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**PROVIDER LICENCE (Compliance with condition G6) 2018/19**

**(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 took all reasonable precautions against the risk of failure to comply with the conditions of the provider licence. To allow this certification to be made, leads (as identified in the column below) are required to declare as to whether the Trust has been c*ompliant / non-compliant* with the following licence conditions during 2018/19 Supporting evidence of how we comply with each condition is set out below.

**SUPPORTING EVIDENCE FOR EACH LICENCE CONDITION**

| **Governance condition** | **Statement of Compliance** | **Supporting evidence** | **Individual responsible for detailing evidence and documentation** |
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| **G1 - Provision of information**  Reflecting the requirements of the Health and Social Care Act 2012, this Condition places an obligation on Licensees to provide the Regulator (NHS Improvement) with the accurate, complete and timely information they require in order to undertake their Licensing functions,  This Condition also allows a requirement for the Regulator (NHS Improvement) to request Licensees to generate information that is not currently collected (i.e. to collect information against certain benchmarks). | **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 are two established contacts for NHS Improvement: the Chief Executive; and the Chief Financial Officer * Minutes of meetings confirm that the Quality Report for 2017/18 was approved by the Board prior to being sent to NHS Improvement and the Quality Report for 2018/19 will follow the same process. Working papers and notes, including the audit opinion, are available to show that the information contained in the Quality Report is accurate and complete, monthly monitoring returns are held on file confirm that the report was sent to NHS Improvement. Minutes of Board meetings show that measures in the Single Oversight Framework were considered by the Board and that the financial plan is also considered by the Board and by the Finance and Performance Committee. The Annual Report and Accounts for 2017/18 were scrutinised by the Audit Committee and signed off by the Board prior to being submitted to NHS Improvement * 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 submitting the Operational Plan; 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 accurate and 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 |
| **G2 - Publication of information**  This Condition requires Licensees to publish information in a manner that is made accessible to the public, as directed or may be required by the Regulator (NHS Improvement) (i.e. to publish performance information in order to promote patient rights to make choices. | **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, Operational Plan, Strategy etc.) * Statement of evidence of how we comply with the Code of Governance is contained in the Annual Report * The Trust has measured itself against the requirements of the Code of Governance in its entirety * 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**  This condition gives NHS Improvement the ability to charge fees and obliges licence holders to pay fees to NHS Improvement if requested in respect of the Regulator exercising its functions. | **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**  This licence condition prevents licensees from allowing unfit persons to become or continue as governors or directors, except with the approval in writing of NHS Improvement.  An unfit person is deemed to be an individual who has been adjudged bankrupt; or who within the preceding five years has been convicted and a sentence of imprisonment (whether suspended or not) for a period of not less than three months was imposed on them; or who is subject to an unexpired disqualification order made under the Company Directors’ Disqualification Act 1986. | **Statement of compliance**  All governors and directors have been deemed to be fit and proper persons as part of the 2017/18 year-end declaration process.  The declaration process which is carried out at the end of 2018/19 is underway and the Trust is expecting its governors and directors to be compliant.  (It should be noted that the CQC fit and proper person test places a further layer of check over and above those of NHS Improvement. These are not dealt with here). | **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 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). | Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro |
| **G5 - NHS Improvement guidance**  General Condition 5 requires that the Licensee at all times has regard to guidance issued by NHS Improvement. Where the Licensee decides not follow NHS Improvement’s guidance it shall inform NHS Improvement of the reasons for that decision. | **Statement of compliance**  The Trust complies with all NHS Improvement guidance when issued.  The requirements of the Foundation Trust Code of Governance have been complied with exceptions as detailed in the Annual Report “comply or explain” sections. | **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 for corporate governance; Finance Manager for finance; Programme Management Officer for the Annual Plan and business plans) * 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 |
| **G6 - Systems for compliance with licence conditions and related obligations**  This condition requires the Licensee to take all reasonable precautions against the risk of failure to comply with the licence, NHS Constitution and NHS Acts.  The Licensee must ensure the establishment and implementation of processes and systems to identify risks and guard against their occurrence. The Licensee shall also regularly review those processes and systems to ensure they have been implemented and are effective.  Not later than two months from the end of each financial year, the Licensee shall prepare and submit to NHS Improvement a certificate to the effect that following a review of these systems and processes its Directors are, or are not, satisfied that within the last full financial year, it took such precautions as were necessary to comply with this Condition. The Licensee shall publish the certificate within one month of its submission to NHS Improvement in such manner as is likely to bring it to the attention of parties reasonably expected to have an interest. | **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. | **Evidence of compliance**  Process of Risk Management   * There is a Risk Management Policy in place * There are several key documents and processes in relation to managing risks and compliance in place: * Risk Registers are in place and monitored and maintained on a regular basis (Strategic, Corporate and Directorate Risk Registers). * A bi-monthly meeting (Risk Management Review Group) takes place, chaired by the Chief Executive. A monthly dashboard is presented to this group, which includes high level information relating to the risk registers across the Trust. This report highlights actions and risks