# AGENDA FOR THE SPECIAL MEETING OF THE BOARD OF DIRECTORS
# TUESDAY 19TH DECEMBER 2017
# VENUE: THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON
# AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

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| **Item 1** | Declarations of Interest. | | |
| **Item 2** | Chairman's Report. | **Chairman** | **Verbal** |
| **Item 3** | To consider any issues raised by Governors. | **Board** | **Verbal** |

Quality Items (9.40 am)

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| **Item 4** | To consider a report on the staffing establishment review. | **EM** | **Attached** |
| **Item 5** | To consider any matters of urgency arising from the meeting of the Quality Assurance Committee held on 7th December 2017. | **HG/EM** | **Verbal** |
| **Item 6** | To receive and note a progress report on managing waiting times in child and adolescent mental health services. | **DB** | **Attached** |

Governance (10.20 am)

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| **Item 7** | To approve the revised Standing Financial Instructions.<br><br>*(Note: the views of the Audit Committee on this matter will be reported verbally to the meeting).* | **DK** | **Attached** |

Items for Information (10.25 am)

**Item 8** To note that the next ordinary meeting of the Board of Directors will be held on **Tuesday 30th January 2018** in The Durham Centre, Belmont Industrial Estate, Durham, DH1 1TN at 9.30 am.

Confidential Motion (10.30 am)

**Item 9** **The Chairman to move:**

*"That representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:*

*Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, the Trust.*

*Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.*

*The amount of any expenditure proposed to be incurred by the Trust under any particular contract for the acquisition of property or the supply of goods or services.*

*Information relating to the financial or business affairs of any particular person (other than the Trust).*

*Information which, if published would, or be likely to, inhibit -*
*(a) the free and frank provision of advice, or*
*(b) the free and frank exchange of views for the purposes of deliberation, or*
*(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.*

*Any advice received or information obtained from legal or financial advisers appointed by the Trust or action to be taken in connection with that advice or information.*

Lesley J Bessant.

**Mrs. Lesley Bessant**
**Chairman**
**13th December 2017**

**Contact:** Phil Bellas, Trust Secretary Tel: 01325 552312/Email: p.bellas@nhs.net

**Item 4**

# BOARD OF DIRECTORS

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|---|---|
| **DATE:** | **19th December 2017** |
| **TITLE:** | **Safe Staffing: An evidence based establishment review of inpatient wards using the Hurst Ward Multiplier Tool and professional judgement approaches.** |
| **REPORT OF:** | **Elizabeth Moody, Director of Nursing and Governance and Joe Bergin, Safe Staffing Programme Manager** |
| **REPORT FOR:** | **Information/decision** |

| **This report supports the achievement of the following Strategic Goals:** | ✓ |
|---|---|
| ***To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing*** | ✓ |
| ***To continuously improve to quality and value of our work*** | ✓ |
| ***To recruit, develop and retain a skilled, compassionate and motivated workforce*** | ✓ |
| ***To have effective partnerships with local, national and international organisations for the benefit of the communities we serve*** | |
| ***To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.*** | ✓ |

## Executive Summary:

This report is to update the Board of Directors on the progress of the in-patient establishment reviews that commenced in early 2017 in line with the NQB Safe Staffing Guidance, 2016. This includes a description of the Trust wide application of the Hurst "*Ward Multiplier Tool for Mental Health"* along with professional judgement approach and including the use of benchmarking with peers via the Care Hours Per Patient Day (CHPPD) data analysis for information collated for the month of September 2017.

No national workforce tool currently incorporates all required factors and so combining methods (triangulation) is recommended as a methodology to arrive at optimal staffing levels. National guidance for conducting establishment reviews recommends the inclusion of quantitative assessments such as those encapsulated in the Hurst multiplier tool and other more qualitative and professional judgement methods to increase confidence in recommended staffing levels and provide balanced assurance. This approach is also advocated by the Royal College of Nursing report (RCN 2010).

The Hurst evidence based tool has provided initial outputs and considerations for the staffing requirements of those wards participating in the Trust wide exercise however it is to be viewed in context with professional judgement outcomes; it is not intended or recommended to be used in isolation of other factors ensuring good quality care. There are identifiable patterns and trends that are apparent from the data which would indicate that some additional investment may be required in relation to in–patient staffing

establishments/registered nursing ratios when examined in conjunction with the professional judgement approach. However, there have been lessons learned from application of the methodology and this remains a snapshot view of a point in time against a backdrop of increasing patient acuity; evolving models of delivering effective care; service transformation; the introduction of new and emerging roles including Nursing Associates, psychology assistants and multi-professional Approved Clinicians as well as innovative methodologies for working more efficiently.

Since the data was collated, some additional investment has already been identified and implemented as set out in section 5, Phase 1. Additionally, recent and planned future service re-provision means that further discussion is required at EMT in January 2018 to review the findings carefully in order to understand the relationship between patient dependency, nursing requirements and current utilisation of budgeted resources in the context set out within section 4 and within the overall financial plan.

It is therefore suggested that the Trust would benefit from further assessment and analysis to develop a phased approach to manage and address ward based establishments as set out in the next steps section of this paper. It is envisaged that once agreed, this is overseen/co-ordinated by the Safe Staffing Programme Board.

**Recommendations:**

For the Board to:

- Review the contents of the report and the issues raised for further investigation and development with regard to staffing establishments on the Trust's inpatient wards, and comment accordingly.
- Approve the phased approach to implementation and further actions as set out in the paper.
- Agree proposed timelines for phases.

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| **MEETING OF:** | **Board of Directors** |
| **DATE:** | **19th December 2017** |
| **TITLE:** | **Safe Staffing: An evidence based establishment review of inpatient wards using the Hurst Ward Multiplier Tool** |

## 1. INTRODUCTION & PURPOSE:

1.1 This paper is a progress report for information regarding the Trusts inpatient wards staffing establishment review commenced in February 2017 based on the Trust wide application of the Hurst "*Ward Multiplier Tool for Mental Health* and the subsequent professional judgements meetings thereafter. It is to provide an update for the Trust and to explore future staffing requirements and methodologies for ongoing review.
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1.2 The National Quality Board (NQB) have defined a set of guidelines [1] with a further resource made available for mental health [2]. The aim is to support the recommendations set out in Francis Report [3] and Hard Truths report [4][5] by providing a set of expectations to deliver "safe, effective, caring, responsive and well led care",[1][2] part of which requires NHS Trusts to use "evidence based tools to inform staffing capacity and capability" [6] aligned and balanced against professional judgement.

## 2. BACKGROUND INFORMATION AND CONTEXT:

### 2.2 Overview of the Evidence Based Tool used – Hurst Tool

2.2.1 The needs of mental health in-patients are individually unique and complex and a generic approach cannot always be applied, a paucity of available tools and processes to measure and categorise the level of need of Mental Health (MH) patients, gives rise to a variation in staffing levels to address local needs. [7]

2.2.2 The ward multiplier tool developed by Professor Keith Hurst provides detailed workforce information and will benchmark staffing numbers calculated on the dependency or levels of need of the patients,[8] and is continuing to be developed, updating the statistical model and increasing the range of clinical areas within the mental health services that it can be applied to (noting caveats as set out in section 4.2).

2.2.3 For the purpose of this Trust wide undertaking, in accordance with HEE, [6][8] the Hurst multiplier tool was used to calculate staffing need based on dependency levels. This required that ward staff and ward managers complete and return assessment scores on patient dependency/acuity. The task was to then convert the occupancy, acuity and actual staffing data into a workload index. Strengths and weaknesses of the tool are highlighted in Table 1 (Appendix 1).

2.2.4 Professional judgement (consensus) and knowledge is an established approach to setting safe staffing levels and is recommended by the Royal College of Nursing and NICE as integral to the establishment review process to inform the skill mix of staff. It is used at all levels to inform real-time decisions about staffing taken to reflect changes in acuity/dependency and activity, and is therefore crucial in providing the local context and the needs of the patient. The triangulation of this experience and

expertise, care quality indicators and performance data in conjunction with the Hurst tool outcomes can then provide a balanced and meaningful view of the staffing requirements. The recommended pro-forma described in the recent NHSI Mental Health draft guidance for conducting a professional review was used for this exercise, which was broadly conducted Trust wide with the inpatient units and wards. Due to the geography and size of the Trust this has been a lengthy and not an insignificant task.

### 2.3 Care Hours Per Patient Day

2.3.1 The Carter Report [9] concluded that current systems around setting appropriate staffing levels systems are not a good guide and recommends a new approach to provide a single consistent way of recording and reporting deployment of staff working on inpatient wards/units – Care Hours Per Patient Day (CHPPD). The report argues that CHPPD gives a more accurate view of the availability of staff and overcomes the limitations of the fixed staff ratios formula approaches by comparing actual versus planned staffing in line with available nursing hours to meet patient need.

2.3.2 This metric is calculated by adding the hours of registered nurses and the hours of healthcare support workers that were on the electronic health roster and dividing the total by number of patients on the ward over a 24 hour period. There was a requirement by NHSI in September 2017 for all Mental Health Trusts from to provide data for CHPPD for the month; Allied Health Professional staff (registered and unregistered) were also included for this exercise, however it is noted that the AHP data returns from this exercise does not equate to the overall AHP provision from the trust, as only AHPs that were rostered directly to a ward were included in the results whereas “pooled” resources were not. The CHPPD information also supports benchmarking with peers for comparable wards as recommended in the NQB guidanc45e.

## 3. HURST DATA COLLECTION

### 3.1 Overview

3.1.1 Each patient on the inpatient ward was assessed each day over a 14 consecutive day period during the months of January and February 2017. This occurred in each of the five Trust localities and across speciality.

3.1.2 This assessment was graded against predefined set criteria identified in the Hurst Tool, and was recorded twice daily (day shift and night shift) and captured in a spreadsheet. These grades were tallied to provide a score for that 12 hour period providing a dependency level (score 1-5), as shown in Table 2 (Appendix 1).

3.1.3 Professional judgement reviews were then conducted with each ward with the Ward Managers/Modern Matrons and representation from Heads of Nursing.

### 3.2 Issues and Observations

3.2.1 Some data quality issues were noted from the data collection process. These now form part of a lessons learnt for future establishment review processes, which should be more robustly managed by the operational managers to ensure that assessment

scores are adequately challenged with regard to the recorded score. These issues include:

- Missing entries and/or missing data elements that may lead to potential false low score. These missing elements/zero scores were amended to give the minimum range value of 1 which may still provide a false low score
- Inconsistent data elements - potentially unrealistic fluctuation of acuity and dependency scores.
- Potential for subjective and differing interpretation by staff of the rating scales in the tool resulting in false low score - this may be influenced by staff being desensitised to levels of acuity in their speciality from a perceived normalised view of their patient group – thereby a false low score of acuity may be recorded. This was highlighted through the professional judgement review for one PICU unit in comparison to AMH wards.

## 4. HURST TOOL OUTCOMES

4.1 The resultant Hurst Tool calculations were then compared against the current budgeted establishment for the wards included in the exercise, across speciality and locality.

### 4.2 Caveats and considerations

The Hurst multiplier is a nationally recognised and a validated approach to gauging nurse staff requirements. However, there are a number of issues that need to be considered;

4.2.1 Calculations were based on Registered Nurse (RN) to Health Care Assistant (HCA) ratios recommended by Hurst Tool as detailed below:

| Speciality | RN to HCA ratio |
|---|---|
| Adult Mental Health | 58% : 42% |
| Mental Health Services for Older People | 48% : 52% |
| Children and Young Persons Services | 66% : 34% |

4.2.2 The current budgeted establishment generally employed by the Trust of RN to HCA ratio is approximately 40%:60% respectively across the majority of wards. This means that on a typical daytime shift less than half the nursing staffs on duty on the Trusts wards are registered nurses. With this skill mix it is recognised there is a risk that care giving may be inappropriately delegated, with few RNs feeling they have the time to supervise health care assistants properly. Although evidence is limited within a mental health setting, for nursing generally there is a growing body of evidence in relation to the increased ratio of qualified nurse staffing leading to improved patient outcomes, reduced mortality and safer care. Evidence in the literature links low staffing levels and skill mix ratios to adverse patient outcomes (Rafferty et al. 2007; NPSA 2009; NICE 2014). Currently for AMH the Trust ratio for RNs per 10 beds is below the national benchmarking mean and median values. The

national benchmark for RNs per 10 beds in older persons services show the Trust to have a value of 7.0 which is also below the national median and mean.

4.2.3 Using the Hurst model on its own will therefore for the trust, produce an increased requirement for RN's above their current establishment and conversely a potential reduction in the HCA establishment. The Hurst data however is to be viewed in context with professional judgement outcomes; it is not intended or recommended to be used in isolation of other factors ensuring good quality care.

4.2.4 The Hurst tool is not as reliable in relation to smaller / specialist areas as the multipliers will recommend staffing levels which are unfeasible for such small numbers of beds.
The Hurst algorithm can produce results that give very low numbers for nightshifts, less than 1 staff member – even negative values. This is particularly the case for smaller units\wards, and those returning low acuity scores for their patients. This was discussed directly with the tool author, Keith Hurst, who confirmed that this was a known artefact in these circumstances and in these instances advised professional judgement is necessary. This situation occurred several times in the resultant dataset and was not felt to be valid for use on Trust night shift establishments.

4.2.5 Based upon professional judgement, a recommendation is made that for this phase of the staffing review, we would therefore maintain the current establishment for nightshift, pending further analysis and exploration of alternative models and strategies for building in flexible nursing resource to meet unplanned but largely predictable episodes of high acuity, dependency and risk 'out of hours'. The Trust has already recently provided significant investment with the Duty Nurse Coordinator role for 'out of hours' periods, which will provide increased support and cover at these times. The additional band 6 roles will feature in the revised establishments within localities. For this first phase of the review process it is suggested the tool is used to define the day shift staffing establishment only.

### 4.3 Professional Judgement Discussions

4.3.1 The professional judgement reviews that were conducted revealed some common themes that include; the need for improved administrative support provision; computers and technology; mandatory training; staff inductions; skill mix; environmental issues; shift patterns; handovers; and feedback to ward staff. These are summarised in Appendix 2. It is to be noted that the Trust have already undertaken actions to those areas that require priority. The feedback will also be used to inform the Model Wards programme.

### 4.4 Additional points to consider with respect to the Hurst outcomes

- As a nursing multiplier tool, it does not take into account multi-disciplinary working. In line with the more recent guidance that requires a broader view to be taken into account such that alongside nursing ratios, other staff groups from the MDT should also be considered. Quality care and treatment should be delivered by the appropriate staff with the required skill set.
- Education, recruitment and retention, and other work supply issues will also need to be considered and examined.
- The recent RPIW outcomes for a Duty Nurse Coordinator has been approved by the Trust which has provided additional resources which represents considerable

additional investment in registered nurse complements at a relatively senior level. These roles will provide support to more junior or less experienced staff at these times and as such enable effective decision making in a timely manner.

- Staffing levels for PICU were recently adjusted and agreed by the Trust in response to CQC recommendations and national guidelines. As such the PICU establishments are already implemented and will only feature in 6 monthly establishment reviews.

4.5 **Initial outputs and considerations**

4.5.1 The data from the Hurst Tool outcomes has been reviewed against the acuity and activity described by the ward; bed numbers; CHPPD; current budgeted establishment; current and previous year spend and WTEs used, including overtime, bank, and agency utilisation and national benchmarks. Initial analysis of information indicates trends apparent within certain areas of speciality, which would indicate that some additional investment may be required in relation to in–patient staffing establishments/registered nursing ratios when examined in conjunction with the professional judgement approach, however also presents some apparent outliers and areas to explore further questions regarding the accuracy of the results.

