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**CORPORATE GOVERNANCE STATEMENT (CGS) 2018/19 and 2019/20**

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

**Table A**

**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 Head of 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 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.
 | Cath Hill,Associate Director for Corporate Governance(Sara Munro) |
| 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:
	+ Annual Accounts
	+ Annual Report
	+ Annual Governance Statement
	+ Corporate Governance Statement
	+ Quality Report
	+ Monthly monitoring returns
	+ Board self-certification
	+ Board Assurance Framework
	+ The Trust’s Strategy
	+ The Operational Plan
	+ Comply or explain statements.
 | * 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
* The Operational Plan
* Comply or explain statement in respect the Code of Governance and the Provider Licence
* Board Assurance Framework.
 | Cath Hill,Associate Director for Corporate Governance(Sara Munro) |
| The Board is satisfied that Leeds and York Partnership NHS Foundation Trust implements:1. 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, Mental Health Legislation Committee, Remuneration Committee, and Nominations Committee
* These committees have substantive members made up from members of the Board of Directors with others, such as senior staff, in attendance
* 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 areas of development.
 | * 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) |
| 1. 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) |
| 1. 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 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.
 | * 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) |
| The Board is satisfied that Leeds and York Partnership NHS Foundation Trust:1. 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 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.
 | * 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
* 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.
 | David Brewin, Assistant Director of Finance(Dawn Hanwell) |
| 1. 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 to delegate
* 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 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 9 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.
 | * 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 Head of 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
* Minutes of the Board of Directors.
 | Cath Hill,Associate Director for Corporate Governance(Sara Munro) |
| 1. 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.
* Peer review process in place to monitor actual practice against standards
 | * 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 and the Finance and Performance Committee
* Minutes of the Board of Directors, the Council of Governors 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) |
| 1. 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 Model approval minute from 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) |
| 1. 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 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 and is interpreted by the CFO and in-house finance team. Shared Business Services manage the core ledger management function and provide real-time information to a pre-determined timetable.
 | * 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 facility and core financial function.
 | Cath Hill,Associate Director for Corporate Governance(Sara Munro) |
| 1. 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
* We have a systematic electronic approach to managing risks, which are managed progressively 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.
 | * 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) |
| 1. 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 Operational Plan.
* We have developed five three-year strategic plans agreed by the Board of Directors as follows:
	+ Clinical Services
	+ Estates
	+ Workforce & Organisational Development
	+ Health Informatics
	+ Quality.
* The strategic plans form the basis of our one year Operational Plan
* Progress against the organisations top priorities as modelled within the Operational Plan is reported to the Board of Directors on a quarterly basis
* 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 one year Operational Plan
* The CCG and NHS England commissioners routinely receive updates on our plans via the Contract Monitoring Board meetings.
 | * Strategic planning cycle
* Progress against our Operational Plan Quarterly Reports
* Annual priorities
 | Amanda Burgess, Strategic Development Manager(Dawn Hanwell) |
| 1. 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:
	+ Health and safety
	+ Adult and child safeguarding
	+ Medicines management
	+ Mental Health Act
	+ Fraud, bribery and corruption
	+ Fire safety
	+ Human resources
	+ Public health
	+ Estates and buildings
	+ 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
* Regular Board training.
 | * 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) |
| The Board is satisfied:1. 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 their 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)ANDAngela Earnshaw Head of Organisational Development(Claire Holmes) |
| 1. 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 monthly 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 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.
* Peer reviews are carried out to benchmark services against CQC standards to ensure ongoing compliance with registration
* 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 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
* The Medical Director chairs the Trust Wide Clinical Governance Group which is focused on quality and safety, clinical audit and effectiveness; and medicines management and Continuous improvement. This makes assurance reports to the Quality for onward reporting to the Board through the Chair’s reporting mechanism.
 | * Quarterly Monitoring Returns signed off by the Board and evidence of submission 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-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.
* 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
* 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’ 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
* 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
* Chair’s reports to the Board
 | Nikki Cooper,Head of Performance Management and Informatics(Joanna Forster Adams)ANDNichola Sanderson, Deputy Director of Nursing(Cathy Woffendin)ANDCath Hill,Associate Director for Corporate Governance(Sara Munro) |
| 1. The collection of accurate, comprehensive, timely and up to date information on quality of care;
 | * The Performance, Information and Data Quality Group (PIDQG) meets monthly 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) |
| 1. 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 monthly 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 Quality and Finance & Performance 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.
* 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
* 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 Performance Overview Groups (EPOG) are in place for all directorates and care groups where quality is discussed.
 | * 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
* 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
* Minutes of the Board of Directors, and Council of Governors
* Board of Director’s cycle of business
 | Nikki Cooper,Head of Performance Management and Informatics(Joanna Forster Adams)ANDNichola Sanderson, Deputy Director of Nursing(Cathy Woffendin)ANDCath Hill,Associate Director for Corporate Governance(Sara Munro) |
| 1. 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
* The Combined Performance and Quality Report contains details of complaints and compliments
* The three quality priorities for quality improvements are set out in the Quality Account and are in line with the three goals as set out in the Strategy. These are underpinned by quality measures
* The Quality Account is publically available in the Annual Report, on the Trust’s website and NHS Choices
* 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.
* IHI Engaged to undertake Comprehensive Review of Quality Improvement Culture
 | * “Sharing Stories” programme
* Patient experience review recommendations and outcome of patient experience review workshop (Valuing inclusion of people)
* 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
* Quality Account / Annual Report
* Terms of Reference of the Quality Committee, agenda papers and minutes.
* Staff Survey results as reported to Board and minutes of the meeting
* NED Visit Feedback Form shared across Board
* IHI Feedback Report and Workshop
 | Linda RoseHead of Nursing and Patient Experience (Cathy Woffendin)ANDNichola Sanderson, Deputy Director of Nursing(Cathy Woffendin)ANDRebecca Le-HairHead of Quality and Clinical GovernanceANDAngela EarnshawHead of Organisational Development (Claire Holmes) |
| 1. 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 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
* We have in place a Governance Assurance Accountability and Performance Framework (GAAP) which clearly sets out the routes of escalation not least to Board where this is appropriate.
 | * 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
* 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.
 | Cath Hill,Associate Director for Corporate Governance(Sara Munro) |
| 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
* 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.
 | * 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 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.
 | Lindsay JensenDeputy Director of Workforce Development (Claire Holmes) |

