Annual Members' Meeting

Tuesday 21 November 2023 at 5.00pm to 6.15pm

Venue: Derwent Room, Pavilions of Harrogate,
Great Yorkshire Showground, Harrogate, North Yorkshire, HG2 8QZ

Registration and refreshments from 4.15pm

Time	Item	Subject	Paper	Lead
5.00pm	1	Open Meeting: Welcome and Introductions	Verbal	Chair
5.05pm	2	Minutes of the Previous Annual Members' Meeting - Held on 5 December 2022 *To note: approved by the Council of Governors on 21 November 2023*	Paper	Chair
5.10pm	3	Council of Governors' – Report from Lead Governor	Presentation	Lead Governor
5.20pm	4	Chief Executive's Overview	Presentation	Chief Executive
5.35pm	5	Annual Report & Accounts 2022/23	Presentation	Director of Finance
5.50pm	6	Membership Strategy	Presentation	GDMEC Governors
6.10pm	7	Updated Constitution	Paper	Chair
	8	Annual Report & Accounts 2021/22	Paper	Chair
6.15pm	9	Closing Address	Verbal	Chair

Harrogate and District NHS Foundation Trust

Annual Members' Meeting
held on Monday, 5 December 2022 at 5.30pm
The Pavilions of Harrogate, Great Yorkshire Showground, Harrogate, HG2 8NZ

Present
Sarah Armstrong, Chair
Jonathan Coulter, Chief Executive Officer
Jackie Andrews, Medical Director
Mark Chamberlain, Chairman, Harrogate Integrated Facilities (HIF)
Donald Coverdale, Public Governor
Martin Dennys, Public Governor
Tony Doveston, Public Governor
Mike Dunn, Public Governor
Kathy Gargan, Public Governor
Angie Gillett, Managing Director, HIF
Suzanne Lamb, Head of Children's Safeguarding/Head of Nursing
Jackie Lincoln, Public Governor
Natalie Lyth, Clinical Director, Community and Children's Directorate
Kathy McClune, Staff Governor
Jordan McKie, Deputy Director of Finance
Russell Nightingale, Chief Operating Officer
Emma Nunez, Executive Director of Nursing, Midwifery and Allied Health Professionals
Richard Owen-Hughes, Public Governor
Andy Papworth, Non-Executive Director
Laura Robson, Non-Executive Director
Wallace Sampson, Non-Executive Director
Kate Southgate, Company Secretary
Richard Stiff, Non-Executive Director
Rick Sweeney, Public Governor
Steve Treece, Public Governor
Angela Wilkinson, Director of Workforce and Organisational Development
Stuart Wilson, Staff Governor
Twenty-three members of the public

Apologies
Sue Eddleston, Public Governor
Clare Illingworth, Stakeholder Governor & Lead Governor
Ian Barlow, Public Governor
Jeremy Cross, Non-Executive Director

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AMM/12/2022/1 Welcome and introductions

The Chair, Sarah Armstrong welcomed all everyone to the Annual members' Meeting. She especially welcomed all the members present in person and those that would be joining via You Tube link. She also informed the meeting that all the Executives were present and ready to answer any questions that the members needed answered.

The Chair also acknowledged that presence of Non-Executive Directors and the Trust's fantastic Governors who volunteer their services and are the eyes and ears for the communities. She also acknowledged the HIF team comprising of the HIF Board Chair and the Managing Director. She expressed that as a collective, we all work together with a sharp focus on service that is effective for our users. She highlighted that there is no hierarchy as we are all important. She stated that regardless of our roles, we are all important in providing the best care to our clients.

Sarah highlighted that this was an opportunity for all the parties to talk about care. Even after the Annual Members Meeting, The Trust is willing to have more interaction with members if they are up for it. She stated that even if the agenda had been crammed, there will be room to take all the questions that the members have.

The Chair referred the members to the minutes and requested that if they had comments, they could bring them up before the end of the session.

Finally, the Chair thanked the members of the Trust for their continued encouragement and support.

AMM/012/2022/2 Minutes of the previous Annual Members' Meeting held on 29 September 2020

The minutes of the previous Annual Members' Meeting held on 06 September 2021 would be approved by the Council of Governors and would be made available on the Trust's website.