beyond their review date and any risk movement over the reporting period. This provides assurance to the Board that risks are monitored and managed within timescales and the risk are appropriate, including mitigation and escalation of risks. In addition, throughout the year the group reviews the care groups’ risk registers in detail. * Each month an update on the Care Groups risk registers are sent to the risk owners, which is RAG rated to provide a reminder to update the register accordingly. * The Board Assurance Framework contains details of the Strategic Risks * External assurance is provided by Internal / External audit in respect of risk processes. The internal follow-up audit of the revised risk management framework, completed March 2018, provided significant assurance * The Strategic Plan contains information regarding processes and systems in place to identify risks * The Annual Report contains information about the Risk Management process * The Audit Committee receives assurance as to the risk management processes in place * The report presented to the Audit Committee in December 2018 provided further evidence of the significant improvements in managing the risk registers. * The strategic risk register is submitted quarterly to the Trust Board as part of the Operational Plan Quarterly Report.   Process for managing risks to complying with the licence   * 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 with gaps identified and actions assigned * 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.   Process for complying with the NHS Constitution     * The NHS Constitution compliance is reported on an annual basis * There is a compliance statement for each element of the NHS Constitution * Each year we ask the lead responsible senior manager to complete the compliance statements that they are responsible for * The updated statements also have an evidence section which is also updated by the lead responsible senior manager * The completed statement and evidence documents are presented to the Trust Wide Clinical Governance Group for approval and assurance purposes. | Pamela Hayward Sampson – Risk Management Lead with lead director = Cathy Woffendin  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. The Licensee shall notify Monitor/NHSI promptly of any application to the CQC for the cancellation of its registration, or the cancellation by the CQC of its registration.  This condition allows the Regulator to withdraw a Licence from Providers whose CQC registration is withdrawn. | **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) * The CQC registration status is contained within the Annual Governance Statement and also in the Quality Report | Lead for evidence = Nichola Sanderson with lead director = Cathy Woffendin |
| **G8 - Patient eligibility and selection criteria**  This Condition requires that Licensees set transparent eligibility and selection criteria, apply those criteria in a transparent way and publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them. | **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.  Where service users are not eligible for a service that service will give advice to referrers on other more suitable services available to meet the patient’s needs.  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 on the Trust’s website * 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)**  The Conditions in Section 5 shall apply whenever the Licensee is subject to a contractual or other legally enforceable obligation to provide a Commissioner Requested Service. A service is considered to be a Commissioner Requested Service if it is of a description which the Licensee is required to provide pursuant to an NHS contract, or any other service which the Licensee has contracted with a Commissioner to provide, as a Commissioner Requested Service. | **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. Leeds CCGs have not acted to formally agree CRS status for services; all LYPFT services (as per statement of purpose) “grandfathered” in when CCGs were set up. We have agreed CRS for 2017/18 FY and anticipate a similar agreement with the Leeds CCGs. However, it remains a commissioner responsibility to resolve this position. | **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 2 years. * 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 strong programme of efficiency and quality improvement (CIPs) is robustly monitored and reported to the Quality Committee and the Finance and Performance Committee * Letter and email exchange with NHS England regarding CRS.   Further information is included the Continuity of Services (CoS) section | Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell |
| **P1 - Recording of information**  From the time of publication by NHS Improvement of Approved Reporting Currencies the Licensee shall maintain records of its costs and of other relevant information in accordance with those Currencies by allocating all costs expended by the Licensee in providing health care services for the purposes of the NHS within that Currency. Such cost allocation methodology and procedures should adhere to the information as set out in the Approved Guidance. | **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 paper was produced and reported to Finance and Performance Committee in April 2018. This paper included the declaration 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**  The Licensee shall provide NHS Improvement with such information and documents as NHS Improvement may require for the purpose of performing its pricing functions. The Licensee shall take all reasonable steps to ensure that the information is accurate and complete. | **Statement of compliance**  The Trust would comply with this condition as the requirement arose. | **Evidence of compliance**   * No requests have been made of the Trust by NHSI as yet. | Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell |
| **P3 - Assurance report on submissions to NHS Improvement**  If required the Licensee shall submit to NHS Improvement an assurance report relating to its costing submission. Such a report shall meet the requirements if it is prepared by an approved auditor, it expresses a view on whether the submission is based on cost records which complies with guidance and provides a true and fair assessment of the information it contains. | **Statement of compliance**  The Trust would comply with this condition as the requirement arose. | **Evidence of compliance**   * No requests have been made of the Trust by NHSI as yet. | Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell |
| **P4 - Compliance with the National Tariff**  Except as approved in writing by NHS Improvement, the Licensee shall comply with the rules and apply the methods concerning charging for the provision of health care services for the purposes of the NHS contained in the national tariff published by NHS Improvement. | **Statement of compliance**  The Trust has adopted local tariffs. | **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. | Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell |
