COMPLIANCE WITH THE PROVIDER LICENCE AND S151(5) OF THE HEALTH AND SOCIAL CARE ACT 2012

DECLARATIONS REQUIRED UNDER THE PROVIDER LICENCE

The Provider Licence requires Boards of NHS providers to self-certify annually compliance with the conditions of the provider licence, including compliance with the governance requirements and (if providing commissioner requested services) that they have the resources available to continue to provide those services.

These declarations are made up of:

1. A statement that we have the systems for compliance with licence conditions and related obligations (Condition G6(3))

   Confirming that, following a review processes and systems, in the Financial Year most recently ended, the Licensee took all such precautions to ensure compliance with the licence conditions.

2. Availability of required resources (Condition CoS7(3))

   Confirm that we have a reasonable expectation that required resources will be available to deliver the designated services in the next 12 months.

3. A corporate governance statement (Condition FT4(8))

   Confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks.

DECLARATIONS REQUIRED IN RELATION TO S151(5) OF THE HEALTH AND SOCIAL CARE ACT 2012

In addition to the self-certifications required under the provider licence, S151(5) of the Health and Social Care Act 2012 requires Foundation Trusts to ensure governors are equipped with the skills and knowledge to undertake their role. The Board needs to provide a statement which shows the level of compliance with this section of the act and will ask the Board to consider the following statement:

In the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in S151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

THE PROCESS FOR COLLECTING EVIDENCE

To ensure the Board can confirm compliance (or not) with the requirements above the process of compiling evidence is overseen by the Associate Director for Corporate Governance and is as follows:

1. All licence conditions were assigned to a senior manager lead and an executive director
2. Evidence to demonstrate compliance was listed on internally generated templates in relation to the general requirements of the licence (G6(3)) and those specific to the governance of a Foundation Trust (FT4)
3. Executive and senior manager leads were asked to review and confirm that the information provided was consistent with their knowledge and understanding of the controls in place to ensure the Trust was compliant with the conditions of the provider licence.
4. The evidence was then reviewed overall by the Associate Director for Corporate Governance. It should be noted that this year due to management of the pandemic there was a greater reliance on the review by the Associate Director for Corporate Governance with ad-hoc enquiries made of senior managers where specific details needed to be clarified
5. The Audit Committee received detailed information on how the Trust complies with the licence conditions and the Chair of the Committee will provide a verbal report on any matter that the committee identifies as being necessary to bring to the attention of the Board.
6. Once the declarations have been agreed by the Board these will be uploaded to the Trust's website in accordance with NHS Improvement requirements.

DECLARATIONS

Attached are the declarations that the Board as agreed to make. These declarations are based on the evidence provided to the Audit Committee and informed by any matters which might impact on the coming year 2020/21.

CONCLUSION

At its meeting on 16 June 2020 the Board was assured of the process for reviewing the evidence of our control systems and processes in place to ensure compliance with the provider licence, and agreed the declarations shown on the attached.

Cath Hill
Associate Director for Corporate Governance
16 June 2020

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

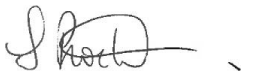
3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

On behalf of the Board of Directors the Audit Committee considered the evidence provided by executive leads as to how each of the licence conditions had been complied with. Based on the evidence provided and its deliberations, the Audit Committee made a recommendation to the Board to endorse the declarations. The Board approved the declarations at its meeting on 16 June 2020 and further information is provided in the attached schedules.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Prof Sue Proctor	**Name**	Sara Munro
Capacity	Chair of the Trust	**Capacity**	Chief Executive
Date	16.6.2020	**Date**	16.6.2020

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A

Declarations for 2019/20 – as agreed by the Board at its meeting on 16 June 2020

Declarations relating to licence conditions G6 (having systems in place to ensure compliance with the licence overall) and CoS7 (having sufficient funds in order to continue to provide services)

	Statement	Declaration
G6(2)	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed compliant 2019/20
CoS(7)	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the required resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed for 2019/20 with an expectation that resources will be available during 2020/21

Declarations relating to licence condition FT4 (systems of good governance required by a Foundation Trust)

	Statement	Declaration and any risks anticipated in 20/21
FT4(8)	The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed compliant 2019/20 It should be noted that some normal systems of governance have been paused with EPRR / command and control arrangements put in place to manage the COVID-19 pandemic. However, whilst paused these systems of good governance are still in place and will be stood back up as the Trust returns to modes of normal operation.

	Statement	Declaration and any risks anticipated in 20/21
FT4(8)	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	As above
FT4(8)	The Board is satisfied that the Trust implements: a) Effective board and committee structures b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees c) Clear reporting lines and accountabilities throughout its organisation	As above
FT4(8)	The Board is satisfied that the Trust effectively implements systems and/or processes: a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern) e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery h) To ensure compliance with all applicable legal requirements.	As above

	Statement	Declaration and any risks anticipated in 20/21
FT4(8)	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c) The collection of accurate, comprehensive, timely and up to date information on quality of care d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	As above
FT4(8)	The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed compliant 2019/20 The Board acknowledges that there are challenges around recruitment due to shortages across nursing and Junior Doctors in some specialities. These shortages are being actively monitored and managed.
Governor training	The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in S151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed compliant 2019/20

PROVIDER LICENCE (Condition G6) 2019/20

(Please note: licence condition FT4 is dealt within the Corporate Governance Statement which is a separate declaration)

Under the Provider Licence (Condition G6) the Board of Directors is required to certify that it is (or is not) satisfied that it takes all reasonable precautions against the risk of failure to comply with the conditions of the provider licence. To allow this certification to be made the table below sets how we comply with each of the licence conditions..