The minutes form the Council of Governors were noted.

AMM/12/2022/3 Presentation – Council of Governors – Lead Governor's Report

Steve Treece, Governor, presented the Lead Governor's Report on behalf of Clare Illingworth who had tendered her apology for the meeting. In his presentation, Steve Treece highlighted that the geographical reach of the Trust has grown and now stretches further south to include West Yorkshire (Wakefield) with the 0-19 Services. This also includes outreach clinics at different locations with the region including Wetherby Primary care Centre, Yeadon Health Centre, Wharfedale General Hospital, Alwoodley Medical Centre and Selby Urgent treatment Centre.

He highlighted that during the period in question, 2021/22, the Trust had 15 elected Governors, 13 public Governors elected by public members with 1 vacancy, 2 Staff Governors elected by staff members with 3 vacancies and 6 Stakeholder nominated Governors. The Chairman introduced Suzanne Lamb, Head of Children's Safeguarding and Head of Nursing.

He also expressed a huge thank you to and bade farewell to Governors who had left the Trust during this period.

Steve also highlighted the importance of Governors and emphasised their role in representing the interests of the members and the wider public and the role of holding the Non-Executive Directors to account for the performance of the board. He reported that the Council of Governor activities had started taking place face to face as scheduled and plans were underway to resume member events.

AMM/12/2022/4. Presentation – CEO's Overview

The CEO, Jonathan Coulter welcomed all the members present and acknowledged their efforts and taking time out to be part of this meeting. He went on to mention that a lot had happened in the period in question and to date.

He further highlighted that the Children's Public Health (0-19) Service was very active operating in 9 local authorities in the North East and Yorkshire. It total, the Trust was looking after 500,000 children which is the largest service in England. Employing over 5000 colleagues, although classified as a small Trust, we are actually a large with a huge impact.

Jonathan Coulter reported that Covid has made a huge difference in how care is provided. There has been a marked increase in backlogs, changing working patterns and different ways of providing health care including community hospitals.

He also reported that there approximately 25,000 people on the waiting list. The plan was to reduce the waiting period and he could safely say that there was no one waiting longer than 2 years. He acknowledged that an increase in time spent in hospital, largely due to capacity constraints in the community, reflects the urgent care pressures being experienced by the NHS currently.

He highlighted that the Hospital continued to deliver on its key mandated contracts across our wide geography and this extended over the last 18 months. Safeguarding demand increased significantly following Covid, more than doubling in a number of areas.

Jonathan also mentioned that the Trust's capital investment initiatives were HDFT's biggest ever investments and focused on a better, greener environment for our patients and staff. He ended by saying that our communities have been supportive, our charity has been fantastic and our colleagues have been wonderful.

The Chair thanked Jonathan Coulter for his presentation.
The Chair welcomed Jordan McKie, Acting Finance Director, to present the Annual report/Accounts for 2021/22.

AMM/12/2021/5 Presentation – Annual report/Accounts for 2021/22 and Future plans

Jordan McKie started off by highlighting last year's major focuses. He stated that the challenge last year was different. It was about productivity and improving efficiencies. During the year in question, the Trust has lived within its resources with significant capital investments. He reported that Covid expenditure continued to be a large portion of our total expenditure.

He reported the Trust replaced aging equipment such as laptops and spent £10 million responding to Covid and approximately £4 million was derived efficiencies and savings, however inflationary pressures continue to cause pressure on the bottom-line.

He further reported that in line with the Trust's KITE values, the Trust had about 480 colleagues receiving cost of living support and the Trust continues to be a living-wage employer. He highlighted that the Trust needed to reduce its agency spend and if we reduce our agency spend to 2019/20 figures, we could be heading towards improvement.

Jordan McKie reported that External audit have issued an unqualified opinion ***"The accounts give a true and fair view of the financial performance and position of the Trust."*** They are satisfied that our Annual Report is consistent with the detailed financial accounts.

He summed up by saying that the plan for the future is to ensure that the Trust operates within its resources and continues to manage the inflationary challenges.

The Chair thanked Jordan McKie for his update and introduced the CEO and Jackie Andrews to present the Trust Strategy.