4.5.2 Recent discussions have been held with Heads of Nursing and Directors of Operations to achieve a further level of professional judgement with regard to the validity and accuracy of the initial results. A paper detailing the triangulated analysis of results will be taken to EMT in January 2018. It is recommended however that the professional judgement approach is taken into consideration along with the results shown in the Hurst tool due to the changing circumstances and issues detailed below.

4.5.3 As part of the re-provision and restructuring of services to accommodate work at Roseberry Park Hospital, the adult mental health ward at Sandwell Park Hospital is currently closed; and similarly it is forecast that there will be a re-provision of AMH and MHSOP services from The Friarage Hospital. Likewise, current developments about future in-patient provision at Harrogate and the new hospital staffing model in York. These will all need to be factored into any recommendations regarding staffing establishments.

4.5.4 It is to be considered that there is a contingency of staff that have moved to Roseberry Park Hospital from AMH wards at Sandwell Park Hospital following the temporary ward closure, and this will also need to be considered in the final analysis.

4.5.5 Since the Hurst data was collated, Teesside MHSOP services are undergoing environmental change due to estates work at Roseberry Park which has involved a change in ward establishments following the realignment of inpatient provision. Staff have been reallocated to Westerdale North ward providing a 24% increase in staffing to the ward (and have increased their bed numbers by 10% also); and to Westerdale South ward resulting in a 30% increase in staffing. It was established at the Tees MHSOP professional judgement meeting that due to this reallocation of resources that staffing was now sufficient for the MHSOP wards in Teesside at this current time. This will need to be factored into the establishment reviews and reviewed on a 6 monthly basis.

4.5.6 Acomb Garth from York was not included in the original exercise due to it not being opened at that time, and will therefore require review in the next phase as will the reduced bed occupancy throughout the periods of existing data collection.

4.5.7 The accuracy and relevancy of the Hurst outcomes for CYPS in these highly specialised services provided by the Trust has been discussed, and it is recommended that professional judgement is to take precedence in determining staffing levels at this time, and for further work to be undertaken with regard to considering other evidence based tools within this area in a subsequent phase of this review.

4.5.8 It is recognised that there are potential changes regarding the restructuring of Adult Rehabilitation services Trust wide to enhance the community provision for this speciality; and additionally in respect to Teesside services due to planned work at the Roseberry Park Hospital site. Again, this will need to be factored into the establishment reviews and reviewed on a 6 monthly basis.

4.5.9 Primrose Lodge and Willow Ward were not captured in the initial review and will be reviewed in a subsequent phase, where it is also suggested that North Yorkshire Adult Rehab service also be reviewed further. For example, The Orchards' financial figures for the total spend on substantive and temporary staffing outturn for 2016/17 and the forecast for 2017/18 is ~1%-2%.above the budgeted establishment respectively, It's average CHPPD metric is on a par nationally and is well above the national median for similar wards. It is suggested that use of temporary staffing may be best is employed for the interim pending further review.

4.5.10 Given the significant difference in values, that are contrary to the professional and clinical view of ward requirements for FLD and supported by current spend on staffing, the recommendation for FLD services at this time is that a further and more focussed review which will explore different approaches and tools will be undertaken in a subsequent phase of the project, collaborating with the Model Ward programme.

4.5.11 The current RN to HCA ratio in Forensic Services has shown to be approximately 33% to 67% RN to HCA ration (as identified during the CHPPD data collection in September 2017) against the 58%:42% recommended by Hurst. As highlighted in section 4.2.4, the tool has limitations in smaller/specialist areas and therefore the results will require further review.

4.5.12 The Hurst Tool multipliers used for FMH were the same as AMH. Feedback from the author, Keith Hurst said that this approach would suffice however, there is currently development on a specific set of multipliers for FMH that reflect the acuity of this service user group. Following further discussion it is felt that it would be appropriate to undertake, similarly as per FLD, a focussed review which will explore different approaches and tools collaborating with the Model Ward programme.

4.5.13 In respect of the potential to increase clinical hours from registered nursing staff, it is suggested that a review of ward based administrative support may benefit this.

## 5. NEXT STEPS

5.1 Phase One of the review as described below is now complete although further discussion is required at EMT in January 2018 to review the findings carefully in

order to understand the relationship between patient dependency, nursing requirements and current utilisation of budgeted resources in the context of the considerations above and the overall financial plan. Further to this the results and recommendations will be presented to the Trust Board in line with NQB guidelines.

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5.2 **Phase One** *(Feb 17 – Dec 17)*

- Undertake establishment reviews using the Hurst Tool
- To establish a duty nursing system across the Trust, providing senior nurse cover across locality groups. This is to provide a consistent, 24/7, senior nursing presence for staff across designated sites (and satellite units). This requires additional staffing of 10.44 WTE Band 6 registered nurses to cover seven nights per week and mobilisation of ward managers and modern matrons across seven days per week in each Locality at an additional total cost of £733,030 per annum.
- Provide increased provision of staff resource to meet needs identified in PICUs which resulted in the addition of a Band 5 registered nurse on each day shift and each night shift at Cedar ward and Bedale ward; an increase of 11.44 WTE at an additional cost of £436,000 per annum.

**Phase Two** *(Jan 18 - December18)*-***Further discussion to take place at EMT to agree priority actions across this phase***

- Subsequent phases of the project to be developed in line with the outputs from establishment review outcomes.
- Consider and agree staffing requirements according to priorities discussed in section 4 to clinical areas highlighted from the Hurst Tool outcomes (EMT paper January 2018).
- Further review of organic and functional MHSOP staffing establishments and requirements.
- Explore the potential of a stepwise approach to meeting recommended RN to HCA ratios and staffing levels as per speciality if proven they are realistic to achieve in respect to the difficulties experienced nationally in recruiting to RNs to post and financially feasible.
- As part of the safe staffing programme, develop a framework that will consider the broader range of roles working flexibly together to ensure that services are purposeful, productive and clinically effective. This will include development and definition of new roles such non-medical Accountable Clinicians (AC), Physician Associates (PA), Nursing Associates, Psychology Assistants roles and the development of skills and knowledge bases for existing roles.
- Develop a framework in conjunction with the model wards programme that determines staffing establishments that are based upon the clinical services required for treatment as stated by the clinical pathway of the patient's journey to deliver outstanding quality care, rather than traditional role definitions.
- Review of tools alternative to Hurst Tool and explore the potential for the Safecare module with Health Roster to support continuing and dynamic review of patient acuity and dependency which will provide robust metrics to inform ongoing establishment reviews (Appendix 2).
- Develop a plan and framework for ongoing and regular establishment reviews annually for all wards, utilising "lessons learnt" i.e. the value of "challenge meetings" to review the recorded data daily and discuss; consideration the

collection period with regard to the size of the Trust and the number of wards involved.

- Evaluate PICU establishments following recent uplift staffing – review with NQB revisiting in 6 months – review environments staffing etc.
- Establishment review of Acomb Garth Ward in York to be undertaken; this ward was not open at the time the initial exercise.
- Further review of all Forensic Services wards collaborating with Model Ward Programme, utilising the best tool and approach to support the determination of required staffing levels.
- Develop a QIS program to gain better understanding of the current practice around patient acuity and observation levels.
- Ongoing work with respect to delivering and maintaining HealthRoster quality and efficiency will continue to be an active aspect of the Safe Staffing Trust wide programme to ensure appropriate and efficient deployment of staff.
- Review of ward based administrative provision.

**Phase Three** (December 18- March19)

- Review of Learning Disability wards, utilising the best tool and approach to support the determination of required staffing levels. Consideration of the national Transforming care programme will be required during this process.
- Further review of Adult Rehabilitation Services wards utilising the best tool and approach to support the determination of required staffing levels, which will be aligned with the Trust wide review of rehabilitation services.
- Review of Eating Disorder Services wards utilising the best tool and approach to support the determination of required staffing levels.
- Revisit nightshift establishments for further review in line with the evaluation of the Duty Nurse Coordinator role.

## 6. IMPLICATIONS

### 6.1 Compliance with the CQC Fundamental Standards:

6.1.1 In order to provide confidence and assurance that the Trust can maintain safe staffing levels a proactive and evidence based approach to staffing establishments is required.

### 6.2 Financial/Value for Money:

6.2.1 This evidence based establishment review has indicated a financial impact to the Trust regarding the provision of the staffing it highlights in the results. However current overspending on flexible staffing to meet patient needs means that some of these costs are already being incurred by the Trust. It should be reinforced that priority areas for investment have over the course of the last 12 months been identified as set out in section 5.2 and implemented (PICU) or are being implemented (out of hours duty nurse provision) which have resulted in additional registered nurse resource.

6.2.2 There are factors to balance and consider against the preliminary view of requirements suggested by the Hurst Tool output that may include changes to the way in which we work such as: staffing according to delivery of care to clinical pathways and models of care; efficient and effective methodologies utilising daily lean management principles; examining the MDT alternatives to simply increasing nursing establishment that may free up the clinical time of the registered nursing staff i.e. increased administration provision; AHP staffing provision; review of the definition of clinical and non-clinical roles; reduction in bed base on wards to increase clinical hours in the patient day. It is expected there will be an evaluation of the operation of the additional resources.

6.2.3 The associated cost from Allocate (software provider) if the use of the Safecare module to be considered going forward; there is a one off upfront cost of £22,300 plus VAT for configuration, training and consultancy which is required regardless of the size of the implementation. Once installed, there is a £27,500 plus VAT recurrent cost, this is a site licence. Unfortunately there is no discount available for piloting. Additional discounts maybe available if other software modules are purchased. A business case will be required should a decision be made by the safe staffing board to pursue.

6.3 **Legal and Constitutional (including the NHS Constitution):**

6.3.1 The Care Quality Commission and NHS England have set regulatory and contractual requirements that the Trust ensures adequate and appropriate staffing levels and skill mix to deliver safe and effective care. Inadequate staffing can result in non-compliance action and contractual breach.

6.3.2 The March 2013 NHS England and CQC directives set out specific requirements that will be checked through inspection and contractual monitoring as they are also included in standard commissioning contracts. The Trust has complied with these directives to date. The 2016 NQB guidance has also been taken into account in the Trust approach.

6.4 **Equality and Diversity:**

6.4.1 Ensuring that patients have equal access to services means staffing levels should be appropriate to demand and clinical requirements.

## 7. RISKS:

7.1 The caveats and considerations discussed in 4.2 impact the results from the evidence based Hurst tool. This will therefore need to be reflected in any decision making processes regarding these outcomes.

7.2 Availability of funding to provide additional staffing establishments will need to be balanced against requirements to provide a safe staffing establishment for the current bed numbers within inpatient services. This is currently mitigated by the current and forecast Trust spend on temporary staffing and overtime.

## 8. CONCLUSIONS:

8.1 The evidence based tool has provided initial results for the staffing requirements for the Trust on those wards participating in the Trust wide exercise. The outputs from the tool are contingent on robust input data. It has been indicated that there are issues of data quality in regard to the data collection process which may influence the obtained results. However even when considering these issues there are patterns and trends that are apparent from the data and as such value remains in these results when examined in conjunction with a triangulated approach including professional judgement.

8.2 However this remains a snapshot view of a point in time against a backdrop of increasing patient acuity; evolving models of delivering effective care; and innovative methodologies for working more efficiently. In order to be responsive to these requirements that these challenges place upon us, and also to the demand upon staffing resources, we require a dynamic and flexible approach to meet these needs in safe and consistent way that will allow for ongoing review of the required staffing establishment.

8.3 In conjunction with the lessons learnt from this initial exercise which can be effectively carried forward on undertaking further establishment reviews, a change in culture and process on the wards is required in line with care pathways and model wards. It is suggested that this will benefit from further assessment, analysis and discussion before considering an approach to fully assess the value and benefit for the Trust of whichever model of staffing is adopted.

## 9. RECOMMENDATIONS:

9.1 For the Board to:

- Review the contents of the report and the issues raised for further investigation and development with regard to staffing establishments on the Trust's inpatient wards, and comment accordingly.
- Approve the phased approach to implementation and further actions as set out in the paper
- Agree proposed timelines for phases.

## 10. REFERENCES

1. National Quality Board. *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe sustainable and productive staffing.* 2016. Available from: https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf (accessed 10 October 2017).

2. National Quality Board. *Safe, sustainable and productive staffing: An improvement resource for mental health. 2017*. Available from: https://improvement.nhs.uk/uploads/documents/Mental_Health_Setting_Improvement_Resource_Engagement.pdf (accessed 10 October 2017).

3. Francis, R. (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary. London: Stationery Office.

4. Department of Health. *Hard Truths: The Journey to Putting Patients First, Vol 1*. 2014. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/270368/34658_Cm_8777_Vol_1_accessible.pdf (accessed 5 October 2017).

5. Department of Health. *Hard Truths: The Journey to Putting Patients First, Vol 2*. 2014. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/270103/35810_Cm_8777_Vol_2_accessible_v0.2.pdf (accessed 5 October 2017).

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## APPENDIX 1

### Further information regarding the Hurst Tool (2015 Version)

| Strengths | Weaknesses |
|---|---|
| Uses variables – discriminates between patients with differing needs | Measures are actual and not predictive |
| Measures workload and patient acuity/dependency | Requires validation of data to prevent 'gaming' |
| Measures throughput | Not suitable for use in small wards |
| | Difficulties with varying shift patterns that can provide inconsistent results |
| Easy to use and understand | Originally designed for Acute Care as the Safer Nursing Care Tool (SNCT) rather than Mental Health |
| | Not suitable for Learning Disability wards |
| | Current criteria possibly subjective and open to interpretation |

**T**

**Table 1 - Strengths and Weaknesses of Hurst Multiplier Tool [10][11]**

The current Hurst Tool (2015 version) calculates the dependency and acuity of the patient by a scoring system from a series of 7 aspects. It is scored according to value falling within a specific range.