SUPPORTING EVIDENCE FOR EACH LICENCE CONDITION

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
General conditions (G) – general requirements applying to all licensed providers			
G1 - Provision of information Obligation to provide Monitor with any information it requires for its licensing functions.	**Statement of compliance** The Trust has robust data collection and validation processes and has a good track record of producing and submitting accurate, complete and timely information to regulators and third parties to allow it to carry out its licenced functions. All NHS Improvement returns are in the required format and are delivered on time. There have been no adverse comments from NHS Improvement regarding late or incomplete returns. All returns are reviewed by at least one other person than the author.	**Evidence of compliance** • There is an established contact for NHS Improvement via the Chief Executive's Office through which quests for information are received • All preparation and publication guidance has been complied with for the Annual Report, Annual Accounts, annual planning and Single Oversight Framework • The Trust has in place a performance team with responsibility for ensuring the data provided to our regulator is correct; a Programme Management Office with responsibility for annual planning; a Corporate Governance Team with responsibility for submitting the Annual Report; and a finance team with responsibility for the Annual Accounts and monthly financial information and returns • There are data collection and validation processes in place to ensure that the data submitted in the reports and returns is accurate • The Board and its sub-committees regularly receive detailed information on quality and finance performance which supports the process for providing NHS Improvement with accurate and timely information.	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
G2 - Publication of information Obligation to publish such information as Monitor may require.	**Statement of compliance** The Trust complies with this condition as requested and information is publicised as required in accordance with all NHS Improvement guidance including the Code of Governance and the Annual Reporting Manual. All NHS Improvement returns form part of the public Board of Directors and Council of Governors' meeting papers and are published on the Trust's website.	**Evidence of compliance** • A Combined Quality and Performance Report is available on the Trust's website • The public Board and Council agendas, minutes and papers are available to the public, including minutes of Board and Council sub-committees (this is done via the website and by hard copy papers at the meeting and is done ahead of the meetings) • Only those matters which are considered confidential (in accordance with a pre-determined set of criteria) are discussed in private. Papers pertaining to this are held confidentially, but may be subject to FOI • The website has details of all the necessary reports on it (which can be requested in an accessible format if necessary) (Quality Report, Annual Report and Accounts, Strategy etc.) • Statement of evidence of how we comply with the Code of Governance is contained in the Annual Report • Freedom of Information Publication Scheme is published on the Trust's website	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro
G3 - Payment of fees to NHS Improvement Gives Monitor the ability to charge fees and for licence holders to pay them.	**Statement of compliance** The Trust will comply with this condition when required. No fees have been levied by NHS Improvement during 2017/18	**Evidence of compliance** • The Chief Financial Officer and the Associate Director for Corporate Governance will be notified of any fees required by NHS Improvement by reviewing all monthly and quarterly updates sent by NHS Improvement • However, there is currently no action required to be taken and the Trust is currently keeping a watching brief on the situation.	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro
G4 - Fit and proper persons Prevents licensees from allowing unfit persons to become or continue as governors or	**Statement of compliance** All governors and directors have been deemed to be fit and proper persons in accordance with the requirements of this licence condition and for directors, in accordance with the CQC regualtions.	**Evidence of compliance** • The Trust has in place a procedure for the ensuring that directors are, on appointment and thereafter, continue to be fit and proper to carry out their role, this includes the requirements of the provider licence • Directors are checked on appointment and every three years	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
directors		and also through a process of annual appraisals. A file of evidence is maintained for each director • The Constitution contains the relevant clauses for becoming or continuing as a director or governor • The application form for non-executive directors asks for a declaration that they are fit and proper persons as per the NHS Improvement licence requirements • The executive director contract and non-executive director appointment letter have been amended to ensure they comply with the fit and proper persons' test as per the NHS Improvement provider licence • There is a Code of Conduct for Directors and Governors which requires them to confirm they are fit and proper in accordance with the Trust's procedures. • Declarations are made by governors on election that they are eligible to hold office and there is no reason by they would be barred • The nomination form for governors is clear as to who may not be a governor (in terms of NHS Improvement's fit and proper persons' test).	
G5 - NHS Improvement guidance Requires licensees to have regard to NHSI Guidance.	**Statement of compliance** The Trust responds to guidance issued by NHS Improvement. Submissions and information provided to NHS Improvement are approved through relevant and appropriate authorization process.	**Evidence of compliance** • The Trust has successfully submitted to the Regulator the Annual Report, Annual Accounts, Quality Report, Operational Plan, Board declarations and quarterly monitoring returns all of which evidences compliance with NHS Improvement's requirements • The Trust receives NHS Improvement guidance updates and publications via email, these are received by key people in the various corporate teams (Associate Director for Corporate Governance; Finance Manager for finance; Programme Management Officer for annual planning) • The Board has consistently had regard to the requirements of the Code of Governance and complied or explained any non-compliance as needed.	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
G6 - Systems for compliance with licence conditions and related obligations Requires providers to take reasonable precautions against risk of failure to comply with the licence.	**Statement of compliance** The Trust is compliant with all conditions of the licence and has made the necessary assurances to the Audit Committee and provided any evidence required to support this and to support the Board making the necessary self-declarations. The risk of not complying with the licence conditions is low as evidenced by this document.	**Evidence of compliance** <u>Process for managing risks to complying with the licence</u> • There is a performance team who monitor compliance with the NHS Improvement targets and provide a report to each Board meeting. This includes an exception report setting out risks of potential breach of any targets • There is a compliance statement for each element of the licence completed each year • The Corporate Governance Statement is completed each year with risks to compliance with the conditions identified • The Annual Governance Statement is reviewed and agreed by the Audit Committee, internal audit, external audit and the Board prior to being signed off by the Chief Executive • The Head of Internal Audit Opinion comments on systems of internal control which help to manage and mitigate risks of not complying with the licence.	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro
G7 - Registration with the Care Quality Commission This condition requires Licensees to be registered at all times with the CQC. And notify NHSI promptly of the cancellation of its registration, or notice to cancel.	**Statement of compliance** The Trust is fully registered with the CQC. All sites are registered and the Director of Nursing, Professions and Quality has responsibility for ensuring the Trust is and remains registered.	**Evidence of compliance** • There is a Director of Nursing, Professions and Quality in post with responsibility for ensuring continuing CQC registration • The Director of Nursing, Professions and Quality has responsibility for informing NHS Improvement of any change in registration • The Trust's current registration document confirms that the Trust is currently unconditionally licensed. The CQC registration has not been cancelled and there is no evidence to demonstrate the threat of revocation of the licence has been issued • No enforcement notices have been received • Where there are any matters for concern action plans are drawn up and closely monitored by the Director of Nursing, Professions and Quality, the CQC Project Group and the Executive Team, with assurances to the Board and its sub-committees (as appropriate)	Lead for evidence = Nichola Sanderson with lead director = Cathy Woffendin