AMM/12/2022/6 Presentation – Trust Strategy for 2022 and Beyond

Jonathan Coulter started by reflecting on the last 15 years of the Trust's existence. He shared that 15 years ago we were a District Hospital and to date the reach has expanded to North Leeds in order to ensure that we were clinically sustainable by spreading our overheads over a wider area.

He reported that the development of the Trust Strategy was a result of wide stakeholder engagement including a public survey with over 150 responses, a staff survey with over 500 responses and over 40 interviews with external and internal stakeholders.

He shared that in line with the Trust values, the 'how' was more important than the 'what'. He emphasised that kindness was the most important value and that success in executing the strategy would not be for HDFT alone.

At this point, he handed over to Jackie Andrews to present on the plans within the clinical services.

Jackie Andrews reported that the Trust had developed new clinical services. She reported that the Trust has set a number of quality priorities which will be scrutinised by the Quality Committee. The strategy is based on what we want as our clinical ambitions and this was a result of lots of engagement with all our stakeholders to determine what we ought to prioritise. She reported that the aim is to become a high quality District Hospital.

She shared that the Trust was still plagued by workforce challenges and the Trust is working on how to attract the best clinicians. She also shared that the Trust had received funding for implementing the electronic Patient Record system. This is a state of the art system that will allow better integration of patient records. The ultimate ambition is to provide the best possible care by providing an environment that promotes patient and staff wellbeing.

The Chair thanked both Jonathan and Jackie for their detailed presentations. She introduced Mark Chamberlain, Chair HIF Board, to provide the Harrogate Integrated Facilities Update.

AMM/12/2022/7 Presentation – Harrogate Integrated Facilities Update

Mark Chamberlain proceeded to introduce HIF. He stated that HIF was established November 2017 and became operational from 2018. He shared that HIF employs 386 staff and has an annual turnover of £20m. He mentioned that the structure means it has the flexibility to serve other customers other than HDFT and that it is wholly owned by HDFT, who are also its major customer.

He reported that HIF's Services include Estate Management, Facilities management, Domestic Services, Catering and Portering, Sterile Services, Medical Equipment Library General and Office Hotel Services.

He shared that in 2021/2022, HIF delivered 77,000 patient meals, carried out 8,886 deep cleans, and a total of 158,639 surgical instruments and 13,304 endoscopes were reprocessed. It transported 29,388 patients around Harrogate Hospital during 2021.

Mark Chamberlain welcomed Angie Gillett to share HIF's achievements and the way forward.

Angie reported that, as part of HIF's achievements, it had continued to support the Trust as we move forward from the COVID Pandemic, with all the teams working to help to improve patient experience. HIF has also established a new leadership team in the organisation with wealth of experience across estates and facilities. This has been supported by its approach to focus on its workforce by recruiting and retaining high calibre staff with the appropriate skills and experience and establishing apprenticeship schemes.

Angie further shared that HIF will continue to delivery on the £14m Salix project as part of the green plan to reduce carbon emissions across the site and to develop the green plan to support the aim to be a net zero organisation by 2040. HIF intends to develop its newsletter and social media platforms to promote HIF in the wider community.

She also reported that HIF is operating in the catering sector, which is a very competitive sector with new regulations that HIF needs to abide by. Looking ahead, HIF will continue to develop its workforce and implement a major recruitment programme across all areas of the organisation. It plans to introduce new ways of working to improve productivity and efficiency and implement the new national food and nutrition standards. She further reported that HIF will continue to improve the infrastructure/estate of the hospital by taking forward the Environment/Sustainability agenda with the implementation of the Green Plan and Travel Plan and building on the work with HDFT to provide services to the wider community who we serve.

The Chairman thanked Angela and Mark for their presentation. She moved to the next item on the agenda, the question and answer session.

AMM/12/2022/8.0 Questions and Answers

The Chair confirmed that members were invited to submit questions in advance of the meeting.

Question 1: John Topping

What progress have you made to obtain the status as a Veteran Aware NHS trust?

Response: Matt Graham

Thank you for your interest in how Harrogate and District NHS Foundation Trust is supporting the armed forces community. I'm pleased to let you know that the Trust received confirmation last week that we have been accredited as "Veteran Aware" by the Veteran's Covenant Healthcare Alliance.

