can take appropriate action to ensure that we deliver our control total.
- 4.3 We are also taking work forward to address the position for 2017/8 which we expect to be challenging in the light of anticipated changes to National Training Contract income as well as efficiency targets for clinical services.
- 4.4 The Planning Guidance for 2017/8 is expected shortly. It is likely that this will attempt to bring forward the contracting round and to propose two year contracts for providers.

## 5 North Central London Sustainability and Transformation Plan

- 5.1 We have continued to be involved in the development of the STP in North Central London. A further submission is due to be made to the national bodies at the end of October.
- 5.2 I attended a "lock in" meeting with other leaders across NCL on 6<sup>th</sup> and 7<sup>th</sup> September focused on key issues which need to be resolved in preparation for the next submission.

## 6 National Training Contract

- 6.1 We continue to work with Health Education England (HEE) to renegotiate the terms of our National Training Contract. An internal Implementation Group has been driving the work and we have been making good progress.
- 6.2 Our aim is to be able to agree heads of terms for the new contract with HEE during the course of the autumn.

## 7 Student recruitment

- 7.1 We expect to finish student recruitment for the 2016/7 Academic year at around 560 (excluding the Associate Centres). While below our target this represents a 20% increase in our performance in 2015/6 and reflect the considerable changes made in our recruitment processes in the last year.

## 8 Century Films

- 8.1 The project, working with Century Films, to produce a series of three documentaries for Channel 4 about the work of the Trust is approaching completion. We currently anticipate the programmes to be broadcast in November.
- 8.2 The programmes cover three aspects of our work with young people. This includes our school Gloucester House, our GIDS service and our community based CAMHS service.
- 8.3 We have seen some of the material and have been assured that Century Films have succeeded in making sensitive and high quality documentaries which will both showcase the work of the Trust and make a contribution to breaking down the stigma for young people experiencing mental health problems.
- 8.4 We have developed a plan for how we can build on the publicity which the documentaries will create to promote the work of the Trust.
- 8.5 We have also learnt that the Radio 4 documentary "Mending Young Minds" which featured the work of the Trust and which was broadcast in August/September 2015 has been shortlisted for the 2016 Mind Media Awards.

## 9 Internal Communications

- 9.1 I have now held three CEO Question Time sessions which have been well attended and have raised some important issues.
- 9.2 The Staff Governors have also held a number of meetings with staff and Paul Burstow and are due to be meeting with the Staff Governors on 29<sup>th</sup> September to discuss how we can best co-ordinate these initiatives.

## 10 Accommodation changes

- 10.1 During the summer we have had to make a number of accommodate changes to find space for the significant number of new staff we have recruited for the GID service.
- 10.2 These changes have not been easy and have highlighted the pressures on and inflexibility of the current building. In general we have successfully completed the project and have been very grateful for the considerable good will shown by the staff affected. There have been a small number of issues which have not yet been satisfactorily addressed and we are continuing to work on these.

Paul Jenkins  
Chief Executive  
20<sup>th</sup> September 2016



## Board of Directors : September 2016

**Item :** 9

**Title :** Public Affairs Strategy

### **Summary:**

The Trust has a clear objective to raise its profile and position itself as a thought leader in the field of mental health. This document sets out how a Public Affairs strategy could support this ambition and what the structures and next steps might be to that end.

This report has been reviewed by the following Committees:

- Management Team, 13 September and 20 September

### **This report focuses on the following areas:**

*(delete where not applicable)*

- Communications
- Finance

**For :** Discussion

**From :** Director of Marketing and Communications

## Tavistock and Portman Public Affairs Strategy

### 1. Introduction

- 1.1. One of our two-year objectives is to raise the profile of the Trust and position it as a thought leader in the area of mental health. While much has changed since their publication, this objective continues to be deemed essential to ensuring the long term survival of the Trust and its unique offer.
- 1.2. At a staff engagement event about communications in May, a discussion led us to consider what our ultimate purpose was. It was felt the objective lacked an aim. While there are a number of worthy reasons to engage in communications activity – both on an educational and transparency level – directing our communications and engagement activity towards achieving more specific goals would help position the Trust as an exceptional source of expertise based on its strong research, academic and clinical experience. This will ultimately help us achieve many other key objectives across our clinical, education & training and consultancy work.
- 1.3. A public affairs strategy will help guide this activity, focus efforts, set up the appropriate internal and external channels, and specify processes for coordinating, logging activity, reporting back and evaluating. The Trust and its staff are already highly engaged with external stakeholders and in a number of outward-facing activities. This piece of work is at least as much about maximising the potential of this activity as it is about do more.

### 2. Objectives

#### 2.1 *Prime objective*

The Trust has a long and proud history of shaping thinking in a number of areas across psychology and child development. It has a track record for innovation and interrogating how best to translate research and knowledge into purposeful interventions and influential theories.

As well as having a duty to share what we know and ensuring that the valuable insights we gain from the work that we do are disseminated widely, we need to be seen to be doing these things. Our long term survival in an increasingly challenging NHS landscape depends on us demonstrating the value we add and making the case again and again for more considered psychologically informed interventions that consider the whole person, their history, their

interpretation of what they are going through and their relationships and hopes.

We have got things to say. We have something to bring to the table when it comes to key societal issues such as life chances, service design, early intervention, etc... By focusing, better joining up and professionalising these efforts, we can further increase our reach and reputation.

We must also ensure our clinical and educational offer is the most relevant it can be and that, to the extent possible, our research supports this. This is as much about shaping the landscape and influencing policy ourselves (both locally and nationally) as it is about gathering intelligence and engaging key stakeholders.

## 2.2 *Specific areas of focus*

*While the Trust operates across the age range and in a number of different settings, having a primary focus on a small number of areas of particular expertise and relevance in the current commissioning environment would seem most productive. These are areas where we feel we can make the biggest impact. The areas selected are:*

1. ***Improving life chances through early intervention and prevention: perinatal and parenting support, public mental health, and vulnerable children*** (including looked-after children, at-risk children, adopted children, children with behavioural problems and a history of exclusion, child sexual abuse, refugee children).
2. ***Our unique psychologically informed approach:*** adopting a holistic, person-centered approach, working in a cross-disciplinary / multi-agency way.
3. ***Promoting mental wellbeing in individuals, organisations, communities and systems,*** building up resilience in front line staff and encouraging reflective practice.

## 2.3 *Education and training*

With regards to our education and training offer, a more detailed stakeholder engagement plan is being developed separately, but largely our focus is on the retention of our HEE National Training Contract, including regional delivery, HEE priorities and educational consultancy. Efforts will be made to ensure activity is joined up wherever possible.

## 2.4 *Our distinctive approach*

Regardless of which segment of the population or mental health issue our services are designed around, they all relate back to our mission and values, chiefly to make a measurable difference to the health and wellbeing of individuals and communities. They also reflect a 'Tavi' approach or brand which needs to be refined and promoted. It touches on:

- being community-based and present where the need is (e.g. schools, primary care, criminal justice system)
- a holistic person-centered approach involving patients in their care
- a strong focus on talking therapies and reflective practice
- prevention and early intervention
- evidence-based approaches

### 2.5 *Desired outcomes*

- The Tavistock is known for its thought leadership and as a centre of excellence in mental health service design & delivery and education & training.
- The Tavistock influences public policy pertaining to mental health, wellbeing and life chances.
- We secure existing contracts and new service commissions.
- We grow our activity as a source of expertise / consultancy in service development.

## 3. Stakeholders

### 3.1 Internal stakeholders

It is proposed a Public Affairs Network (PAN) is put together led by the Director of Communications and Marketing. Further details about internal mechanisms can be found below. Internal stakeholders are our greatest asset. Staff, NEDs and Governors provide a wealth of expertise and insight as well as fantastic networks and connections. They are authoritative and have broad interests and influences.

Whether it's their publications, their special relationships with key commissioners, or their ability to expertly talk about their subjects with authority and eloquence, it is vital we capitalise on as many opportunities to a) involve internal stakeholders in any new activity b) maximise reach and potential of existing events and relationships.

### 3.2 *External stakeholders*

We have a wide range of stakeholders which reflect the breadth of the work of the Trust. In each of the categories listed below, we have both local level stakeholders and national ones. It will be crucial that this piece of work reflect as much on enhancing local relationships as on seeking to influence national opinion leaders.

At the Board away day, a suggestion was made to survey our stakeholders and gain a better understanding of their perceptions of us, our areas of strength and where we might improve, and how we might best partner with them in the pursuit of common goals. At **Appendix 1** is a brief for how this work might be carried out. While we intend to go out to tender, it is important to note budget for this

activity has not been identified and we may need to review this and find another way to take stock and benchmark.

**Partners** – across education, training, research and clinical services

**Commissioners** – both local and national, current and prospective

**Professional bodies and royal colleges**

**Think tanks, patient and lobby groups**

**Policy makers** – DH, NHSE, NCL STP, NICE, MPs and Peers, local authorities, CCGs.

**Alumni** – a separate but related piece of work is happening in this space and the two will be closely coordinated.

#### 4. **Internal mechanisms**

In order to strengthen our voice externally, we need to better co-ordinate efforts. This means more transparency, planning, division of duties and engagement of staff and other internal stakeholders across the Trust in this work.

A public affairs network (PAN) would comprise senior and less senior staff, NEDs, Governors, etc.... Following a kick off meeting to agree TORs and basic principles for how to take the strategy forward, this group would operate mainly virtually through an online collaboration tool to avoid adding to the meeting tally. This would be supplemented by task specific meetings where necessary. Any decisions on activity would go to Management Team.

Following discussion with IM&T, it is exploring the use of a free online resource called Slack as a collaboration tool for the group. This should not include any commercially sensitive or personal data. Simultaneously, IM&T is exploring customer relations management systems for the Trust. This is something which has been on the cards for some time and would be of huge benefit to a number of lines of activity including this one. Again this is something that will require as yet unidentified budget. Such a tool would expand substantially on the capabilities of an online collaboration tool and allow us to properly manage relationships with stakeholders including greater transparency, up-to-date intelligence etc...

#### 5. **External channels**

There are a number of channels at our disposal. We benefit from a strong reputation in the field of mental health and have a recognised brand. While a full reputation audit would give us a chance to explore which of these work best, there is no doubt that different channels will be needed to cater to the range of stakeholders we are looking to reach and the diversity of means at our disposal to engage them. Activity in this area will be as much about harnessing and maximising existing activity as setting up new and exciting events and projects. This will cover:

**Face to face individual meetings** – collating a list of relevant meetings in a central location, setting up meetings with key stakeholders.

**Policy seminars** (e.g. life chances) – organising policy shaping events with key opinion leaders and policy makers.

**Conferences** – ensuring wide reach for research and publications etc. through international conferences

**Publications** – maximising promotion of Tavi publications (inc staff and alumni publications)

**Media** – As well as sustaining a proactive approach to media work, using the Channel 4 series to promote the work of the Trust.

**Social media** – Ensuring the new digital manager (starting 19<sup>th</sup> September) acts as a social media champion to increase activity through central corporate channels as well as from staff.

**Web** – our site and others. Make full use of the promotional potential of the new website and actively seek new content for it.

**Visits** – help support ministerial and other visits to the Trust (again using Channel 4 series as a hook).

**Alumni events** – host a series of events starting 22 Nov both for and with alumni.

**Exhibition** – As part of the 2020 anniversary, work with the Centenary team to organise an exhibition working with partners, including the Wellcome Collection if possible.

## 6. Milestones

- Setting up the Public Affairs Network
- Stakeholder analysis and mapping
- Reputation audit - tbc
- Detailed strategy inc. planning of engagement techniques
- Assessment and follow through

## 7. Evaluation

A reputation audit would allow us to establish a baseline and give us crucial insight into how we are currently perceived. It would have to follow from an extensive internal exercise to map our stakeholders to ensure a representative sample was approached. This should be supplemented by KPIs around media coverage, web traffic to our site, evaluation of events, etc.

Laure Thomas  
Director of Marketing and Communications  
20 September 2016

## Appendix 1

### Reputation audit – draft brief for tender

#### **Introduction:**

The Tavistock and Portman NHS FT is looking to commission a reputation audit to explore the views key stakeholders and opinion formers hold about the Trust, its work and its role within the wider mental health landscape. We are looking for a wide-ranging audit that includes insights from contacts across the NHS, social care, Government, higher education, professional bodies and the voluntary sector.

The health and social care landscape is evolving and we're continually reviewing our position within it. In a challenging and changing context we need to understand where we can add most value, and an important part of this is the need to have an informed sense of our identity – both in terms of what we stand for and want to offer – and how others perceive us. In these straightened times it is even more necessary to offer services that closely meet the needs of our key stakeholders, make our offer relevant, and position ourselves clearly.

