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
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	**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	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro

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that is not currently collected (i.e. to collect information against certain benchmarks).		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.	
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	**Statement of compliance**	**Evidence of compliance**	Lead for evidence = Cath Hill – Associate Director

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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.	The Trust will comply with this condition when required. No fees have been levied by NHS Improvement during 2017/18	• 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.	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	**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	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro

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disqualification order made under the Company Directors' Disqualification Act 1986.		persons' test).	
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.	**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** <u>Process of Risk Management</u> • There is a Risk Management Policy in place • There are several key documents and processes in relation to managing risks and compliance in place: o 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	Pamela Hayward Sampson – Risk Management Lead with lead director = Cathy Woffendin

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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		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. <u>Process for managing risks to complying with the licence</u> • There is a performance team who monitor compliance with the NHS Improvement targets and provide a report to each Board meeting. This includes an exception report setting out risks of potential breach of any targets • There is a compliance statement for each element of the licence completed each year with gaps identified and actions	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
manner as is likely to bring it to the attention of parties reasonably expected to have an interest.		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. <u>Process for complying with the NHS Constitution</u> • 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.	
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	**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	Lead for evidence = Nichola Sanderson with lead director = Cathy Woffendin

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
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.		• 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	
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	**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	**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.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell

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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.	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.	• 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	
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	**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

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
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.			
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	**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

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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.			
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,	**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

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
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.			
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	**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

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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.			
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	**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

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care.			
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	**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

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obligation to provide the service as a Commissioner Requested Service.			
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	**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** <u>Corporate Governance</u> • Assurances of good corporate governance and financial management are demonstrated through the use of internal and external audit, which challenge and review key areas of the organisation • The Trust has a Constitution in place, and also complies with all other guidance and good practice in terms of documentation in place	Lead for evidence = Cath Hill – Associate Director for Corporate Governance with lead director = Sara Munro

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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.		• There is a detailed risk management procedure in place including Strategic, Corporate and Directorate Risk Registers • There is a Board Assurance Framework in place which is reported to the Board, Audit Committee and Board sub-committees • Annual Governance Statement is reviewed by the Board and signed by the Chief Executive • The Trust has a Corporate Governance Policy in place which sets out the processes, structures and procedures in place to govern the Trust • Internal audit and external audit ensure a sound system of internal controls are in place and report these to the Audit Committee. The outcome of all reports are reported to the Audit Committee • Self-assessment under the Code of Governance with the necessary declarations being made in the Annual Report. <u>Financial Management</u> • Standing Financial Instructions and a Scheme of Delegation are in place which outline financial responsibilities and 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 = 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	**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

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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.			
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	**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

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of NHS Improvement to impose such an undertaking although there is no current requirement in this regard.			
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

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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;	**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

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
• 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.			
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

Leeds and York Partnership NHS
NHS Foundation Trust

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	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
		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.	