This is in addition to us signing the Armed Forces Covenant, being reaccredited as a Defence Employer Recognition Scheme Silver Award holder earlier this year and, through our Armed Forces Champions group, putting in place a range of policies and other support to members of the armed forces community.

Question 2: Lucy Pettit

What is the board's current position on digital projects to improve efficiencies and collaborative working for example task management that awards promote diagnostics within secure networks?

Response: Jackie Andrews

I probably touched on this when I was talking about the digital programme that we have but essentially all of the above. We are at a stage where we have entered into procurement of an Electronic Patient Record (EPR) system. It's a bit of a misnomer because most EPR are actually digital management systems with many other things included. I think the short answer is once we know what EPR system we are having; we will know how many other things we can add to it. So yes, everything that you have touched on in your question is currently being discussed.

Question 3: Doug Masterton

Will the Trust be affected by the planned strike by nurses and ambulance workers?

Response: Jonathan Coulter

In terms of the industrial action, I am sure that people are aware that national Royal College of Nurses (RCN) went out to ballot and in some organisations the threshold to strike was met. HDFT was one such organisation so we work for an organisation where the RCN did get the mandate for strike action and you will probably also be aware through public news that in this instance, we are not one of those organisations who have been chosen to go on strike from 23rd December. So, we won't be directly affected obviously by the strike action from the RCN but clearly there is still a mandate and if industrial action goes on into the new year, that may come to Harrogate.

In terms of other health workers unions, they also recently announced the results of their ballots and as an organisation, HDFT did not get a mandate to undertake industrial action, but they did in the ambulance services so the Yorkshire Ambulance Service, which covers our area, will be affected by industrial action which takes place on the 20th of December as well.

We have plans in place to manage that so that emergency care is protected. If there is a strike that starts in the future, we will have plans and we are talking constructively with the unions about how we organise ourselves to make sure that we protect services particularly urgent care services which we don't really want any disruption to. We are working well with trade unions on that issue.

Question 4: Alan Lunn

Just from a general point, I would like to congratulate the trust keeping a social positive approach to our health. How difficult is it working with a negative national picture and pressure and so forth?

Response: Jonathan Coulter

It is really important as an organisation for us to think about what we can do rather than what we can't do, which makes a huge difference. We provide care to lots of people every day, to people that rely on us, people that are often very vulnerable and that we always need to recognise that actually what we do is so valuable. So, whilst there might be challenges whether it's staffing challenges, financial challenges or Covid challenges or whatever it might be, there is always something that we can do to make that better and there will always be services that we will continue to provide. Yes we need to recognise that there are difficulties but there are always things that we can do better.

In terms of the national negativity, to be fair, some of that negativity is caused by some of the pressure which the health service and the care services are under at the moment. In terms of the recovery from Covid, some of the concerns from colleagues that work in the service in terms of the burnout and moral, it just makes it more important for us as a leadership team in the organisation to remain positive because if we could prescribe kindness we would because with kindness we better outcomes for patients. We want to be a great place to work as we have a very important job to do, and we will maintain our positive outlook all the way through.

Question 5: Harrogate Hospital Radio

In 2018 when our studios were moved from the Trust, my team got a lot of comments from patients about entertainment and as you know that we provide radio services to patients in Stafford and in HDFT and we provided over 200 FM and Wi-Fi radios to different departments. It was mentioned back in 2018 that Wi-Fi Spark was going to be replaced by Auspedia. We have never really heard anything about that. Can you give us an update?

Response: Jackie Andrews

Once again thanks for all you do and for such an incredible service – it's just amazing. I can't give you the details about Wi-Fi right now, but the EPR will not be related to the Wi-Fi directly. We have had a number of conversations about our Wi-Fi networks over the years and I know we remain challenged with providing it across HDFT. Can we take this offline, and I will find out where we are with the Wi-Fi networks.

Question 6: Alan Lunn

What was the motivation to create HIF?