In light of this we are looking to commission an organisation to conduct a series of in-depth interviews with key stakeholders and opinion formers to understand their views, concerns and expectations. This research will cover the full spectrum of stakeholders, both those we have established relationships with and those we are looking to develop relationships with in the future.

The research is designed to

- **explore stakeholders' attitudes and awareness** towards the Tavistock and Portman NHS FT's role and remit;
- **examine the value** of the Trust and its work;
- **understand how stakeholders feel** about the way in which the Trust **engages with them**;
- identify what the Trust can **do to improve** and
- what its **role should look like in the future** by **establishing a benchmark** to work from.

#### **Background about the Trust:**

[The Tavistock and Portman NHS FT \(T&P\)](#) is a specialist mental health Trust which provides community based mental health services and postgraduate education and training to the health, education and social care workforce. 70% of our clinical work is with children, young people and families and the rest spans the age range. We also have an active research and development portfolio.

#### **Our own perceptions of the Trust's reputation:**

Whilst not wishing to influence in any way the outcome of the audit, we feel that some initial observations would be helpful. The Trust is subject to inspection of its roles as a provider of clinical and higher education services by the Care Quality Commission and the Quality Assurance Agency for Higher Education (QAA) respectively. The Trust also conducts research and is part of the National Institute for Health Research North Thames Clinical Research Network. Recent inspections by the CQC and QAA have given us some detailed feedback on the work that we do and we are pleased that both organisations recognise the high quality of what we do and the commitment and care of our staff. We are lucky to have a long serving and incredibly loyal staff body with high retention rates and believe their expertise and work is rated highly by those they interact with in partner agencies and other stakeholders. Our focus on education and training as well as research we hope demonstrates our commitment to quality and continuous professional development. Our specialist expertise and small size may also give rise to some less positive reactions, and we would like to explore the extent to which we may be seen as 'a bit of an anomaly' in the current NHS environment, whether this results in us appearing exclusive and privileged, and if so how we may be able to counter this.

### **Research objectives**

Broadly speaking we would like to identify where people see or focus the value of our 'brand' and offer and where we can make improvements, with the specific objectives:

1. Explore how stakeholders **define** the Tavistock and Portman NHS Foundation Trust (T&P) and their attitudes and awareness towards its role and remit;
2. Examine the **value** of T&P and its work;
3. Identify what T&P can do to **improve** and what its role should look like in the future health and social care landscape as well as where we are currently adding substantial value; and
4. Understand how stakeholders feel about the way in which T&P engages and communicates with them.

### **Stakeholders**

The research will focus primarily on professionals' feedback, for this audit we will not be seeking the views of patients or the public. We regularly gather this feedback via other methods. We will help identify individuals to speak to which will cover a range of roles and functions to get a broad picture. While not all of these organisations will be included in the final list, they give a good sense of who our main stakeholders are.

#### Central Government / Policy

- Department of Health
- National Institute for Health and Care Excellence

- Care Quality Commission
- Quality Assurance Agency
- Department for Education / Work and Pensions / Ministry of Justice (vulnerable children)

Clinical commissioners (existing):

- NHS England (National specialised commissioning: Gender Identity Development Service & the Portman Clinic)
- Public Health England
- City & Hackney Clinical Commissioning Group
- Westminster
- Haringey Clinical Commissioning Group
- Kent County Council
- Hertfordshire Clinical Commissioning Group
- Royal National Orthopaedic Hospital NHS Trust
- New Rush Hall School
- Milton Keynes Local Authority

Clinical commissioners (potential):

- **NB: this should include commissioners from outside London and areas where we have previously tendered**

***North Central London (NCL) Commissioners***

- Camden Clinical Commissioning Group & Camden (local authority)
- Barnet Clinical Commissioning Group & Barnet London Borough (local authority)
- Enfield Clinical Commissioning Group & Enfield Council
- Haringey Clinical Commissioning Group & Haringey London (local authority)
- Islington Clinical Commissioning Group & Islington (local authority)

***North Central London (NCL) Providers:***

- Barnet, Enfield and Haringey NHS Foundation Trust (Mental Health)
- Camden and Islington NHS Foundation Trust (Mental Health)
- Great Ormond Street Hospital for Children NHS Foundation Trust (Specialist Trust)
- Moorfields Eye Hospital NHS Foundation Trust (Specialist Trust)
- Royal Free London NHS Foundation Trust (Acute Trust)
- Royal National Orthopaedic Hospital NHS Trust (Specialist Trust)
- The Whittington Hospital NHS Trust (Acute Trust)
- University College London Hospitals NHS Foundation Trust (Acute Trust)

### Education commissioners:

- Health Education England / HENCEL
- Local authorities

### Partners

- University of Essex
- Mind (Camden, or national?)
- Coram
- Anna Freud Centre
- Impetus – the private equity foundation
- Dartington Social Research Unit

### Think tanks and lobby groups

- Mental Health Foundation
- Rethink
- Mind
- Education Policy Institute

### Professional bodies

- Royal College of Psychiatrists
- Faculty for Public Health
- British Psychoanalytic Council
- Association of Child Psychotherapists
- Association of Family Therapy
- British Psychological Society
- British Association of Social Workers

### Media

- **If you wanted this in scope, we could recommend some contacts**

### Other:

- GP Practice
- Chief Executive of another mental health Trust
- Chief Executive of another acute Trust
- Regional partners

### **Scope**

The scope of the research includes:

- In-depth, one to one, interviews with identified stakeholders
- In line with our objectives, a full write up of the research with recommendations.

### **Method**

We will take a qualitative approach and primarily look to use structured, in-depth, one to one interviews to gather feedback from key stakeholders and opinion formers from across the NHS, social care, voluntary, Government and higher education sectors in England.



## Board of Directors: September 2016

**Item: 10**

**Title:** Clinical Quality Strategy Update: embedding quality improvement across the Trust

**Summary:**

The CQC noted that we approved our Clinical Quality Strategy in January 2016 and recommended further development in order to 'ensure that quality improvement becomes embedded across the trust and leads to systematic assessment and monitoring of performance and continuous improvement in the safety and quality of services provided'. (CQC Report, May 2016)

In response to this, the Board determined that we should develop a revised Clinical Quality Strategy and Framework to set the direction to achieve Trust wide engagement in an integrated approach to clinical quality improvement. This brief report outlines progress to date and will be followed by a full report to the Board in November 2016.

**This report focuses on the following areas:**

- Quality
- Patient / User Experience
- Patient / User Safety
- Equality
- Risk

**For:** Approval

**From:** Louise Lyon, Director of Quality and Patient Experience

## Update on the extension of the Clinical Quality Strategy to include our strategy for embedding quality improvement across the Trust

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1. The Board approved our Clinical Quality Strategy in January 2016 with the understanding that the strategy would be further developed once we had received feedback from the CQC inspection. The strategy outlined our aims and objectives and the structures supporting clinical quality monitoring and development, but at that stage, did not set out our approach to embedding a quality improvement culture across the Trust.
- 1.2 The aims and indicators for the two year strategy (2015-17) are appended. We are making solid progress in pursuit of the majority of the aims.
- 1.3 Whilst the CQC recognised that we had recently approved our Clinical Quality Strategy, they noted that further development was needed in order to ‘ensure that quality improvement becomes embedded across the trust and leads to systematic assessment and monitoring of performance and continuous improvement in the safety and quality of services provided’.
- 1.4 In response to this, the Board determined that we should develop a revised Clinical Quality Strategy and Framework to set the direction to achieve Trust wide engagement in an integrated approach to clinical quality improvement. This brief report outlines progress to date and will be followed by a full report to the Board in November 2016.
- 1.5 The revised clinical quality strategy will set out how we will address the gap between ‘Good’ and ‘Outstanding’ clinical service quality. The three principle aims are:
  - To better embed clinical quality improvement which is owned at a local level and is coordinated across the Trust
  - To make better use of data to drive improvement
  - To bring together quality improvement initiatives to demonstrate measurable improvement for patient benefit
2. It is clear that for quality improvement to become embedded, it needs to be owned across the trust from the frontline staff to the Board, to reflect the views of our patients, their families, friends and carers and the views of our stakeholders, such as our commissioners and those who oversee the quality of our services locally and nationally.
- 2.1 A process of consultation began with our Quality Summit with the CQC on 7<sup>th</sup> July 2016. This was a helpful event which made clear that our services are well regarded by our CQC inspection team and highly valued by the stakeholders, including patient representatives, who attended the event. The CQC in effect challenged us to set out our framework for demonstrating the quality of the distinctive psychological approaches we provide. This is where we have much to contribute to the overall quality of mental health services, through establishing the effectiveness in practice of our interventions and setting out the conditions required to maintain high quality services such as reflective practice, clinical supervision and staff wellbeing.
- 2.2 Stakeholders called on us to participate in the development of services for groups as yet less well served, such as older people, and to look outwards to learn more about how we could improve our services by consulting with service users, referrers, commissioners, voluntary sector providers,

NHS providers and local and national bodies. We were encouraged to benchmark our performance against other organisations, where possible.

3. The Quality Group was convened to lead the development of our clinical quality improvement programme.

### 3.1 Membership

- Louise Lyon, Director of Quality and Patient Experience (Convenor)
- Rob Senior, Medical Director
- Caroline McKenna, Associate Medical Director
- Marion Shipman, Associate Director of Quality and Governance
- Irene Henderson, Clinical Governance Manager
- Jessica Yakeley, Adult and Forensic Services Directorate representative
- Vacant, Children, Young Adults and Families Directorate representative

- 3.2 The Group's task is to provide leadership and coordination of quality improvement across the Trust. It will develop a vision of excellence based on a wide consultation process. The group is exploring successful quality improvement methodologies to determine which may be most suitable for our services. It is unlikely that one approach will be suitable for all services, but we need clarity of purpose and defined goals.

- 3.3 The Quality Group devised a programme for the Leadership event on 12<sup>th</sup> July 2016. All clinical team managers were invited to this event. The aim was to engage key staff in thinking about what we regard as the most important elements of excellent clinical quality and how this would then inform our approach to quality improvement. The afternoon started with interviews with patients about their journey through our services. In order to improve services we need to draw on patient experience, clinical knowledge and experience and relevant, reliable and accessible quantitative and qualitative data. The afternoon also included a presentation on clinical audit and its use as a key quality improvement tool.

- 3.4 Team managers were asked to take the discussion back to their teams. Some teams are already engaged in quality improvement projects. For those who were not yet part of a project, it was suggested that teams might look at case files to review patients' journeys as a means of highlighting opportunities for improvement or highlighting good practice to be shared. Team managers were invited to report back to the Quality Group via directorate leads by 26<sup>th</sup> September 2016. The Quality Group will then plan further events to celebrate and share good practice and learn from initiatives taking place across the Trust.

- 3.5 The Quality Group will review the reports from Team Managers in order to look at synergies across the Trust and, as part of the wider consultation, to develop our vision of excellence. The task then will be to identify methodologies which remain true to our values, support creative approaches and can stand up to public scrutiny. We will explore how we might partner with other organisations around Quality Improvement training and learning opportunities.

- 3.6 Quality improvement, broadly defined, needs to become part of everyday work and ideally more an enhancement of the experience of working in our clinical teams as a clinician or an administrator rather than another burden. We have a highly motivated staff group who, as evidenced by the CQC, are highly caring and committed. This commitment and the maintenance of staff morale are both key to continuing to improve our clinical services.

4. A number of developments over recent months will support us in taking forward our work on clinical quality improvement.
  - a) The development of performance dashboards, especially those tailored to team level.
  - b) Caroline McKenna and Marion Shipman have brought in their learning about Quality Improvement methodologies, such as those developed by the Institute for Healthcare Improvement (IHI) and used in other NHS mental health trusts.
  - c) The CareNotes optimisation programme is proceeding successfully, although further work remains.
  - d) We have recently appointed a Patient Safety Officer and a Clinical Audit Officer.
  - e) A project to implement clinical audit and NICE guidance functions on the Allocate system commenced in the week beginning 12<sup>th</sup> September 2016.
  - f) Embedding of PPI and growth of patient/carer reference groups, and more refined analysis of patient feedback from a range of sources.
  - g) The Clinical Quality and Patient Experience work stream is developing a capacity to synthesise and analyse data from a number of sources, which will be significantly enhanced with the further development of dashboards.
  - h) Project to improve and extend collection of equalities data to ensure equitable access and services tailored to specific groups where indicated.
  - i) Review of outcome measures and focus on health economics.