**Hurst Assessment Criteria**

- Observation levels
- Help required with personal care
- Continence needs and requirements
- Escorting requirements
- Eating and drinking needs
- Nursing interventions required
- Parents or relatives support required

A grading, according the predefined assessment scale in the tool, was given to each patient for each dayshift and each nightshift. These grades were tallied to provide a score for that 12 hour period providing a dependency level, as shown in Table 2 below, which is reproduced from the Hurst Tool.[11]

Data collection was over a two week period where Hurst states that the average should ideally be from at least a four-week assessment period."[12]

| | |
|---|---|
| **Dependency 1.** General observations. | Self-caring service users who are able to do most daily living activities unaided. Core therapeutic interventions are provided. |
| **Dependency 2.** General observations. | More dependent on ward staff for his/her personal care needs. Requires more than base-level core interventions. |
| **Dependency 3**. May be on intermittent observations. | Heavily reliant on ward team for his/her safety and care. |
| **Dependency 4.** May be on intermittent observations or 1-1 observations for part of the day. | Dependent on the ward team for his/her safety and care. Requires high engagement and intervention. |
| **Dependency 5**. Enhanced observations. | Requires 24 hrs observation and engagement. |

**Table 2 - Hurst Multiplier Tool Dependency Ratings[12]**

**APPENDIX 2**

**Summary of feedback from Professional Judgement Discussions**

- The provision of administrative support to the wards appears to be varied across the Trust.
- Computer networks in general were reported as being “old” and “slow”, but was noted that where Virtual Desktop was implemented that this was reported as successful and had improved the situation. Laptops would be preferable over desktops to allow tasks to be completed on the ward rather than the office.
- Issues reported as impacting upon mandatory training were; smartcard problems and subsequent access to eLearning; geographical issues for North Yorkshire and York & Selby localities by way of training not being available locally. Access to Resus and MOVA training were also highlighted as an issue generally re availability of courses which has subsequently been addressed by the Trust.
- Staff inductions regarding compliance rates were reported as being good.
- Issues were raised regarding skill mix and the balance of experience of staff on the wards, i.e. number of staff on preceptorship, mixed availability of provision of multidisciplinary staff across the Trust, medical recruitment issues. Therapeutic activities to match patient needs are reported to be generally well provided by the MDT in most areas, however AMH and FMH would benefit from increased OT resource which would allow this to be fully supported.
- Teesside and North Yorkshire report numerous issues with the hospital sites at Roseberry Park and Harrogate – the Trust has commenced work to address this.
- York also reported environmental issues in particular the relative isolation of the units from each other in terms of available support, and temporary staffing remains an issue and is dependent upon agency at present due to the current limited bank staff establishment. The Temporary staffing team is currently working in respect to this. The Trust is currently in the process of proving a “new build” hospital in York.
- Mixed feedback in response to shift patterns. Staff views are that they like the 12 or 11½ hours shifts due to the flexibility they have, but find consecutive shifts difficult. Some Ward Managers felt it made shifts “better to cover” whereas it was also mentioned that it is an issue when covering sickness. It was said that 12 hour shifts can provide continuity for the patient, it was reported that communication and staff meetings were problematic due to: “no consistency” and “many days between shifts”. Some areas feel the shift pattern does not reflect the periods of acuity, and now operate a twilight shift and a shift pattern that manages these peak times for incidents. One service expressed that 12 hour shifts may not be the best way to meet patient need. The Trust are involved in research with York University regarding 12 hour shift patterns.
- Two FMH wards state that CQC inspections did highlight issues with staffing and capacity which were being addressed, otherwise feedback from regulators did not identify any issues related to staffing, and was felt to be generally positive.
- Student feedback was reported as “good” and “positive” across the wards, although there was mention regarding the reduced numbers of mentors
- Feedback regarding ward handovers reported back that PIPA has improved handover. Some wards in FMH report that it works well where most others feel that the time is insufficient particularly where it is not the same staff as for the previous days, and is further impacted by the number of temporary staff on shift.

## APPENDIX 3

## Safecare Module

One the many points highlighted by staff on the professional judgement discussions was that the running of the Hurst Tool was a snapshot on a particular point in time which may or may not be indicative of the true picture experienced the ward on a day to day basis. On discussion with peers from other NHS Acute Trusts it was fed back of the benefits from the daily use of the Hurst Tool which is supported by an additional software module to the Health Roster system, called Safe Care. It utilises the Hurst Tool and allows for daily assessment by score rating and professional judgement to proactively view staffing levels and requirements. It will record red flag incidents and provides the continuous view rather than a snapshot to effectively review staffing establishments on a 6-12 monthly basis without the overhead of the large undertaking for this exercise. This promotes continuing workflow as opposed to batching of work, and so supports the lean methodology of efficient working practices.

Additional benefits are that it will allow a level of oversight across the local site and provide a broader context to aid in determining the daily establishment as it gives a current and dynamic picture on acuity and dependency. A key element of this process seen to be most important is the “challenge meetings” that take part in the daily huddles to discuss the assessment of the patients from the visible data. As part of lessons learnt from this Trust based exercise, this “challenge” approach is likely to have provided a more robust and accurate set of data. It will then allow for the use of a better informed view of current needs in allocating staff to meet patient needs. Used alongside professional judgement, bearing in mind the current client group being assessed and their expected timescales of rate of recovery, this may then also support a the predictive assessment to address issues in advance regarding temporary and flexible resourcing to be most effective and responsive to care requirements.

A review to be carried out of alternative approaches and models in addition to the Hurst Tool that the Trust may consider for future and ongoing evidence based establishment reviews. Safecare is being used by peer mental health trusts, further discussion and exploration with other peer Trusts also to be undertaken regarding the benefits seen, and elaboration on how the Safecare module has been adapted more specifically for Mental Health without infringing upon intellectual properties of the Hurst Tool, whist maintaining its statistical validity in outcomes. An example of a recognised and alternative evidence based planning tool is the Scottish Workload and Workforce Planning Tool developed by NHS Scotland since 2004 for acute and mental health services, which will support their soon to be legislated annual review processes for staffing.

**ITEM NO. 6**

**FOR GENERAL RELEASE**

**Board of Directors**

| | |
|---|---|
| **DATE:** | **19 December 2017** |
| **TITLE:** | **CYPS Management of Waiting Times Update** |
| **REPORT OF:** | **David Brown** |
| **REPORT FOR:** | **Information** |

| **This report supports the achievement of the following Strategic Goals:** | ✓ |
|---|---|
| ***To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing*** | ✓ |
| ***To continuously improve the quality and value of our work*** | ✓ |
| ***To recruit, develop and retain a skilled, compassionate and motivated workforce*** | ✓ |
| ***To have effective partnerships with local, national and international organisations for the benefit of the communities we serve*** | ✓ |
| ***To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve.*** | ✓ |

**Executive Summary:**

The Board has received previous reports regarding the work under way to address concerns about excessive waits within CAMHS services. This report includes an update from each locality and provides the position reported up to October 2017 together with a narrative regarding the key areas of action that have been completed and/or are under way. Additional information is provided regarding Autism Spectrum Disorder (ASD) waiting time issues and action which has been taken to date.

**Recommendations:**

The Board is asked to receive this paper and give comment and direction as appropriate.

| | |
|---|---|
| **MEETING OF:** | **Board of Directors** |
| **DATE:** | **19 December 2017** |
| **TITLE:** | **CYPS Management of Waiting Times Update** |

## 1. INTRODUCTION & PURPOSE:

**1.1** The purpose of this report is to update the Trust Board on progress made in minimising waiting times for children & young people accessing our CAMHS services including the Autism Spectrum Disorder (ASD) pathway.

## 2. BACKGROUND INFORMATION AND CONTEXT:

**2.1** The Board has received previous reports regarding the work under way to address concerns about excessive waits within CAMHS services. This report includes details from each locality and provides the position reported to October 2017 and a narrative regarding the key areas of action that have been completed and/or are under way.

**2.2** There has been increasing pressure on the CAMHS service to deliver ASD assessments leading to delays in delivery of a diagnosis for the child or young person. This issue has been widely publicised and therefore each area provided a more detailed update regarding waits and delivery of this pathway. Prevalence rates for autism are estimated between 1 and 2%. Referral rates will vary across localities.

**2.3** To support further understanding of the context for performance in each Locality the Board has requested an analysis of the funding/investment in CAMHS services across the Trust. A summary table of waiting times and investment by Locality can be found in Appendix 1.

## 3. KEY ISSUES:

### 3.1 DURHAM & DARLINGTON

#### 3.1.1 Durham and Darlington all waiting times:

- The locality continues to sustain achievement of waiting times, with 99% of young people having their initial assessment within 4 weeks of referral.

- The locality continue to monitor waiting times as part of daily lean management; any cases breaching the 4 week wait are explored and resolved.

- The locality also monitors waits for a second appointment, ensuring that a second appointment is offered within 9 weeks of referral, ensuring they do not have “hidden waiters”. They are consistently achieving around 85% of young people being offered their second appointment within 9 weeks of referrals; again

breaches are linked to delays in the initial assessment due to engagement or choice.

| 2017 | May | June | July | August | September | October |
|---|---|---|---|---|---|---|
| **% seen in 4 weeks** | 91.29% | 95.93% | 95.36% | 95.17% | 96.18% | 97.30% |
| **Numbers waiting more than 4 weeks** | 13 | 9 | 10 | 7 | 8 | 7 |

### 3.1.2 ASD Update

**Current Position**

- The diagnostic pathway for children and young people is split into two groups. For those young children under the age of five years, paediatrics take the lead with the ASD coordinator (TEWV) working into the pathway. For children over the age of five, TEWV is the lead on the pathway. The main pressures around demand and capacity are related to the pathway for children over five years of age.

- Prevalence of Autism Spectrum Disorders in the UK is estimated, at the lower rate, of 1% of the population. The following table extrapolates this for the local population:

| CYP | CYP Population | Prevalence % | ASD Prevalence |
|---|---|---|---|
| Darlington | 21203 | 1% | 212 |
| Easington | 20563 | 1% | 206 |
| North Durham | 54241 | 1% | 542 |
| South Durham | 35737 | 1% | 357 |
| **County Durham/Darlington** | **131744** | | **1317** |
| | | | |

- Referrals have increased by 127% (between 2013/14 and 2016/7) across County Durham & Darlington. Below is the breakdown across the locality. The locality has liaised with Commissioners around this increase to explore strategies to prevent the escalation of waiting times. Durham & Darlington CAMHS have been asked to complete three business cases within the last eighteen months, one of which was a multi-agency bid. None of these bids have been taken forward as an agreed recurring solution to provide timely access to the diagnostic autism assessment.

Referral Data

| | 2013/14 | 2016/17 | % increase |
|---|---|---|---|
| **North Durham** | **196** | **260** | **33%** |
| **South Durham** | **47** | **187** | **297%** |
| **Easington** | **41** | **135** | **229%** |
| **Darlington** | **17** | **100** | **488%** |
| **TOTAL** | **301** | **682** | **127%** |

- There are currently 442 children waiting for an ASD assessment across the locality, the waiting time for each team is shown below.

| Team | Weeks |
|---|---|
| North Durham | 117 |
| South Durham | 84 |
| Easington | 50 |
| Darlington | 9 |

- The locality has reviewed the demand and the resources needed to meet the demand. If the current capacity and demand remains unchanged, they expect the trajectory of four to six weeks to be added to the waiting time every month.

| Month | Referrals (Demand) | Formulations completed (Capacity) |
|---|---|---|
| May | 59 | 38 |
| June | 70 | 29 |
| July | 66 | 35 |
| August | 36 | 27 |
| September | 53 | 41 |
| October | 45 | 47 |

- The diagnostic pathway is a multi-agency pathway. There is close working and collaboration between partners. However all partners are experiencing difficulties with capacity. The Speech and Language (SaLT) input is provided by Stockton and Hartlepool Acute Foundation Trust. Flow through the pathway is dependent on SaLT assessment and, as TEWV do not operationally manage this, Durham and Darlington are not in a position to increase the throughput without additional sessions from SaLT.

- Durham & Darlington have 4.00 WTE ASD coordinators, 0.80 WTE consultant psychologists and 0.50 WTE SaLT commissioned to deliver the pathway. There are currently 279 young people undergoing an ASD assessment.

- All young people on the ASD pathway have an ASD coordinator who is responsible for facilitating the assessment and pathway implementation. The ASD Coordinator takes on a specific role by providing a single point of contact for the family, young person and other professionals involved. Delivery of the main elements of the TEWV assessment is being consumed by core CAMHS staff. The increase in referrals and demand on core CAMHS also has a significant impact on the capacity within the teams.

### 3.1.3 What Durham and Darlington have done to reduce waiting times

- The service held a Kaizen event in September 2016 to review the ASD pathway. The locality was also allocated non-recurrent funding for ASD waiting times at this time.

- The Kaizen looked at removing all elements of non-value added waste from the pathway, strengthening Tier 2 screening, whilst front-loading some of the observations before starting the pathway, such as school observations and differential diagnosis. The metrics reviewed at 90 days showed an improvement in waiting times as shown below.

**Key Metrics**

| | Baseline | After |
|---|---|---|
| Longest Wait for Assessment | 76 weeks | 18 weeks |
| Time from assessment to formulation | 36 weeks | 16 weeks |
| Numbers on the pathway | 209 | 309 |
| Numbers Waiting | 381 | 128 |

- When non-recurrent funding ended, the waiting times began to deteriorate. This was despite the changes to the pathway and TEWV continuing to employ at risk two posts (band 4 Assistant Psychologists) beyond the agreed funding period 2016/17 to continue to input into the pathway. Retrospective funding was agreed for these posts in November 2017.

### 3.1.4 What the locality can do to streamline the process

- The service has again been allocated non-recurrent funding to reduce waiting times. The bid submitted in September requested non-recurrent funding to address the waiting list and recurrent funding to support a long term solution.

- Although the service welcomes this investment, this needs to be followed up with a long term strategic plan. Recruiting into funding that will end in four months is difficult. They have therefore sought expressions of interest and will look at staff willing to increase part time hours, secondment of SaLT from adult LD and agency.

- The service has reviewed options to streamline the pathway and favour the option to use the short term funding to pilot a five day assessment. They are currently looking at staff secondment to support this. They anticipate that this will commence in December 2017 and will run until March 2018. The service will use QIS methodology to monitor the improvements to feedback to Commissioners and the Board.

- The CCG have a Kaizen event planned in January 2018. The service has sought clarity on the scope of the event and has been advised that this is to review the multi-agency partnership. Whilst the service recognises this is an important piece of work, they have had no clarity how this will impact positively on capacity and demand.

- Educational Psychology was asked to commence an autism review earlier this year. This was to scope what is available for children and young people with speech and language difficulties which may include autism.

- This is an important piece of work as it will focus on the needs of young people rather than the push to look at diagnosis. There is much interest around autism and discussions focused on the diagnosis. As a provider, the locality are working with Local Authority colleagues, particularly in education, to ensure that children and young people who present with social and communication difficulties are able to access support that is not dependent on a diagnosis. This is in line with the Local Authorities Local Offer and Special Educational Needs & Disability (SEND).

- This piece of work is now being referred to as the Autism Review. TEWV are involved in this review; however this is not about the diagnostic pathway but may impact on demand.

### 3.1.5 Conclusion

- The service will look to pilot a streamlined assessment over five days. Findings from this will be shared with SDG and Commissioners.

- Whilst the locality welcomes the opportunity to use the short term funding to pilot an alternative model, they do not believe that allocation of non-recurrent funding at the latter stage of the financial year is an effective use of resource. The service would welcome clarity around long term strategic commissioning to address the pressures around the increase in referrals for an autism assessment.

## 3.2 TEES

### 3.2.1 Tees all waiting times

- The service has sustained the improved performance of time waiting from referral to initial appointment at target for over 18 months, this has improved further with the current position being 99% (October 2017).

- The waiting times continue to be monitored through daily and weekly management processes (Purposeful and Productive Community Services (PPCS) Stage 1 tools).

- The service is now engaging with Stage 2 of PPCS and looking at the whole system and clinical quality. This entails engaging with Commissioners and CCGs alongside the children's workforce.

- The DNA rate is currently 10.6%.

- The support and leadership of the team managers has been pivotal to this success, with them managing and leading the plans/processes that were identified in the previous reports.

Examples of developing new ways of working include:

- The locality staff have been involved in training and development of the children's workforce and have now commenced training with parents in receipt of children's mental health services to increase their understanding of difficulties. The early feedback is positive in that parents are saying this new learning is helping them support their children and understand why clinicians/ service advise what they do.

- The training also has included Mental Health First Aid to schools, LA and parents/carers helping to support them (particularly around challenging times – ie suicide), strengthen confidence and reduce referrals.

- The locality are currently training Children's Psychological Wellbeing Practitioners (CWPs) in Wave 6 of CYP-IAPT. This development is embedded within the business plan and the service is committed to including these roles within the skill mix of the service, thus providing high intensity work for low level difficulties. They have also committed to having more CWP training posts in Wave 7 to provide further skill mix within the workforce.

- The service is also aware of QIS work done around core groups that should be offered in each team and are currently completing a baseline of what is currently offered to map against the QIS work and will then agree a core set of groups – to enable more numbers of children/young people to be seen.