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
		• The CQC registration status is contained within the Annual Governance Statement	
G8 - Patient eligibility and selection criteria Requires licence holders to set transparent eligibility and selection criteria for patients and apply these in a transparent manner	**Statement of compliance** Patient eligibility and selection criteria is made available to the general public, through publishing services on the Trust website which state what is offered and to whom it is offered. Service specifications are in place and publicly available which describe how services are provided to the person including types of interventions to be offered.	**Evidence of compliance** • Information is on the Trust's website about our services • Clinical Audit carries out audits that investigate and review these criteria as evidenced by the list of audits • Strengthened access to Community Mental Health Services through Community Redesign • Single point of access for CCG commissioned services to reduce variance and aid selection of service to meet service user's needs.	Lead of evidence = Andy Weir Interim Deputy Chief Operating Officer with lead director = Joanna Forster Adams
G9 - Application of Section 5 (Continuity of Services) Sets out the conditions under which a service will be designated as a Commissioner Requested Services (CRS)	**Statement of compliance** The Trust is compliant with this condition and has agreed its commissioner requested services. There are no disputes in relation to what services are classified as commissioner requested (CRS).	**Evidence of compliance** • The Board has confidence in the ability to provide a continuity of services as evidence of the financial standing of the Trust • There are systems and processes in place to ensure that it will continue to operate as a 'going concern' for at least the next year. • The Annual Report contains a statement of going concern which is agreed by the Board • The Trust has a strong working relationship with key strategic commissioning partners and is working closely with them to facilitate delivery of services to service users • There are a set of agreed growth principles in place against which any growth opportunities are assessed • A programme of efficiency and quality improvement (CIPs) is monitored and reported to the Quality Committee and the Finance and Performance Committee. Further information is included the Continuity of Services (CoS) section	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
Obligations about **pricing (F)** – obliges providers to record pricing information, check data for accuracy and, where required, charge commissioners in line with tariff. Applies to all licensed providers who provide services covered by national tariff.			
P1 - Recording of information Obligation of licensees to record information, particularly about costs	**Statement of compliance** The Trust is compliant with this condition and its implementation is in line with current financial procedures of the Trust including the following of HFMA guidance.	**Evidence of compliance** • Reference costing information is provided to the Finance and Performance Committee. • There is a declaration provided to NHS Improvement relating to the self-assessment quality checklist and costing was in line with NHSI's Approved Costing Guidance • The Trust operates a costing timetable which details key dates for recording of information.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell
P2 - Provision of information Obligation to submit costing information to Monitor	**Statement of compliance** The Trust responds to guidance and requests from NHS Improvement. Information provided is approved through the relevant and appropriate authorisation processes. The Trusts' accounting systems and processes ensure appropriate recording of cost information. The Trust's accounts are subject to both internal and external audit each year.	**Evidence of compliance** • Submission of costing information. • Audit reports on the annual accounts • Financial procedures and Standing Financial Instructions	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell
P3 - Assurance report on submissions to NHS Improvement Obliges licensees to submit an assurance report confirming that the information provided is accurate.	**Statement of compliance** The Trust responds to guidance and requests from NHS Improvement. Information provided is approved through the relevant and appropriate authorisation processes. The Trusts' accounting systems and processes ensure appropriate recording of cost information. The Trust's accounts are subject to both internal and external audit each year.	**Evidence of compliance** • Submission of assurance reports information. • Audit reports on the annual accounts • Financial procedures and Standing Financial Instructions	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
P4 - Compliance with the National Tariff Obliges licensees to charge for NHS health care services in line with national tariff.	**Statement of compliance** All contracts are agreed annually and are in line with the national tariff. The Trust continues to work with its commissioners on the requirement to develop a local tariff within the terms of national guidance.	**Evidence of compliance** • Finance managers have access to the NHSI Approved Costing guidance and the Department of Health reference cost guidance through the shared network drive, and these provide guidance on the rules and methods that the Trust should adhere to when charging for the provision of healthcare. • Evidence of discussions and meetings with commissioners	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell
P5 - Constructive engagement concerning local tariff modifications Requires licence holders to engage constructively with commissioner and to reach agreement locally before applying to NHS Improvement for a modification.	**Statement of compliance** The NHS Standard contract, which has been signed off by the Chief Financial Officer of the Trust and Chief Officers of CCGs, shows that each service provided has a price and cost attached to it there is also engagement with commissioners in relation to pricing.	**Evidence of compliance** • Standard contracts • Costing working papers • Minutes of commissioner clustering sub group	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell
Obligations around **choice and competition (C)** – obliges providers to help patients make the right choice of provider, where appropriate, and prohibits anti-competitive behaviour where against patients' interests. This applies to all licensed providers.			
C1 - The right of patients to make choices Protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a	**Statement of compliance** The Trust fully complies with the provision of clear and truthful information for service users and does not offer or give any benefits or inducements to refer service users of commission services. It has complied with the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and	**Evidence of compliance** • Service user surveys are undertaken by the Trust which document overall service user choice. This shows that service users have a choice of provider under the NHS Constitution • The Trust website details a list of services available to service users • Monthly performance reports available via the Trust's website • Standards of Business Conduct in place • Anti-fraud and Bribery Policy circulated to staff • Hospitality and gifts procedure in place	Lead for evidence = Andy Weir – Interim Deputy Chief Operating Officer with lead director = Joanna Forster Adams

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
choice of provider. There is also an obligation that gifts and benefits will not be accepted in order that individuals may gain advantage .	Standing Rules) (Amendment) Regulation 2013 removing mental health service exemptions from certain of the obligations that previously existed in relation to choice. The Trust publishes information about its services on the Trust's website and also publishes information about performance in relation to service targets and measures allowing service users to make a more informed choice about services.	• Declaration of interest procedure in place for directors, governors and staff • Information is available via choose and book where applicable, and NHS Choices.	
C2 - Competition oversight Prevents providers from entering into or maintaining agreements that have the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	**Statement of compliance** The Trust fully supports the principles of competition and works openly with partners to provide comprehensive and complementary services to benefit service users. The Trust is aware of the requirements of competition in the health sector and would seek legal and or specialist advice should the Board decide to enter into any structural changes such as mergers or Joint Ventures.	**Evidence of compliance** • The Financial Planning Group, has responsibility for contract management and contracts are monitored through this group and help ensure that no unlawful arrangements are entered into • A Whistleblowing Policy is in place • No whistleblowing occurrences had highlighted any agreements that distorted competition • The Trust has completed a Partnership Procurement Framework which enables us to simplify procurement from third sector providers.	Lead for evidence = Andy Weir – Interim Deputy Chief Operating Officer with lead director = Joanna Forster Adams
Obligations to enable **integrated care (IC)** – enables the provision of integrated services and applies to all licensed providers.			
IC1 - Provision of integrated care Requires Licensee to act in the interests of people who use healthcare services by facilitating the development and maintenance of	**Statement of compliance** The Trust is fully supportive of the delivery of integrated care. There is extensive engagement with other providers to ensure services are joined up and that integrated care is provided where possible. The Trust is also involved in the development and implementation of New Models of Care.	**Evidence of compliance** • The Trust actively works with its partners, through formal and informal mechanisms to foster and enable integrated care and is involved in several pilots aimed at developing new ways of working and new models of delivery. • A number of services provided are done so through partnership working with other local stakeholders. • The Trust plays an active role in Integrated Care Systems in West Yorkshire & Harrogate, and signatory to a Memorandum	Lead for evidence = Andy Weir – Interim Deputy Chief Operating Officer with lead director = Joanna Forster Adams