**Louise Lyon**  
**Director of Quality and Patient Experience**  
20<sup>th</sup> September 2016

## Appendix

Extract from the Trust Clinical Quality Strategy 2015-17, January 2016

### Aims and Indicators

Domain	No	Aim	Example of Interventions	Indicators
SAFE	1	To improve the identification, assessment and management of patients where there is evidence of domestic violence and abuse.	<ul style="list-style-type: none"> <li>• Baseline review of data</li> <li>• CareNotes review/ amendments</li> <li>• Patient involvement</li> <li>• Staff interventions</li> </ul>	Safety improvement plan to be drafted by April 2016 using quality improvement methodology. This forms part of the Trust Sign up to Safety Campaign commitments. Link work into NICE Quality Standard for this area – due in 2016.
	2	To improve the identification and management of high risk patients.	<ul style="list-style-type: none"> <li>• Introduce Mandatory Attendance at Clinical Risk Assessment Training to improve clinician’s knowledge of self-harm and suicide.</li> <li>• Assessment of staff knowledge</li> <li>• Review patient records and possible CareNotes review/ amendments</li> <li>• Clinical Audit</li> </ul>	Safety improvement plan to be drafted by April 2016 using quality improvement methodology. This forms part of the Trust Sign up to Safety Campaign commitments.
	3	To improve awareness among clinicians of the role patients digital lives can have on mental health	<ul style="list-style-type: none"> <li>• Raise awareness of the impact of patients’ digital lives on well-being through conferences and training events. Digital lives assessment included in risk assessment for under 18s.</li> <li>• CareNotes review / amendments.</li> </ul>	Safety improvement plan to be drafted by April 2016 using quality improvement methodology. This forms part of the Trust Sign up to Safety Campaign commitments.
EFFECTIVE	4	To improve awareness of best practice and use of guidance and research to inform clinical practice.	<ul style="list-style-type: none"> <li>• Further embed NICE Guidance awareness, research and service development e.g. IMPACT study, MBT for ASPD, i-Thrive.</li> <li>• Increase adherence to evidence based guidelines and practice where appropriate but evidence too of a culture that is interested in documenting and measuring “real world” practice just as it occurs, i.e. practice based evidence.</li> </ul>	CareNotes records to demonstrate awareness of best practice. Practice based evidence of increased effectiveness.

	5	To develop further effective clinical practice: best value, patient determined outcome indicators, and impact on wider health economy	<ul style="list-style-type: none"> <li>• Consultation with health economist, work with service users and carers to develop indicators of the outcomes that matter most to the lives of service users and carers.</li> <li>• A focus on measurement for improvement – demonstrating that change is going in the right direction i.e. demonstrating that change is an improvement.</li> <li>• Clinical audit and quality improvement methodology training and implementation.</li> </ul>	Small scale projects Training attendance and increase in use of clinical audit and quality improvement projects.
	6	Effective physical health care assessment and intervention, mental and physical well-being.	<ul style="list-style-type: none"> <li>• Interventions will be agreed, supporting staff to recognise physical health issues relating to known public health areas that link with mental health e.g. alcohol, smoking, nutrition, and signposting patients to appropriate support services internally and externally to the Trust.</li> <li>• Establish links with relevant third sector organisations.</li> </ul>	Safety improvement plan to be drafted by April 2016 using quality improvement methodology. This forms part of the Trust Sign up to Safety Campaign commitments.
CARING	7	To improve service and support provision for carers.	<p>Carers' needs assessments</p> <ul style="list-style-type: none"> <li>• Carers involved in staff selection, carers as members and governors.</li> <li>• Carers involved in patient involvement activities e.g. word of mouth and improved information for carers, especially young carers.</li> </ul>	Carers survey shows that over 75% of identified carers believe their needs have been taken into account.
	8	To ensure that staff will always be compassionate and caring.	<ul style="list-style-type: none"> <li>• Implement value based recruitment</li> <li>• Support for staff</li> <li>• Reflective practice</li> <li>• Staff well-being</li> </ul>	<ul style="list-style-type: none"> <li>• Staff survey results indicate high levels of engagement and well-being.</li> <li>• Staff and Patient FFT results show that that our results match or exceed benchmark data.</li> <li>• Patient survey results show that 95% feel treated well by the people who saw them.</li> </ul>

RESPONSIVE	9	To improve patient access through improved management of waiting times.	<ul style="list-style-type: none"> <li>• Issues raised with Commissioners models of waiting list management in development.</li> <li>• Service redesign to make best use of resources.</li> <li>• Service user and care consultation on waiting list management.</li> </ul>	Minimal waiting time target breaches for Trust reasons. Progressive targets to be agreed with relevant local and national Commissioners.
	10	To improve patient and carer involvement in care planning.	Review current shared decision making and agree interventions to improve this.	ESQ shows that 90% service users and carers feel involved in important decisions about their care.
	11	To increase learning from complaints, compliments, concerns and incidents across the organisation.	Qualitative and quantitative data gathered from Experience of Service Questionnaires (ESQ), PALs, incident reports, staff 'Worries and Concerns' six-monthly survey.	<ul style="list-style-type: none"> <li>• Evidence of change, where feasible, in practice in response to feedback.</li> <li>• Evidence that improvements in practice are shared across the Trust.</li> </ul>
	12	To have excellent communications with referrers and discharge/onward referral management and post treatment support.	<ul style="list-style-type: none"> <li>• GP communication survey</li> <li>• Discharge audit</li> <li>• Development of service user community through 'word of mouth' project.</li> </ul>	<ul style="list-style-type: none"> <li>• GP survey indicates improvements.</li> <li>• Discharge audit.</li> </ul>
WELL-LED	13	To develop excellent team level leadership and management to deliver improved, measurable quality outcomes.	<ul style="list-style-type: none"> <li>• Leadership and management training.</li> <li>• Training in Quality Improvement methodologies, including clinical audit at team level.</li> </ul>	<ul style="list-style-type: none"> <li>• Increased use of performance data to improve measurable, quality outcomes.</li> <li>• Training to inform team development with evidence of participation in learning across the Trust.</li> <li>• Completion of one team quality improvement project in four clinical teams.</li> </ul>
	14	Accessible and intelligible quality indicator data available at patient, team, service line, directorate, management team, Board and Commissioner levels.	<ul style="list-style-type: none"> <li>• Performance dashboard development.</li> <li>• Appointment of Clinical Information Development Lead (CCIO).</li> <li>• Consultation with Commissioner.</li> <li>• Consultation with staff.</li> </ul>	<ul style="list-style-type: none"> <li>• Fully compliant with Monitor Quality Assurance Framework.</li> <li>• Data dashboards validated as clinically and managerially useful.</li> </ul>



## Board of Directors : September 2016

**Item :** 11

**Title :** Finance and Performance Report

### **Summary:**

After the five months of the new year, a surplus of £1,030k is reported after restructuring costs, £368k above the revised planned surplus of £600k.

New posts, funded by our commissioners in order to meet higher service demand, have now been filled. As a result, overall costs are due to be significantly higher in the remainder of the year, and the surplus will reduce. The forecast for the full year is a surplus of £800k, in line with our revised control total. At present, the detailed forecast is slightly below the £800k target, but management action is being taken to ensure that we achieve this.

The cash balance at 31 August was £3,809k, which is £601k below Plan. Late payments have offset the higher surplus and lower capital expenditure.

The Board are asked to approve the renewal of the financing facility, section 2.3.2, for a further 12 months.

**For :** Information. Approval of financing facility renewal.

**From :** Simon Young, Director of Finance

## 1. **External Assessments: NHS Improvement**

- 1.1 NHS Improvement have accepted the Trust's 2016/17 Plan. As noted previously, the Plan has a control total – i.e. required surplus – of £800k, which includes the allocation of £500k from the “targeted element” of the Sustainability and Transformation Fund.
- 1.2 The return for August was submitted on 15 September with an FSRR of 4. The Trust's governance rating remains Green.
- 1.3 NHS Improvement has announced that the present Risk Assessment Framework, which includes the FSRR, will be replaced from October 2016 by a new Single Oversight Framework (SOF) which will apply both to Trusts and Foundation Trusts. The stated aim is to “shift the emphasis away from regulation and performance management and towards identifying how we can best help providers make the improvements they want to make for patients.”

## 2. **Finance**

### 2.1 **Income and Expenditure 2016/17** (Appendices A and B)

- 2.1.1 The budget has been revised to reflect the changes outlined in 1.1 above. The additional £500k income, spread evenly across the year, is shown on line 2 in Appendix B; and is included in Clinical Income on Appendix A. The first quarterly instalment was received in August.
- 2.1.2 After August, the Trust is reporting a surplus of £1,030k after restructuring costs, £263k above the revised budget. Income is £11k above budget, and expenditure £318k below budget.
- 2.1.3 The cumulative income position to date of £11k favourable is mainly due to the following:
  - 2.1.3.1 Clinical Income is £38k above budget overall. Adult and Forensic Services income is £81k under budget due to a shortfall on NPA income and credit notes relating to last year; which is offset by a GIDU over-performance payment from 2015/16 and Day Unit high pupil numbers.
  - 2.1.3.2 Consultancy Income is £75k below target due to TC Income below budget which has been offset by reduced expenditure.
  - 2.1.3.3 Training is £18k above plan but this trend will not continue after the start of the new academic year as student numbers are below the anticipated level but still higher than last year.
- 2.1.4 The favourable position of £318k on the expenditure budget was due mainly to the under spends of £229k in GIDU, £155k in Primary Care and £97k in Tavistock Consulting due to vacancies and lower than expected non pay costs.

- 2.1.5 There are currently 588 Whole Time Equivalent (WTE) funded posts in July, of which 574 were occupied including 39 WTE bank and 19 agency staff. Additional posts will be added as the increased funding for GIDS is phased in later in the year
- 2.1.6 Agency staff expenditure was £432k after 5 months, which is 42% over the cap set by NHS Improvement. This is one of the metrics in the new SOF rating from October: it is essential that we do not exceed the cap by more than 50%; and better not to exceed it by more than 25% at year end.
- 2.1.7 The contingency reserve is a shortfall of £89k; however, three cost centres with significant underspends in the first quarter are expected still to have at least part of this underspend by the end of the year.
- 2.1.8 Though the surplus is ahead of plan after five months, some of this is due to the phasing of costs; and income for the remainder of the year is not all secured.

## 2.2 Forecast Outturn

- 2.2.1 The detailed forecast surplus of £601k after restructuring, as shown in Appendices A and B, is £199k below budget. However, this reflects the outturn if no remedial action were taken by management; with actions currently being planned and taken, the control total of an £800k surplus is still expected to be achieved.
- 2.2.2 At this stage in the financial year it is difficult for both the Finance Department and budget holders to make a robust forecast but after discussions with budget holders we have assumed the following. Further work will be done with budget holders, to inform next month's report.
- 2.2.3 Clinical income is currently predicted to be £89k above budget due to GIDS Named Patient Agreements (NPA's) and the Day Unit over-performing against targets.
- 2.2.4 Training income is expected to be £451k below plan due to a shortfall on student fee and HEFCE income. This will be offset by a reduction in Training expenditure of £443k.
- 2.2.5 TC Consultancy income is expected to be £213k below target but expenditure is forecast to be £302k below budget
- 2.2.6 Clinical expenditure is expected to be £87k below budget:
  - 2.2.6.1 GIDS is expecting to reduce their £229k under spend to £195k. The reason the current trend will not continue is due to additional costs for refurbishing the new GIDS accommodation coupled with recruitment to the majority of the newly funded posts in September and October.
  - 2.2.6.2 Primary Care is £155k under spent after month 5 due to vacancies in Camden TAP and City & Hackney Project. There are plans to recruit

temporary staff to reduce the size of the waiting list within City & Hackney which will reduce the under spend to £81k at year end.

2.2.7 Training expenditure is expected to be £443k under budget at year end:

2.2.7.1 FNP is expected to be £125 below budget largely due to lower than budgeted Partner and training programme costs.

2.2.7.2 Junior Medical staff is expected to remain at £54k below budget.

2.2.7.3 DET are currently forecasting an under spend of £185k although they do require some flexibility to enable expenditure to reflect student recruitment numbers.

2.2.8 The Central functions are currently forecasting an over spend of £312k which is primarily due and unbudgeted Relocation revenue costs.

2.2.9 Known restructuring costs are currently £115k and were not included in the Plan.

## 2.3 Cash Flow

2.3.1 The actual cash balance at 31 August was £3,809k this is a decrease of £1,543k on last month and is £601k below Plan. The reduced balance was due to the quarterly payment in advance from Health Education England (in July). The shortfall against Plan is mainly due to a delay in raising the first two quarterly FNP contract invoices for £707k each; these have now been raised, after Public Health England provided the necessary information, and payment is expected shortly. There are also old year payments still outstanding of £800k; the largest old year debtor has agreed to schedule payment for £267k owed. These shortfalls have been offset by the larger than planned surplus and capital below plan.