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
		• There is an appropriate risk management process in place and supporting procedures to ensure safe services are delivered and that lessons are learnt from incidents both internal and external to the Trust. • The Trust has in place appropriately qualified internal audit and external audit teams providing assurance on all aspects of the business of the Trust.	
The Board has regard to such guidance on good corporate governance as may be issued by NHSI from time to time.	• There is in place a governance structure which has the capacity and capability to interpret and implement the corporate governance guidance as issued by NHS Improvement • There are appropriate supporting structures and teams to implement such guidance. These teams are appropriately qualified, trained and resourced • In terms of the corporate governance documents the Board is able to demonstrate delivery of: o Annual Accounts o Annual Report o Annual Governance Statement o Corporate Governance Statement o Quality Report	• Annual Accounts • Annual Report • Annual Governance Statement • Corporate Governance Statement • Quality Report • Monthly monitoring returns • Board self-certification • The Trust's Strategy and supporting strategies • 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)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	o Monthly monitoring returns o Board self-certification o Board Assurance Framework o The Trust's Strategy o The Operational Plan o Comply or explain statements.		
The Board is satisfied that Leeds and York Partnership NHS Foundation Trust implements: a) Effective board and committee structures;	• The Board of Directors has beneath it a comprehensive sub-committee structure consisting of an Audit Committee, Finance and Performance Committee, Quality Committee, 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	• Sub-committee Terms of Reference • Governance Structure • Minutes of the Board of Directors and minutes of each sub-committee • Effectiveness questionnaires.	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	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.		
b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and	• The Board and each of its sub-committees have Terms of Reference agreed by that sub-committee and ratified by the Board • The role of each person (whether a substantive member or in attendance) is clearly set out in the Terms of Reference • There is an agreed memorandum of understanding between the Chair and Chief Executive setting out their division of responsibilities • There is a scheme of delegation • There is a comprehensive meetings	• 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	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	manual and schedule of training on all aspects of running meetings.	• Meetings Administration Manual and schedule of training.	
c) Clear reporting lines and accountabilities throughout its organisation.	• The Board of Directors is accountable locally to members and members of the public through the Council of Governors and to its commissioners for the delivery of services through legally binding contracts • The Trust is also accountable to its regulators including NHS Improvement and the CQC • The Board of Directors and the Council of Governors have clear sub-committee structures with reports from each being made to it on the work they have carried out on its behalf. The Executive Team reports into the Board through the Chief Executive. The Executive Management Team meeting has a fully formed governance structure beneath it which supports the work of the executive directors in respect of the day-to-day management of the Trust • Agreed Terms of Reference for the Board, Council, EMT and their respective sub-committee structures are in place for all groups and committees • The Board has in place a number of high	• Terms of Reference for Board, Council, Executive Team and respective sub-committees that include an organogram for reporting • Terms of Reference for all groups and committees in the operational governance structure • Governance structure reporting organogram • Constitution • Matters reserved and scheme of delegation • Division of Duties between the Chair and Chief Executive • NHS Foundation Trust Accounting Officers' Memorandum • Meetings Administration Manual • Meetings Map • Governance, Accountability, Assurance and Performance Framework	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	level documents which set out accountabilities and responsibilities: the Constitution; Matters Reserved and Scheme of Delegation; division of duties between the Chair and the Chief Executive, the Chief Executive's Memorandum of Accounting • Each executive director has a clearly defined portfolio with clear accountability for their area of responsibility. Objectives are set each year for directors and are appraised by the Chief Executive • All job and role descriptions have a clear indication of the accountability lines of reporting and a process for objective setting and appraisal is in place • There is a Governance, Accountability, Assurance and Performance Framework in place which sets out accountability and reporting lines for performance • All groups and committees in the governance structure have Terms of Reference with parent groups shown in terms of reporting and escalation.		
The Board is satisfied that Leeds and York Partnership NHS Foundation Trust:	• Standing Financial Instructions (SFIs) and Financial Procedures (FPs) in place • External audit services procured and regularly market tested	• Standing Financial Instructions • Financial Procedures • Internal Audit Reports • External Audit Reports	David Brewin, Assistant Director of Finance