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
integrated services.		of Understanding with both • The Trust is an active partner in the Leeds system and works with a number of third sector and voluntary partners to provide care to service uers.	
Conditions to support **continuity of services (CoS)** – allows Monitor/NHS Improvement to assess whether there is a risk to services and to set out how services will be protected if a provider gets into financial difficulty. Applies to providers of commissioner requested services (CRS) only.			
CoS1 - Continuing provision of Commissioner Requested Services Prevents licensees from ceasing to provide CRS or from changing the way in which they provide CRS without the agreement of relevant commissioners.	**Statement of compliance** The Trust is delivering a list of services that meet the requirements of the CQC and which are in accordance with a signed contract with our commissioners. Any disposals which may affect the provision of service, these would have to be approved by the Commissioners prior to disposal. If any services in the future fell outside this framework, or were due to be cancelled in the future, this would be discussed during a meeting with the commissioning services and advised to the Finance and Performance Committee and the Board of Directors.	**Evidence of compliance** • Signed contracts • Activity information provided to the Financial Planning Group and the Board of Directors • The Finance and Performance Committee has been assured of clinical services' contracts and any risks associated with them • The terms of reference for the Financial Planning Group include mechanisms to oversee contract management • CQC Inspection Report from the 2017 inspection showing that the appropriate services are being delivered.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell
CoS2 - Restriction on the disposal of assets Licensees must keep an up-to-date register of relevant assets used in commissioner requested services (CRS) and to seek Monitor/NHS Improvement's consent before disposing of these assets if Monitor	**Statement of compliance** The Trust maintains an asset register and will comply with the terms of the condition regarding asset disposal as required. The asset register shows that there have been no ad-hoc disposals within the year which would have required prior consent from NHSI.	**Evidence of compliance** • The Finance Department holds and updates the asset register which lists owned and leased properties, and equipment over a value of £5,000 • NHSI receives the annual planning commentary and templates which contain a list of assets due to be disposed throughout the year. This is a full asset register including land and buildings which encompass all of the Commissioner Requested Services • The approval letter in relation to the Trust's Annual Plan, which contained the list of disposals for the coming year, confirming that this had been approved by NHSI.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
has concerns about the licensee continuing as a going concern.			
CoS3 - Standards of corporate governance and financial management Licensees are required to adopt and apply systems and standards of corporate governance and management, which would be seen as appropriate for a provider of NHS services and enable the Trust to continue as a going concern.	**Statement of compliance** The Trust has sound, well developed systems of corporate and financial governance.	**Evidence of compliance** <u>Corporate Governance</u> • Assurances of good corporate governance and financial management are demonstrated through the use of internal and external audit, which challenge and review key areas of the organisation • The Trust has a Constitution in place, and also complies with all other guidance and good practice in terms of documentation in place • There is a detailed risk management procedure in place including Strategic, Corporate and Directorate Risk Registers • There is a Board Assurance Framework in place which is reported to the Board, Audit Committee and Board sub-committees • Annual Governance Statement is reviewed by the Board and signed by the Chief Executive • The Trust has a Corporate Governance Policy in place which sets out the processes, structures and procedures in place to govern the Trust • Internal audit and external audit ensure a sound system of internal controls are in place and report these to the Audit Committee. The outcome of all reports are reported to the Audit Committee • Self-assessment under the Code of Governance with the necessary declarations being made in the Annual Report. <u>Financial Management</u> • Standing Financial Instructions and a Scheme of Delegation are in place which outline financial responsibilities and	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
		thresholds • Operational Plan with financial projections • Annual Report and Accounts which detail financial management procedures and the end of year out-turn • The Combined Quality and Performance Report includes financial information which is presented to the Board • Financial performance information is presented to the Finance and Performance Committee.	Hanwell
CoS4 - Undertaking from the ultimate controller Requires licensees to put a legally enforceable agreement in place to stop the ultimate controller from taking action that would cause the licensee to breach its licensing conditions.	**Statement of compliance** The Trust is a Public Benefit Corporation and neither operates nor is governed by an Ultimate Controller arrangement so this licence condition does not apply.	**Evidence of compliance** • Not applicable.	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro
CoS5 - Risk pool levy Obliges licensees to contribute to the funding of the 'risk pool' (insurance mechanism to pay for vital services if a provider fails).	**Statement of compliance** Not applicable.	**Evidence of compliance** This is currently not a requirement.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
CoS6 - Co-operation in the event of financial stress Applies when a licensee fails a test of sound finances and obliges the licensee to co-operate with NHS Improvement.	**Statement of compliance** There is no evidence that the Trust is not a going concern and no requests have been made of the Trust by NHSI. In the event of this being applicable the Trust would comply with this condition as required.	**Evidence of compliance** • In year monthly financial reporting stating the Trust has a strong 'financial risk rating • Annual planning cycle and financial monitoring signalling a strong use of resources. • Financial reporting scrutinised by the Finance and Performance Committee and Board demonstrating strong financial management • Achievement of year-end control total	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell
CoS7 - Availability of resources Requires licenses to act in a way that secures resources to operate commissioner requested services (CRS).	**Statement of compliance** The Trust is compliant with this condition, having made a declaration and is declaring a Financial risk rating of 1. Approval of the Trust's financial plan is discussed at Board and also at the Finance and Performance Committee.	**Evidence of compliance** • Combined Quality Performance Report with the financial information and projections included in this is presented to the Board • Finance and Performance Committee papers and minutes showing that the Committee is content that the Trust remains financially viable • Operational Plan submission and financial projections for the coming years, again demonstrating on-going financial viability • Quarterly review by NHSI and correspondence to show that NHSI have no concerns about the Trust's financial position • Signed and committed contracts which are predominantly block contracts • CIPs process for monitoring is in place which is overseen by the Programme Management Office, the Finance and Performance Committee, the Quality Committee, the Board and Financial Planning Group • Capital programme is kept under constant review through the Finance and Performance Committee and the Board.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
Governance licence **conditions for Foundation Trusts (FT)** – provides obligations for Foundation Trusts around appropriate standards of governance. Applies to Foundation Trusts only.			
FT1 - Information to update the register of NHS FTs The Licensee shall ensure that NHS Improvement has available to it written and electronic copies of the following documents: • The current version of Licensee's constitution; • The Licensee's most recently published annual accounts and any report of the auditor on them; and • The Licensee's most recently published annual report.	**Statement of compliance** The Trust has supplied and will continue to supply the required information in order for NHS Improvement to keep the register of Foundation Trust's up to date. This includes the submission of the Annual Report and Accounts and the Constitution when it was updated.	**Evidence of Compliance** • The Board and Audit Committee have cycles of business which include the scrutiny and approval of the Annual Report and Accounts • Copies of the Annual Report and Accounts and the current version of the Constitution are provided to NHS Improvement for inclusion its website • A copy of the auditor's report on the Accounts and Annual Report was included in the document which was submitted to NHS Improvement • The documentation relating to the latest version of the constitution was provided to NHS Improvement within 28 days of the adopted change.	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro
FT2 - Payment to NHS Improvement in respect of registration and related costs Should NHS Improvement determine that the Licensee must pay to NHS Improvement a fee in respect of NHS	**Statement of compliance** No fees have been levied by NHS Improvement.	**Evidence of Compliance** • Not applicable.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
Improvement's exercise of its functions the Licensee shall pay that fee to NHS Improvement within 28 days of the fee being notified.			
FT3 - Provision of information to advisory panel The Licensee shall comply with any request for information or advice made of it.	**Statement of compliance** Prior to the advisory panel being disbanded there had been no request for the Trust to comply with any requests made by the panel.	**Evidence of Compliance** • Not applicable.	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro
FT4 - NHS Foundation Trust governance arrangements Gives NHS Improvement continued oversight of the governance of foundation trusts**.**	**Statement of compliance** The Trust has sound governance processes in place and reviews of these arrangements are a core part of the internal audit annual work programme. This was also evidenced in the outcome of the well-led review of the Trust's governance arrangements and by subsequent CQC reviews	**Evidence of Compliance** • A separate document has been produced to demonstrate how the Trust meets each of the different elements of good governance as set out in the licence.	