- Tees are piloting recovery-focussed care planning through the use of My Careplan to empower clients and parents/carers in the ownership of their mental health solutions. Early feedback from families is positive

- There have been recent discussions with Northumbria University re new models in the future training of CWPs. Possibilities could include candidates/services funding the training at the University and services providing the clinical placements. Once training is successfully completed the services would then go through recruitment processes to employ suitable CWPs.

| 2017 | May | June | July | Aug | Sept | Oct |
|---|---|---|---|---|---|---|
| **% seen in 4 wks** | 98.98% | 97.91% | 98.76% | 98.68% | 97.99% | 98.99% |
| **Numbers waiting more than 4 wks** | 5 | 11 | 5 | 4 | 7 | 4 |

### 3.2.2 ASD Update

**Current Position**

- In Tees there is an increasing demand in referrals relating to possible ASD. This is both in relation to the 'screening' part of the assessment to see whether there are sufficient difficulties experienced by the child/young person to allocate to the specialist assessment pathway and also in the numbers of children/young people being allocated to the specialist assessment pathway. This increase in demand and no increase in capacity (in fact capacity is compromised further in that external partners in the specialist assessment and MAAT meetings are decreasing which puts extra demand on the service) is impacting on the waiting times/service.

**Tees ASD Waiting Position September 2017**

| September 2017 | Hartlepool | | Stockton | | Middlesbrough | | Redcar | |
|---|---|---|---|---|---|---|---|---|
| Age | Under 5 | Over 5 | Under 5 | Over 5 | Under 5 | Over 5 | Under 5 | Over 5 |
| Number on Waiting List | 32 | 60 | 193 | 267 | 25 | 26 | 27 | 32 |
| Period of wait months | 11 | 15 | 47 | 44 | 6 | 6 | 6 | 8 |
| Wait if referred today into specialist ASD assessment months today | 11 | 15 | 47 | 44 | 6 | 6 | 9 | 8 |

- At the end of September 2017 there were 662 children and young people waiting.
- The longest ASD time wait is in Stockton with a 44 month wait. The length of time an individual would wait if referred today would be up to 4 years based on the present capacity and pathway.

- It should be noted that individuals have been seen in Tees CAMHS service and the wait is associated with access to a multi-agency assessment.

- It is important to understand that the present referral rates are not indicative of prevalence. The expected rate would be around 1.2% of the child population. The only area in Teesside meeting prevalence is Stockton.

**Impact of resourcing ASD diagnosis is having on CAMHS resources**

- It is estimated that the present demand for ASD assessment is resulting in utilising around 4,000 direct contacts at an estimated additional cost of £480,000, based on £120 per direct face to face contact.

- The funding received for the ASD pathway across Teesside is approximately £200,000.

- This clearly has an impact on the General CAMHS team with a particular pressure on Stockton CAMHS.

### 3.2.3 What Tees have done to reduce waiting times

- Tees has tested a model where the diagnostic assessment process was condensed into a 10 day period. The feedback from families was positive.

- The process enabled the practitioners involved in the assessment to respond to timely information and give feedback as part of the 10 day process.

- It did require the use of internal TEWV resource to carry out the pilot. If the locality were to replicate it they would need additional speech and language therapy, psychology and ring fenced medical time as well as additional ASD coordinator time in Stockton.

- The time commitment was reduced whilst improving quality for the young people and their families.

- Costs are reduced by approximately 50% against the existing pathway cost of approximately £3,600.

- Feedback from clinicians involved was that it was really helpful to be acting on very up-to-date information, seeing the child and family in a timely fashion and being able to feedback to the family within days of the assessment process.

- Clinicians did however feel the process felt pressured and raised concern that it may be difficult for some families to give that level of time commitment in such a condensed period of time.

### 3.2.4 Recommendation

- It would be recommended to carry out a larger pilot to test out the condensed process.

- It would be beneficial to offer this to people who are presently waiting but also to people who are newly referred to the pathway.

## 3.3 NORTH YORKSHIRE

### 3.3.1 North Yorkshire all waiting times

- Although the service continues to experience an increase in referrals, the locality have achieved a sustained improvement in relation to access to service targets. This success is supported through the Single Point of Access (SPoA) which ensures the service have considered risk and the young person is waiting for ongoing assessment and interventions at the right place. Cases which are shown to wait over 4 weeks are due to failing to respond to telephone contact, delay in responding to letter and/or choice of appointment.

- During 2017/18 the locality have undertaken a review of our SPoA to ensure continuous improvement and respond to increasing demand. As a result they have realigned the urgent care practitioner posts (whose role is now covered through the new Crisis and Intensive Home Treatment service) to create a dedicated Single Point of Access cell across the locality.

- The model will operate on a hub and spoke approach with clinical staff operating from all 3 main locality bases and a central hub in Northallerton. This enables them to develop a consistent approach to access, robust daily lean management and enhance engagement with the wider children's workforce, particularly the local authority Multi-agency Assessment Team based in Northallerton. They are aiming for the changes to be in place by January 2018.

- The service is committed to the continued involvement in CYP IAPT and has been successful in its bid to introduce six Children's Psychological Wellbeing Practitioners (CWP) trainees in 2018/19 across the service. The CWP role will enhance the opportunity to deliver timely evidence based interventions and recovery with an aim to increase productivity. These posts are fully funded by NHS England for one year therefore Tees are proposing to embed the role into the service post 2018/19 through skill mix.

- Although North Yorkshire is sustaining progress, they recognise there is work still to be done to sustain the improvement to meet increasing demand and improve the current position against access to second appointment. To support this, the locality are undertaking a dedicated review of capacity and demand. A thematic action plan will be developed to support delivery of improvement but also identify gaps in service.

- A key area to address will include engagement with the wider children's workforce and Commissioners to reduce referrals that are subsequently signposted. This would ensure children and young people get access to the right service at the right time and reduce the waste within the SPoA of assessing young people whose needs could be best met by other providers review.

| 2017 | May | June | July | Aug | Sept | Oct |
|---|---|---|---|---|---|---|
| % seen in 4 wks | 93.02% | 95.19% | 98.26% | 97.92% | 97.85% | 94.71% |
| Numbers waiting more than 4 wks | 15 | 10 | 3 | 1 | 2 | 9 |

### 3.3.2 ASD Update

**Current Position**

Key issues for North Yorkshire:

- A significant number of referrals are received by SPoA where the presenting problem is anxiety or challenging behaviours which really are core/intrinsic features of ASD rather than a co-morbid mental health condition.

- The lack of post-diagnostic services for ASD means that these are very difficult to signpost to other services.

- Post-diagnostic support locally is very minimal so that, although families get a post diagnostic appointment at the CDC and invitation to a parents initial psychoeducation group (Cygnet / ASCEND / Early Bird), there is no continuing support. Problems often become exacerbated at transition points such as school change or puberty but there is no support for families in terms of refresher interventions.

- Many of the problems associated with ASD (such as anxiety, need for predictability, sensory sensitivity) simply accumulate over time until CYP do have a mental health presentation and come into CAMHS with quite entrenched difficulties in behaviours and expectations and disrupted family functioning.

- ADHD often co-presents with ASD and can be the 'vehicle' by which a young person with ASD comes into service.

- Anxiety, OCD, school refusal, low mood/self-harm, gender dysphoria are particularly prevalent and have a complex interaction with challenging behaviour and significant learning difficulty/disability which have implications for intervention in that interventions (including pharmacological interventions) often need to be bespoke adaptations of pathway interventions; take longer; often have less successful outcomes; or occasionally need specialist knowledge which is not readily available within the generic service.

- Where CAMHS have accepted a referral and subsequently made a referral for an ASD assessment, families are left feeling that they are in a lengthy limbo, potentially with no ongoing help. The need for some diagnostic clarity makes it challenging to find a way of delivering CAMHS interventions until this is present.

- There is a view that that a number of our most challenging patients who appear to have an emerging personality disorder might actually be more helpfully/accurately described as having ASD but the waiting list for assessment makes it difficult to have anything but the most tentative formulation about this.

- The locality don't have LD CAMHS as a separate service – some of the young people with ASD and LD have very problematic access to services and they end up without the staff to be able to help effectively. And whilst Tees have benefited hugely from CYPS IAPT this has all been talking therapies.

In summary the apparent increase in prevalence of ASD is having a major impact upon the North Yorkshire CAMHS service in terms of numbers, complexity, length in service and adaptations to pathway interventions that make staff feel under-equipped to give the young person the best possible support. Possibly even more importantly the lack of availability of post-diagnostic ASD services (whether these be in health, education or the LA) means that many young people are ending up in a specialist mental health service because needs have not been met at an earlier stage.

## 3.4 VALE OF YORK

### 3.4.1 Vale of York all waiting times

- Whilst the performance against the 4 week target presents an improving picture, there remain concerns about the level of internal waiters, awaiting intervention. The service is now providing internal waiting list information to the CCG about the number of young people waiting in individual pathways. This has been agreed following a Single Item Quality Meeting in which the CCG requested greater assurance on this matter. The CCG is aware that this is locally held data and is not validated via the Trust's performance team.

- The Service's Single Point of Access (SPA) has now been running in shadow form since the beginning of November 2016. Telephone access appointments are being delivered within 24 hours in the majority of cases and face to face follow up appointments are being offered within 4 weeks. These are being captured as second appointments within the service, post telephone consultation. The staffing of both the SPA and the number of Initial Comprehensive Assessment (ICA) slots available has been modelled to take account of seasonal variation to avoid a backlog forming at the busiest times for the service.

- Further to the job planning work described in the last report, a number of staff have requested to either remain solely in SPA, whilst others have requested more pathway sessions. Individual job plans have been revised to successfully meet staff needs and maximise their clinical interest and skills.

- The service is currently involved in an ASD waiting list initiative, utilising the services of both private practitioners and Trust staff employed in other CAMHS Teams. This initiative will run from October to April 2018, with the intention of

increasing the number of assessments completed by 36 – 40 depending on staff availability.

| 2017 | May | June | July | Aug | Sept | Oct |
|---|---|---|---|---|---|---|
| % seen in 4 wks | 64.53% | 80% | 93.12% | 95.15% | 88.73% | 92.6% |
| Numbers waiting more than 4 wks | 72 | 39 | 13 | 8 | 16 | 14 |

### 3.4.2 ASD Update

**Current position**

- The Vale of York, at end of November 2017, have 142 waiters for ASD assessment with an expected wait of 53 weeks average.

- They have a waiting list initiative where the Trust has given £65,000 to use to reduce waiting time. They have allotted this to two out-of-locality clinicians (20 cases) and a private provider (20 cases), with the target that these 40 cases will be seen by April 2018 which should impact on waiting times.

- The locality are seeing a rise in referrals for ASD as awareness of the condition grows. They have met as a locality to look at their processes and have developed an internal diagnostic forum in November 2017. This is because local paediatricians have withdrawn from the shared forum (citing unhappiness with commissioning arrangements), however at present there is no speech and language input into the forum**.**

- They are also looking to amalgamate the neurodevelopmental pathways - ADHD and ASD and train respective clinicians to undertake both assessments to make this leaner - this requires Autism Diagnostic Observation Schedule (ADOS) training.

### 3.4.4 What Vale of York have done to reduce waiting times

**Proposed solutions**

**Proposal one**

- A proposed single ASD pathway for 0-18 years was developed in October 2016. The Core Team Members were an Admin coordinator, Clinical Psychology, Speech and Language Therapy and a Paediatrician.

- The model was based on 15 referrals per month having an initial meeting, health checks, assessment, formulation, feedback and follow up.

- Unfortunately the CCG have been unable to identify additional resources and the delivery of this pathway.

**Proposal two**

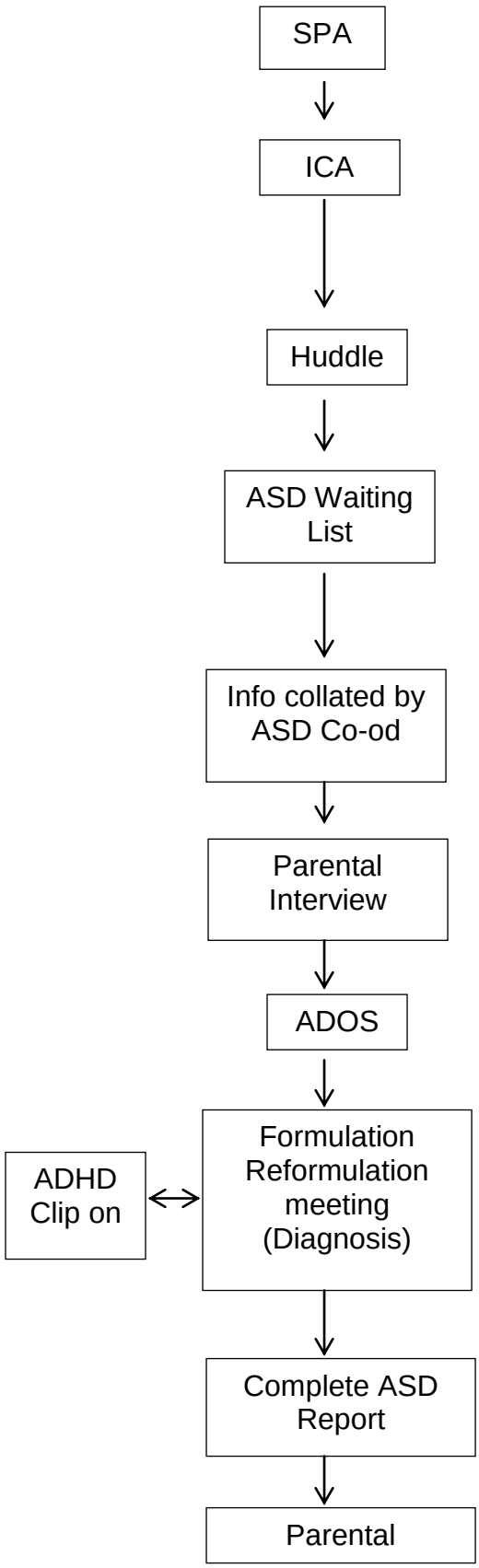
- As a result of no resource being forthcoming for the proposal one, ASD pathways have now been separated into under 5s and over 5s and the locality no longer offers the post-diagnostic parenting support to the parents/carers of those children diagnosed by the under 5 ASD team within CAMHS.

- The locality are no longer able to accept any further referrals onto this post-diagnostic pathway given the significant pressures they have in meeting the needs of the over 5 ASD pathway. This difficult decision to proceed in this way has been confirmed as acceptable by the CCG in recognition of the known challenges for ASD services whilst the pathway is reviewed by the CCG as of December 2017.

- The service will be adopting this new pathway (see flow chart below), though remains non-NICE compliant without the involvement of a speech and language therapist.

- They would welcome a review to this position as part of a whole 0-18 years ASD pathway review should this be possible in the future.