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
a) Effectively implements systems and/or processes to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively;	• 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	• 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.	(Dawn Hanwell)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	Impact Assessment Process.		
b) Effectively implements systems and/or processes for timely and effective scrutiny and oversight by the Board of the Licence holder's operations;	• The Board has in place a cycle of business which it has agreed for those items that it wants to receive on a cyclical basis throughout the year. It has also put in place a schedule setting out those duties that it has 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	• 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)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	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.		
c) Effectively implements systems and/or processes to ensure compliance with health care standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	• Identified compliance actions following CQC inspections are monitored through the CQC Project Group, and assurances made to the Quality Committee (a Board sub-committee). Quarterly updates are provided to the Trust's Board by the Director of Nursing, Quality and Professions • Any risks to compliance are identified and managed through a live risk assessment and treatment plan • Risks to compliance are identified within the Combined Quality and Performance Report and any necessary actions in place to ensure compliance and improvements are documented.	• Terms of reference for the CQC Project Group • Action minutes of the CQC Project Group • Updated and reviewed CQC Action Plan • Combined Quality and Performance (CQPR) Report as presented to the Board, the Council of Governors, Quality Committee 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	Nichola Sanderson, Deputy Director of Nursing (Cathy Woffendin)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	• Peer review process in place to monitor actual practice against standards	commissioners.	
d) Effectively implements systems and/or processes for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern);	• Standing Financial Instructions (SFIs) and Financial Procedures (FPs) in place • Internal and external audit services • Regular reporting of detailed financial information, Single Oversight Framework Finance and use of Resources score to Board, Finance & Performance Committee and Financial Planning Group • Financial planning and modelling. Board approval of financial model as set out in the Operational Plan • Executive Directors involvement in the Financial Planning Group and Finance and Performance Committee which receive reports detailing all relevant clinical income risks and opportunities and strategies and action plans developed • Estates strategy developed to support service strategy and capital programme agreed • In line with SFIs, all significant clinical and non-clinical developments subject to Board approving a business case	• 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)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	which details the economic case • Budgetary Control Framework and Virement Procedure in place to support effective management and control.		
e) Effectively implements systems and/or processes to obtain and disseminate accurate, comprehensive, timely and up-to-date information for Board and Committee decision-making;	• The Board and its sub-committees have in place an annual cycle of business, action logs, and bring forward system for agenda management to ensure that papers are received in an appropriate and timely manner • Minutes of meetings are formally presented to the next available "parent group" meeting both for 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	• 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)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	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.		
f) Effectively implements systems and/or processes to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	• The Board of Directors receives the Combined Quality and Performance Report which sets out the Trust's performance against internal and external requirements, measures and targets (local, regulatory and contractual) • The Council of Governors receives a performance report on a quarterly basis • Any risks to performance are identified within the combined Quality and Performance Report and any necessary actions in place to ensure compliance and improvements are documented • The CQPR is routinely shared with the Trust's main commissioner and published on the Trust's website • We have a systematic electronic approach to managing risks, which are	• Combined Quality and Performance Report as presented to the Board, Board sub-committees and the Council of Governors • Minutes of the Board of Directors, the Council of Governors and the Board sub-committees • Pages on the Trust website • Emails from the performance team to show we share the CQPR with commissioners.	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	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.		
g) Effectively implements systems and/or processes to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery;	• We have in place a strategic planning cycle which outlines the process by which we develop and monitor progress against the Operational Plan. • We have developed five three-year strategic plans agreed by the Board of Directors as follows: o Clinical Services o Estates o Workforce & Organisational	• Strategic planning cycle • Progress against our Operational Plan Quarterly Reports • Annual priorities	Amanda Burgess, Strategic Development Manager (Dawn Hanwell)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	Development o Health Informatics o 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.		
h) Effectively implements systems and/or processes to ensure compliance with all applicable legal requirements.	• Policies and procedures in place are referenced to the appropriate legislation including in the areas of: o Health and safety o Adult and child safeguarding o Medicines management o Mental Health Act	• Policies and procedures and reference to Section where relevant legislation is listed • Committee structure detailing those that are a legislative requirement • Directors' portfolios • Directorate and team structures.	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	o Fraud, bribery and corruption o Fire safety o Human resources o Public health o Estates and buildings o Information governance. • Statutory committees have been established within the committee structure to ensure compliance with relevant legislation (e.g. Health and Safety Committee) • Appropriately qualified executive directors with clear portfolios and responsibility for ensuring compliance with legislation within their functional areas • Directorate structures and teams established to ensure appropriately trained and qualified staff to oversee the implementation and adherence to relevant legislation • Regular Board training.		
The Board is satisfied: a) That there is sufficient capability at Board level to provide effective	• 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	• Executive director job and portfolio descriptions and recruitment process documentation • Non-executive director role descriptions and recruitment process	Cath Hill, Associate Director for Corporate Governance