Leeds and York Partnership NHS
NHS Foundation Trust

CORPORATE GOVERNANCE STATEMENT (CGS) 2019/20 and 2020/21

(How we comply with Condition FT4 of the Provider Licence)

SUPPORTING EVIDENCE FOR EACH GOVERNANCE CONDITION

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
The Board is satisfied that Leeds and York Partnership NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	The Board is satisfied that Leeds and York Partnership NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	• The Trust has in place a Board of Directors which is properly constituted and governed by Terms of Reference. It has beneath it a fully formed structure of sub-committees each chaired by a non-executive director, and appropriately monitored by the Board via reports from their chairs • The Trust has in place an appropriately constituted Council of Governors and an appropriate sub-committee structure to carry out its work • The executive and non-executive directors are appropriately qualified and experienced to lead the organisation; carry out their roles; and provide effective challenge within Board meetings, its sub-committee structure and within the wider organisation • The Board has been assured by the Associate Director for Corporate Governance and the last CQC inspection that its members are Fit and Proper and that the Trust has in place a Fit and Proper Person Procedure which meets the CQC regulations • The Board has an agreed strategy incorporating goals and objectives, and five	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
		supporting strategies setting out the key priorities. It receives reports on progress against its priorities through its sub-committees • The Board has agreed, supports and promotes a set of values which it promotes throughout the Trust • The Board has agreed a schedule setting out those matters that are reserved to the Board and those it has delegated • The CEO has ensured the executive directors' portfolios are clearly defined and that appropriate management structures are in place to support the delivery of health care services and the delivery of their responsibilities as Accounting Officer. • There is an appropriate risk management process in place and supporting procedures to ensure safe services are delivered and that lessons are learnt from incidents both internal and external to the Trust. • The Trust has in place appropriately qualified internal audit and external audit teams providing assurance on all aspects of the business of the Trust.	
The Board has regard to such guidance on good corporate governance as may be issued by NHSI from time to time.	• There is in place a governance structure which has the capacity and capability to interpret and implement the corporate governance guidance as issued by NHS Improvement • There are appropriate supporting structures and teams to implement such guidance. These teams are appropriately qualified, trained and resourced • In terms of the corporate governance documents the Board is able to demonstrate delivery of: o Annual Accounts o Annual Report	• Annual Accounts • Annual Report • Annual Governance Statement • Corporate Governance Statement • Quality Report • Monthly monitoring returns • Board self-certification • The Trust's Strategy and supporting strategies • Comply or explain statement in respect the Code of Governance and the Provider Licence	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	o Annual Governance Statement o Corporate Governance Statement o Quality Report o Monthly monitoring returns o Board self-certification o Board Assurance Framework o The Trust's Strategy o Comply or explain statements.	• Board Assurance Framework.	
The Board is satisfied that Leeds and York Partnership NHS Foundation Trust implements: a) Effective board and committee structures;	• The Board of Directors has beneath it a comprehensive sub-committee structure consisting of an Audit Committee, Finance and Performance Committee, Quality Committee, Workforce Committee, Mental Health Legislation Committee, Remuneration Committee, and Nominations Committee • The sub-committees are chaired by non-executive directors; have only Board members as substantive members (both executive and non-executive); are attended by appropriately qualified and experienced senior managers; and where appropriate are observed by governors • Each of its committees report back to the Board by way of a report from the chair of the committee highlighting the main areas of discussion and any matter to be escalated • The Terms of Reference for each Board sub-committee is clear that they are concerned with governance and assurance and those matters of day-to-day management are dealt within directorate structures reporting to the Executive Management Team • A review of effectiveness is required to be carried out at least annually and a report made to the 'parent group' in respect of the outcome and any	• Sub-committee Terms of Reference • Governance Structure • Minutes of the Board of Directors and minutes of each sub-committee • Effectiveness questionnaires.	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	areas of development.		
b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and	• The Board and each of its sub-committees have Terms of Reference agreed by that sub-committee and ratified by the Board • The role of each person (whether a substantive member or in attendance) is clearly set out in the Terms of Reference • There is an agreed memorandum of understanding between the Chair and Chief Executive setting out their division of responsibilities • There is a scheme of delegation • There is a comprehensive meetings manual and schedule of training on all aspects of running meetings.	• Terms of Reference for the Board and its sub-committees • Job and role descriptions for executive directors and non-executive directors • Job descriptions for all staff reporting to and attending committees • Terms of Reference for Board sub-committees set out the reason for each senior manager attending • Document detailing the division of responsibility between the Chair and Chief Executive • Scheme of Delegation • Meetings Administration Manual and schedule of training.	Cath Hill, Associate Director for Corporate Governance (Sara Munro)
c) Clear reporting lines and accountabilities throughout its organisation.	• The Board of Directors is accountable locally to members and members of the public through the Council of Governors and to its commissioners for the delivery of services through legally binding contracts • The Trust is also accountable to its regulators including NHS Improvement and the CQC • The Board of Directors and the Council of Governors have clear sub-committee structures with reports from each being made to it on the work they have carried out on its behalf. The Executive Team reports into the Board through the Chief Executive. The Executive Management Team meeting has a fully formed governance structure beneath it which supports the work of the executive directors in respect of the day-to-day management of the Trust • Agreed Terms of Reference for the Board, Council, EMT and their respective sub-committee	• Terms of Reference for Board, Council, Executive Team and respective sub-committees that include an organogram for reporting • Terms of Reference for all groups and committees in the operational governance structure • Governance structure reporting organogram • Constitution • Matters reserved and scheme of delegation • Division of Duties between the Chair and Chief Executive • NHS Foundation Trust Accounting Officers' Memorandum • Meetings Administration Manual • Meetings Map • Governance, Accountability, Assurance and Performance Framework	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	structures are in place for all groups and committees • The Board has in place a number of high level documents which set out accountabilities and responsibilities: the Constitution; Matters Reserved and Scheme of Delegation; division of duties between the Chair and the Chief Executive, the Chief Executive's Memorandum of Accounting • Each executive director has a clearly defined portfolio with clear accountability for their area of responsibility. Objectives are set each year for directors and are appraised by the Chief Executive • All job and role descriptions have a clear indication of the accountability lines of reporting and a process for objective setting and appraisal is in place • There is a Governance, Accountability, Assurance and Performance Framework in place which sets out accountability and reporting lines for performance • All groups and committees in the governance structure have Terms of Reference with parent groups shown in terms of reporting and escalation.		
The Board is satisfied that Leeds and York Partnership NHS Foundation Trust: a) Effectively implements systems and/or processes to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively;	• Standing Financial Instructions (SFIs) and Financial Procedures (FPs) in place • External audit services procured and regularly market tested • Internal Audit service in place through a consortium arrangement • Regular reporting of detailed financial information to Board, Financial Planning Group, Finance and	• Standing Financial Instructions • Financial Procedures • Internal Audit Reports • External Audit Reports • Papers and minutes of Board, Finance & Performance Committee, Financial Planning Group, and Operational Delivery Group • Procurement work plan quarterly progress report to Finance & Performance Committee	David Brewin, Assistant Director of Finance (Dawn Hanwell)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	Performance Committee and Operational Delivery Group • Procurement work plan in place • Estates strategy developed to support the service strategy • In line with SFIs, all significant clinical and non-clinical developments are subject to Board approving a business case which details the economic case • Involvement in national and local benchmarking exercises • Chief Executive and Executive Director representation at Leeds 'place based' implementation groups to ensure Trust services operate efficiently, economically and effectively in the context of the wider Leeds health and social care economy • Partnership Procurement Framework in place to deliver efficient and effective engagement of voluntary sector organisations • Cost Improvement Programme Quality Impact Assessment Process.	• Estates Strategy quarterly progress report to Finance & Performance Committee • Board minutes • Output from local and national benchmarking exercise • Meetings notes and terms of reference • Framework documentation • Quality and Deliverability Impact Assessment forms and minutes and terms of reference for the Star Chamber.	
b) Effectively implements systems and/or processes for timely and effective scrutiny and oversight by the Board of the Licence holder's operations;	• The Board has in place a cycle of business which it has agreed for those items that it wants to receive on a cyclical basis throughout the year. It has also put in place a schedule setting out those duties that it has delegated • The Associate Director for Corporate Governance has responsibility for ensuring that papers are presented to the Board in accordance with its business cycle and for ensuring other papers are delivered within agreed timeframes • The Associate Director for Corporate Governance also has responsibility for ensuring good flows of	• Annual Cycle of Business for the Board of Directors • Scheme of Delegation and Matters Reserved • Terms of Reference (Board, Council and their sub-committees) • Attendance by the Associate Director for Corporate Governance at all sub-committee meetings under the Board of Directors and Council of Governors • Minutes of meetings and Board • CEO Report to Board • Board sub-committees Terms of Reference and minutes	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	information between the Board, the Council of Governors, including through the sub-committee structure and that papers move through the governance structure in a timely manner. This is achieved through cycles of business, Terms of Reference of committees and action logs • The work of the Board's sub-committees is reported via reports and from the chair of the committee to the next available Board meeting • The Executive Team has established a comprehensive structure of reporting beneath it with all groups and committees having agreed Terms of Reference. There are 10 executive-led groups reporting to the Executive Management Team, each being chaired by an executive director. • The Chief Executive's Report will include those significant items that need to be brought to the attention of the Board. This supplements other substantive papers from executive directors to the Board.	• Minutes of the Board of Directors.	