Response: Mark Chamberlain

It was a number of things but largely it was about some of the challenges that the organisation faced at the time. In the sort of areas of work that HIF covers, it can be really difficult to get quality staff using conventional terms and conditions. HIF has a flexibility to do things slightly differently. It does not necessary equate to a higher salary, but it provides a flexibility that you can go according to market rate. There was also a need to create a focus on the sort of work that HIF does which did not really exist in the previous environment. It also created an opportunity to explore other opportunities to provide services within our community but outside the Trust which HIF could provide. Our aspirations are to grow that a little bit. The reality is that we have had quite a few things to fix internally.

Comment: Jane Headley

I just realised that you have five weeks of placements for Leeds University medical students, and I did realise that you were teaching people and I know they had a very structured time for five weeks and looking after the elderly. I think they have come to the right place.

Question 7: John Edwards

Could you tell us about Covid and how it is affecting the Trust?

Response: Jonathan Coulter

We currently have about 10 or 12 patients in hospital beds who have got Covid. They are not here because they have Covid, but they have Covid and would have been in the hospital anyway. That has come up a little bit in the last week or two. But certainly since the vaccination program, we have a lot more people in the hospital who happen to have Covid rather than being in because of Covid and that highlights the success of the vaccination programme. Earlier in the year , one of the main issues we had was the impact of Covid was that lots of our staff had Covid and at one point we had 250 colleagues who had Covid and had to be off work which caused us problems in terms of service delivery. The big issue then was around members of staff who had to be absent due to them having Covid. We had an earlier wave during autumn but that has dropped now but there is an anticipation that this will come back up after Christmas but we will wait and see.

AMM/12/2022/9 closing address

The Chair formally thanked everyone for attending the meeting.

There being no further business, the meeting was formally closed.

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ANNUAL MEMBERS' MEETING
21 NOVEMBER 2023

Title:	Annual Report & Accounts 2022-23
Responsible Director:	Director of Finance
Author:	Director of Finance

Purpose of the report and summary of key issues:	To present the Trust's annual report and accounts for 2022-2023.	
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	
	Person Centred, Integrated Care; Strong Partnerships	
	Great Start in Life	
	At Our Best: Making HDFT the best place to work	
	An environment that promotes wellbeing	
	Digital transformation to integrate care and improve patient, child and staff experience	
	Healthcare innovation to improve quality	
Corporate Risks	n/a	
Report History:	Report reviewed and approved at: • Trust Board on 30 August 2023 • Audit Committee on 6 September 2023 • Laid before Parliament on 16 October 2023 • Council of Governors' Meeting on 21 November 2023	
Recommendation:	To ratify the Annual Report & Accounts 2022-23 for publication, including on the Harrogate & District NHS Foundation Trust website.	

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Annual Report and Accounts

1 April 2022 to 31 March 2023

teamHDFT
At our best

HARROGATE AND DISTRICT NHS FOUNDATION TRUST

Annual Report and Accounts

1 April 2022 to 31 March 2023

Presented to Parliament pursuant to Schedule 7 paragraph 25 (4) (a) of the National Health Service Act 2006

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Contents

Overview

This section introduces the work of Harrogate and District NHS Foundation Trust (HDFT). It sets out our Vision, Values and Strategy and highlights some of our strategic developments and achievements of the 2022-2023 financial year.

HDFT's Chair's Welcome and Statement

Thank you for taking the time to read our Annual Report. I wanted to start by offering my unwavering thanks and support to our colleagues at HDFT. This, as previous years, has been one of change, challenge and pressure where our teams have moved and adapted to maintain the high quality of care our patients and service users expect and deserve. Their ability to respond and adapt to change has continued to be remarkable. Our colleagues have supported one another, worked flexibly and in areas that they are not always familiar with through some very challenging circumstances. They have done this with kindness, integrity, teamwork and with equality to service users and one another.

This year has seen HDFT develop a new 5 year strategy which recognises the challenges and pressures we have faced over recent years. This document has now set the future direction of HDFT and defines our ambitions and aspirations for the future. Our strategy shows the commitment we have to providing the best possible levels of care and we can only do that with the help of all of our outstanding colleagues.

I have been especially pleased to see the positivity of our culture displayed in our recent NHS Staff Survey. Given the professionalism, dedication and commitment our colleagues show every day, it has also come as no surprise to me that during the year HDFT as an organisation, as teams and as individuals have been given a range of awards and achievements, despite the challenges that we have faced.