**Table B**

The Board of Directors is required to respond *compliant/non-compliant* with the following governance conditions, setting out any risks and mitigating actions planned for each. Compliance with each condition is at the date of this statement (31.03.19) and also a declaration of forward compliance with the coming financial year (1.04.19 to 31.3.20).

| **Governance condition** | **Compliance with the governance condition at the end of 31.03.19** | **Forward compliance with the governance condition for 01.04.19 – 31.03.20** | **Any risks to compliance** **(NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)** | **Any actions proposed to manage such risks** | **Individual responsible (senior manager for completion / director for approval)** |
| --- | --- | --- | --- | --- | --- |
| 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. | Compliant | Compliant | None | Not applicable | Cath Hill,Associate Director for Corporate GovernanceConfirmed by Sara Munro |
| The Board has regard to such guidance on good corporate governance as may be issued by NHSI from time to time. | Compliant | Compliant | None | Not applicable | Cath Hill,Associate Director for Corporate GovernanceConfirmed by Sara Munro |
| The Board is satisfied that Leeds and York Partnership NHS Foundation Trust implements:1. Effective board and committee structures
 | Compliant | Compliant | None | Not applicable | Cath Hill,Associate Director for Corporate GovernanceConfirmed by Sara Munro |
| 1. Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
 | Compliant | Compliant | None | Not applicable | Cath Hill,Associate Director for Corporate GovernanceConfirmed by Sara Munro |
| 1. Clear reporting lines and accountabilities throughout its organisation.
 | Compliant | Compliant | None | Not applicable | Cath Hill,Associate Director for Corporate GovernanceConfirmed by Sara Munro |
| The Board is satisfied that Leeds and York Partnership NHS Foundation Trust:1. Effectively implements systems and/or processes to ensure compliance with the Licence holder’s duty to operate efficiently, economically and effectively;
 | Compliant | Compliant | None | Not applicable | David BrewinAssistant Director of FinanceConfirmed by Dawn Hanwell |
| 1. Effectively implements systems and/or processes for timely and effective scrutiny and oversight by the Board of the Licence holder’s operations;
 | Compliant | Compliant | None | Not applicable | Cath Hill,Associate Director for Corporate GovernanceConfirmed by Sara Munro |
| 1. 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;
 | Compliant | Compliant | None | Not applicable | Nichola SandersonDeputy Director of NursingConfirmed by Cathy Woffendin |
| 1. 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);
 | Compliant | Compliant | None | Not applicable | David Brewin Assistant Director of FinanceConfirmed by Dawn Hanwell |
| 1. Effectively implements systems and/or processes to obtain and disseminate accurate, comprehensive, timely and up-to-date information for Board and Committee decision-making;
 | Compliant | Compliant | None | Not applicable | Cath Hill,Associate Director for Corporate GovernanceConfirmed by Sara Munro |
| 1. 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;
 | Compliant | Compliant | None | Not applicable | Cath Hill,Associate Director for Corporate GovernanceConfirmed by Sara Munro |
| 1. 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;
 | Compliant | Compliant | None | Not applicable | Amanda BurgessStrategic Development ManagerConfirmed by Dawn Hanwell |
| 1. Effectively implements systems and/or processes to ensure compliance with all applicable legal requirements.
 | Compliant | Compliant | None | Not applicable | Cath Hill,Associate Director for Corporate GovernanceConfirmed by Sara Munro |
| The Board is satisfied that:1. There are systems and processes to ensure That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