| **P5 - Constructive engagement concerning local tariff modifications**  The Licensee shall engage constructively with Commissioners, with a view to reaching agreement in any case in which it is of the view that the price payable for the provision of a service for the purposes of the NHS in certain circumstances or areas should be the price determined in accordance with the national tariff for that service subject to modifications. | **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 |
| **C1 - The right of patients to make choices**  Subsequent to a person becoming a patient of the Licensee and for as long as they remain such a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, they are notified of that choice and told where information about that choice can be found. Information and advice about patient choice made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that assists patients in making well informed choices.  In the conduct of any NHS activities, the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services. | **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 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. | **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 * Declaration of interest procedure in place for directors, governors and staff * Information is available via choose and book where applicable, and NHS Choices. | Lead for evidence = Andy Weir – Interim Deputy Chief Operating Officer with lead director = Joanna Forster Adams |
| **C2 - Competition oversight**  The Licensee shall not enter into any agreement or other arrangement or engage in activities which have the object or which have (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of NHS care. | **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 |
| **IC1 - Provision of integrated care**  The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling its provision of health care services for the purposes of the NHS to be integrated with the provision of such services by others. | **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**   * There is no private sector presence that would cause the Trust to be detrimental to the provision of healthcare for the purposes of the NHS provision * The Trust is an active participant in the local health and social care economy and is working in partnership with stakeholders to further integrate services and address issues that adversely affect efficient service operation across the health economy * The Trust has a track record of working on integrated care pathways with other providers i.e. adult social care, learning disability services, the third sector and children’s services. | Lead for evidence = Andy Weir – Interim Deputy Chief Operating Officer with lead director = Joanna Forster Adams |
| **CoS1 - Continuing provision of Commissioner Requested Services**  The Licensee shall not cease to provide, or materially alter the specification, any Commissioner Requested Service other than with the agreement in writing of all Commissioners to which the Licensee is required by a contractual or other legally enforceable obligation to provide the service as a Commissioner Requested Service. | **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**  The Licensee shall establish and maintain an asset register which lists every relevant asset used by the Licensee for the provision of Commissioner Requested Services.  The Licensee shall not dispose of, or relinquish control over, any relevant asset except with the consent in writing of NHS Improvement. | **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 Operational Plan 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 Strategic 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 |
| **CoS3 - Standards of corporate governance and financial management**  The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as suitable for a provider of the Commissioner Requested Services provided by the Licensee, and providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern. | **Statement of compliance**  The Trust has sound, well developed systems of corporate and financial governance. The Trust has a Use of Resources score of 1.  The Trust commissioned a well-led review by Deloitte which was concluded in 2017/18. | **Evidence of compliance**  Corporate Governance   * 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.   Financial Management   * Standing Financial Instructions and a Scheme of Delegation are in place which outline financial responsibilities and 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. | 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 Hanwell |
| **CoS4 - Undertaking from the ultimate controller**  The Licensee shall procure from each company or person the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking, in favour of the Licensee, that the ultimate controller will refrain from any action which would be likely to cause the Licensee to be in contravention of any of its obligations. Equally, the ultimate controller will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to NHS Improvement. | **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**  The Licensee shall pay to NHS Improvement any sums required to be paid in consequence of any requirement imposed on providers by the dates by which they are required to be paid. This condition future proofs the ability of NHS Improvement to impose such an undertaking although there is no current requirement in this regard. | **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 |
| **CoS6 - Co-operation in the event of financial stress**  If NHS Improvement gives notice that it is concerned about the ability of the Licensee to carry on as a going concern, the Licensee shall provide such information as NHS Improvement may direct to Commissioners and others as NHS Improvement may direct, allow such persons as NHS Improvement may appoint to enter premises owned or controlled by the Licensee and co-operate with such persons as NHS Improvement may appoint to assist in the management of the Licensee’s affairs, business and property. | **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 ‘Use of Resources’ score * Operational plan and financial monitoring signalling a strong use of resources score. * 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**  The Licensee shall act to secure that it has, or has access to, the Required Resources. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee. | **Statement of compliance**  The Trust is compliant with this condition, having made a declaration upon submission of the operational plan 2018/19 (and likewise the same declaration for 2019/20 plan). In addition to this the Trust is declaring a Use of Resources score 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 have been achieved for 2018/19 a robust 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 |
| **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 Improvement’s exercise of its functions the Licensee shall pay that fee to NHS Improvement within 28 days of the fee being notified. | **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 |
| **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 |