We recognise that during testing times we must work as a team to achieve our goals and this ethos is a focus for our system working. During the year we have been committed to operating as a strong system partner by providing and receiving support from others including other NHS Trusts, independent providers, local authorities, charities and the voluntary and community sector. Collaboration is key to ensuring our communities thrive in these testing times.

At HDFT we have a strong and collaborative Trust Board and I would like to thank all of my Executive Director, Non-executive Director and Associate Non-executive Director colleagues for the commitment and dedication they have shown, HDFT would not be the organisation it is without your leadership. I would also like to pay tribute to the input of our governing body who continue to give up their valuable time for the good of the organisation.

I look forward to 2023-2024 as we continue to progress our aims and ambitions for HDFT, we will move forward as a team and continue to push for a bright future.

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Sarah Armstrong
Chair
Harrogate and District NHS Foundation Trust

A Message from Jonathan Coulter, HDFT Chief Executive

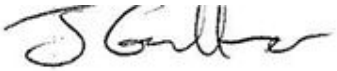
As I look back at 2022/23 and reflect on another year in the life of the NHS in general and HDFT in particular, I am struck by the consistency of what we have done and what we aspire to do. Our purpose within the NHS is to improve the health of our population and provide support to people when they need us, and this has remained unchanged for the 75 years of the NHS. We are aware of the importance of the NHS and the responsibility we have to our population, and we continue to be ambitious and restless to improve our services and provide the care and support that people deserve to receive.

In HDFT we know that there are 200,000 people around Harrogate and North Leeds who rely on us for hospital care, 500,000 children from Wakefield in the south to Northumberland in the north who we provide support to, and 600,000 people to whom we provide a broad range of community services. We do this through our dedicated and skilled teams of colleagues, and by working with our health and care partners which include West Yorkshire and Humber and North Yorkshire integrated care systems, nine local authorities, numerous GP practices, and the voluntary sector. And whilst I highlight the significant number of people with whom we interact every day, and highlight the range of organisations with whom we work, we must never lose sight of the individual person, the patient, the child, the carer, the relative, who at that moment in time are in need of our support.

I could highlight many services and improvements that we have delivered during the year but I would not be able to do justice to the range of things that our teams do every day, in Harrogate and Ripon hospitals, and across our wide community geography, and I would urge you to read the Annual Report alongside our Quality Report to gain a sense of what we have done over the last twelve months. I would specifically though like to welcome colleagues from the Wakefield 0-19 children's service who joined us during the year, and we aim to continue to provide great services to the children and families of Wakefield and share learning across all of our local authority children's service areas.

As you will know, the services we provide could not be delivered without over 5,000 colleagues who work for HDFT. It hasn't always been easy for colleagues over the last few years. The legacy from the COVID-19 pandemic is significant, with a backlog of care, safeguarding demand increasing, mental health concerns increasing, and the wider social changes and impact which colleagues have had to come to terms with. It has also been a period where the cost of living has put personal pressure on colleagues and put pressure on the demand for health and care services. Throughout the year we have tried to support all of our colleagues, recognise the challenges that they face, and also recognise and appreciate the wonderful things that they do. Services are provided to people, by people, and the dedication, the commitment, the optimism, and the sense of collective teamwork from those that deliver care alongside those that support the delivery of care, has been truly outstanding and humbling.

So thank you to you for being interested in HDFT and reading our Annual Report, thank you to our partners with whom we work to provide services, and most of all thank you to all of the over 5,000 colleagues for what you do all day, every day to help us deliver the care and support to our patients, our children, and our communities.



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Jonathan Coulter
Chief Executive
Harrogate and District NHS Foundation Trust

About Us

Harrogate and District NHS Foundation Trust (HDFT) was founded under the Health and Social Care (Community Health and Standards) Act 2003 and authorised as an NHS Foundation Trust from 1 January 2005.

HDFT is the principal provider of hospital services to the population of Harrogate and the surrounding district, and also provides services to North and West Leeds. In total this covers a catchment population for the acute hospital of approximately 316,000 people. In addition, the Trust provides some community services across North Yorkshire (with a population of 621,000 people) and provides Children's and Young People's Public Health Services between birth and 19 (or in some cases 25) years of age in North Yorkshire, County Durham, Darlington, Middlesbrough, Stockton-On-Tees, Sunderland, Gateshead, Northumberland and Wakefield. The Trust's Children's Public Health Services look after almost 600,000 children across these localities.