c) Effectively implements systems and/or processes to ensure compliance with health care standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	• Identified compliance actions following CQC inspections are monitored through the CQC Project Group, and assurances made to the Quality Committee (a Board sub-committee). Quarterly updates are provided to the Trust's Board by the Director of Nursing, Quality and Professions • Any risks to compliance are identified and managed through a live risk assessment and treatment plan • Risks to compliance are identified within the Combined Quality and Performance Report and any necessary actions in place to ensure compliance and improvements are documented.	• Terms of reference for the CQC Project Group • Action minutes of the CQC Project Group • Updated and reviewed CQC Action Plan • Combined Quality and Performance (CQPR) Report as presented to the Board, the Council of Governors, Quality Committee the Finance and Performance Committee and Workforce Committee • Minutes of the Board of Directors, the Council of Governors, Board sub-committees and the Executive Team • Emails from the Clinical Quality Assurance Service to evidence sharing the CQPR with commissioners.	Nichola Sanderson, Deputy Director of Nursing (Cathy Woffendin)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	• Peer review process in place to monitor actual practice against standards		
d) Effectively implements systems and/or processes for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern);	• Standing Financial Instructions (SFIs) and Financial Procedures (FPs) in place • Internal and external audit services • Regular reporting of detailed financial information, Single Oversight Framework Finance and use of Resources score to Board, Finance & Performance Committee and Financial Planning Group • Financial planning and modelling. Board approval of financial model as set out in the Operational Plan • Executive Directors involvement in the Financial Planning Group and Finance and Performance Committee which receive reports detailing all relevant clinical income risks and opportunities and strategies and action plans developed • Estates strategy developed to support service strategy and capital programme agreed • In line with SFIs, all significant clinical and non-clinical developments subject to Board approving a business case which details the economic case • Budgetary Control Framework and Virement Procedure in place to support effective management and control.	• Standing Financial Instructions • Financial Procedures • Internal & External Audit Reports • Papers and minutes to Board, Finance and Performance Committee and Financial Planning Group • Financial Plan approval by Trust Board • Terms of reference for Financial Planning Group and Finance and Performance Committee • Estates Strategy • Budgetary Control Framework and Virement Policy	David Brewin, Assistant Director of Finance (Dawn Hanwell)
e) Effectively implements systems and/or processes to obtain and disseminate accurate, comprehensive, timely and up-to-date information for Board and Committee decision-making;	• The Board and its sub-committees have in place an annual cycle of business, action logs, and bring forward system for agenda management to ensure that papers are received in an appropriate and timely manner • Minutes of meetings are formally presented to the next available "parent group" meeting both for	• Annual cycle of business for Board and its sub-committees • Chair's reports are presented to 'parent groups' with appropriate cover sheets • Data Quality Policy • Statement of Auditing Standards (SAS) No 70 for assurance on the SBS provision of ledger	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	information and so issues can be escalated as necessary • Reports to the Board and its sub-committee meetings are written by appropriately qualified and trained staff, and are approved by the lead director before being presented to meetings • Performance information in respect of clinical services, quality, workforce and finance is one of the main reporting tools informing Board and sub-committee decision making. To ensure there is accurate real-time performance information there is a Data Quality Policy clearly identifying roles and responsibilities for data input and collection and a performance team led by the Chief Financial Officer to interpret and present the information • Financial information is also presented to the Board by the CFO. Shared Business Services manage the core ledger management function and provide real-time information to a pre-determined timetable.	facility and core financial function.	
f) Effectively implements systems and/or processes to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	• The Board of Directors receives the Combined Quality and Performance Report which sets out the Trust's performance against internal and external requirements, measures and targets (local, regulatory and contractual) • The Council of Governors receives a performance report on a quarterly basis • Any risks to performance are identified within the combined Quality and Performance Report and any necessary actions in place to ensure compliance and improvements are documented • The CQPR is routinely shared with the Trust's main commissioner and published on the Trust's website	• Combined Quality and Performance Report as presented to the Board, Board sub-committees and the Council of Governors • Minutes of the Board of Directors, the Council of Governors and the Board sub-committees • Pages on the Trust website • Emails from the performance team to show we share the CQPR with commissioners.	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	• We have a systematic electronic approach to managing risks, which are managed through the governance structure within the Trust • The Operational Plan includes an assessment of the risks associated with each of the Trust's priorities • Risks identified in the Operational Plan are managed by a lead manager and are monitored through the Programme Management Office • The Executive Risk Management Group has oversight of the strategic risks and any risks scored 15+ • The Executive Performance Overview Group oversees performance in the care groups and corporate directorates and provides support and challenge to staff in the services in relation to performance.		
g) Effectively implements systems and/or processes to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery;	• We have in place a strategic planning cycle which outlines the process by which we develop and monitor progress against the Annual Plan. • We have developed five three-year strategic plans agreed by the Board of Directors as follows: o Clinical Services o Estates o Workforce & Organisational Development o Health Informatics o Quality. • The strategic plans form the basis of our Annual Plan • Progress against the organisation's top priorities as modelled within the Annual Plan is reported to the Board of Directors on a quarterly basis	• Strategic planning cycle • Progress against our Annual Plan Quarterly Reports • Annual priorities	Amanda Burgess, Strategic Development Manager (Dawn Hanwell)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	• The Programme Management Office is responsible for monitoring, supporting and reporting on the delivery of the organisation's top priorities as outlined in the five strategic plans and our Annual Plan • The CCG and NHS England commissioners routinely receive updates on our plans via the Contract Monitoring Board meetings.		
h) Effectively implements systems and/or processes to ensure compliance with all applicable legal requirements.	• Policies and procedures in place are referenced to the appropriate legislation including in the areas of: o Health and safety o Adult and child safeguarding o Medicines management o Mental Health Act o Fraud, bribery and corruption o Fire safety o Human resources o Public health o Estates and buildings o Information governance. • Statutory committees have been established within the committee structure to ensure compliance with relevant legislation (e.g. Health and Safety Committee) • Appropriately qualified executive directors with clear portfolios and responsibility for ensuring compliance with legislation within their functional areas • Directorate structures and teams established to ensure appropriately trained and qualified staff to oversee the implementation and adherence to relevant legislation	• Policies and procedures and reference to Section where relevant legislation is listed • Committee structure detailing those that are a legislative requirement • Directors' portfolios • Directorate and team structures.	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	• Regular Board training.		
The Board is satisfied: a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;	• Appointments based on merit to non-executive director roles linked to required skill sets of the Board • Appointments based on merit to executive director posts, utilising an assessment centre approach and based on agreed criteria derived from job descriptions and portfolios • Appraisals for non-executive directors and executive directors are carried out with actions agreed in areas of development • Reports on the outcome of the non-executive directors' appraisals being made to the Appointments and Remuneration Committee and Council of Governors • Full induction programmes completed for Board members • Ongoing Board workshops on topics relevant to Board development • NHS Providers programmes of NED training accessible to all non-executive directors. • Board members participate in a programme of Board development workshops. • Board members receive individual development, tailored to their roles and development objectives • Board members take part in appraisal and supervision to support development	• Executive director job and portfolio descriptions and recruitment process documentation • Non-executive director role descriptions and recruitment process documentation • Reports to the Appointments and Remuneration Committee and Council of Governors on the outcome of the appraisals of the non-executive directors. • Induction information • Board workshop schedules and topics discussed • Directors' pen portraits • Appraisal processes • Planned Board Development Plan. • Board Development Programme Schedule	Cath Hill, Associate Director for Corporate Governance (Sara Munro)
b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	• The Board of Directors and the Executive Team receive a Combined Quality and Performance (CQPR) Report which sets out Trust performance against external requirements, including NHS Improvement targets and other national / local standards.	• Monitoring Returns submitted to NHS Improvement • Combined Quality & Performance Report as presented to the Board of Directors & Executive Team • Combined Quality & Performance Report sections as presented to the relevant sub-	Nikki Cooper, Head of Performance Management and Informatics (Joanna Forster