**ASD Pathway – to be implemented from December 2017**




- Screening pack sent
- School/parental info requested

Current View – Safety Plan – Care Plan
ROMS initial completed ($T_2$)
Confirm multi agency involvement
Info re SALT/PAED/EP involvement

ICA clinician to discuss in Huddle/Formulation before allocation to ASD waiting list

- Letter to SALT requesting relevant information for assessment
- Letter to Paed requesting relevant information for assessment
- Paed assessment request via GP

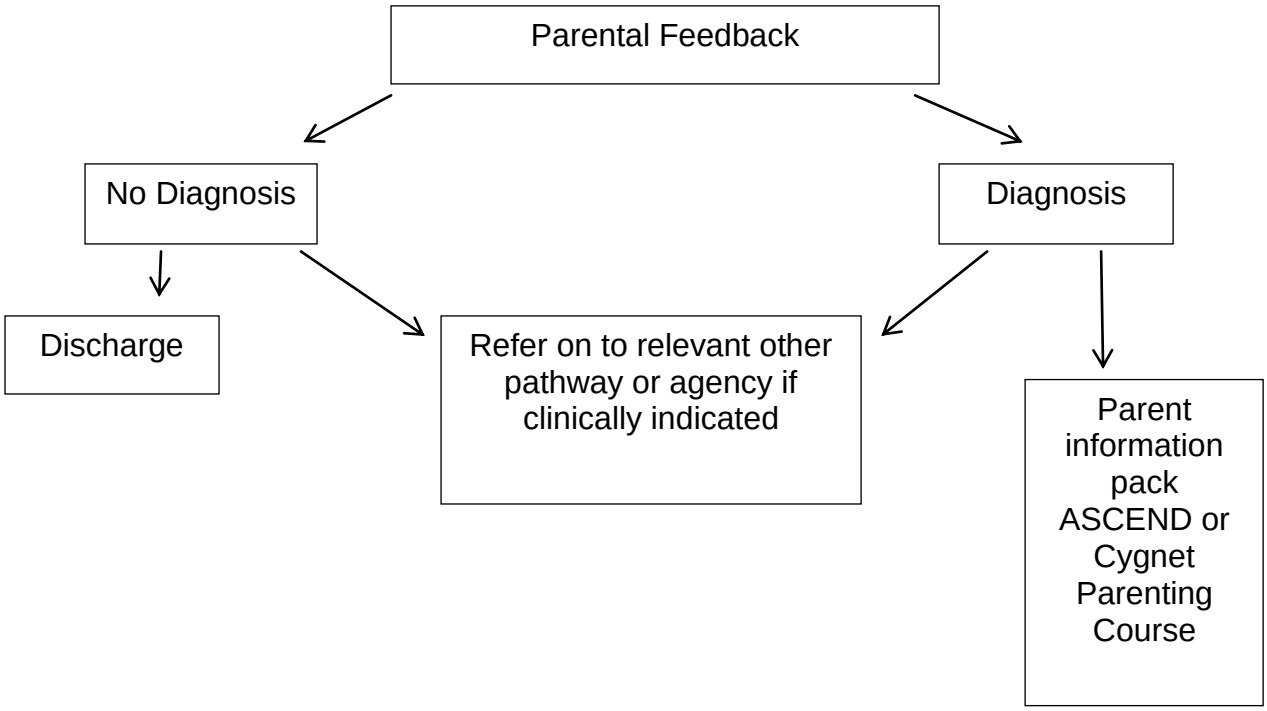
- OMS review ($T_2$)
- V review

- ROMS Review YP ($T_2$)

- School observation if required.
- Cognitive assessment if required.

- Diagnosis entry on Paris
- Update Current View

- Give ASD Report




### 3.4.5 What the locality needs

- With regard to resourcing requirements across all of the CAMHS Pathways, a capacity and demand exercise was undertaken in May 2017 to identify the required staffing levels to both remove the waiting lists and thereafter run sustainable services. Autism cases were considered as part of the Neurodevelopmental pathway.

- Once deficit hours are cleared to maintain the projected demand based on the referral profile the model indicated the need for 562 hours (4.5 WTEs) per month are required as minimum compared to a current capacity of 622 (5.0 WTEs).

- This has been shared with Commissioners; however no further resource has been identified internally or externally but a request has been made by commissioners for more information about internal waiters.

## 4. OVERALL SUMMARY

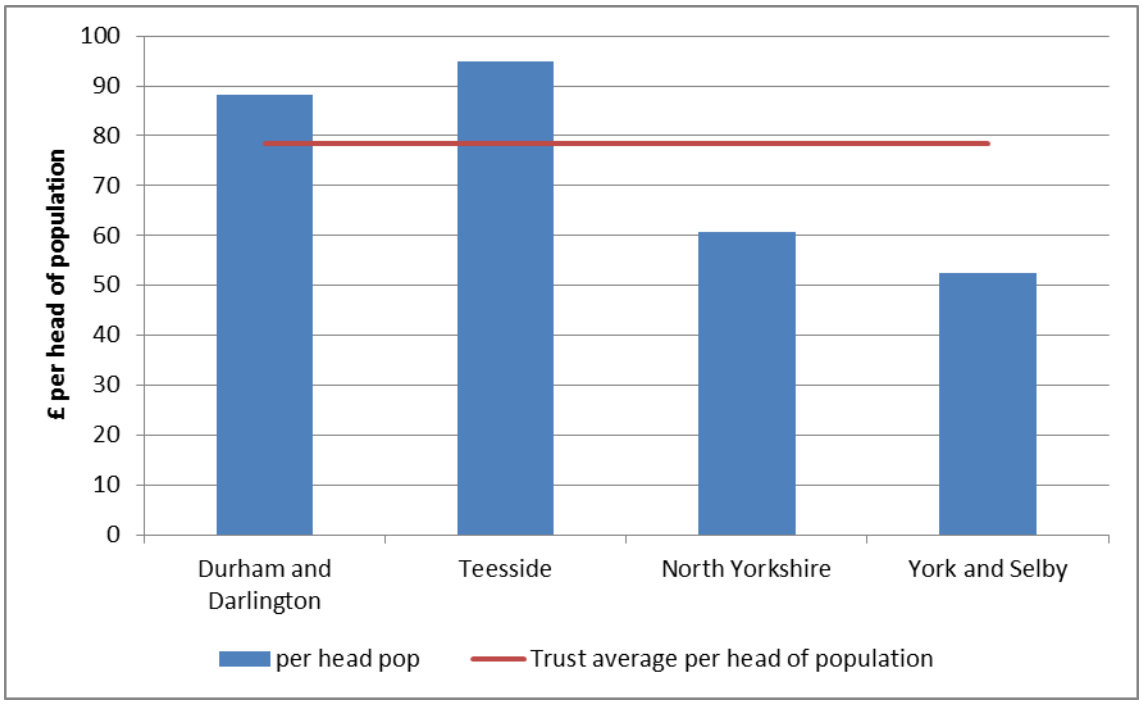
- Overall waiting times at the end of October 2017 range between 92% and 99% of children and young people being seen within 4 weeks. Localities have between 4 and 14 young people who have not been seen in 4 weeks.
- Indications are changes in process and tight management have led to an improved picture with sustained performance over the last 6 months. The service are now focusing on second appointment and treatment waiting times.

- The position regarding ASD presents a more worrying picture. The report demonstrates waiting times which are up to 44 months. Considerable effort is being made by locality staff to redesign pathways and negotiate funding arrangement with Commissioners. There has been little or no additional resource from this. The situation is made more complex as the ASD pathway in parts is dependent on other agencies carrying out certain aspects.

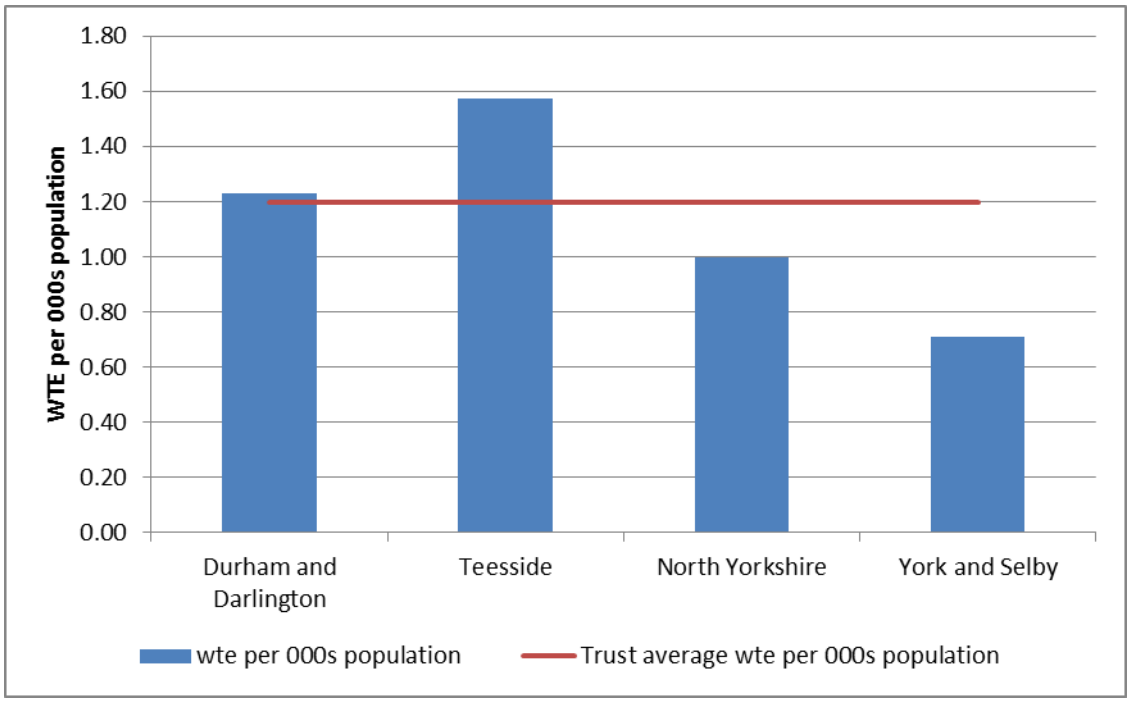
## 5. FUNDING

| Locality | 17/18 Total Investment | 17/18 LA income | 17/18 other income | 17/18 Total investment | Child Population* | per head of population |
|---|---|---|---|---|---|---|
| | £ | £ | £ | £ | | £ |
| Durham and Darlington | 10,763,698 | 116,648 | 745,160 | 11,625,506 | 131744 | 88.24 |
| Teesside | 11,176,666 | 434,140 | 159,823 | 11,770,629 | 123980 | 94.94 |
| North Yorkshire | 4,749,986 | 382,388 | 68,410 | 5,200,784 | 85572 | 60.78 |
| York and Selby | 3,560,457 | 76,174 | 0 | 3,636,631 | 69137 | 52.60 |
| | | | | | | |
| **TRUST** | **30,250,807** | **1,009,350** | **973,393** | **32,233,550** | **410432** | **78.54** |

Values are for total funding and are also shown per head of GP population.



The following graph shows the WTE per 000s population




## 6. IMPLICATIONS:

### 6.1 Compliance with the CQC Fundamental Standards:

There are no implications on Compliance with the CQC Fundamental Standards.

### 6.2 Financial/Value for Money:

There are no direct financial implications of this paper

### 6.3 Legal and Constitutional (including the NHS Constitution):

There are no legal or constitutional implications of this paper.

### 6.4 Equality and Diversity:

There are no equality or diversity implications of this paper.

### 6.4 Other implications:

There are no other implications of this paper.

## 7. RISKS:

These matters are covered within the locality risk registers.

## 8. CONCLUSIONS:

Waiting time pressures are a key priority for clinical teams across the Trust. The position within CAMHS services over the last year or so has been a significant cause for concern. Much effort continues to be invested into

addressing these pressures to support a reduction in overall waiting times across the speciality.

**9. RECOMMENDATIONS:**

The Board is asked to receive this paper and give comment and direction as appropriate.

**David Brown**
**Acting Chief Operating Officer**
**December 2017**

**Appendix 1**

## All referrals 2016 (including internal referrals)

| Locality | % seen in 4 weeks Updated from above paper | Numbers waiting more than 4 wks | All referrals 2016 (inc internal referrals) To update | External T2 & T3 referrals (Jan – Nov) | Children's population | Finance (£) CCG, local authority and other commissioner (total funding) | Commissioned Services | WTE staff |
|---|---|---|---|---|---|---|---|---|
| Durham & Darlington | 99.1% (Nov 17) | 4 (Nov 17) | 7958 | 3272 | 131744 | 11,625,506 | PMHWS Tier 2<br>CAMHS Tier 3<br>Enhanced Crisis<br>Intensive Home Treatment<br>CLD | 162.11 |
| Teesside | 99.0% (Oct 17) | 4 (Oct 17) | 7914 | 2986 | 123980 | 11,770,629 | PMHWS Tier 2<br>CAMHS Tier 3<br>Enhanced Crisis<br>Intensive Home Treatment<br>CLD | 194.90 |
| North Yorkshire | 94.7% (Oct 17) | 9 (Oct 17) | 2747 | 1365 | 85572 | 5,200,784 | PMHWS Tier 2<br>CAMHS Tier 3<br>LAC<br>Enhanced Crisis<br>Intensive Home Treatment | 85.34 |
| York & Selby | 92.6% (Oct 17) | 14 (Oct 17) | 2540 | 1314 | 69137 | 3,636,631 | PMHWS Tier 2<br>CAMHS Tier 3<br>CAMHS<br>Enhanced Crisis<br>Intensive Home Treatment<br>Liaison (A&E)<br>CLD | 49.08 |

Tees, Esk and Wear Valleys
NHS Foundation Trust

**ITEM NO. 7**

**BOARD OF DIRECTORS**

| | |
|---|---|
| **DATE:** | **19 December 2017** |
| **TITLE:** | **Update to SFIs** |
| **REPORT OF:** | **Drew Kendall, Interim Director of Finance and Information** |
| **REPORT FOR:** | **Decision, Assurance and Information** |

| **This report supports the achievement of the following Strategic Goals:** | ✓ |
|---|---|
| ***To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing*** | |
| ***To continuously improve to quality and value of our work*** | |
| ***To recruit, develop and retain a skilled, compassionate and motivated workforce*** | |
| ***To have effective partnerships with local, national and international organisations for the benefit of the communities we serve*** | |
| ***To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.*** | ✓ |

## Executive Summary:

The Trust Standing Financial Instructions (SFIs) require periodic review to ensure they reflect current practice and remain relevant to both the changing environment and working practices.

All changes proposed are itemised in this report, and a full copy of the Trust SFIs are attached as appendix 1.

The proposed amendments will ensure that the Trust's Constitution and Standard Financial Instructions remain compliant with the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012); and remain appropriate for the changing needs of the organisation.

## Recommendations:

The Board of Directors is requested to agree the amendments as set out in this paper, as recommended by the Audit Committee 14 December 2017 including scheme of delegation (page 43).

Tees, Esk and Wear Valleys
NHS Foundation Trust

| | |
|---|---|
| **MEETING OF:** | **Board of Directors** |
| **DATE:** | **19 December 2017** |
| **TITLE:** | **Update to SFIs** |

## 1. INTRODUCTION & PURPOSE

1.1 The Board of Directors is asked to agree to the updates to the Standing Financial Instructions (SFIs).

## 2. BACKGROUND INFORMATION

2.1 The proposed amendments are necessary due to recent audit recommendations, increased controls with regards the NHS England guidance titled "Managing conflicts of interest in the NHS" and to review existing items.

## 3. KEY ISSUES:

3.1 The Standard Financial Instructions detail the financial responsibilities, policies and procedures to be adopted by the Trust and apply to everyone working for the Trust and its constituent organisations.

3.2 A complete copy of the SFIs is included as Appendix 1.

- Yellow items are new / have been updated.
- Green items are to be deleted.
- Blue items will be updated following approval of the updates

3.3 In reviewing SFIs a number of additional changes were identified:

- Amended to reference NHS Improvement rather than Monitor,
- Included requirement to embed the principles included within NHS England's "Managing Conflicts of Interest in the NHS" guidance (2.2.6, page 5),
- Amended presentation of 10.2 (page 21) to make more user friendly,
- Updated 10.3 (page 22) as Director of Finance and Information approves all procurement waivers,
- Added procurement thresholds (page 25)
- Updated and replaced 1.3 (page 25/26)
- Removed section 5 (page 28) as this is no longer best practice (**This is replaced by section 10.2**).
- Page 44/45 Updated high risk investment decisions narrative to comply with NHS Improvement guidance.