	Actual	Plan	Variance
	£000	£000	£000
Opening cash balance	3,356	3,356	0
Operational income received			
NHS (excl HEE)	6,561	7,170	(609)
NHS England (GIDS)	2,718	2,640	78
PHE (FNP)	748	1,926	(1,178)
General debtors (incl LAs)	3,626	4,710	(1,084)
HEE for Training	5,671	4,632	1,039
Students and sponsors	638	725	(87)
Other	182	0	182
	20,144	21,803	(1,659)
Operational expenditure payments			
Salaries (net)	(7,265)	(7,610)	345
Tax, NI and Pension	(5,876)	(6,225)	349
Restructuring	(203)	(363)	160
Suppliers	(5,968)	(5,704)	(264)
	(19,312)	(19,902)	590
Capital Expenditure	(384)	(1,224)	840
Loan drawdown	0	375	(375)
Interest Income	5	2	3
Payments from provisions	0	0	0
PDC Dividend Payments	0	0	0
Closing cash balance	3,809	4,410	(601)

2.3.2 We are seeking approval to renew the Trust's financing facility of £1m with Lloyds Bank for a further 12 months from 1 November 16 at a cost of £4k. Though this no longer counts in NHS Improvement's liquidity calculation, and though we do not expect to need to borrow, the facility provides a safety margin to ensure that in the event of temporary cash shortage (e.g. due to a major delay in payments from commissioners), the Trust could continue to pay staff and suppliers.

## 2.4 Better Payment Practice Code

2.4.1 The Trust has a target of 95% of invoices to be paid within the terms. During August we achieved 91% (by number) and 97% by value for all invoices. The cumulative total for the year was 93% by number and 95% by value. In line with previous Board discussions, this is considered satisfactory; Finance will continue to work with colleagues to avoid delays as far as possible, but no additional action is planned.

## 2.5 Capital Expenditure

2.5.1 The capital budget for the year is £2,480k in total which includes £1,100k for the Relocation Project up to Full Business Case.

2.5.2 Up to 31 August, expenditure on capital projects was £384k. This included £331k on IM&T and £46k on the Relocation project. This is £840k below plan due to the Relocation Project and the various IM&T projects not making the

expected progress at this stage. Expenditure for the year is forecast to be £1,943k mainly due to reduced capital spending on Relocation.

2.5.3 The Relocation project cumulative capital costs up to 31 March 2016 were £575k but this was reduced to £112k on the advice of our external auditors with the balance being charged to revenue. (These figures exclude £76k for the portacabin extension, which has been capitalised as a separate asset).

Capital Projects 2016/17	Budget 2016/17	Actual YTD August 2016	Forecast 2016/17	Spend 2014/15	Spend 2015/16	Total Project	
						Spend to date	Budget to date
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Estates General	190	-	190			-	190
Relocation Project up to OBC	-	-	-		50	50	50
Relocation Project up to FBC	1,100	46	500		62	108	1,162
DET Works Phase 1		7	7			7	-
<b>Total Estates</b>	<b>1,290</b>	<b>53</b>	<b>697</b>	<b>-</b>	<b>112</b>	<b>165</b>	<b>1,402</b>
IM&T Infrastructure	300	150	300			150	300
IM&T Project Posts	125	-	125			-	125
IM&T Developments	390	-	390			-	390
IDCR	50	50	50	389	268	707	707
Student Info. Mgmt System	325	75	325			75	325
Det Intranet	-	56	56		16	72	31
<b>Total IT</b>	<b>1,190</b>	<b>331</b>	<b>1,246</b>	<b>389</b>	<b>284</b>	<b>1,004</b>	<b>1,878</b>
<b>Total Capital Programme</b>	<b>2,480</b>	<b>384</b>	<b>1,943</b>	<b>389</b>	<b>396</b>	<b>1,169</b>	<b>3,280</b>

### 3. Consultancy

3.1 Tavistock Consulting are a net £22k ahead of budget after five months. This consists of expenditure £97k under spent, offset by consultancy income £75k below budget. TC have forecast income to be £213k below budget and expenditure to be £302k below budget at year end.

3.2 Departmental consultancy is on budget after August.

Carl Doherty  
Deputy Director of Finance  
16<sup>th</sup> September 2016

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST										APPENDIX A	
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2016-17											
	Aug-16			CUMULATIVE			FULL YEAR 2016-17				
	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	REVISED BUDGET £000	OPENING BUDGET £000	FORECAST OUTTURN £000		
<b>INCOME</b>											
1 CLINICAL	2,157	2,170	13	10,962	11,000	38	24,773	20,500	24,862		
2 TRAINING	1,583	1,615	32	8,184	8,202	18	20,845	20,740	20,394		
3 CONSULTANCY	90	45	(44)	448	374	(75)	1,076	1,104	855		
4 RESEARCH	4	7	3	24	27	3	55	53	55		
5 OTHER	56	54	(2)	270	296	27	576	571	611		
<b>TOTAL INCOME</b>	<b>3,890</b>	<b>3,892</b>	<b>2</b>	<b>19,888</b>	<b>19,899</b>	<b>11</b>	<b>47,324</b>	<b>42,967</b>	<b>46,776</b>		
<b>OPERATING EXPENDITURE (EXCL. DEPRECIATION)</b>											
6 CLINICAL DIRECTORATES	1,870	1,908	(38)	9,314	8,971	343	21,818	18,454	21,731		
7 OTHER TRAINING COSTS	981	975	6	5,480	5,373	107	14,384	14,263	13,941		
8 OTHER CONSULTANCY COSTS	57	34	23	290	193	97	687	687	384		
9 CENTRAL FUNCTIONS	707	759	(52)	3,498	3,690	(192)	8,338	8,233	8,649		
10 TOTAL RESERVES	(7)	0	(7)	(37)	0	(37)	(89)	(291)	0		
<b>TOTAL EXPENDITURE</b>	<b>3,607</b>	<b>3,676</b>	<b>(68)</b>	<b>18,545</b>	<b>18,227</b>	<b>318</b>	<b>45,137</b>	<b>41,345</b>	<b>44,706</b>		
<b>EBITDA</b>	<b>282</b>	<b>216</b>	<b>(66)</b>	<b>1,343</b>	<b>1,672</b>	<b>329</b>	<b>2,187</b>	<b>1,622</b>	<b>2,070</b>		
ADD:-											
11 BANK INTEREST RECEIVED	1	1	(1)	3	6	(2)	8	8	9		
LESS:-											
12 DEPRECIATION & AMORTISATION	68	54	14	338	290	48	815	850	781		
13 FINANCE COSTS	0	0	0	0	0	0	0	0	0		
14 DIVIDEND	48	49	(0)	242	243	(1)	580	480	582		
<b>SURPLUS BEFORE RESTRUCTURING COSTS</b>	<b>167</b>	<b>115</b>	<b>(53)</b>	<b>767</b>	<b>1,145</b>	<b>378</b>	<b>800</b>	<b>300</b>	<b>716</b>		
15 RESTRUCTURING COSTS	0	54	(54)	0	115	(115)	0	0	115		
<b>SURPLUS/(DEFICIT) AFTER RESTRUCTURING</b>	<b>167</b>	<b>61</b>	<b>(107)</b>	<b>767</b>	<b>1,030</b>	<b>263</b>	<b>800</b>	<b>300</b>	<b>601</b>		
<b>EBITDA AS % OF INCOME</b>	7.3%	5.6%		6.8%	8.4%		4.6%	3.8%	4.4%		



APPENDIX D														
	2016/17 Plan	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
		£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening cash balance		3,356	4,349	4,382	4,417	4,346	4,410	4,289	4,404	4,473	4,586	4,707	4,785	3,356
Operational income received														
NHS (excl HEE)		1,388	1,888	1,518	1,088	1,288	1,088	1,088	1,088	1,088	1,088	1,088	1,088	14,786
NHS England (GIDS)		528	528	528	528	528	528	528	528	528	528	528	528	6,336
PHE (FNP)		984	236	236	236	236	236	236	236	236	236	236	236	3,576
General debtors (incl LAs)		1,300	1,010	700	1,000	700	700	700	972	970	773	970	1,071	10,866
HEE for Training		926	926	926	926	926	926	926	926	926	926	926	926	11,116
Students and sponsors		325	150	150	100	0	200	800	200	200	400	200	100	2,825
Other		0	0	0	0	0	0	0	0	0	0	0	0	0
		5,451	4,738	4,058	3,878	3,678	3,678	4,278	3,950	3,948	3,951	3,948	3,949	49,505
Operational expenditure payments														
Salaries (net)		(1,522)	(1,522)	(1,522)	(1,522)	(1,522)	(1,522)	(1,522)	(1,522)	(1,522)	(1,522)	(1,522)	(1,522)	(18,264)
Tax, NI and Pension		(1,245)	(1,245)	(1,245)	(1,245)	(1,245)	(1,245)	(1,245)	(1,245)	(1,245)	(1,245)	(1,245)	(1,245)	(14,940)
Restructuring		0	(144)	0	0	(219)	0	0	0	0	0	0	0	(363)
Suppliers		(1,600)	(1,559)	(1,107)	(929)	(509)	(729)	(1,328)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(12,761)
Capital Expenditure		(4,367)	(4,470)	(3,874)	(3,696)	(3,495)	(3,496)	(4,095)	(3,767)	(3,767)	(3,767)	(3,767)	(3,767)	(46,328)
Loan		115	115	115	15	15	(79)	(218)	(264)	(219)	(213)	(154)	(114)	(2,485)
Interest Income		0	1	0	1	0	1	0	0	1	0	1	0	5
Payments from provisions		0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividend Payments		0	0	0	0	0	(240)	0	0	0	0	0	(240)	(480)
Closing cash balance		4,349	4,382	4,417	4,346	4,410	4,289	4,404	4,473	4,586	4,707	4,785	4,673	4,673
		3,356	5,071	4,582	3,790	5,352	3,809	4,721	4,836	4,905	5,018	5,139	5,151	3,356
Operational income received														
NHS (excl HEE)		1,275	1,820	1,132	1,473	861	1,088	1,088	1,088	1,088	1,088	1,088	1,088	14,177
NHS England (GIDS)		45	661	925	558	529	528	528	528	528	528	528	528	6,414
PHE (FNP)		748	0	0	0	0	1,410	236	236	236	236	236	236	3,572
General debtors (incl LAs)		1,179	729	694	301	723	700	700	972	970	773	970	1,071	9,782
HEE for Training		2,391	133	134	2,824	189	926	926	926	926	926	926	926	12,155
Students and sponsors		306	56	71	113	92	200	800	200	200	400	200	100	2,738
Other		25	27	66	34	30	0	0	0	0	0	0	0	182
		5,969	3,426	3,022	5,303	2,424	4,852	4,278	3,950	3,948	3,951	3,948	3,949	49,020
Operational expenditure payments														
Salaries (net)		(1,499)	(1,429)	(1,434)	(1,427)	(1,476)	(1,522)	(1,522)	(1,522)	(1,522)	(1,522)	(1,522)	(1,522)	(17,919)
Tax, NI and Pension		(1,167)	(1,189)	(1,235)	(1,131)	(1,154)	(1,245)	(1,245)	(1,245)	(1,245)	(1,245)	(1,245)	(1,245)	(14,591)
Restructuring		(4)	(199)	0	0	0	0	0	0	0	0	0	0	(203)
Suppliers		(4,143)	(3,936)	(3,729)	(3,658)	(3,846)	(3,496)	(4,095)	(3,767)	(3,767)	(3,767)	(3,767)	(3,767)	(45,738)
Capital Expenditure		(112)	20	(86)	(84)	(122)	(220)	(218)	(264)	(219)	(213)	(220)	(205)	(1,943)
Loan		0	0	0	0	0	15	150	150	150	150	150	60	725
Interest Income		1	1	1	1	1	1	1	0	1	0	1	0	8
Payments from provisions		0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividend Payments		0	0	0	0	0	(240)	0	0	0	0	0	(240)	(480)
Closing cash balance		5,071	4,582	3,790	5,352	3,809	4,721	4,836	4,905	5,018	5,139	5,151	4,948	4,948



## Board of Directors : September 2016

**Item :** 12

**Title :** Department of Education and Training Board Report

**Purpose:**

To update on issues in the Education & Training Service Line.  
To report on issues considered and decisions taken by the  
Training & Education Programme Management Board at its  
meeting of 12<sup>th</sup> September 2016.