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	• Any risks to performance are identified within the report and any necessary actions in place to ensure compliance and improvements are documented. • The relevant sections of this report are also reviewed in more detail at the Trust Board's Quality and Finance & Performance Sub-Committees and further explanatory reports provided as requested. • The Council of Governors also receives a summarised version of the report on a quarterly basis. • This report is routinely shared with the Trust's main commissioner and published on the Trust's website.	committees and Council of Governors. • Minutes of the Board of Directors, Sub-Committees, the Council of Governors and the Executive Team • Pages on the Trust website • Emails from the Clinical Contracts Manager to show we share the CQPR with commissioners • Notes from quality / activity & finance meetings with commissioners which show the CQPR has been discussed.	Adams)
	• Peer reviews are carried out to benchmark services against CQC standards to ensure ongoing compliance with registration	• Combined Quality Performance Report • Trust Board reporting template and sub group templates highlight areas of compliance • Peer reviews and self-assessments • Mental Health Act CQC reviews and returns • Trust Board sub group minutes and exec led group minutes	Nichola Sanderson, Deputy Director of Nursing (Cathy Woffendin)
	• A Quality Committee is in place, chaired by the non-executive director with responsibility for quality and has, as substantive members, the Director of Nursing, Professions and Quality, the Medical Director and the Chief Operating Officer • The Quality Committee receives assurance on compliance with those standards required for high quality and the safe delivery of care • The Quality Committee will seek assurance and opportunities to improve clinical quality, defined as issues looking at clinical effectiveness, patient	• Terms of Reference of the Quality Committee showing the membership and its duties • Minutes from the Quality Committee • Quality Committee papers include the quality performance report / learning lessons, integrated risk report and workforce performance report • Evidence of the Quality Committee's annual schedule of work relating to quality and safety issues. • Evidence of quality issues being discussed at the Board. For example, sharing patients'	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	experience and patient safety • The Quality Committee has an annual schedule of work which incorporates both regular planned updates and deep dives on quality and safety related issues • The Trust Board receives regular updates on quality and safety as part of its annual work schedule and via the monthly chair's report from the chair of the Quality Committee and the CQPR. • Regular Executive Performance Overview Groups (EPOG) are in place for all Directorates and care groups where quality is discussed.	stories, learning from deaths, CQC action plans, complaints, claims and compliments and chair's reports from the Quality Committee • Annual schedule of dates and times for the Executive Performance Overview Group (EPOG) • Slides and action notes from EPOG, where patient centred care and quality is a specific topic area	
	• The Medical Director chairs the Trust Wide Clinical Governance Group which is focused on quality and safety and reports into the Quality Committee	• Terms of Reference for Trust Wide Clinical Governance Group showing the membership and its duties • Minutes and chair's reports from Trust Wide Clinical Governance (TWCG) • Programme of Peer reviews	Rebecca Le-Hair Head of Quality and Clinical Governance
c) The collection of accurate, comprehensive, timely and up to date information on quality of care;	• The Performance, Information and Data Quality Group (PIDQG) and provides a focus for the organisation in assuring the collection of high quality data; audits undertaken on behalf of the group are used to improve performance and quality. • Robust processes in place for collecting data from throughout the organisation relating to quality of care. • Data quality reports produced weekly and monthly to support improved record keeping. • Clinical effectiveness team provides support for clinical audit and service evaluation	• Combined Quality and Performance Report as presented to the Board, its sub-committees and the Council of Governors • Minutes of the Board of Directors, its sub-committees and the Council of Governors • Quality Committee papers including service quality reports, learning from complaints and incidents. • Minutes and papers from the Performance, Information and Data Quality Group (PIDQG).	Nikki Cooper, Head of Performance Management and Informatics (Joanna Forster Adams)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
d) That the Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care;	• The Board of Directors and the Executive Team receive a Combined Quality and Performance (CQPR) Report which sets out Trust performance against external requirements, including NHS Improvement targets and other national / local standards. • Any risks to performance are identified within the report and any necessary actions in place to ensure compliance and improvements are documented. • The relevant sections of this report are also reviewed in more detail at the Trust Board's Sub-Committees and further explanatory reports provided as requested. • The Council of Governors also receives a summarised version of the CQPR on a quarterly basis.	• Combined Quality and Performance Report as sent to the Board, its sub-committees and the Council of Governors • Minutes and papers from the Board's sub-committees	Nikki Cooper, Head of Performance Management and Informatics (Joanna Forster Adams)
	• Detailed assessments of compliance through Peer Reviews with CQC registration are undertaken using the Key Lines of Enquiry (KLoE), and 'should / must do's' following the publication of inspection reports, with sign off from leads and lead executive directors. Assessments of compliance are reported on a quarterly basis to the Trustwide Clinical Governance Group and the CQC Project Group	• Completed and signed Peer reviews demonstrating compliance with CQC registration • Trust Board minutes and papers • Minutes of CQC Project Group • CQC must do / should do action plans	Nichola Sanderson, Deputy Director of Nursing (Cathy Woffendin)
	• There is a cycle of business which sets out when reports will be received. This is co-ordinated with data closedown dates • The Trust has a Governance, Accountability, Assurance and Performance (GAAP) framework in place which is used at all levels of the organisation As set out in the GAAP, regular Executive	• Minutes of the Board of Directors, and Council of Governors • Board of Director's cycle of business	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	Performance Overview Groups (EPOG) are in place for all directorates and care groups where quality is discussed.		
e) That Leeds and York Partnership NHS Foundation Trust including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources;	• The Board of Directors receives stories from service users, carers and staff members through its monthly "Sharing Stories" sessions • Compliance will be further supported by an external Patient experience review which will include the views of all relevant stakeholders	• Full suite of recruitment and selection procedures including Temporary Staffing Procedure • Procedure and arrangements in place to adhere to Fit and Proper Persons Test for Board Members and other key posts • Medical Revalidation Procedure • Supervision Procedure for clinical staff • Educational Sponsorship and Study Leave Procedure • Compulsory Training Procedure and programme • Compliance reports to managers for up-take of compulsory training and Combined Quality and Performance Report to Quality Committee and Board • Evidence of Consultant Appraisals and revalidation decisions • ORSA reports to Board and minutes of that Board meeting • Appraisal Procedure for Agenda for Change staff with Combined Quality and Performance Report to Quality Committee and Board on completion data for appraisals • Monthly reports to managers on Professional Registration renewals • Regular reports on bank fill rates. • Trust Strategy • Workforce and OD Strategic Plan 2018-21 • Organisational Structures • Apprenticeship Programme which includes support worker and wider workforce development	Linda Rose Head of Nursing and Patient Experience (Cathy Woffendin)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