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
organisational leadership on the quality of care provided;	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	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	(Sara Munro) AND Angela Earnshaw Head of Organisational Development (Claire Holmes)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	• Board members take part in appraisal and supervision to support their development		
b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	• The Board of Directors and the Executive Team receive a 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.	• 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.	Nikki Cooper, Head of Performance Management and Informatics (Joanna Forster Adams) AND

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	• Peer reviews are carried out to benchmark services against CQC standards to ensure ongoing compliance with registration	• Combined Quality Performance Report • Trust Board reporting template and sub group templates highlight areas of compliance • Peer reviews and self-assessments • Mental Health Act CQC reviews and returns • Trust Board sub group minutes and exec led group minutes	Nichola Sanderson, Deputy Director of Nursing (Cathy Woffendin) AND
	• A Quality Committee is in place, chaired by the non-executive director with responsibility for quality and has, as substantive members, the Director of Nursing, Professions and Quality, the Medical Director and the Chief Operating Officer • The Quality Committee receives assurance on compliance with those standards required for high quality and the safe delivery of care • The Quality Committee will seek assurance and opportunities to improve clinical quality, defined as issues looking at clinical effectiveness, patient	• Terms of Reference of the Quality Committee showing the membership and its duties • Minutes from the Quality Committee • Quality Committee papers include the quality performance report / learning lessons, integrated risk report and workforce performance report • Evidence of the Quality Committee's annual schedule of work relating to quality and safety issues. • Evidence of quality issues being discussed at the Board. For example, sharing patients' stories, learning from deaths, CQC action plans, complaints,	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	experience and patient safety • The Quality Committee has an annual schedule of work which incorporates both regular planned updates and deep dives on quality and safety related issues • The Trust Board receives regular updates on quality and safety as part of its annual work schedule and via the monthly chair's report from the chair of the Quality Committee and the CQPR. • Regular Executive Performance Overview Groups (EPOG) are in place for all Directorates and care groups where quality is discussed • 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.	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	
c) 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	• Combined Quality and Performance Report as presented to the Board, its sub-committees and the Council of Governors	Nikki Cooper, Head of Performance Management and

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	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	• 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).	Informatics (Joanna Forster Adams)
d) That the Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care;	• The Board of Directors and the Executive Team receive a 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	• Combined Quality and Performance Report as sent to the Board, its sub-committees and the Council of Governors • Minutes and papers from the Board's sub-committees	Nikki Cooper, Head of Performance Management and Informatics (Joanna Forster Adams)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	requested. • The Council of Governors also receives a summarised version of the CQPR on a quarterly basis.		AND
	• Detailed assessments of compliance through Peer Reviews with CQC registration are undertaken using the Key Lines of Enquiry (KLoE), and 'should / must do's' following the publication of inspection reports, with sign off from leads and lead executive directors. Assessments of compliance are reported on a quarterly basis to the Trustwide Clinical Governance Group and the CQC Project Group	• Completed and signed Peer reviews demonstrating compliance with CQC registration • Trust Board minutes and papers • Minutes of CQC Project Group • CQC must do / should do action plans	Nichola Sanderson, Deputy Director of Nursing (Cathy Woffendin)
			AND
	• 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	• Minutes of the Board of Directors, and Council of Governors • Board of Director's cycle of business	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	(EPOG) are in place for all directorates and care groups where quality is discussed.		
e) That Leeds and York Partnership NHS Foundation Trust including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources;	• The Board of Directors receives stories from service users, carers and staff members through its monthly "Sharing Stories" sessions • Compliance will be further supported by an external Patient experience review which will include the views of all relevant stakeholders	• "Sharing Stories" programme • Patient experience review recommendations and outcome of patient experience review workshop (Valuing inclusion of people)	Linda Rose Head of Nursing and Patient Experience (Cathy Woffendin) AND
	• The Combined Performance and Quality Report contains details of complaints and compliments	• Combined Performance and Quality Report • External commissioned report on patient experience and engagement • Inclusion workshop held on 22 March, presentation and themes from the day • Community mental health survey • SUN and Sunray minutes	Nichola Sanderson, Deputy Director of Nursing (Cathy Woffendin) AND
	• The three quality priorities for quality improvements are set out in the Quality Account and are in line with the three	• Quality Account / Annual Report • Terms of Reference of the Quality Committee, agenda papers and	Rebecca Le-Hair Head of Quality and Clinical