 | CompliantCompliant | CompliantCompliant | None None | Not applicableNot applicable | Angela Earnshaw Head of Organisational DevelopmentConfirmed by Claire HolmesANDCath Hill,Associate Director for Corporate GovernanceConfirmed by Sara Munro |
| 1. There are systems and processes to ensure that the Board’s planning and decision-making processes take timely and appropriate account of quality of care considerations;
 | CompliantComplaintComplaint | CompliantCompliantCompliant | NoneNoneNone | Not applicableNot applicableNot applicable | Nikki Cooper,Head of Performance Management and Informatics(Joanna Forster Adams)ANDCath Hill,Associate Director for Corporate Governance(Sara Munro)ANDNichola Sanderson, Deputy Director of Nursing(Cathy Woffendin) |
| 1. There are systems and processes to ensure the collection of accurate, comprehensive, timely and up to date information on quality of care;
 | Compliant | Compliant | New Electronic Patient Record system implementation in November 2019 could result in a temporary glitch in data availability or capture | Programme Manager in place overseeing the implementation;Robust testing plans being developed;Project governance structure in place | Nikki Cooper,Head of Performance Management and Informatics(Joanna Forster Adams) |
| 1. There are systems and processes to ensure that the Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care;
 | CompliantCompliantCompliant | CompliantCompliantCompliant | New Electronic Patient Record system implementation in November 2019 could result in a temporary glitch in data availability or captureNoneNone | Programme Manager in place overseeing the implementation;Robust testing plans being developed;Project governance structure in placeNot applicableNot applicable | Nikki Cooper,Head of Performance Management and Informatics(Joanna Forster Adams)ANDNichola Sanderson, Deputy Director of Nursing(Cathy Woffendin)ANDCath Hill,Associate Director for Corporate Governance(Sara Munro) |
| 1. There are systems and processes to ensure 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; and
 | CompliantCompliantCompliantCompliant | CompliantCompliantCompliant Compliant | A temporary reduction of available staff in the Patient experience team following the review will challenge the ability to centrally manage patient and carer feedback. NoneNoneNone | The service will agree key priority areas during the transition period with the executive lead and engage in the recruitment of appropriately skilled staff. Corporate oversight and management will be led through a Strategic level steering group chaired by the executive lead.Not applicableNot applicableNot applicable | Linda RoseHead of Nursing and Patient Experience (Cathy Woffendin)ANDNichola Sanderson, Deputy Director of Nursing(Cathy Woffendin)ANDAngela EarnshawHead of Organisational Development (Claire Holmes)ANDAlison KenyonInterim Associate Director(Joanna Forster Adams) |
| 1. There are systems and processes to ensure 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.
 | Compliant | Compliant | None | Not applicable | Cath Hill,Associate Director for Corporate Governance(Sara Munro) |
| 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. | Compliant | Compliant | National occupational shortages in nursingIncreased use of bank and agency staff to support services Impact of Brexit. There are also challenges in the recruitment of doctors and again a programme of work to oversee this is in hand. | Part of the NHSI Retention ProgrammeAdditional resource to support workforce planning across the TrustAdditional resource to deliver strategic resourcing to support, recruitment, talent management and career development Increase collaboration across the MH ICS for WY&H Improvements to the quality and skills of the internal bank workforce | Lindsay JensenDeputy Director of Workforce DevelopmentConfirmed by Claire Holmes |