		• Monthly Safer Staffing reports to NHS England. • Board Development Programme • Quality Committee Terms of Reference showing membership and duties of the Committee. • "Sharing Stories" programme • Patient experience review recommendations and outcome of patient experience review workshop (Valuing inclusion of people)	
	• The Combined Performance and Quality Report contains details of complaints and compliments	• Combined Performance and Quality Report • External commissioned report on patient experience and engagement • Inclusion workshop held on 22 March, presentation and themes from the day • Community mental health survey • SUN and Sunray minutes	Nichola Sanderson, Deputy Director of Nursing (Cathy Woffendin)
	• The Board of Directors receives in depth information and analysis of the NHS Staff Survey, highlighting where improvements have been achieved and further work is required. It also receives information in respect of the results from the Service User Surveys through its Quality Committee. • NED's undertake structured service visits including evening visits.	• Staff Survey results as reported to Board and minutes of the meeting • NED Visit Feedback Form shared across Board	Angela Earnshaw Head of Organisational Development (Claire Holmes)
f) That there is clear accountability for quality of care throughout Leeds and York Partnership NHS Foundation Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	• A Quality Committee is in place, chaired by the non-executive director with responsibility for quality and has substantive membership from the Director of Nursing, Professions and Quality, Medical Director and the Chief Operating Officer • The Quality Committee receives assurance on clinical governance in the Trust and monitors compliance with those standards required for	• Terms of Reference of the Quality Committee showing the membership and duties of the Committee • Minutes of the Quality Committee • Papers to the Quality Committee • Minutes of reports made to the Board of Directors outlining the work of the Committee and any issues that need to be escalated to Board	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	high quality delivery of care • The Quality Committee has responsibility for seeking assurance and opportunities to improve clinical quality and safety, which is defined as issues looking at clinical effectiveness, patient experience and patient safety • Any matters which it feels should be escalated to Board will be done by the chair of the committee in their report to the next available Board meeting.	• Chair's reports from the Quality Committee to the Board • The GAAP framework set out the reporting and escalation arrangements from front line services to the Trust Board and from the Board to front line services.	
The Board of Leeds and York Partnership NHS Foundation Trust effectively implements systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licence holder's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Condition of this Licence.	• A full suite of recruitment and selection procedures in place ensuring appropriate selection, recruitment and retention of staff; with pre-employment checks carried out (DBS, qualifications and references) to ensure suitability for the post • Procedure and arrangements in place to adhere to Fit and Proper Persons Test for Board Members and other key posts • GMC, NMC and HPC interface with Electronic Staff Record (ESR) system to ensure professional registration compliance • A medical revalidation procedure and consultant appraisal procedure in place with Organisational Readiness Assessment System (ORSA) reports being made to the Board of Directors • Professional Registration Procedure incorporating nurse revalidation process • Programme of Continuing Professional Development (CPD) for all professional staff	• Full suite of recruitment and selection procedures including Temporary Staffing Procedure • Procedure and arrangements in place to adhere to Fit and Proper Persons Test for Board Members and other key posts • Medical Revalidation Procedure • Supervision Procedure for clinical staff • Educational Sponsorship and Study Leave Procedure • Compulsory Training Procedure and programme • Monthly compliance reports to managers for up-take of compulsory training and Combined Quality and Performance Report to Quality Committee and Board • Evidence of Consultant Appraisals and revalidation decisions • ORSA reports to Board and minutes of that Board meeting • Appraisal Procedure for Agenda for Change staff with Combined Quality and Performance	Lindsay Jensen Deputy Director of Workforce Development (Claire Holmes)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	• Professional Clinical Leads in post across the Trust • A risk based compulsory training programme in place for all staff (including bank staff) with up-take reports being made to the Board in the monthly Combined Quality and Performance Report • Establishment of staffing ratios and skill mix reporting supported by an E-Rostering system • Safer Staffing reports for inpatient units reported to NHS England via Unify system • An internal temporary staffing resource (bank staff) with individuals being required to go through a recruitment and selection process ensuring they are appropriately trained and skilled, thereby ensuring a high level of quality of care from the temporary staffing resource • Agency workers procured through national frameworks to ensure compliance with employment and training requirements • Appraisals carried out for all Board members and all Agenda for Change staff with performance in respect of completion of staff appraisals being reported to the Board and monitored on an ongoing basis by the Quality Committee • Director of OD and Workforce is a substantive member of the Quality Committee.	Report to Quality Committee and Board on completion data for appraisals • Monthly reports to managers on Professional Registration renewals • Regular reports on bank fill rates. • Trust Strategy • Workforce and OD Strategic Plan 2018-21 • Organisational Structures • Apprenticeship Programme which includes support worker and wider workforce development • Monthly Safer Staffing reports to NHS England. • Board Development Programme • Quality Committee Terms of Reference showing membership and duties of the Committee.	

Leeds and York Partnership NHS
NHS Foundation Trust

STATEMENT IN RESPECT OF TRAINING FOR GOVERNORS 2019/20

The following sets out the evidence to allow the Board to assess whether it is complaint with the requirement to ensure that governors have the skills and competencies to carry out their duties.

Governance condition		Supporting evidence demonstrating compliance
The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Compliant	• Induction training provided for all new governors • Individual meetings between the Chair and governors to determine any specific needs • Action plan to incorporate the needs of governors into the forward plan for the Council of Governors • Workshop sessions on Council of Governors' days covering information about our services • Service visits with non-executive directors • Board to Board between the Council of Governors and the Board of Directors • Bespoke training provided by NHSI on accountability and also core skills – to be provided on a cyclical basis.