Appendix A

G6 (3) - Systems for compliance with licence (deadline for Board sign off - 31 May 2021			
The Board is required to respond 'Confirmed' or 'Not confirmed' to the following statement. Explanatory information should be provided where required.			
	Statement	**Response (and supporting information/ assurance)**	**Risks and Mitigations**
	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** At Audit Committee on 4 May 2021 the draft annual accounts and the draft charitable accounts were received. The Trust's Internal Audit progress report highlighted that they believe that the Head of Internal Audit Opinion would confirm that "there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently". The Head of Internal Assurance Report is planned to be presented to the Audit Committee at its 4 June 2020 meeting. This is a key piece of evidence to support compliance against this condition of the provider licence. Further evidence to support this condition includes the Board Workshops and Board meeting discussions on the Annual Plan 2021/22, including all known risks to compliance, risk reports presented to each Audit Committee and Board meetings, the development of the Board Assurance Framework supported by the Annual Assurance Framework Opinion from Internal Audit, Resource Committee reports, Quality Committee reports, the Integrated Board Reporting arrangements, the quality governance review and the "Our Best" programme of work. The Trust's information processes provide the opportunity to review performance data across multiple domains, to improve the availability and accuracy of data and the flow of information and assurance through the governance structure.	No risks identified

FT4 Declaration - Corporate Governance Statement & Training of Governors (deadline for Board sign off - 30 June 2021)			
The Board is required to respond 'Confirmed' or 'Not confirmed' to the following statements, setting out any risks and mitigating actions planned for each one.			
	Statement	**Response (and supporting information/ assurance)**	**Risks and Mitigations**
1.	The Board is satisfied that the Licensee 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** The Annual Governance Statement (AGS) outlines the main arrangements in place to ensure the Trust applies the principles, systems and standards of good corporate governance expected of it as a provider of health and social care services. (the AGS for 20/21 is planned to be considered by the Audit Committee on 4 June 2021) There is an internal audit programme including clinical audits in place, under the direction of the Audit Committee to ensure systems and processes are appropriately tested. The external auditors deliver a robust annual audit plan reporting directly to the Audit Committee.	No risks identified
2.	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.	**Confirmed** Declaration of compliance included in Annual Report; NHSI segmentation as per its Single Oversight Framework; Well Led assessment by the CQC last rated as "Good.	No risks identified
3.	The Board is satisfied that the Licensee 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; and	**Confirmed** The Board Committee structures reporting to the Board are defined and supported through a review of Committee Terms of Reference and reporting arrangements. The Board has formally delegated specific responsibilities to the Committees listed below, summary Chair's reports and formal minutes are provided to the Board following each of their meetings. • Quality Committee	No risks identified

	(c) Clear reporting lines and accountabilities throughout its organisation.	• Resource Committee • Remuneration Committee • Audit Committee • People and Culture Committee The Trust's governance structure ensures the appropriate flow and review of information at service level and up through the divisions to Senior Management Team (SMT) and SMT supporting groups, providing assurance to the Board and its Committees. The quality/clinical governance structure has been reviewed and revised and continuation of the corporate governance review is being taken forward. The monthly SMT meeting provides scrutiny and monitoring of operational performance, which supports the working of the Board's Committees, with SMT directly reporting to the Board of Directors. An internal audit review of governance through the working of the Board Assurance Framework and conflict of interest policy and processes was carried out during 2020/21. Findings of the audit is planned to be presented to the 4 June 2021 Audit Committee meeting.	
	The Board is satisfied that the Licensee effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;	**Confirmed** The Board's infrastructure includes Board scrutiny/assurance Committees and various operational groups, to ensure that the Board of Directors can be assured that the organisation's decisions and business are monitored effectively and efficiently. During the year the Trust adjusted its systems and processes during the COVID pandemic to ensure it could perform as well as it could in such unprecedented times. Gold command structure was initiated reporting up to the Board with a main focus on operational delivery for part of the year before recovery plans and strategic developments were reinstated. There are clear escalation routes up to the Board of Directors (as described above).	No risks identified

	(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;	b) SMT and supporting groups scrutinise key areas of performance including quality, workforce, finance, operational and contractual. The Committees review performance and risk by exception (and in accordance with ToR) at each meeting and subsequently provide assurance to the Board of Directors through the Chair's reports highlighting any key recommendations or key risks identified.	
	(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;	c) The Quality Committee reviews the patient experience and quality report, with quality performance data available and the Trust's compliance with CQC fundamental standards using an on-line tool to support service self-assessments against the CQC domains. The Trust also commissioned an independent review of its clinical and quality governance to ensure it can continually adjust to the changing needs internally and externally, to provide the best possible care to its patients, families and carers. An approved Quality Improvement and Audit Programme is in place, overseen by the Audit Committee. The requirement for the Trust to produce an Annual Quality Report for 2020-21 for inclusion in the Annual Report has been paused nationally due to COVID-19 pandemic; the Trust will, however, produce an Annual Report in accordance with the revised Annual Reporting Manual. The Trust will also produce a Quality Account in accordance with regulatory requirements.	
	(d) For effective financial decision-making, management and control *(including but not restricted to appropriate systems and/or processes to ensure the Licensee's*	d) The Trust reviewed its Standing Financial Instructions (SFIs) in 2019/20 to reflect current procurement practices and to respond to COVID; this determines the agreed framework for financial decision making, management and control. Follow consideration by the Audit Committee and Board these temporary changes were made permanent in 2020/21.	