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	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	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	Governance AND Angela Earnshaw Head of Organisational Development (Claire Holmes)
f) That there is clear accountability for quality of care throughout Leeds and York Partnership NHS Foundation Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including	• 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	• Terms of Reference of the Quality Committee showing the membership and duties of the Committee • Minutes of the Quality Committee • Papers to the Quality Committee • Minutes of reports made to the Board of Directors outlining the work of the Committee and any issues that need to be escalated to Board	Cath Hill, Associate Director for Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
escalating them to the Board where appropriate.	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.	• Chair's reports from the Quality Committee to the Board • The GAAP framework set out the reporting and escalation arrangements from front line services to the Trust Board and from the Board to front line services.	
The Board of Leeds and York Partnership NHS Foundation Trust effectively implements systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licence holder's organisation who are sufficient in	• 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	• 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	Lindsay Jensen Deputy Director of Workforce Development (Claire Holmes)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
number and appropriately qualified to ensure compliance with the Condition of this Licence.	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	• 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	

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	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.	workforce development • Monthly Safer Staffing reports to NHS England. • Board Development Programme • Quality Committee Terms of Reference showing membership and duties of the Committee.	

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 Governance Confirmed by Sara Munro

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 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 Governance Confirmed by Sara Munro
The Board is satisfied that Leeds and York Partnership NHS Foundation Trust implements: a) Effective board and committee structures	Compliant	Compliant	None	Not applicable	Cath Hill, Associate Director for Corporate Governance Confirmed by Sara Munro

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)
b) 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 Governance Confirmed by Sara Munro
c) Clear reporting lines and accountabilities throughout its organisation.	Compliant	Compliant	None	Not applicable	Cath Hill, Associate Director for Corporate Governance Confirmed by Sara Munro

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: a) 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 Brewin Assistant Director of Finance Confirmed by Dawn Hanwell
b) 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 Governance Confirmed by Sara Munro

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)
c) Effectively implements systems and/or processes to ensure compliance with health care standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	Compliant	Compliant	None	Not applicable	Nichola Sanderson Deputy Director of Nursing Confirmed by Cathy Woffendin
d) Effectively implements systems and/or processes for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern);	Compliant	Compliant	None	Not applicable	David Brewin Assistant Director of Finance Confirmed by Dawn Hanwell

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)
e) Effectively implements systems and/or processes to obtain and disseminate accurate, comprehensive, timely and up-to-date information for Board and Committee decision-making;	Compliant	Compliant	None	Not applicable	Cath Hill, Associate Director for Corporate Governance Confirmed by Sara Munro
f) Effectively implements systems and/or processes to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	Compliant	Compliant	None	Not applicable	Cath Hill, Associate Director for Corporate Governance Confirmed by Sara Munro

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)
g) Effectively implements systems and/or processes to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery;	Compliant	Compliant	None	Not applicable	Amanda Burgess Strategic Development Manager Confirmed by Dawn Hanwell
h) 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 Governance Confirmed by Sara Munro
The Board is satisfied that: a) There are systems and processes to ensure That there is sufficient capability at	Compliant	Compliant	None	Not applicable	Angela Earnshaw Head of Organisational Development