- An updated document control sheet is required following approval.

3.4 The updated SFIs were approved by EMT 22 November 2017, with minor amendments as detailed below:

- Update "Director of Finance" to "Director of Finance and Information" throughout the document,
- Changed wording of "Annual Plan" to "Business Plan" for consistency throughout the document.

3.5 **The updated SFIs were approved by the Audit Committee 14 December 2017, with minor amendments (updated in attached SFIs) as detailed below**:

- Update the report recommendation to reference Board approval of SFI's **and** scheme of delegation,
- Move the tendering procedure to be a standalone appendix 3 to improve the flow of the report (previously included following section 10),
- Updated 2.2.1 in line with counter fraud directions.

## 4. IMPLICATIONS / RISKS

4.1 There are no direct quality, financial, equality and diversity implications associated with this paper.

## 5. CONCLUSIONS

5.1 The proposed amendments will ensure that the Trust's Constitution and Standard Financial Instructions remain compliant with the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012); and remain appropriate for the changing needs of the organisation.

## 6. RECOMMENDATIONS

6.1 The Board of Directors is requested to agree the amendments as set out in this paper, as recommended by the Audit Committee 14 December 2017 including scheme of delegation (page 43).

**Drew Kendall**
**Interim Director of Finance and Information**

Tees, Esk and Wear Valleys
NHS Foundation Trust

**TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST**

# STANDING FINANCIAL INSTRUCTIONS

DECEMBER 2017

(Approved by the Board of Directors)

Tees, Esk and Wear Valleys
NHS Foundation Trust

**DOCUMENT CONTROL – Standing Financial Instructions**

| | |
|---|---|
| Application | These SFIs pertain to all areas, departments and services of Tees, Esk and Wear Valleys NHS Foundation Trust |
| Associated policy reference and title | |
| Date of Ratification | December 2017 |
| Date of Review | March 2019 |
| Replacing | Standing Financial Instructions (September 2014) |
| Lead | Drew Kendall |
| Members of working party | Consultation with the Audit Committee on 14th December 2017 |

This policy has been agreed and accepted by: (Director)

| Name | Designation | Signature | Date |
|---|---|---|---|
| Drew Kendall | Director of Finance and Information | | 19th December 2017 |

This policy has been ratified by:

| Board of Directors or Board of Directors Sub Committee (specify) | Date of Board of Directors or Sub Committee |
|---|---|
| **Board of Directors** | 19th December 2017 |
| This policy has gone through an equality impact assessment (EqIA) | Date of EqIA<br>**TBC** |

# STANDING FINANCIAL INSTRUCTIONS

EXECUTIVE SUMMARY

1. Under Standing Order 3 the Board must adopt Standing Financial Instructions as an Integral Part of Standing Orders setting out the responsibilities of individuals.

2. The Board operates within a Constitutional framework which includes its Standing Orders. In addition to the Standing Orders and SFIs, there will be a Scheme of Delegation, Financial Procedural Notes and locally generated rules and instructions. Collectively these must comprehensively cover all aspects of financial management and control. In effect, they set the business rules which Directors and employees (including employees of third parties contracted to the Trust) must follow when taking action on behalf of the Board.

# CONTENTS

# 1. INTRODUCTION

## 1.1 GENERAL

1.1.1 These Standing Financial Instructions (SFIs) are issued under Standing Order 3 of the Board of Directors. They shall have effect as if incorporated in the Standing Orders of the Trust.

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 which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice. These statements 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 and Information.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director or Associate Director of Finance and Information MUST BE SOUGHT BEFORE YOU ACT.

1.1.5 **FAILURE TO COMPLY WITH SFIs IS A DISCIPLINARY MATTER WHICH 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 in these instructions; and

(a) "Trust" means the Tees, Esk and Wear Valleys NHS Foundation Trust;

(b) "Board" means the Board of Directors of the Foundation Trust;

(c) "Budget" means a resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

(d) "Chief Executive" means the Accounting Officer of the Trust;

(e) "Director of Finance and Information" means the chief financial officer of the Trust;

(f) "Budget Holder" means the Director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation; and

(g) "Legal Adviser" means the properly qualified person appointed by the Trust to provide legal advice.

1.2.2 Wherever the title Chief Executive, Director of Finance and Information, or other nominated officer is used in these instructions, 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 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 exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

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

(d) defining specific responsibilities placed on Directors and employees as indicated in the Scheme of Delegation (Annex 2 to the Standing Orders of the Board of Directors).

1.3.2 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation Document adopted by the Trust. (The extent of delegation should be kept under review by the Board.)

1.3.3 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities and is responsible to the Board for ensuring that its financial obligations and targets are met.

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

1.3.5 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 Instructions.

1.3.6 <u>The Director of Finance and Information is responsible for:</u>

(a) implementing the Trust financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) 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;

(c) 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;

and, without prejudice to any other functions of Directors and employees to the Trust, the duties of the Director of Finance and Information include:

(d) the provision of financial advice to the Trust and its Directors and employees;

(e) the design, implementation and supervision of systems of financial control; and

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

1.3.7 All Directors and employees, individually and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.8 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 instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.9 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 and Information.

## 2. AUDIT

### 2.1 AUDIT COMMITTEE

2.1.1 In accordance with Standing Orders the Board shall establish an Audit Committee which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;
(b) reviewing financial and key control systems;
(c) ensuring compliance with Standing Orders and Standing Financial Instructions;
(d) reviewing schedules of losses and compensations and making recommendations to the Board.

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 chairman of the Audit Committee should raise the matter at a full meeting of the board. Exceptionally, the matter may need to be referred to the Council of Governors.

2.1.3 It is the responsibility of the Director of Finance and Information to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when an internal audit service provider is changed.

## 2.2 FRAUD AND CORRUPTION

2.2.1 In line with the Foundation Trust terms of authorisation, the Chief Executive and Director of Finance and Information shall monitor and ensure compliance with Service Condition 24 of the NHS Standard Contract.

2.2.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS fraud and corruption manual and guidance.

2.2.3 The Local Counter Fraud Specialist shall report to the Director of Finance and Information and regularly liaise on all matters of fraud and corruption.

2.2.4 The Local Counter Fraud Specialist shall investigate all cases of suspected fraud and corruption.

2.2.5 The Local Counter Fraud Specialist shall work with the Director of Finance and Information to ensure compliance with the Bribery Act 2010 is embedded into Trust policies and procedures.

2.2.6 The Local Counter Fraud Specialist shall work with the Director of Finance and Information to ensure compliance with the Managing Conflicts of Interest in the NHS (NHS England 2017) is embedded into Trust policies and procedures.

## 2.3 DIRECTOR OF FINANCE AND INFORMATION

2.3.1 The Director of Finance and Information is responsible for:

(a) 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;

(b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation, and other irregularities;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

(i) a clear statement on the effectiveness of internal control,

(ii) major internal financial control weaknesses discovered,
(iii) progress on the implementation of internal audit recommendations,
(iv) progress against plan over the previous year,
(v) strategic audit plan covering three to five years,
(vi) a detailed plan for the coming year.

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

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under an employee's control; and

(d) explanations concerning any matter under investigation.

## 2.4 ROLE OF INTERNAL AUDIT

2.4.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences,
(ii) waste, extravagance, inefficient administration,
(iii) poor value for money or other causes.

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 and Information must be notified immediately.

2.4.3 The Head of Internal Audit shall report direct to the Director of Finance and Information and shall independently refer audit reports to the appropriate officer designated by the Chief Executive. Failure to take any necessary remedial action within a reasonable period shall be reported to the Chief Executive and the Audit Committee. Where in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation of the objectivity of the audit, the Head of Internal Audit shall have access to report

direct to the Chairman of the Trust or the Senior Independent Director, as appropriate.

2.4.4 A representative of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee Members (initially through the Chairman of the Committee), the Chairman and Chief Executive of the Trust.

### 2.5 EXTERNAL AUDIT

2.5.1 The external auditor is appointed by the Council of Governors and paid for by the Trust. It is the role of the Audit Committee to ensure a cost-efficient and independent external audit service is provided to the Trust throughout each audit engagement. Should there appear to be a problem, then this should be raised with the external auditor and referred on to the Council of Governors if the issue cannot be resolved.

2.5.2 The firm providing External Audit Services shall not be commissioned to undertake non-audit activities except in accordance with the "Policy on the Engagement of the External Auditor for Non-Audit Services", as approved by the Audit Committee.

## 3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

### 3.1 PREPARATION AND APPROVAL OF BUSINESS PLANS AND BUDGETS

3.1.1 The Chief Executive will compile and submit to the Board a Business Plan which takes into account financial targets and forecast limits of available resources. The annual business plan will meet the requirements of NHS Improvement and contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

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

(a) be in accordance with the aims and objectives set out in the Business Plan;

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds; and

(e) identify potential risks.

3.1.3 The Director of Finance and Information shall monitor financial performance against budget and business plans, periodically review them, and report to the Board.

3.1.4 All budget holders must provide information as required by the Director of Finance and Information to enable budgets to be compiled.

3.1.5 The Director of Finance and Information has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

## 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:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service; and
(f) the provision of regular reports upon the discharge of those delegated functions.

The budgetary delegation for revenue and capital expenditure limits together with investment approval are detailed in Appendix 1.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

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 and Information will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:
    (i) income and expenditure to date showing trends and forecast year-end position;
    (ii) movements in working capital;
    (iii) capital project spend and projected outturn against plan;
    (iv) explanations of any material variances from plan;

(v) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance and Information's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

3.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

(b) 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

(c) 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.

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 Business 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 applications relating to capital are contained in Chapter 12.)

**3.5 MONITORING RETURNS**

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

## 4. ANNUAL ACCOUNTS AND REPORTS

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

(a) prepare financial returns in accordance with the guidance given by NHS Improvement and the Treasury, the Trust's accounting policies, and international reporting financial standards;

(b) prepare, certify and submit annual financial reports to NHS Improvement in accordance with current guidelines; and

(c) submit financial returns to NHS Improvement for each financial year in accordance with its prescribed timetable.

4.2 The Trust's Audited Annual Accounts must be presented to a public meeting of the Council of Governors.

4.3 The Trust will publish an Annual Report, in accordance with requirements set out by NHS Improvement, and present it at the Annual General Meeting of the Council of Governors and the Annual Members Meeting. The document will comply with the requirements detailed in the FT Annual Reporting Manual.

## 5. BANK AND GBS ACCOUNTS

### 5.1 GENERAL

5.1.1 The Director of Finance and Information is responsible for managing the Trusts banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/Directions issued from time to time by HM Treasury and NHS Improvement.

5.1.2 The Board shall approve the banking arrangements.

### 5.2 BANK AND GBS ACCOUNTS

5.2.1 The Director of Finance and Information is responsible for:

(a) bank accounts and Government Banking Service (GBS) accounts;

(b) establishing separate bank accounts for the Trusts non-exchequer funds;

(c) ensuring payments made from bank or Government Banking Service (GBS) accounts do not exceed the amount credited to the account except where arrangements have been made; and

(d) reporting to the Board all arrangements made with the Trusts bankers for accounts to be overdrawn.

5.2.2 No member of staff, other than the Director of Finance and Information, shall open a bank account in the Trust's name.

### 5.3 BANKING PROCEDURES

5.3.1 The Director of Finance and Information will prepare detailed instructions on the operation of bank and Government Banking Service (GBS) accounts which must include:

(a) the conditions under which each bank and Government Banking Service (GBS) account is to be operated;

(b) the limit to be applied to any overdraft; and

(c) those authorised to sign cheques or other orders drawn on the Trusts accounts.

5.3.2 The Director of Finance and Information 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 and Information 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 Trusts banking business.

5.4.2 Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Board.

## 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 and Information is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Director of Finance and Information is also responsible for the prompt banking of all monies received.

### 6.2 FEES AND CHARGES

6.2.1 The Trust shall follow the advice in the "NHS Costing" Manual in setting prices for services delivered.

6.2.2 The Director of Finance and Information 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 All employees must inform the Director of Finance and Information promptly of money due arising from transactions which they initiate/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 and Information 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.

6.3.3 Overpayments 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 and Information is responsible for:

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

(b) ordering and securely controlling any such stationery;

(c) 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

(d) 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 and Information.

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 Chief Executive, or an officer designated by him/her, is responsible for negotiating contracts for the provision of services to patients in accordance with the Business Plan, and for establishing the arrangements for providing extra-contractual services. In carrying out these functions, the Chief Executive should take into account the advice of the Director of Finance and Information regarding:

(a) costing and pricing of services;

(b) payment terms and conditions; and

(c) amendments to contracts and extra-contractual arrangements.

7.2 Contracts should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. Contract prices should comply with "Costing for Contracting" guidelines.

7.3 The Director of Finance and Information shall produce regular reports detailing actual and forecast contract income with a detailed assessment of the impact of the variable elements of income.

7.4 Any pricing of contracts at marginal cost must be undertaken by the Director of Finance and Information and reported to the Board.

## 8. TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND EMPLOYEES

### 8.1 REMUNERATION

8.1.1 The Board should formally agree, the precise terms of reference of the Remuneration Committee, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (The Terms of Reference of this Committee are set out in the Integrated Governance Strategy.)

8.1.2 The Committee will:

(a) advise the Board about appropriate remuneration and terms of service for the Chief Executive and other executive directors (and other senior employees), including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms;

(iv) approving local clinical excellence awards for consultant medical staff;

(b) make such recommendations to the Board on the remuneration and terms of service of executive directors (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trusts circumstances and performance and to the provisions of any national arrangements for such staff where appropriate;

(c) monitor and evaluate the performance of individual executive directors (and other senior employees as may be determined by the Board); and

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

8.1.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of executive directors. Minutes of the Board's meetings should record such decisions.

8.1.4 The Board will approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee.

8.1.5 The Trust will remunerate the Chairman and Non-executive Directors in accordance with the instructions of the Council of Governors.

## 8.2 FUNDED ESTABLISHMENT

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

8.2.2 The funded establishment can only be varied within the delegated limits.

## 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:

(a) unless authorised to do so by the Chief Executive or through delegated powers; and

(b) within the limit of his/her approved budget and funded establishment.

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

## 8.4 PROCESSING OF PAYROLL

8.4.1 The Director of Finance and Information is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;
(b) the final determination of pay;

(c) making payment on agreed dates; and

(d) agreeing method of payment.

8.4.2 The Director of Finance and Information will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee;

(h) procedures for payment by cheque, bank credit, or cash to employees;

(i) procedures for the recall of cheques and bank credits

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash; and

(m) 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:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Director of Finance and Information's instructions and in the form prescribed by the Director of Finance and Information; and

(c) 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 Director of Finance and Information must be informed verbally immediately and subsequently in writing.

8.4.4 Regardless of the arrangements for providing the payroll service, the Director of Finance and Information shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and those suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.4.5 The Director of Finance and Information shall verify that the rate of pay and relevant conditions of service are in accordance with current agreements and that proper compilation of the payroll and payments have been made. Disputes arising in the interpretation of conditions of service shall be referred to the Director of Human Resources for resolution.

8.4.6 All employees shall be paid monthly by bank credit, unless otherwise agreed by the Director of Finance and Information.