	ability to continue as a going concern);	Systems of internal control are in place and are subject to regular audit on an annual basis through the Trust's internal audit programme and by external auditors. The Resource Committee and Audit Committee are the principal Committees that maintain oversight on this area. It is determined that there are robust systems and processes in place to monitor and oversee all CIP schemes. The Trust has a good track record of effective financial management and of achieving its statutory financial duties and this is of particular note during the COVID pandemic period.	
	(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;	e) The Board and Committee meeting dates are scheduled to allow the most up-to-date information to be provided to meetings for scrutiny and assurance. The Standing Orders for the Practice and Procedure of the Board of Directors enable the Chairman to call a meeting of the Board at any time. The review of the quality governance framework is evidence of continued review and refresh required to ensure the information provided to the Board is timely and up to date.	
	(f) To identify and manage (*including but not restricted to manage through forward plans*) material risks to compliance with the Conditions of its Licence;	f) The Trust has an approved Risk Policy in place, the Board Assurance Framework (BAF) and Corporate Risk Register provide the framework through which risks are considered, reviewed and managed. The BAF was paused during 2020/21, a decision the Board made to enable greater focus on operational areas, which it believed was required during the earlier months of the pandemic. Directorates review their risks locally at department level and also at directorate level reporting to the Corporate Risk Review Group on a	

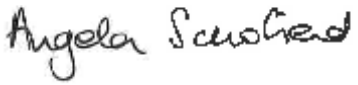
		monthly basis, which discussed the management of risks to also assess common themes, which could create a greater risk to the Trust and could affect the achievement of the Trust's strategic objectives. Any such risks would be added to the BAF. SMT monitors corporate risks and receives an overall organisational risk update to determine the robust management of risks prior to an update being presented to the Board. The Board receives a summary of the Corporate Risk Register/Board Assurance Framework at each of its meetings.	
	(g) To generate and monitor NHS Improvement 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; and	g) The Trust has an Annual Planning process that ensures future business plans are developed and supported by appropriate engagement across the organisation. The Annual Plan is discussed in detail at the Resource Committee and by the Board before this is approved.	
	(h) To ensure compliance with all applicable legal requirements.	h) The governance, risk and control processes in place ensures that any risks to legal requirements are considered to ensure the Trust remains compliant.	
5.	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;	**Confirmed** a) There are appraisal processes in place to support Board members individually and collectively. The outcome of appraisals are reported to the Remuneration Nomination and Conduct Committee for Non-executive Directors, including the Chairman and to the Remuneration Committee for the Executive Directors including the Chief Executive.	No risks identified

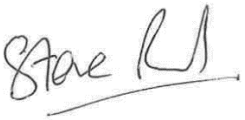
	(b) That the Board's planning and decision making processes take timely and appropriate account of quality of care considerations; (c) There is collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account, as appropriate, views and information from these sources; and	b) There are QIA and EIA processes in place to support decision making processes for any service development or changes and any impact on the quality of care is carefully considered. c) The Quality Committee supports the monitoring of information on the quality of care; the monthly SMT receive a quality performance report from the Chief Nurse/Director of Nursing and the Quality Committee consider a detailed patient experience and quality report. Review and refresh of the quality/clinical governance in 2020/21 aims to further strengthen this area. The Quality Committee Chair reports any key decisions, risks and escalations to the Board. d) As above - the Board receives a report from the Quality Committee Chair and receives approved minutes of the Committee at the Board meeting held in private. The Board also receives the Quality Account. e) During the pandemic Board members face to face visits were paused in accordance with lock down rules and social distancing requirements. There were alternative arrangement put in place. Virtual meetings were held from the outset of the pandemic, the Freedom to Speak Up arrangements were strengthened with the support of associate FTSUGs and champions, the "At Our Best" programme to support the cultural agenda, the health and well-being offer was particular strengthened, which was all overseen by a newly formed People and Culture Committee. One of the Non-executive Directors (NED) is nominated as a NED lead to support 'Freedom to Speak Up' for the Trust and the Chief Nurse and Director of Workforce and OD support the assurance	

		arrangements in place to provide advice and support to the Board as necessary. The members of the Board, particularly NEDs met with the Council of Governors virtually during 20/21 to continually communicate and engage and to take account of views from outside the organisation, the members and public who the Governors represent. The Council of Governors Membership and Engagement Committee had met to consider agile ways of working to engage with members and the public in restricted social distancing arrangements and non-social distancing arrangements to feed into the member engagement plan.	
	(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	f) There is clear accountability for quality of care through the governance structures in place across the Trust, which reported to the Chief Nurse, Medical Director and Chief Executive. This area was strengthened during 2020/21 with the appointment of the Deputy Chief Nurse; Deputy Medical Directors and a clinical governance lead.	
6.	The Board is satisfied that there are systems to ensure that the Licensee 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** All members of the Board, Clinical Directors, Deputy Medical Directors and Deputies and those that carrying out a role to provide advice to the Board comply with the requirements of the Fit and Proper Persons Regulation. All members of the Board and senior decision makers are required to comply with the declaration of interests including loyalty interest policy, which was refreshed and processes and systems strengthened during the year. The annual appraisal process supports effective succession planning through talent conversations and a number of senior managers are engaged in national programmes to support their development to Director level, as appropriate.	No risks identified

		The Board of Directors during the year had considered its development needs discussing through its Board Workshops. External facilitation was engaged to support the Board development agenda throughout the year.	

We can confirm that the Board of Directors of Harrogate & District NHS Foundation Trust approved the plans in place at their meeting held on 25th May 2021.





Angela Schofield
Chairman
Harrogate & District NHS Foundation Trust
26 May 2021

Steve Russell
Chief Executive
Harrogate& District NHS Foundation Trust
26 May 2021