Our Acute Services

Harrogate District Hospital has:

- an Emergency Department;
- extensive outpatient facilities;
- an Intensive Therapy Unit and a High Dependency Unit;
- a Coronary Care Unit;
- five main theatres and a Day Surgery Unit with three further theatres;
- The Hospital provides emergency, urgent, outpatients, day case and inpatient services across a comprehensive range medical and surgical specialties.
- The Sir Robert Ogden Macmillan Centre (SROMC) provides assessment, diagnosis and treatment for patients with cancer.

- Dedicated purpose-built facilities are also provided on site for Cardiology, Endoscopy, Pathology, Pharmacy, Imaging and Therapy Services, as well as a Child Development Centre, Stroke Ward and Women's Unit.
- The Trust provides Maternity Services with an Antenatal Unit, Central Delivery Suite, Special Care Baby Unit (SCBU) and Post Natal ward, together with an Early Pregnancy Assessment Unit.

Overview

Ripon Community Hospital has:

- an inpatient rehabilitation ward;
- minor injuries unit;
- diagnostics and offers a range of outpatient services to Ripon and the surrounding area.
- It also provides a base for the integrated health and social care Community Care Team and community midwifery services in the Leon Smallwood unit.

HDFT also acts as the first contact for access to more specialist services through alliance-based working with neighbouring hospitals. These extended services are provided by visiting consultants, or alternatively by the patient travelling to hospitals in York or Leeds.

The range of hospital services that are provided in partnership with York and Scarborough Teaching Hospital NHS Foundation Trust (YSTHFT) include Breast and Cervical Screening, Dermatology, Ear Nose and Throat (ENT), Neurophysiology, Non-Surgical Oncology, Ophthalmology, Oral and Maxillofacial Surgery, Orthodontics, Renal Medicine, Rheumatology, Urology, and Vascular. An outpatient renal dialysis unit is provided at a facility on the Harrogate District Hospital site, managed by YSTHFT.

In addition, HDFT has a number of established clinical links with the Leeds Teaching Hospitals NHS Trust (LTHT). These include care for Coronary Heart Disease, Plastic Surgery, Specialist Paediatrics, visiting consultants providing additional support to HDFT's own Neurology service and access to specialist Cancer Services. Links have also been strengthened with commissioners in Leeds, providing further services in Orthopaedics and General Surgery and an outpatient clinic for ENT services at Chapeltown Health Centre.

Additional outpatient outreach clinics are held at:

- Wetherby Primary Care Centre and Yeadon Health Centre for the specialities of Dermatology, Gastroenterology, General Surgery, Gynaecology, Maternity, Neurology, Paediatrics, Respiratory, Rheumatology, Urology, and Vascular clinics.
- Alwoodley Medical Centre which includes clinics for the specialties of Endocrinology, Audiology, ENT, General Surgery, Gynaecology, Orthopaedics, Rheumatology and Urology.
- There is also a dedicated Radiology service providing plain film x-ray and ultrasound services to support the clinics listed above, as well as providing GP Direct Access for the surrounding practices.

Patient choice is an important part of the NHS Constitution and patients from surrounding areas frequently choose HDFT for their care. HDFT will continue working in partnership with the local Integrated Care Systems (ICSs) to expand secondary care services and meet this demand.

Our Community Services

HDFT also provides a range of community services in Harrogate and the local area as well as across North Yorkshire. Our dedicated and experienced staff, who are based in the communities they serve, offer expertise across a variety of disciplines and work closely with primary care, acute hospitals, social care, mental health and voluntary sector providers.

Services include:

- Community Podiatry Services;
- District and Community Nursing;
- Community Therapy Services;
- GP Out of Hours Services;
- Infection Prevention and Control/Tuberculosis Liaison Services;
- Minor Injury Units;
- Older People and Vulnerable Adults Services;
- Safeguarding Children Services;
- Community Dental Services;
- Specialist Community Services.