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)
Board level to provide effective organisational leadership on the quality of care provided;	Compliant	Compliant	None	Not applicable	Confirmed by Claire Holmes AND Cath Hill, Associate Director for Corporate Governance Confirmed by Sara Munro
b) 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;	Compliant	Compliant	None	Not applicable	Nikki Cooper, Head of Performance Management and Informatics (Joanna Forster Adams)

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)
	Complaint	Compliant	None	Not applicable	AND Cath Hill, Associate Director for Corporate Governance (Sara Munro) AND
	Complaint	Compliant	None	Not applicable	Nichola Sanderson, Deputy Director of Nursing (Cathy Woffendin)

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)
c) 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)
d) 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;	Compliant Compliant	Compliant Compliant	New Electronic Patient Record system implementation in November 2019 could result in a temporary glitch in data availability or capture None	Programme Manager in place overseeing the implementation; Robust testing plans being developed; Project governance structure in place Not applicable	Nikki Cooper, Head of Performance Management and Informatics (Joanna Forster Adams) AND Nichola Sanderson, Deputy Director

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)
	Compliant	Compliant	None	Not applicable	of Nursing (Cathy Woffendin) AND Cath Hill, Associate Director for Corporate Governance (Sara Munro)
e) 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	Compliant	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.	The service will agree key priority areas during the transition period with the executive lead and engage in the recruitment of appropriately skilled staff.	Linda Rose Head of Nursing and Patient Experience (Cathy Woffendin)

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)
appropriate views and information from these sources; and				Corporate oversight and management will be led through a Strategic level steering group chaired by the executive lead.	AND
	Compliant	Compliant	None	Not applicable	Nichola Sanderson, Deputy Director of Nursing (Cathy Woffendin)
					AND
	Compliant	Compliant	None	Not applicable	Angela Earnshaw Head of Organisational Development

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)
	Compliant	Compliant	None	Not applicable	(Claire Holmes) AND Alison Kenyon Interim Associate Director (Joanna Forster Adams)

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)
f) 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)

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 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 nursing Increased 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 Programme Additional resource to support workforce planning across the Trust Additional 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 Jensen Deputy Director of Workforce Development Confirmed by Claire Holmes

Leeds and York Partnership NHS
NHS Foundation Trust

STATEMENT IN RESPECT OF TRAINING FOR GOVERNORS 2018/19

The Board of Directors are required to respond *compliant/non compliant* with the following statutory requirement, setting out any risks and mitigating actions planned for each. Compliance is at the date of this statement as at 31 March 2019.

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

Proposed Declarations

	Statement	Declaration
G6(3)	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed compliant 2018/19
CoS(7)	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed for 2019/20
FT4(8)	The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed compliant 2018/19
FT4(8)	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed compliant 2018/19
FT4(8)	The Board is satisfied that the Trust implements: a) Effective board and committee structures b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees c) Clear reporting lines and accountabilities throughout its organisation	Confirmed compliant 2018/19

	Statement	Declaration
FT4(8)	The Board is satisfied that the Trust effectively implements systems and/or processes: a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern) e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery h) To ensure compliance with all applicable legal requirements.	Confirmed compliant 2018/19
FT4(8)	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c) The collection of accurate, comprehensive, timely and up to date information on quality of care d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed compliant 2018/19 Although it is recognised that with the implementation of the new patient records' system (CareDirector) there could be a temporary dip in the information available. This is being managed through robust testing and contingency plans are in place. With regard to engaging with service users and carers it is recognised that much work is going on in the Trust to strengthen these arrangements, including recruitment to the Patient Experience Team.

	Statement	Declaration
FT4(8)	The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed compliant 2018/19 The Board acknowledges that there are challenges around recruitment due to shortages across nursing and Junior Doctors in some specialities. These shortages are being actively monitored and managed.
Governor training	The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in S151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed compliant 2018/19 The Board acknowledges that there is work ongoing to develop the training programme.