**This report focuses on the following areas:**

*(delete where not applicable)*

- Quality
- Risk
- Finance
- Communications

**For :** Noting

**From :** Brian Rock, Director of Education and Training/Dean of  
Postgraduate Studies

## Department of Education and Training Board Report

### 1. Introduction

- 1.1 The Training and Education Programme Management Board met on 12<sup>th</sup> September 2016 and discussed the issues presented in this report.

### 2. National Training Contract

- 2.1 The programme board was advised that work continued to develop in relation to the national contract.
- 2.2 The contract for 2016/7 has now been signed off.
- 2.3 The three work streams (portfolio review, educational consultancy and finance/reporting) are developing their various projects.

### 3. Student Recruitment

- 3.1 Laure Thomas presented a paper on this item. She explained that we are nearing the closing applications for the 2016/17 academic year.
- 3.2 Key figures updated from more recent recruitment reports are:
- 3.2.1 921 submitted applications
  - 3.2.2 614 offers made
  - 3.2.3 527 offers accepted
  - 3.2.4 This compares to 736 applications and 322 at the same period last year, which represents a 25% increase in the number of applications received.
  - 3.2.5 The number of places accepted is up substantially from this time last year, but this is in part attributable to improved data quality.
- 3.3 The report included projections for final numbers for each portfolio. All with the exception of social work and social care are currently short of their target.
- 3.4 At present we are likely to hit around 560 students without including Associate Centre recruitments. This includes some

reduction for attrition. This is around 20% higher than last year but falls short of the target

3.5 The programme board acknowledged that the targets had been challenging and that there had been significant improvements in recruitment processes in the past year.

3.6 Plans are being put in place to review the recruitment cycle of 2015/16 to identify what went well, where improvements can be made and to prepare for the 2016/17 cycle.

#### **4. Visiting Lecturers**

4.1 Fiona Hartnett and Craig de Sousa presented a paper on this item which outlined the continuing work reviewing visiting lecturers.

4.2 The programme board discussed the proposals with a particular focus on the communication and engagement with VLS. It was emphasised that it was important this took place and that we highlighted the benefits and improvements that the review would bring once concluded.

#### **5. ICT Project**

5.1 David Wyndham Lewis updated the programme board as to the progress of the ICT project.

5.2 He explained that the project was currently RAG rated as red. This is largely down to resourcing however he has put systems in place and was confident the project would move to amber before the next programme board.

5.3 The team have revised their plans in relation to data migration and exactly what needs to be completed before the system goes live in November for applications. This has reduced concerns in this area.

#### **6. QAA Update**

6.1 Simon Carrington presented a paper on the outcome of the QAA review, the report was received over the summer.

- 6.2 The overall judgement was that the Trust met the requirements of the UK Quality Code.
- 6.3 Good practice was highlighted in a number of areas including the integration between clinical and academic areas. The library was also singled out as an area of good practice as was our work with our University partners and TEL.
- 6.4 Recommendations were made around feedback to students, working with external examiners, annual monitoring process in particular communication of the outcomes of this processes and improving clarity of information.
- 6.5 An action plan will be finalised this month. The QAA will return next year to assess how we are implementing that plan.

## **7. TEL Developments**

- 7.1 Simon Kear presented a paper on this item which focussed on a proposal for the Trust to deliver a Massive Open Online Course (MOOC).
- 7.2 The group discussed the proposal. It was suggested that it would be a good marketing tool however the links between people completing a MOOC and enrolling on a more significant course is not proven.
- 7.3 They also discussed the costs and the time pressures on staff to develop and deliver these courses.
- 7.4 It was agreed that there was broad strategic support for the proposal, particularly if this connected with the Trust's objective to reach large parts of the workforce and increase geographic coverage.

## **8. Website**

- 8.1 Laure Thomas advised that the new website had now gone live and there had been increasing traffic to the Education and Training pages.
- 8.2 There are still some small issues which are being worked out particularly in relation to the CPD pages but these are being worked

through and the new Digital Communications Manager will be in post next week which will offer further support.

## **9. AGM**

9.1 The programme board was advised that this year's AGM will have an education and training focus.

9.2 A number of former students have been invited to speak and describe how their course helped them in their career in a facilitated discussion with one of our Portfolio Managers, Peter Griffiths. Chris Caldwell from Health Education England will also be speaking.

**Brian Rock**

**Director of Education and Training/Dean of Postgraduate Studies**

**18<sup>th</sup> September 2016**



## Board of Directors : September 2016

**Item : 7**

**Title : CQSG Committee Report, Q1, September 2016**

### **Purpose:**

This report gives an overview of performance of clinical quality, safety, and governance matters according to the opinion of the CQSGC. 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:

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

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

### **This report focuses on the following areas:**

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

**For : Discussion**

**From : Rob Senior, CQSGC Chair**

**CQSGC MINUTES FROM A MEETING HELD**  
**AT 11:00, TUESDAY 6<sup>TH</sup> SEPTEMBER 2016, BOARDROOM**

<b>Members</b>	<b>Present?</b>
Rob Senior, Medical Director (& CQSGC Chair) (RS)	Y
Paul Burstow, Trust Chair (PB)	Y
Dinesh Bhugra, Non-Executive Director (DB)	N
Anthony Levy, Public Governor (AL)	Y
George Wilkinson, Public Governor (GW)	Y
Paul Jenkins, Chief Executive (PJ)	N
Simon Young, Senior Information Risk Owner (SY)	Y
Louise Lyon, Director of Clinical Quality and Patient Experience (LL)	Y
Sally Hodges, CYAF Director (SH)	Y
Julian Stern, Director of Adult and Forensic Services (JS)	Y
Caroline McKenna, Clinical Outcomes & Clinical Audit Lead (CMK)	N
Elisa Reyes Simpson, Associate Dean for Academic Governance and Quality Assurance (ERS)	Y
Marion Shipman, Associate Director Quality and Governance (MS)	Y
Irene Henderson, Clinical Governance & Quality Manager (& CQSGC Secretary) (IH)	Y

<b>AP</b>	<b>Item</b>	<b>Action to be taken</b>	<b>By</b>	<b>Deadline</b>
1	4	<i>AMD to consider Trust compliance and assurance of Duty of Candour.</i>	AMD	30 <sup>th</sup> October 2016
2	5a	<i>MS to investigate and improve the 'healthy options' provided by the vending machine.</i>	MS	30 <sup>th</sup> October 2016
3	5a	Consider how the performance dashboards live data will impact on the work of this committee which usually looks at Trust activity retrospectively.	ALL	30 <sup>th</sup> October 2016
4	5b	Investigate crisis planning section within the CQC updated action plan, and decide if the success criteria wording is accurately capturing what is required.	AMD	30 <sup>th</sup> October 2016
5	5b	<i>LL agreed to investigate how and if any data captured on paper is being stored prior to upload.</i>	LL	30 <sup>th</sup> October 2016
6	6	<i>MS agreed to confirm and ensure that there is appropriate signage in relation to CCTV at the Tavistock and all external sites.</i>	MS	30 <sup>th</sup> October 2016
7	7	<i>LL agreed to take this the Data Analysis and Reporting Committee (DARC) for a decision on ICD10 coding and will report back to this workstream.</i>	LL	30 <sup>th</sup> October 2016
8	7	SY agreed to amend the rating to amber for the following two areas: Clinical Information Assurance and Corporate Records.	SY	15 <sup>th</sup> September 2016
9	8	<i>LL agreed to check the TADS data for any information or evidence on attempted suicides.</i>	LL	30 <sup>th</sup> October 2016

***Items in italics should be reported through the respective work streams.***

<b>Item</b>	<b>Action</b>
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## 1 Chair's opening remarks

RS opened the meeting and confirmed the workstream reports being presented today were covering Q1 2016-17. He also confirmed and that there had been two previous sets of CQSGC minutes to consider for Q1, in the May report and the extraordinary meeting in June regarding the CQC report and action plan.

## 2 Apologies for absence: Paul Jenkins and Caroline McKenna

## 3 Notes from the last meeting

RS noted there were two sets of notes to review:

1: May CQSGC.

2. June Extraordinary CQSGC including the CQC Report and Action Plan. Please see Appendix A.

These were accepted as true records with the following requested amendments:

- ❖ MS reworded a paragraph in the CGR section regarding following the procedure for reporting incidents to NRLS and removing any mention of dissatisfaction of the work of her predecessor.
- ❖ Re Duty of Candour: MS requested a change in the wording from "failed to meet national standards for duty of candour" to "may not be meeting national requirement for duty of candour".
- ❖ LL's title was corrected

## 4 Matters arising

There was some discussion around Trust compliance with the latest Duty of Candour: It was agreed the new Associate Medical Director would consider our compliance in this area and provide assurance to the Board via the Patient Safety and Clinical Risk workstream of the CQSGC.<sup>1AMD</sup>

It was noted that all actions would be addressed via the workstream reports except the last action to update the clinical governance handbook, which IH confirmed has been updated and will be published in late September for the new clinical trainees.

## 5 REPORTS FROM WORK STREAM LEADS

### 5a A: CLINICAL QUALITY AND PATIENT EXPERIENCE WORKSTREAM

LL introduced her report and stated there were no specific concerns. It was noted that the vending machine newly introduced healthy eating options were perhaps not as healthy as we had hoped and MS will investigate if the selection can be improved. <sup>2MS</sup>

There was much discussion around data capture and accuracy and it was noted that although we are meeting our targets for the most part, we need to ensure that going forward, we are collecting robust and useful information.

SH alerted the committee to the introduction of new performance information dashboards, which some of her team have produced, which will negate the need to run separate audits and provide reports with live and accurate data for the first time. Once these dashboards are in place, it is felt that staff will have the capacity to interrogate the data, make it meaningful for clinicians and enable benchmarking internally and externally.

PB stated that these performance dashboards, once introduced, would have an impact on the way this committee functions as currently it considers data retrospectively. The committee agreed to consider this once the dashboards are in place and revisit how this committee will function in the future. <sup>3ALL</sup>

**The committee accepted the report with an amber rating, with the expectation that by Q4 the rating will have achieved green.**

### 6 B: CORPORATE GOVERNANCE AND RISK WORKSTREAM

MS introduced her report with an overall green rating for all elements in Q1, and noted the risk register had now been updated and will go to the July Board. MS also confirmed the business continuity plans needed some more work and Lisa Tucker, Health and Safety Manager, is working with our outreach services to ensure this.

AL noted the number of violent incidents had reduced. MS explained most of the violent incidents occur at Gloucester House school and there was a new class introduced and the children were unsettled but they have since settled down so the incidents have reduced.

AL asked about the CCTV in relation to whether people are made aware of the CCTV operating at the Trust and whether there are tape storage and viewing protocols in place. SH stated there were notices clearly on display in the CAMHS directorate and that the CCTV is used as a deterrent. The committee asked for confirmation of signage at

entrances and other areas of the Trust and MS agreed to confirm<sup>6MS</sup> and ensure that there is appropriate signage in relation to CCTV at the Tavistock and all external sites.

**The Committee accepted the report assurance of a green rating for Q1.**

## **7 C: INFORMATION GOVERNANCE WORKSTREAM**

SY introduced his updated report, with an overall rating of red for Q1. The revised paper had been circulated by email the week before the meeting. Paper copies were tabled. SY highlighted that the plan to roll out ICD10 training for adult clinical staff had now become redundant because NHS Digital, formerly HSCIC, have agreed we are no longer required to complete ICD10 clinical coding. However, SY invited clinical colleagues to confirm if despite not needing to complete ICD10 coding for reporting purposes, whether the Trust would find ICD10 coding beneficial. It was noted that ICD10 coding is often used for benchmarking purposes and this should be considered when deciding whether to go forward with ICD10 coding. LL agreed to take this to the Data Analysis and Reporting Committee (DARC) for a decision on ICD10 coding and will report back to this workstream.<sup>7LL</sup>

AL asked why the IMT Security assurance rating was green for Q1 if the data loss protection system was not in place in Q1. SY confirmed that although the full data loss protection system was not implemented in Q1, and there are still some minor pieces of work that need to be completed, there have been adequate controls put in place, so confirmed this rating can remain green as the risk is being managed.

PB asked about the apparent differing messages in relation to Clinical Information Assurance and Corporate Records (items 5 and 6) in that they are rated as green in Q1 yet the text suggests they are still a risk and asked if the rating should change to amber or red. SY<sup>8SY</sup> acknowledged there was still work to be done in both areas to reach a green rating, for which plans have been put in place, and agreed to amend the rating to amber for Q1.

AL referred to the summary and asked for clarification on the statement, the Trust is in breach of all its clinical contracts. SY explained that all Trusts should reach a minimum level 2 IG not to be considered in breach. To date there have been no consequences to these breaches and although the commissioners and the CSU (commissioning support unit) want this area to be addressed they do not consider it to be a risk.