### 8.5 CONTRACT OF EMPLOYMENT

8.5.1 The Board shall delegate responsibility to the Director of Human Resources for:

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

(b) dealing with variations to, or termination of, contracts of employment.

## 9. NON-PAY EXPENDITURE

### 9.1 DELEGATION OF AUTHORITY

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

9.1.2 The Chief Executive will set out:

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

(b) 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 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 adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the appropriate Director or Head of Service shall be consulted.

9.2.2 All goods and services will be procured through the Trust's electronic purchasing system (Cardea). Where this is not possible agreement with the Director of Finance and Information should be sought.

9.2.3 The Director of Finance and Information shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

9.2.4 The Director of Finance and Information will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained in line with procurement systems (electronic or written); and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; Tendering and Contract procedures are detailed further within section 10.

(b) prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of directors/employees (including specimens of their signatures) authorised to certify invoices, orders and requisitions.

(ii) Certification that:

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

- 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;

- 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;

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

- the account is arithmetically correct;

- the account is in order for payment.

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

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

9.2.5 Where an officer certifying accounts relies upon other officers to do preliminary checking he/she shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed the order and negotiated the prices and terms

9.2.6 In the case of contracts for building and engineering works which require payment to be made on account during progress of the works the Director of Finance and Information shall make payment on receipt of a certificate form the appropriate Technical Consultant or Officer. Without prejudice to the responsibility of any Consultant, or Estates Officer appointed to a particular building or engineering contract, a contractor's account shall be subjected to such financial examination by the Director of Finance and Information and any general examination by the Estates Officer as may be considered necessary, before the person responsible to the Trust for the contract issues the final certificate. To assist financial control, a contracts register should be established.

9.2.7 PFI unitary payments should be approved as per the agreed contract and in line with the scheme of delegation.

Separate contract variations for PFI additional works should utilise the PFI contract variation procedure within the PFI contract. PFI variations should be approved and monitored via the capital projects steering group within the overall scheme of delegation (for both capital costs and unitary payment consequences).

9.2.8 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) the appropriate Director/Head of Service 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 prepayment agreement unable to meet their commitments;

(b) the Director of Finance and Information will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and

(c) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director/Head of Service or Chief Executive if problems are encountered.

9.2.9 Official orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance and Information;

(c) state the Trust's terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

(e) only be issued on receipt of a duly authorised, correctly coded requisition.

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

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

(b) contracts above specified thresholds are advertised and awarded in accordance with EC and GATT rules on public procurement and comply with the White Paper on Standards, Quality and International Competitiveness (CMND 8621);

(c) where consultancy advice is being obtained, the procurement of such skills must be in accordance with guidance issued by HM Treasury and the Department of Health;

(d) 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:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance and Information on behalf of the Chief Executive;

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

(g) 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 by an official order (to be raised immediately following the verbal / written order) and clearly marked "Confirmation Order". Examples of expenditure where a verbal order is permitted are clinical equipment that is required urgently, training courses and room hire; however verbal orders are only to be used as a last resort;

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

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

(j) changes to the list of directors/employees authorised to certify invoices are notified to the Director of Finance and Information;

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

(l) petty cash records are maintained in a form as determined by the Director of Finance and Information.

9.2.11 The Chief Executive must ensure that the Trusts Standing Orders are compatible with the requirements of the Trust and consistent with the term of its authorisation. In addition Standing Orders must also be compatible with the requirements of building and engineering contracts (CONCODE) and land and property transactions (ESTATECODE). The technical audit of these contracts shall be the responsibility of the relevant Director. The Director of Finance and Information 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 these codes.

## 9.3 GRANTS TO OTHER BODIES

9.3.1 Grants to other bodies for the provision of patient services shall be consistent with the Trust's terms of its authorisation and within the terms of relevant patient service contracts.

For grants of up to £1,001 the Director responsible for the service may grant approval, for grants up to £5,001 the Chief Executive may grant approval. Above these sums the Board only may grant approval.

## 10. TENDERING AND CONTRACT PROCEDURE

10.1 Duty to comply with Standing Orders – The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Financial Instructions (except where Suspension of SFIs is applied).

10.2 Formal Competitive Tendering (including request for quotes, formal tendering and use of frameworks) – The Trust shall ensure that the following are procured in accordance with the law to avoid potential legal action by suppliers and to maximise value achieved from its contractual arrangements:

- the supply of goods,
- materials and manufactured articles
- rendering of services including all forms of management consultancy services for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens);
- disposals

10.3 Formal tendering procedures may be waived with approval from the Director of Finance by officers to whom powers have been delegated by the Chief Executive without reference to the Chief Executive (except in (c) to (f) below) where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed £50,000, (this figure to be reviewed annually); or

(b) the timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for waiving tender procedures; or

(c) specialist expertise is required and there is clear and convincing evidence readily at hand that it is available from only one source; or

(d) the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different parties for the new task would be inappropriate; or

(e) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; or

(f) where provided for in the Capital Investment Manual. The limited application of the single tender rules should not be used to avoid competition or for administrative convenience or to avoid further work to a party originally appointed through a competitive procedure.

10.4 Except where SFI 10.3, or a requirement under SFI 10.2, applies, the Board shall ensure that invitations to tender are sent to a sufficient number of companies to provide fair and adequate competition as appropriate, and in no case less than three companies, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

10.6 Tendering procedures are set out in Attached 1 (page 27).

10.7 Competitive Quotations – are required where formal tendering procedures are waived under SFI 10.3 (a) or (b) and where the intended expenditure or income exceeds, or is reasonably expected to exceed £10,000.

10.8 Where quotations are required under SFI 10.9 they should be obtained from at least three companies based on specifications or terms of reference prepared by, or on behalf of, the Board.

10.9 Quotations should be in writing unless the Chief Executive or their nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotation should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

10.10 All quotations should be treated as confidential, attached to the purchase order and should be retained for inspection.

10.11 The Chief Executive or their nominated officer should evaluate the quotations and select the one which gives the best value for money. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.

10.12 Waivers to competitive quotations approved by the Director of Finance and Information may be obtained for the following purposes:

a) the supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive or their nominated officer, possible or desirable to obtain competitive quotations.

b) the goods/services are required urgently. Failure to place the work properly is not a justification for waiving tender procedures.

c) where specialist expertise is required and is available from only one source.

10.13 Where tendering or competitive quotation is not required – The Trust shall use the agreed management procurement process for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented. Procurement shall normally be through the procurement process unless agreed by the Chief Executive or a nominated officer.

10.14 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house.

The Board may also determine from time to time that in-house services should be market tested by competitive tendering.

10.15 Private Finance – When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;

(b) Where the sum exceeds delegated limits (at the time of writing £8m except for property leases where the other level is £4m).

(c) The proposal must be specifically agreed by the Board of Directors in the light of such professional advice as should reasonably be sought in particular with regard to vires.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

10.16 Contracts – The Trust may only enter into contracts within its statutory powers and shall comply with:

(a) Standing Orders;
(b) The SFIs;
(c) EU Directives and other statutory provisions;

10.17 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

10.19 Healthcare Services Contracts – shall be drawn up in accordance with Department of Health model contracts.

10.20 The Chief Executive shall nominate officers with power to negotiate for the provision of healthcare services with purchasers of healthcare.

10.21 Cancellation of Contracts – Except where specific provision is made in model forms of Contracts or standard Schedules of Conditions approved for use within the National Health Service and in accordance with Standing Financial Instructions 10.2 and 10.3, there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation:

(a) If the contractor shall have offered, or given or agreed to give, any person any gift (exceeding £10) or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract of any other contract with the Trust; or

(b) for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Trust; or

(c) if the like acts shall have been done by any person employed by them or acting on his behalf (whether with or without the knowledge of the contractor); or

(d) if in relation to any contract with the Trust the contractor or any person employed by them or acting on their behalf shall have committed any offence under the Prevention of Corruption Acts 1889 and 1916 and other appropriate legislation

10.22 Determination of Contracts for Failure to Deliver Goods or Material –

There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice cancel the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good (a) such default, or (b) in the event of the contract being wholly cancelled the goods or material remaining to be delivered.

The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

10.23 Contractors Involving Funds Held on Trust – shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Act.

## 11. EXTERNAL BORROWING AND INVESTMENTS

### 11.1 EXTERNAL BORROWING

11.1.1 The Director of Finance and Information will advise the Board of Directors concerning the Trust's ability to pay dividend on, and repay, both the Public Dividend Capital and any proposed new borrowing. The Director of Finance and Information is also responsible for reporting periodically to the Board concerning loans and overdrafts where relevant.

11.1.2 Any application for a loan or overdraft will only be made by the Director of Finance and Information or by an employee so delegated by him.

11.1.3 The Director of Finance and Information must prepare detailed procedural instructions concerning applications for loans and overdrafts.

11.1.4 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Director of Finance and Information.

11.1.5 All long term borrowing must be consistent with the plans outlined in the current Business Plan.

### 11.2 INVESTMENTS

11.2.1 Temporary cash surpluses must be held only in such public or private sector investments as approved within the Trust's Investment Policy.

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

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

## 12. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

### 12.1 CAPITAL INVESTMENT

12.1.1 The Chief Executive:

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

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

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

12.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the *Capital Investment Manual*) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

(ii) appropriate project management and control arrangements; and

(b) that the Director of Finance and Information has certified professionally to the costs and revenue consequences detailed in the business case.

12.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "Estatecode".

The Director of Finance and Information shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

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

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

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trusts Standing Orders.

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

**12.2 PRIVATE FINANCE**

12.2.1 When the Trust proposes to use finance which is to be provided other than through its own internally generated resources, the following procedures shall apply:

(a) The Director of Finance and Information shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) The proposal must be specifically agreed by the Board, NHS Improvement (using the parameters of the Guidance on Transactions

for NHS Foundation Trusts) and, if the size of the scheme warrants it, it may be necessary to seek HM Treasury approval.

## 12.3 ASSET REGISTERS

12.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance and Information concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

12.3.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Charges Manual and sufficient to meet audit standards.

12.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

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

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) lease agreements in respect of assets held under a finance lease and capitalised.

12.3.4 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).

12.3.5 The Director of Finance and Information shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

12.3.6 The value of each asset shall be in accordance with the Trust's valuation policy as determined by the Board of Directors..

12.3.7 The value of each asset shall be depreciated in accordance with the Trust's accounting policies and will be reflective of each assets remaining life.

## 12.4 SECURITY OF ASSETS

12.4.1 The overall control of fixed assets is the responsibility of the Chief Executive. Each employee of the Trust has a responsibility to exercise a duty of care over the assets of the Trust.

12.4.2 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. Any breach of agreed security practices must be reported in accordance with instructions.

12.4.3 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance and Information. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset; and

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.4.4 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance and Information.

12.4.5 Any damage to the Trusts 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.

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

## 13. STORES AND RECEIPT OF GOODS

13.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stocktake;

(c) valued at the lower of cost and net realisable value.

13.2 Subject to the responsibility of the Director of Finance and Information for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance and Information. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of fuel oil of a designated estates manager.

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

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

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

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

13.7 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance and Information 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 and Information any evidence of significant overstocking and of any negligence or malpractice (see also 14, Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

## 14. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

### 14.1 DISPOSALS AND CONDEMNATIONS

14.1.1 The Director of Finance and Information must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

14.1.2 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 and Information of the estimated market value of the item, taking account of professional advice where appropriate.

14.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose, as per the delegated limits in the Scheme of Delegation;

(b) disposed of via the Supplies department, in accordance with the agreed procedure.

14.1.4 The Supplies department shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance and Information who will take the appropriate action.

## 14.2 LOSSES AND SPECIAL PAYMENTS

14.2.1 The Director of Finance and Information must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Director of Finance and Information must also prepare a "fraud response plan" that sets out the action to be taken both by persons detecting fraud and those persons responsible for investigating it.

14.2.2 Any employee discovering or suspecting a loss of any kind must immediately inform their Head of Department, who must immediately inform the Chief Executive and the Director of Finance and Information, or inform an officer charged with responsibility for responding to concerns involving loss or fraud confidentially. This officer will then appropriately inform the Director of Finance and Information and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance and Information must immediately inform the police if theft or arson is involved.

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

(a) the Board, and

(b) NHS Improvement

14.2.4 Within limits delegated to it by HM Treasury and NHS Improvement, the Board of the Trust shall approve the writing-off of losses.

14.2.5 The Director of Finance and Information shall be authorised to take any necessary steps to safeguard the Trusts interests in bankruptcies and company liquidations.

14.2.6 For any loss, the Director of Finance and Information should consider whether any insurance claim can be made.

14.2.7 The Director of Finance and Information shall maintain a Losses and Special Payments Register in which write-off action is recorded.

14.2.8 No special payments exceeding delegated limits shall be made without the prior approval of NHS Improvement and HM Treasury.

## 15. INFORMATION TECHNOLOGY

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

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trusts data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act;

(b) ensure that adequate (reasonable) 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;

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

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

(e) The Director of Finance and Information 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.

15.2 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trusts in a consortium wish to sponsor jointly) all responsible directors and employees will send to the Director of Finance and Information:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

15.3 The Director of Finance and Information 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.

15.4 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance and Information shall periodically seek assurances that adequate controls are in operation.

15.5 Where computer systems have an impact on corporate financial systems the Director of Finance and Information shall satisfy himself that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

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

(c) Director of Finance and Information staff have access to such data; and

(d) such computer audit reviews as are considered necessary are being carried out.

15.6 The Director of Finance and Information and Information as Senior Information Risk Owner shall:

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

(b) ensure that adequate and reasonable 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;

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

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

## 16. PATIENTS' PROPERTY

16.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

16.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

16.3 The Director of Finance and Information must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

16.4 Where Department of Health instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance and Information.

16.5 In all cases 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. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor in writing.

## 17. FUNDS HELD ON TRUST

### 17.1 INTRODUCTION

17.1.1 The discharge of this Body's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes. The Director of Finance and Information shall ensure that each fund is managed appropriately with regard to its purpose and to its requirements.

17.1.2 This Section of the SFIs shall be interpreted and applied in conjunction with the rest of these Instructions, subject to modifications contained herein.

17.1.3 The Board hereby nominates the Director of Finance and Information to have primary responsibility to the Board for ensuring that these SFIs are applied in close liaison with the Board's Legal Adviser.

### 17.2 EXISTING TRUSTS

17.2.1 The Director of Finance and Information shall arrange for the administration of all existing trusts in conjunction with the Legal Adviser. They shall ensure that a governing instrument exists for every trust and shall produce detailed codes of procedure covering every aspect of the financial management of funds held on trust, for the guidance of directors and employees. Such guidelines shall identity the restricted nature of certain funds.

17.2.2 The Director of Finance and Information shall periodically review the funds in existence and shall make recommendations to the Board regarding the potential for rationalisation of such funds within statutory guidelines.

17.2.3 The Director of Finance and Information may recommend an increase in the number of funds where this is consistent with this Body's policy for ensuring the safe and appropriate management of restricted funds, e.g., designation for specific wards or departments.

## 17.3 NEW TRUSTS

17.3.1 The Director of Finance and Information shall, in conjunction with the Legal Adviser, arrange for the creation of a new trust where funds and/or other assets, received in accordance with this Body's policies, cannot adequately be managed as part of an existing trust.

17.3.2 The Legal Adviser shall present the governing document to the Board for adoption as required in Standing Orders for each new trust. Such document shall clearly identify, inter alia, the objects of the new trust, the capacity of this Body to delegate powers to manage and the power to assign the residue of the trust to another fund contingent upon certain conditions, e.g., discharge of original objects.

## 17.4 SOURCES OF NEW FUNDS

17.4.1 In respect of **Donations**, the Director of Finance and Information shall:

(a) provide guidelines to officers of this Trust as to how to proceed when offered funds. These to include:

(i) the identification of the donors intentions;
(ii) where possible, the avoidance of new trusts;
(iii) the avoidance of impossible, undesirable or administratively difficult objects;
(iv) sources of immediate further advice; and
(v) treatment of offers for personal gifts; and

(b) provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into this Body's trust funds and that the donor's intentions have been noted and accepted.

17.4.2 In respect of **Legacies And Bequests**, the Director of Finance and Information shall:

(a) provide guidelines to officers of this Trust covering any approach regarding:

(i) the wording of wills;
(ii) the receipt of funds/other assets from executors;

(b) where necessary, obtain grant of probate, or make application for grant of letters of administration, where this Trust is the beneficiary;

(c) be empowered, on behalf of this Body, to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty; and

(d) be directly responsible, in conjunction with the Legal Adviser, for the appropriate treatment of all legacies and bequests.

17.4.3 In respect of **Fund-raising**, the Director of Finance and Information shall:

(a) after consultation with the Legal Adviser, deal with all arrangements for fund-raising by and/or on behalf of this Trust and ensure compliance with all statutes and regulations;

(b) be empowered to liaise with other organisations/persons raising funds for this Trust and provide them with an adequate discharge. The Director of Finance and Information shall be the only officer empowered to give approval for such fund-raising subject to the overriding direction of the Board;

(c) be responsible, along with the Legal Adviser, for alerting the Board to any irregularities regarding the use of this Trust's name or its registration numbers; and

(d) be responsible, after due consultation with the Legal Adviser, for the appropriate treatment of all funds received from this source.

17.4.4 In respect of **Trading Income,** the Director of Finance and Information shall:

(a) be primarily responsible, along with the Legal Adviser and other designated officers, for any trading undertaken by this Trust as corporate trustee; and

(b) be primarily responsible, along with the Legal Adviser, for the appropriate treatment of all funds received from this source.

17.4.5 In respect of **Investment Income** , the Director of Finance and Information shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

## 17.5 INVESTMENT MANAGEMENT

17.5.1 The Director of Finance and Information shall be responsible for all aspects of the management of the investment of funds held on trust. The issues on which he/she shall be required to provide advice to the Board shall include:-

(a) in conjunction with the Legal Adviser, the formulation of investment policy within the powers of this Trust under statute and within governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;

(b) the appointment of advisers, brokers, and, where appropriate, fund managers and:

(i) the Director of Finance and Information shall agree, in conjunction with the Legal Adviser, the terms of such appointments; and for which

(ii) written agreements shall be signed by the Chief Executive;

(c) pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme;

(d) the participation by this Trust in common investment funds and the agreement of terms of entry and withdrawal from such funds;

(e) that the use of trust assets shall be appropriately authorised in writing and charges raised within policy guidelines;

(f) the review of the performance of brokers and fund managers;

(g) the reporting of investment performance.

## 17.6 DISPOSITION MANAGEMENT

17.6.1 The exercise of this Trust's dispositive discretion shall be managed by the Director of Finance and Information in conjunction with the Board. In so doing he/she shall be aware of the following:

(a) The objects of various funds and the designated objectives;

(b) the availability of liquid funds within each trust;

(c) the powers of delegation available to commit resources;

(d) the avoidance of the use of exchequer funds to discharge trust fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by trust funds at the earliest possible time;

(e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of this Trust; and

(f) the definitions of "charitable purposes" as agreed by the Department of Health with the Charity Commission.

## 17.7 BANKING SERVICES

17.7.1 The Director of Finance and Information shall advise the Board and, with its approval, shall ensure that appropriate banking services are available to this Trust as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

## 17.8 ASSET MANAGEMENT

17.8.1 Assets in the ownership of or used by this Body as corporate trustee, shall be maintained along with the general estate and inventory of assets of the Body. The Director of Finance and Information shall ensure:

(a) in conjunction with the Legal Adviser, that appropriate records of all assets owned by this Trust as corporate trustee are maintained, and that all assets, at agreed valuations, are brought to account;

(b) that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;

(c) that donated assets received on trust rather than into the ownership of the Secretary of State shall be accounted for appropriately;

(d) that all assets acquired from funds held on trust which are intended to be retained within the trust funds are appropriately accounted for, and that all other assets so acquired are brought to account in the name of the Secretary of State.

## 17.9 REPORTING

17.9.1 The Director of Finance and Information shall ensure that regular reports are made to the Board with regard to, inter alia, the receipt of funds, investments, and the disposition of resources.

17.9.2 The Director of Finance and Information shall prepare annual accounts in the required manner which shall be submitted to the Board within agreed timescales.

17.9.3 The Director of Finance and Information, in conjunction with the Legal Adviser, shall prepare an annual trustees' report (separate reports for charitable and non-charitable trusts) and the required returns to the Charity Commission for adoption by the Board.

## 17.10 ACCOUNTING AND AUDIT

17.10.1 The Director of Finance and Information shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

17.10.2 The Director of Finance and Information shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. He/she will liaise with external audit and provide them with all necessary information.

17.10.3 The Board shall be advised by the Director of Finance and Information on the outcome of the annual audit. The Chief Executive shall ensure that the Annual Audit Letter or its equivalent is considered by the Audit Committee prior to submitting it to the Board.

## 17.11 ADMINISTRATION COSTS

16.11.1 The Director of Finance and Information shall identify all costs directly incurred in the administration of funds held on trust and, in agreement with the Board, shall charge such costs to the appropriate trust accounts.

## 17.12 TAXATION AND EXCISE DUTY

17.12.1 The Director of Finance and Information shall ensure that this Body's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the

preparation and submission of the required returns and the recovery of deductions at source.

## 18. RETENTION OF DOCUMENTS

18.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with Parts 1 and 2 of the NHS Code of Practice on Records Management (2006).

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

18.3 Documents held in accordance with Parts 1 and 2 of the NHS Code of Practice on Records Management (2006) shall only be destroyed at the express instigation of the Chief Executive, records shall be maintained of documents so destroyed.

## 19. RISK MANAGEMENT & INSURANCE

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

19.2 The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the control of risk;

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

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including, internal audit, clinical audit, health and safety review;

(f) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to make a Statement on Internal Control within the Annual Report and Accounts as required by NHS Improvement

19.3 The Director of Finance and Information shall ensure that insurance arrangements exist in accordance with the risk management programme.

# APPENDIX 1

## SCHEME OF DELEGATION

## BUDGETARY DELEGATION

### Revenue Expenditure Limits

| Level | Signatories | Limit |
|---|---|---|
| L1 | Chief Executive, Director of Finance and Information | above £100,000 |
| L2 | Executive Director | up to £100,000 |
| L3 | Director of Operations / Clinical Director / Associate Director / Head of Service | up to £50,000 |
| L4 | Service Manager / Head of Department | up to £20,000 |
| L5 | Team / Ward Managers | up to £5,000 |

### Capital Expenditure Limits

| Level | Signatories | Limit |
|---|---|---|
| L1 | Chief Operating Officer, Director of Finance and Information and Information | Above £100,000 |
| L2 | Associate Director of Finance and Information<br>Director of Operations – EFM<br>Head of Information Services<br>Head of Digital transformation | up to £100,000 |
| L3 | Head of Financial Planning and Investment,<br>Head of Capital Development | up to £50,000 |
| L4 | Capital Project Leads | up to £20,000 |

**Investment approval**

The table below indicates the decision rights for different types of investment. The Trust will use NHS Improvement s assessment approach to identifying high risk investments as a basis for identifying which investments require the higher level of scrutiny of the Resources Committee and/or the Board.

| Size of Investment | High Risk? | Delegated Power of Decision | Reported to |
|---|---|---|---|
| Under £250,000 | No | Executive Directors | Executive Management Team |
| | Yes | Resources Committee | Board of Directors |
| £250,000 - £1m | No | Resources Committee | Board of Directors |
| | Yes | Board of Directors | Board of Directors |
| Over £1m | All | Board of Directors | Board of Directors |

***NB All major high risk investments that are reportable to NHS Improvement will need Board approval first.***

**RISK EVALUATION FOR HIGH RISK INVESTMENT DECISIONS**

NHS Improvement published a document '*Guidance on Transactions for NHS Foundation Trusts*'. The document is aimed at high risk investments defined as:

- **Statutory transactions:** i.e. all investments that are reportable to NHS Improvement under the thresholds for reporting investments in the compliance framework (see Appendix 2).

- **Other transactions:** all investments that may have any one or more of the following characteristics:

    - projects funded through private finance initiatives (PFIs)
    - contracts to provide services > 10% of income
    - material capital investments > 10% of total equity
    - other mergers, acquisitions, investments or divestments
    - joint ventures
    - changes in indemnity arrangements that exceed the thresholds
    - other organisational forms initially developed as new care models

These are the types of investment which the investment policy is designed to cover together with investing funds in other organisations/companies or establishing joint venture companies etc. which although not included in NHS Improvement's lists may also be considered to be a higher risk.

APPENDIX 2

## STATUTORY TRANSACTIONS

As per the Trust's constitution, a "Significant transaction" means:

45.3.1 A contract or other agreement which will lead to an increase by 5% or more in the proportion of the Trust's total income in any financial year attributable to activities other than the provision of goods and services for the purposes of health service in England and which is not included in the latest approved version of the Forward Plan; or

45.3.2 The establishment of a Subsidiary; or

45.3.3 A transaction which meets any one of the following criteria:

- the gross assets which are subject to the transaction are greater than 10% of the gross assets of the Trust; or
- the earnings before interest, taxes, depreciation, and amortization ("EBITDA") attributable to the assets which are subject to the transaction are greater than 25% of the EBITDA of the Trust; or
- the income attributable to the assets which are subject to the transaction is greater than 15% of the total income of the Trust.

45.4 For the purposes of 45.3.2 above "subsidiary" means a corporate body in which the Trust:

45.4.1 holds a majority of the voting rights; or

45.4.2 is a member and has the right to appoint or remove a majority of its board of directors; or

45.4.3 is a member and controls alone, pursuant to an agreement with others, a majority of its voting rights.

**Appendix 3**

## TENDERING PROCEDURE

The procurement of goods and services must be carried out in line with the following procurement thresholds (update at as 1st January 2016):

| Anticipated Expenditure (life of contract or 4 years) | Procurement Route | Minimum Lead Time* |
|---|---|---|
| Less than £10,000 | CARDEA catalogue items | Variable however where contracts are in place generic items should be handled within 7/14 days (to delivery) |
| £10,000 - £49,999 | Competitive Quotation | 1-3 months dependant on complexity of requirement. |
| £50,000 - £164,176 | Formal Competitive Tender | 6-8 months |
| Greater than £164,176 | EU Public Procurement | 6-8 months for a general EU procurement process. However, more complex work programmes requiring system implementation may take significantly longer. (Best practice would suggest 12 months) |
| Varying levels of expenditure<br><br>(please seek advice from the procurement team) | Mini Competition | 1-3 months dependant on complexity of requirement (complex requirements may take significantly longer) |

### 1. INVITATION TO TENDER

1.1 All invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted using the Trust procurement portal, unless exceptional circumstances (agreed with Procurement team) allow for a manual return.

1.2 Every tender for goods, materials, manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Section 1.3 and below.

1.3 Every tender for building and engineering works, except for maintenance work only where Estmancode guidance should be followed, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or Department of the Environment (GC/Wks) standard forms of contract amended to comply with Concode.

When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institute of Mechanical 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 Institution of Civil Engineers. The standard documents should be amended to comply with Concode and, in minor respects, to cover special features of individual projects.

1.3 Every tender for building and engineering works shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or New Engineering Contracts (NEC) standard forms of contract; or amended to comply with the requirements of a European Union Compliant Construction Contractor Framework, such as Yor Build, dependent upon value.

When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institute of Mechanical 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 Institution of Civil Engineers. The standard documents should be amended to cover specific features of individual projects

## 2. RECEIPT, SAFE CUSTODY AND RECORD OF FORMAL TENDERS

2.1 Formal competitive tenders shall be submitted on the Trusts procurement portal.

2.2 The date and time of receipt of each tender will form part of the system audit trail.

2.3 The procurement department shall receive tenders for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with Section 3.

## 3. OPENING FORMAL TENDERS

3.1 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders they shall be opened in the presence of two senior officers designated by the Chief Executive.

3.2 Every paper tender received shall be stamped with the date of opening and initialled by two of those present at the opening.

3.3. A permanent record shall be maintained to show for each set of competitive tender invitations dispatched:

(a) the names of firms/individuals invited;

(b) the names of and the number of firms/individuals from which tenders have been received;

(c) the total price(s) tendered;
(d) closing date and time;
(e) date and time of opening; and the record shall be signed by the persons present at the opening.

3.4 Except as in Section 3.5 below, a record shall be maintained of all price alterations on tenders, i.e. where a price has apparently been altered, and the

final price shown shall be recorded. Every price alteration appearing on a tender and the record should be initialled by two of those present at the opening.

3.5 A report shall be made in the record if, on any one tender, price alterations are so numerous as to render the procedure in Section 3.4 unreasonable.

## 4. ADMISSIBILITY AND ACCEPTANCE OF FORMAL TENDERS

4.1 In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Chief Executive.

4.2 Tenders received after the due time and date may be considered only if the Chief Executive or nominated officer decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The Chief Executive or nominated officer shall decide where such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the procurement department at its next meeting.

4.3 Technically late tenders (i.e. those despatched in good time but delayed through no fault of the tenderer) may at the discretion of the Chief Executive be regarded as having arrived in due time.

4.4 Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon his initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under Section 4.2.

4.5 Where examination of tenders reveals errors which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing their offer.

4.6 Necessary discussions with a tenderer of the contents of their tender, in order to elucidate technical points etc., before the award of a contract, need not disqualify the tender.

4.7 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by the procurement department.

4.8 Where only one tender / quotation is received the Trust shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

4.9 A tender other than the lowest (if payment is to be made by the Trust), or other than the highest (if payment is to be received by the Trust) shall not be accepted where quality of product is equal.

4.10 Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or nominated officer.

## 5. LIST OF APPROVED FIRMS (replaced by 10.2 page 23)

5.1 The Director of Finance and Information shall compile and maintain a list of approved firms and individuals from whom tenders may be invited, as provided for in 10.5, and shall keep these under review. The lists shall be selected from all firms which have applied for permission to tender provided that:

(a) in the case of building, engineering and maintenance works, the Chief Executive is satisfied on their capacity, conditions of labour, etc., and that the Director of Finance and Information is satisfied that their financial standing is adequate.

(b) in the case of the supply of goods, materials and related services, and consultancy services the Chief Executive or the nominated officer is satisfied as to their technical competence, and that the Director of Finance and Information is satisfied that their financial standing is adequate.

(c) in the case of the provision of healthcare services to the Trust by a private sector provider, the Director of Finance and Information is satisfied as to their financial standing and the Medical Director is satisfied as to their technical/medical competence.

5.2 The Trust shall arrange for advertisements to be issued as necessary, and not less frequently than every third year, in trade journals and national newspapers inviting applications from firms for inclusion in the prescribed lists.

5.3 If in the opinion of the Chief Executive or the Director of Finance and Information it is impractical to use from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), the Chief Executive should ensure that appropriate checks are carried out on technical and financial capability of firms invited to tender or quote.

5.4 A permanent record should be made of the reasons for inviting a tender or quotation other than from an approved list.