**The committee accepted the overall assurance rating as red for Q1 with an expectation that this will rise to amber in Q2 with the reported plans in place.**

## D: PATIENT SAFETY AND CLINICAL RISK WORKSTREAM

8

IH, Clinical Governance and Quality Manager, introduced the report, which was produced by the previous Associate Medical Director, Jessica Yakeley, who has now stepped down. IH stated the overall rating was amber for Q1 and noted the main areas that require further work are in clinical risk assessment and producing and managing crisis plans. IH noted the Trust was fully compliant with medical revalidation and there were no concerns in relation to incidents and incident reporting.

AL questioned why there was such a delay in appointing a patient safety officer if this was perceived as a risk. RS stated that we had tried to recruit to this post on several occasions and that we had finally been able to appoint an officer who started on 5<sup>th</sup> September 2016. SY asked how aligning lists of children on CPP with LA was managed with referrals from other boroughs and IH confirmed that part of the patient safety officer's role would be to work with our other referring boroughs to ensure we have the latest child protection information on all referred children.

There was some discussion around the recent suicides of patients known to the Trust and RS confirmed he has appointed case investigators. It was noted that the timing and nature of the committee sometimes means looking at very retrospective information but RS confirmed that where there are critical lessons to be learned, or something is key or very urgent, such as SIs (serious incidents) then timelier reporting to the CQSGC would be required. RS also confirmed that the Board would<sup>9LL</sup> always be made aware of such circumstances in Part II of the Board.

AL asked how and if attempted suicides are recorded, like "near misses" so lessons can perhaps be learned from them. MS briefly outlined how the Trust might be contacted, but stressed it would be extremely unlikely if the patient had been discharged from the Trust for more than six months after treatment. RS stated that the Trust has grappled with the possibility of longer term follow up after treatment for our patients. LL stated the TADS study provides evidence that longer term follow up after treatment could be highly beneficial in cases of mental health patients relapsing. LL agreed to check the TADS data for any information or evidence of attempted suicides.

**The committee accepted the overall rating of amber for Q1.**

9 **AOB:** There was no other business raised.

10 **Notice of future meetings:**

11am, Tuesday 1st November 2016  
11am, Tuesday 7<sup>th</sup> February 2017  
11am, Tuesday 2<sup>nd</sup> May 2017  
11am, Tuesday 5<sup>th</sup> September 2017  
11am, Tuesday 7<sup>th</sup> November 2017

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## APPENDIX A

### CQC ACTION PLAN

- ❖ LL introduced the CQC updated action plan, noting the three “musts dos” and the remaining recommendations are “should dos”, and confirmed this updated CQC action plan has not yet been submitted to the Management Team.
- ❖ LL stated she was satisfied that we are on track to deliver all items within the action plan, though much work was needed to be done to ensure its completion.
- ❖ The main concern within the plan was the need to ensure appropriate Crisis Plans were in place for relevant patients and CMcK already has a training plan in place to be rolled out across the Trust over the coming months.
- ❖ It was also noted that the work of the CareNotes Optimisation Group would enable many of the targets to be completed.
- ❖ LL confirmed the CQC are happy with our progress to date on timescales for delivering the “must do” changes, but it was worth noting that the Trust remains “registered with conditions” until we have fully implemented the action plan, when our registration will change to “full registration” which is what the Trust is aiming for.
- ❖ AL asked for clarification on the success criteria for risk assessment suggesting the wording of the criteria suggests it is sufficient to “increase clinicians” awareness of risk assessment” but perhaps it should state the success criteria would be “for clinicians to have completed risk assessments on all their relevant cases”. RS noted that when he had investigated this concern, he found that staff were in fact completing risk assessments but not documenting it. The committee agreed to ask the new Associate Medical Director to look into this once they are in post.
- ❖ AL asked if we should be extending the requirements to include items such as whether the agreed crisis plans are being sent to GP/referrers, carers or third sector volunteer organisations with the patients consent sought. ERS stated that there is reference made to this in the Adult Safeguarding consent section of the policy.
- ❖ AL also asked about the infection control for legionella and whether there’s a system in place to check this regularly and who holds this information. MS explained that this was managed via our Estates and Facilities Manager, Paul Waterman, and we have documented evidence of our contract and certification for each chlorination inspection. This information can be made available on request.
- ❖ PB asked a question in relation to when the Risk Management Strategy and Policy was being reviewed and implemented, which committee or body were monitoring this. MS stated the policy amendment would go via the EMT and then the Board.
- ❖ AL asked why paper records were still being used now that we have an integrated digital care record for patients. SY explained that while most Trust services were now using the digital care record a small number of services, like GIDS (Gender Identity Service) are in fact using the digital care

record but because of the nature of how often and how long they see patients for, they are capturing some their patient activity on Word documents and then uploading them to CareNotes, ensuring the patient has a complete record. AL asked what happens to the original paper record prior to it being typed in Word and LL agreed to investigate how and if any data captured on paper is being stored prior to upload.

- ❖ PB asked whether the £200k figures stated on page 21 was a permanent or temporary budget uplift. JS explained that Camden had provided this temporary uplift in order to facilitate a blitz on crisis planning data capture but that it was a short term fix as the adult and forensic services had planned for approximately 600 patients but were in fact having well over this number, but as a Trust we have done all we can to facilitate this growing need and the commissioners are currently happy with our progress. JS also pointed out that our adult services are not IAPT services and often treatment cannot be delivered in such short treatment periods.
- ❖ As a final point LL confirmed this committee provides Board assurance on the CQC updated action plan.



## Board of Directors : September 2016

**Item :** 14

**Title:** Responsible Officer's Report: Revalidation of Medical Staff.

**Purpose:**

The purpose of this report is to assure the Board about the fitness to practice of medical staff in the Trust.

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 focuses on the following areas:**

- Quality
- Patient / User Safety
- Risk

**For :** Noting

**From :** Dr Rob Senior, Medical Director & Responsible Officer

## Responsible Officer's Report – Revalidation of Medical Staff

### Summary

- 1) We have agreed with the GMC all doctors for whom we are the designated body and all have been given a date for revalidation. The report which follows from the revalidation and appraisal lead outlines the systems and processes we have established to facilitate and support the revalidation of doctors in the Trust.
- 2) To date, 46 doctors have been recommended for revalidation by Dr Senior, the responsible officer. None have been deferred or had their license to practice refused.
- 3) Of the 48 consultants for whom Dr Senior is their Responsible Officer (RO), only two were deferred, one consultant returning from maternity leave and one consultant whose revalidation date coincided with their joining our appraisal system, and therefore needed the recommendation date deferred.
- 4) The Responsible Officer for our medical trainees is the Postgraduate Dean in HENCEL our Local Education and Training Board.
- 5) None of the doctors for whom the Tavistock and Portman NHS FT is the designated body is currently subject to any GMC fitness to practice procedures or any imposed conditions or undertakings.

**Dr Rob Senior**  
**Medical Director,**

**Responsible Officer**

## Medical Appraisal and Revalidation at the Tavistock and Portman NHS Foundation Trust

### Report for the Board

1. The Revalidation Lead and Rob Senior email regular updates on revalidation to all doctors in the Trust. All medical staff in the Trust have been informed that revalidation requires them to have a full appraisal which has to be recorded on the electronic system of SARD. They have also been informed that the Trust cannot allow medical staff who are not revalidated to continue to work with patients and that failure to have up to date appraisals, properly recorded, can impede incremental progression.

### **2. Doctors on honorary contracts and other 'external' doctors**

2.1 We are obliged to appraise and revalidate any existing medically qualified honorary employed by the Trust who wishes to be revalidated and is not employed by another NHS provider or Designated Body. This includes doctors employed on an honorary contract. Currently there are 5 or 6 doctors in this position.

A new income stream has been generated by the revalidation team by accepting relevant external consultants, who are not paid or employed by the Tavistock, to join our revalidation programme, making the Tavistock their designated body.

We currently have 10 external doctors who pay an annual fee of £1,000 to join the programme.

These-doctors will have access to some of the mandatory training provided by the Trust such as CPR, as well as limited CPD opportunities, e.g. the Scientific Meetings.

2.2 Although we have been willing to have external consultants join our programme particularly if they were formerly employed here or have some other connection, we need to bear in mind we have limited resources to appraise and revalidate our existing medical staff, and need to be very careful about accepting new medically qualified people as honoraries in future. We cannot guarantee that appraisal and revalidation will be offered as a condition of their contract with us.

### **3. Internal audit**

3.1 An internal audit is due to be carried out in autumn 2016 following the audit conducted in 2014, to ensure our systems and processes are fit for purpose.

The Responsible Officer is responsible for all consultant, staff grade and associate specialist doctors in the Trust ie all non-training grade doctors. Professor Tim Swannick is the Responsible Officer for all trainees in North and North East London.

**Rob Senior,  
Medical Director and Responsible Officer  
September 2016**

## Board of Directors : September 2016

**Item :** 15

**Title :** Standing Financial Instructions

**Purpose:**

The purpose of this report is to present proposed changes to Standing Financial Instructions. This report highlights the 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, amended, and all references have been updated.

The Instructions are included, for reference.

This report has been reviewed by the following Committees:

- Management Team, 13<sup>th</sup> September 2016

**This report focuses on the following areas:**

*(delete where not applicable)*

- Quality
- Risk
- Finance

**For :** Approval

**From :** Carl Doherty, Deputy Director of Finance  
Gervase Campbell, Trust Board & Company Secretary

SFI

## 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 Internal Audit, the Counter Fraud and the Audit Committee.
- 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 Limits of Expenditure

2.1.1 **Paragraphs 9.3.1 and 9.3.2** define the thresholds where proposed expenditure requires either three quotations or a formal tendering process. The level of the thresholds has been reviewed in comparison to a sample of other NHS organisations provided by the Internal Auditors; it was found that the threshold levels are still sufficient.

2.1.2 Appendix A paragraph 4.4.3 has been updated to include EU tendering thresholds on the recommendation of the internal auditors.

#### 2.2 Formal Competitive Tendering

2.2.1 **Paragraph 6.2.4** of Appendix A has been revised to include the requirement to complete a quotation acceptance form.

2.2.2 **Appendix F** has been included to provide a standard format for accepting quotations. The completed form should be sent to the Procurement officer.

#### 2.3 Contracting and Tendering Procedure

2.3.1 **Appendix A, Paragraph 5.1.2** has been added to allow use of an e-auction or other form of electronic tendering process to achieve best value.

Carl Doherty, Deputy Director of Finance  
Gervase Campbell, Trust Board & Company Secretary  
September 2016

## Standing Financial Instructions

Ratified by:	Board of Directors
Date ratified:	29 <sup>th</sup> September 2016
Lead Director / Manager:	Director of Finance Gervase Campbell, Trust Secretary
Name of responsible committee / individual:	Audit Committee / David Holt
Date issued:	September 2016
Review date:	September 2017

SFI

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## Standing Financial Instructions

### 1 Introduction

#### 1.1 General

- 1.1.1 These *Standing Financial Instructions (SFIs)* shall have effect as if incorporated in the *Board of Directors Standing Orders (BDSOs)*<sup>1</sup>.
- 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 *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*<sup>2</sup>, 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.
- 1.1.6 Officers of the Trust should further note that they must disclose forthwith to the Chief Executive any material non-compliance with

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<sup>1</sup> For *BDSOs*, see Tavistock & Portman NHS Foundation Trust, *Constitution, Election Rules, Standing Orders*, October 2015

<sup>2</sup> Tavistock & Portman NHS Foundation Trust, *Scheme of Delegation of Powers*, June 2016

*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 *Health and Social Care Act 2012*;

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 Council 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 “Council 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 *Health and Social Care Act 2012*. 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 NHS Improvement, which incorporates 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, 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 "the Trust" shall mean the Tavistock and Portman NHS Foundation Trust; and
  - 1.2.1.16 "Trust Secretary" shall mean 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 of 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;
  - 2.1.1.7 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 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 NHS Protect.
- 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*<sup>3</sup>. There should be a competitive process for the appointment of a Local Counter Fraud Specialist every five years.

The Local Counter Fraud Specialist shall report to the Director of Finance and shall work with staff in NHS Protect 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 Fraud & Bribery 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 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*<sup>4</sup>;
- 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;

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<sup>3</sup> NHS Protect, *NHS Counter Fraud and Corruption Manual*

<sup>4</sup> Monitor, *Audit Code for NHS Foundation Trusts*, December 2014

- 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

- 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*<sup>5</sup> provides that Internal Audit should accord with the objectives, standards and practices set out in the *Government Internal Audit Standards*<sup>6</sup>, which states that Internal Audit is an independent and objective appraisal service within an organisation:
  - 2.4.4.1 Internal auditing is “an independent, objective assurance and consulting activity designed to add value and improve an organisation’s operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes”<sup>7</sup>.
- 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*<sup>8</sup>. 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 Council 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,

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<sup>5</sup> Monitor, *NHS Foundation Trust Accounting Officer Memorandum*, August 2015

<sup>6</sup> HM Treasury, *Government Internal Audit Standards*, June 2013

<sup>7</sup> *The Definition of Internal Auditing*, © 1999 Copyright by The Institute of Internal Auditors, in HM Treasury, *Government Internal Audit Standards*, June 2013, p.7

<sup>8</sup> HM Treasury, *Government Internal Audit Standards*, June 2013

and techniques to be adopted, in particular the *Audit Code for NHS Foundation Trusts*<sup>9</sup>.

### 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
- 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:

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<sup>9</sup> Monitor, *Audit Code for NHS Foundation Trusts*, December 2014

- 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 the Trust's audited annual accounts must be presented to the Council of Governors at a general meeting of the Council of Governors.
- 4.3 The Chief Executive will publish an Annual Report, in accordance with guidelines on local accountability, and present it to the Council of Governors at a general meeting of the Council of Governors.
- 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 *Mental Health Tariffs*, 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.

### 6.3 Debt recovery

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

6.3.2 Income not received should be dealt with in accordance with losses procedures<sup>10</sup>.

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<sup>10</sup> See HM Treasury, *Managing Public Money*, Annex 4.10 "Losses and Write Offs", and Annex 4.13 "Special Payments", August 2015

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 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 as required by the Provider Licence.

7.2 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable contracts with Clinical Commissioning Groups and other commissioners for the provision of NHS services.

- 7.3 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services, whether clinical or non-clinical, the responsible officer should ensure that an appropriate contract is present and signed by both parties.
- 7.4 All contracts shall be legally binding, shall comply with best costing practice and shall be so devised as to manage contractual risk, in so far as is reasonably achievable in the circumstances of each contract, whilst optimising the Trust's opportunity to generate income.
- 7.5 In carrying out these functions, the Chief Executive should take into account the advice of Directors regarding:
- 7.5.1 costing and pricing of services and/or goods;
  - 7.5.2 payment terms and conditions;
  - 7.5.3 billing systems and cash flow management;
  - 7.5.4 the contract negotiating process and timetable;
  - 7.5.5 the provision of contract data;
  - 7.5.6 contract monitoring arrangements;
  - 7.5.7 amendments to contracts; and
  - 7.5.8 any other matters relating to contracts of a legal or non-financial nature.
- 7.6 The Director of Finance shall produce regular reports detailing actual and forecast service activity income with a detailed assessment of the impact of the variable elements of income.

## **8 Terms of Service and Payment of Directors and Employees**

### **8.1 Remuneration and terms of service**

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

- 8.1.2 The Terms of Reference will include delegated authority to take decisions on the remuneration and terms of service of the Chief Executive and other Executive Directors.
  - 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 Council of Governors.
- 8.2 Funded establishment
- 8.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.
  - 8.2.2 Where external funding is obtained for a new service or post, the budget will be revised.
  - 8.2.3 Except as in 8.2.2, the funded establishment of any department may not be varied without the approval of the Chief Executive.
- 8.3 Staff appointments
- 8.3.1 No Director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration unless:
    - 8.3.1.1 authorised to do so by the Chief Executive;
    - 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. 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 *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*<sup>11</sup>;

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;

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

<sup>11</sup> See <http://www.payontime.co.uk/>



- 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.
- 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 visits<sup>12</sup>;
- 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;

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<sup>12</sup> See also Department of Health, *Health Service Guideline (93)5: Standards of business conduct for NHS staff*, for guidance on standards of business conduct for NHS staff

- 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*<sup>13</sup> and all other applicable policy and guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.
- 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 *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*). To check whether prospective expenditure exceeds the thresholds for EU Procurement rules, see *SFI Appendix A*
- 9.3.3 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 requisition being placed on the e-procurement system. A copy of the authorisation form should be retained by the originating department and the Procurement Officer (see *SFI Appendix C*).

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<sup>13</sup> Department of Health, *Estatecode*, January 2014

## 9.4 Bankruptcy clauses in contracts

- 9.4.1 Trust contracts are to explicitly state that the Trust is to be made aware of any bankruptcy of any customer or supplier.
- 9.4.2 The Director of Finance should make every effort to apprise himself of any formal insolvency arrangement applied to any customer or supplier.
- 9.4.3 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.
- 9.4.4 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.

### 10.2 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*<sup>14</sup>.
- 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.

## 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

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<sup>14</sup> Monitor, *Managing Operating Cash in NHS Foundation Trusts*, December 2005

- 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 Monitor guidance 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 *SFI Appendix A*, 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*<sup>15</sup> guidance and *BDSOs*.
- 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 Supporting NHS providers: guidance on transactions for NHS foundation trusts<sup>16</sup>; 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 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:

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<sup>15</sup> Op. cit.

<sup>16</sup> Monitor, Supporting NHS providers: guidance on transactions for NHS foundation trusts  
Updated March 2015

- 11.3.3.1 properly authorised and approved agreements, architect's certificates, supplier's invoices, and other documentary evidence in respect of purchases from third parties;
  - 11.3.3.2 stores, requisitions, and wages records for own materials and labour, including appropriate overheads; and
  - 11.3.3.3 lease agreements in respect of assets held under a finance lease and capitalised.
- 11.3.4 Where capital assets are sold, scrapped, lost, or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate) (see also *SFI 13*).
- 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*<sup>17</sup>.
- 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;

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<sup>17</sup> Monitor, *NHS Foundation Trust Annual Reporting Manual 2015/16*, May 2016

- 11.4.2.5 periodic verification of the existence of, condition of, and title to, assets recorded;
  - 11.4.2.6 identification and reporting of all costs associated with the retention of an asset; and
  - 11.4.2.7 reporting, recording and safekeeping of cash, cheques, and negotiable instruments.
- 11.4.3 All discrepancies revealed by verification of physical assets to the *Fixed Asset Register* shall be notified to the Director of Finance.
- 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 losses<sup>18</sup> (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 is delegated to departments.
- 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 officer. Wherever practicable, stocks should be marked as health service property.
- 12.4 Stocktaking arrangements shall be agreed with the Director of Finance.

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<sup>18</sup> See HM Treasury, *Managing Public Money*, Annex 4.10 "Losses and Write Offs", and Annex 4.13 "Special Payments", August 2015

- 12.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.
- 12.6 The designated 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*.
- 12.7 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*<sup>19</sup> – which also lays down the limits of authority delegated to the Trust. The Director of Finance must also prepare an Anti-Fraud and Bribery Procedure<sup>20</sup> 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*<sup>21</sup>.
- 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.
- 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.

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<sup>19</sup> HM Treasury, *Managing Public Money*, Annex 4.10 "Losses and Write Offs", and Annex 4.13 "Special Payments", August 2015

<sup>20</sup> See Tavistock & Portman NHS Foundation Trust, Anti Fraud and Bribery Procedure April 2014

<sup>21</sup> Department of Health, *HSC 1999/062: Countering Fraud in the NHS notification of possible disciplinary, civil or criminal proceedings*, March 1999

- 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 property.

- 16.1.2 *BDSO 1.4.1* and *BDSO 1.4.2* 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 of Reference which:
- 16.1.3.1 shall ensure that the Trust's charitable funds are managed appropriately with regard to the Declaration of Trust and appropriate legislation, and
  - 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 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 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 Trustee’s 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 Records Management Code of Practice for Health and Social Care<sup>22</sup>.

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

17.3 Documents held under *Records Management Code of Practice for Health and Social Care 2016*<sup>23</sup> shall only be destroyed at the express instigation of the Chief Executive. Records shall be maintained of documents so destroyed.

### 18 Risk Management and Insurance

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

18.2 The programme of risk management shall include:

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<sup>22</sup> Records Management Code of Practice for Health and Social Care 2016

<sup>23</sup> Ibid.

- 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*<sup>24</sup>.
- 18.4 The Director of Finance, shall ensure that insurance and/or risk pooling arrangements exist in accordance with the risk management programme and in accordance with NHS England 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 The Trust Constitution sets out the Trust's duty, as respects health services for which it is responsible, that persons to whom those services are being, or may be, provided for, directly or through representatives, be included in and consulted on:
- 19.2.1 the planning of the provision of those services;
  - 19.2.2 the development and consideration of proposals for changes in the way those services are provided; and
  - 19.2.3 decisions to be made by that body affecting the operation of those services.

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<sup>24</sup> Op. cit.

## 20 Gifts & Hospitality

- 20.1 All staff are expected to be aware of the Trust's *Gifts and Hospitality Procedure*<sup>25</sup>, a copy of which is available on the Trust's Intranet.
- 20.2 All items covered by the Trust's *Gifts and Hospitality Procedure* are to be recorded in the Trust's *Register of Gifts and Hospitality*, held by the Trust Secretary.
- 20.3 Commercial sponsorship to attend courses and conference is acceptable only where permission is obtained in advance, and provided the conference is relevant.

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<sup>25</sup> Tavistock & Portman NHS Foundation Trust, *Gifts and Hospitality Procedure*, April 2012

## Appendix A

### 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*<sup>26</sup>.

#### 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*<sup>27</sup> 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;

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<sup>26</sup> See Tavistock & Portman NHS Foundation Trust, *Constitution, Election Rules, Standing Orders*, October 2015, Tavistock & Portman NHS Foundation Trust, *Standing Financial Instructions*, September 2016, and Tavistock & Portman NHS Foundation Trust, *Scheme of Delegation of Powers*, June 2016

<sup>27</sup> 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 Services<sup>28</sup>)

- 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 2015*) (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 2015*), *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 where the Director of Finance agrees in writing that the framework provides satisfactory evidence that good value can be achieved; and
  - 4.3.1.3 where under *SFI 13*, in the case of disposal of assets, formal tendering procedures are not required.

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<sup>28</sup> See *The Public Contracts Regulations 2015*, Schedule 3. Part B services are listed as: hotel and restaurant services; transport by rail; transport by water; supporting and auxiliary transport services; legal services; personnel placement and supply services; investigation and security services, other than armoured car services; education and vocational health services; health and social services; and recreational, cultural and sporting services; other services

- 4.3.2 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 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 their next meeting.

#### 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 2015* 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 and whether the tender crosses the EU Procurement thresholds detailed below.

#### 4.4.3 EU Tender Thresholds

	Supply, Services <sup>1</sup> and Design Contracts	Works Contracts <sup>2</sup>	Social and other specific services <sup>3</sup>
Central Government <sup>4</sup>	£106,047 €135,000	£4,104,394 €5,225,000	£589,148 €750,000
Other contracting authorities	£164,176 €209,000	£4,104,394 €5,225,000	£589,148 €750,000
Small Lots	£62,842 €84,000	£785,530 €1,000,000	n/a

1 With the exception of the following services which have different thresholds or are exempt:

- Social and other specific services (subject to the light touch regime) Article 74.
- Subsidised services contracts specified under Article 15.
- Research and development services under Article 14 (specified CPV codes are exempt).

2 With the exception of subsidised works contracts specified under Article 13.

3 As per Article 74. Services are listed in Annex XIV. Applying in Scotland from March 2016.

4 Schedule 1 of the Public Contracts Regulations lists the Central Government Bodies subject to the WTO GPA. These thresholds will also apply to any successor bodies.

#### 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. 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 Where use of an e-auction or other form of electronic tendering process is required to achieve best value, then a proposal to use such an electronic system may be submitted to the Director of Finance with details of how fairness and transparency will be ensured and demonstrated by the system.

If the Director of Finance agrees in writing that the proposed electronic system of tendering is necessary, fair and transparent, then it may be used in place of the postal system described in paragraph 5.1.3, 5.3 to 5.6, and the details and agreement recorded in the *Register of Tenders*.

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

- 5.1.3.1 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
- 5.1.3.2 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.
- 5.2.3 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.

5.2.4 Every invitation to tender for building or engineering works (except for maintenance work, when *Estatecode*<sup>29</sup> 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 designated by the Chief Executive. Such senior officers 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*).

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

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<sup>29</sup> Op. cit

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 officer from the Finance Directorate from serving as one of the two senior 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.
- 5.7.3 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.
- 5.7.4 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 retained with the *Register of Tenders*.
- 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:
  - 5.7.5.1 experience and qualifications of team members;
  - 5.7.5.2 understanding of client's needs;
  - 5.7.5.3 feasibility and credibility of proposed approach; and
  - 5.7.5.4 ability to complete the project on time.
- 5.7.6 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.

- 5.7.7 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.
  - 5.7.8 The use of these procedures must demonstrate that the award of the contract was:
    - 5.7.8.1 not in excess of the going market rate / price current at the time the contract was awarded; and
    - 5.7.8.2 the best value for money.
  - 5.7.9 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*.
- 5.9 Tender reports to the Board of Directors
- 5.9.1 Reports to the Board of Directors will be made on an exceptional circumstance basis only.
- 5.10 Lists of approved firms
- 5.10.1 Responsibility for maintaining list
    - 5.10.1.1 An officer 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.

- 5.10.1.2 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.
- 5.10.1.3 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 Equality Act 2010 and any amending and/or related legislation or binding guidance.
- 5.10.1.4 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 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.

## 5.10.2 Building and engineering construction works

- 5.10.2.1 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*<sup>30</sup> guidance.

### 5.10.3 Financial standing and technical competence of contractors

5.10.3.1 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 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 Procurement Officer.

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

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<sup>30</sup> Op. cit

The Quotation Acceptance form in *Appendix F* should be completed 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 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 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*<sup>31</sup>;
- 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

- 11.1 Competitive tendering or quotation procedures shall not apply to the disposal of:
  - 11.1.1 any matter in respect of which best value can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;
  - 11.1.2 obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust; and
  - 11.1.3 items with an estimated sale value of less than £2,000, this figure to be reviewed on a periodic basis.

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<sup>31</sup> Op. cit

## 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, the 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 (if applicable):**

--

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

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SFI

<b>Proposed supplier:</b>				
<b>Reason why competitive tendering is not considered practicable:</b> <i>(Refer to SFI Appendix A, paragraph 4.3.2)</i>				
<b>Proposed by:</b>				
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;"></td> <td style="text-align: right; font-size: small; color: gray;">DD/MM/YYYY Y</td> </tr> <tr> <td style="border-top: 1px solid black; padding-top: 5px;">Director / Manager responsible for project</td> <td style="border-top: 1px solid black; padding-top: 5px; text-align: right;">Date</td> </tr> </table>		DD/MM/YYYY Y	Director / Manager responsible for project	Date
	DD/MM/YYYY Y			
Director / Manager responsible for project	Date			
<b>Approved by:</b>				
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Director of Finance	Date			
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;"></td> <td style="text-align: right; font-size: small; color: gray;">DD/MM/YYYY Y</td> </tr> <tr> <td style="border-top: 1px solid black; padding-top: 5px;">Chief Executive</td> <td style="border-top: 1px solid black; padding-top: 5px; text-align: right;">Date</td> </tr> </table>		DD/MM/YYYY Y	Chief Executive	Date
	DD/MM/YYYY Y			
Chief Executive	Date			
<b>Recorded in the <i>Register of Tenders</i> by:</b>				

<hr/>	DD/MM/YYYY Y
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 recorded on this form and counter-signed by the Chief Executive or Director of Finance.
3. This form and a copy of the requisition in question must then be sent to the Procurement Officer.
4. This form must then be sent to the Trust Secretary. The details 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** *(if applicable):*

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

**Proposed supplier:**

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

<b>Works, goods, or services to be purchased or contracted:</b>	
<b>Length of proposed contract</b> <i>(if applicable):</i>	
<b>Value of purchase or contract:</b> <i>(show annual and total value, if applicable)</i>	
<b>Summary of Tenders</b>	
<b>Organisation 1</b>	
Tendered Sum	
Experience and qualification	

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

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## 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.

<b>Have the requirements of the specification been met</b>				
<b>Was the project / goods delivered within the agreed timescale</b>				
<b>Was the project / goods delivered within the tendered sum</b>				
<b>Reviewed by:</b>				
<table style="width: 100%; border: none;"> <tr> <td style="border-top: 1px solid black; width: 60%;"></td> <td style="border-top: 1px solid black; width: 40%;"></td> </tr> <tr> <td style="border: none;">Name &amp; Job Title</td> <td style="border: none; text-align: center;">DD/MM/YYYY Date</td> </tr> </table>			Name & Job Title	DD/MM/YYYY Date
Name & Job Title	DD/MM/YYYY Date			

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

## Appendix F

### Quotation Acceptance Form

1. The Trust's requirements for accepting quotations are set out in *SFI Appendix A, Paragraph 6.2*
2. Once completed this form must be sent to the Procurement Officer.

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

<b>Length of proposed contract</b> <i>(if applicable):</i>	
<b>Value of purchase or contract:</b> <i>(show annual and total value, if applicable)</i>	
<b>Summary of Quotations</b>	
<b>Organisation 1</b>	
Sum	
<b>Organisation 2</b>	
Sum	
<b>Organisation 3</b>	
Sum	
<b>Accepted Quotation</b>	

<b>Name of Organisation</b>	
<b>Reasons for accepting quotation</b>	
<b>I confirm that the accepted quotation represents the best value for money</b>	
_____ Name & Job Title	DD/MM/YYYY Date
_____ Name & Job Title	DD/MM/YYYY Date
<b>I confirm that the accepted quotation will not commit the Trust to expenditure in excess of that which has been allocated</b>	
_____ Name & Job Title	DD/MM/YYYY Date
_____ Name & Job Title	DD/MM/YYYY Date

SFI



## Board of Directors : September 2016

**Item :** 16

**Title :** Constitutional Amendments – Executive Director representation on the Board of Directors

**Summary:**

This paper seeks the Board of Directors agreement to approve two changes to the composition of the Board of Directors: a change of job title for an existing voting director, and the addition of a new non-voting director.

Constitutional changes need to be approved by the Board of Directors, the Council of Governors and by the Trust members at the Annual General Meeting. Monitor no longer has a role in approving foundation trusts' constitutions.

The Board is asked to approve these changes to the Constitution. The Council of Governors will also be asked to agree the changes, and they are subject to ratification by members at the AGM.

**For :** Approval

**From :** Trust Secretary

## Constitutional Amendments

### 1. Introduction

- 1.1 Membership of the Board of Directors is governed by our constitution and any changes to the membership of our Board require a change in our constitution as a Foundation Trust.
- 1.2 Changes to the Constitution need to be approved by the Board of Directors, the Council of Governors and at the Annual General Meeting. Monitor no longer has a role in approving foundation trusts' constitutions although trusts are still required to forward a copy of their amended constitutions to Monitor for publishing on Monitor's website.

### 2. Proposed change to Board composition

- 2.1 In the wake of our visit by CQC and to strengthen our senior management capacity in respect of quality I am proposing extending Louise Lyon's current role in respect of quality and patient experience to become a full time post.
- 2.2 We have already agreed a number of objectives in our 2 Year Strategic Plan in respect of quality, patient experience and the wellbeing of our staff group and initial feedback from CQC suggests a number of other issues we will need to address. In particular, there will be a challenge for us to implement a more systematic approach to quality improvement across the organisation. Strengthening our senior leadership capacity will be crucial to meeting internal and external expectations in this area.
- 2.3 As a result of this it will be necessary to make a new appointment to the role of Director of Adult and Forensic Services. There are some important challenges in this area and the new post-holder would be responsible for taking forward the recommendations of the Adult Services Development Group
- 2.4 It is proposed that both post-holders should be members of the Board subject to agreement of a change to our constitution. A proposed wording the constitutional amendments is shown at **Annex A**.
- 2.5 It is proposed that the Director of Adult and Forensic Services is a non-voting role, in common with the Director of CYAF.
- 2.6 In considering adding additional non-voting Executive Directors it is important to consider the balance between Executive and Non-Executive directors on the Board. We must, and we do, have a Non-Executive majority when it comes to voting positions. However, the custom of our Board culture means that voting is very rare, and so the distinction between voting and non-voting members is blurred, with

all Directors on the Board contributing to the discussions equally. We do already have two non-voting members, and we have never had any indication from any of our board reviews that this is a problem, but it is a potential issue that must be recognised. Our opinion is that the advantages of the change outweigh the potential downsides at this time.

### **Recommendation**

- 3.1 The Board of Directors is requested to agree a proposal to amend the Constitution of the Trust to include an additional non-voting post for the Director of Adult and Forensic Services and to change the title of an existing executive director. This will be subject to agreement by the Council of Governors and ratification at the AGM.

Paul Jenkins/Gervase Campbell  
Chief Executive/Trust Secretary  
September 2016

## **Annex A – Proposed amendment to the Constitution**

It is proposed to change the wording of section 19 of the constitution to increase the number of non-voting Executive Directors from 2 to 3, and to change the title of one existing Executive Director. New wording/paragraphs are indicated in italics below.

### **19 Board of Directors – Composition**

19.1 The Trust is to have a Board of Directors, which shall comprise both Executive and Non-Executive Directors

19.2 The Board of Directors is to comprise:

19.2.1 A Non-Executive Chair;

19.2.2 five other Non-Executive Directors; and

19.2.3 five voting Executive Directors and *three* non-voting Executive Directors

19.3 One of the Executive Directors shall be the Chief Executive.

19.4 The Chief Executive shall be the Accounting Officer.

19.5 One of the Executive Directors shall be the Finance Director.

19.6 One of the Executive Directors is to be a registered medical practitioner.

19.7 One of the Executive Directors shall be the Director of Education and Training/ Dean of Postgraduate Studies.

19.8 *One of the Executive Directors shall be the Director of Quality and Patient Experience.*

19.9 One of the Executive Directors shall be the Director of Children, Young Adults and Family Services (CYAF); this Executive Director will be a non-voting Executive Director.

19.10 *One of the Executive Directors shall be the Director of Adult and Forensic Services; this Executive Director will be a non-voting Executive Director.*

19.11 One of the Executive Directors is to be a registered nurse or a registered midwife; this Executive Director will be non-voting Executive Director.

**BOARD OF DIRECTORS (PART 1)**

Meeting in public

Tuesday 27<sup>th</sup> Sept 2016, 14.00 – 16.00

Lecture Theatre, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

**AGENDA**

<b>PRELIMINARIES</b>				
<b>1.</b>	<b>Chair's Opening Remarks</b> Prof Paul Burstow, Trust Chair		Verbal	-
<b>2.</b>	<b>Apologies for absence and declarations of interest</b> Prof Paul Burstow, Trust Chair	To note	Verbal	-
<b>3.</b>	<b>Minutes of the previous meeting</b> Prof Paul Burstow, Trust Chair	To approve	Enc.	p.1
<b>3a.</b>	<b>Outstanding Actions</b> Prof Paul Burstow, Trust Chair	To note	Verbal	-
<b>4.</b>	<b>Matters arising</b> Prof Paul Burstow, Trust Chair	To note	Verbal	-
<b>REPORTS &amp; FINANCE</b>				
<b>5.</b>	<b>Student Story – CYAF Complex Needs</b>	To discuss	Verbal	-
<b>6.</b>	<b>Service Line Report – Complex Needs, CYAF</b> Dr Rachel James, Associate Clinical Director	To discuss	Enc.	p.9
<b>7.</b>	<b>Trust Chair's and NEDs' Reports</b> Prof Paul Burstow, Trust Chair	To note	Verbal	-
<b>8.</b>	<b>Chief Executive's Report</b> Mr Paul Jenkins, Chief Executive	To note	Enc.	p.26
<b>9.</b>	<b>Public Affairs Strategy</b> Ms Laure Thomas, Director of Communications & Marketing	To discuss	Enc.	p.31
<b>10.</b>	<b>Quality Improvement Plan Update</b> Ms Louise Lyon, Director of Quality & Patient Experience	To note	Enc.	p.42
<b>11.</b>	<b>Finance and Performance Report</b> Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	Enc.	p.49
<b>12.</b>	<b>Training and Education Report</b> Mr Brian Rock, Director of Education and Training/Dean	To note	Enc.	p.58
<b>13.</b>	<b>Q1 CQSG Report</b> Dr Rob Senior, Medical Director	To note	Enc.	p.63
<b>14.</b>	<b>Responsible Officer's Revalidation Report</b> Dr Rob Senior, Medical Director	To note	Enc.	p.72

<b>15.</b>	<b>Standing Financial Instructions</b> Mr Simon Young, Deputy Chief Executive & Director of Finance	To approve	Enc.	p.76
<b>16.</b>	<b>Constitution Changes – board composition</b> Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.153
<b>CLOSE</b>				
<b>17.</b>	<b>Notice of Future Meetings</b> <ul style="list-style-type: none"> <li>• Tuesday 4<sup>th</sup> Oct 2016: Joint Boards Meeting, 12.30pm – 5.30pm</li> <li>• Wednesday 5<sup>th</sup> Oct 2016: AGM, 4.00pm – 7.00pm, Tavistock Centre</li> <li>• Tuesday 29<sup>th</sup> Nov 2016: Board Meeting, 2.00pm – 5.30pm</li> </ul>		Verbal	-