Our Children's and Young People's Services

HDFT is the largest provider of Children's and Young People's Public Health Services (also known as 0-19 or 0-25 services) in England. We support almost 600,000 children and their families in County Durham, Sunderland, Darlington, Middleborough, Stockton, Gateshead, Northumberland, North Yorkshire and Wakefield. These are universal services which are delivered by multi-disciplinary teams led by Specialist Children's Public Health Nurses, both as Health Visitors (for children up to 5 years old) and School Nurses (for children from 5 years old).

The needs and voices of children, young people and families are at the core of the service which is designed to identify and address their needs at the earliest opportunity, as well as to recognise and build on the strengths that are within individuals. This enables them to be part of the solution to overcome challenges and identify and develop resources within communities so that children, young people and families have access to support when and where they need it. We work closely with other trusts, local authorities and other organisations to be a strong partner. We are part of the local governance and system working for children's services and we tailor our services to the strengths and challenges of the local population. Many of these services are now delivered through partnership agreements with local authorities and this is a strategy we are keen to replicate in other areas because it enables long term investment and development of the services.

Our Subsidiary Company

In 2018 HDFT established a wholly owned subsidiary company, Harrogate Healthcare Facilities Management Ltd to provide it with estates and facilities services. The company currently trades as Harrogate Integrated Facilities (HIF) and, while the vast majority of its activity directly supports the Trust to deliver its services, the company has begun to offer services to external organisations such as the Duchy Hospital and a number of dental surgeries.

HDFT in Numbers

3 INTEGRATED CARE SYSTEMS	OVER **5,000** COLLEAGUES	**21,000** VIRTUAL OUTPATIENT ATTENDANCES
118,000 HOME VISITS	HOSPITAL CATCHMENT AREA **c316,000**	**£350M** TURNOVER
LOOKING AFTER OVER **600,000** CHILDREN	COMMUNITY SERVICES POPULATION **c621,000**	LARGEST **EMPLOYER** IN HARROGATE AND DISTRICT
55,000 EMERGENCY DEPARTMENT ATTENDANCES	OVER **2,000** CANCER TREATMENTS	

Overview

Our Strategy – 2022 and Beyond

Overview

The aim of our Strategy is to establish shared understanding and clarity for our workforce, Board of Directors and partners about the Trust's purpose, ambitions and priorities. It provides a framework to align our endeavours and mobilise our resources and workforce. Our Strategy is for everyone in the Trust, in every role and every function. It drives our activities as a Trust, as Directorates, Services and individually.

We exist to serve two groups:

- the patients who we care for in our hospitals and community services in Harrogate and District, including wider North Yorkshire; and
- the children and young people who we support through our Children's and Young People's Public Health Services across large parts of the North East and Yorkshire.

Our Strategy makes it clear that our patients and children always come first.

Our purpose is to improve the health and wellbeing of our patients, children and communities. As well as caring for patients when they are unwell, we can also help improve people's health and contribute to the wellbeing of our communities through our services and how we use our resources.

Our Strategy guides our decision-making about today's priorities, ensuring they support our purpose and long-term ambitions. Annually, we set clear, specific priorities and objectives for each ambition and goal, and track their delivery through the Board Assurance Framework and our governance and management processes.

Overview

Our strategic objectives for 2022-23 were:

Best Quality, Safest Care

- Improve theatres' safety
- Reduce pressure ulcers and falls
- Implementing the learning from clinical investigations
- Reduce medication errors
- Improve patient communications

Person Centred, Integrated Care; Strong Partnerships

- Increase elective capacity through theatre productivity and outpatient transformation to ensure no patients wait over two years for treatment
- Initiate projects to build additional theatre capacity at Wharfedale and Harrogate Hospitals
- Reduce waiting times in the Emergency Department by improving the environment and implementing an Urgent Treatment Centre model
- Improve patient flow through the hospital, including out of hospital services to support discharge

Great Start in Life

- Develop a Children's Public Health Services Strategy and operating model
- Re-start implementation of Hopes for Healthcare, our principles for supporting children and young people in our services
- Deliver the actions from the Ockenden Report into our own Maternity Services

At Our Best: making HDFT the best place to work

- Look after our people
- Embed a culture of belonging
- Embrace new ways of working
- Growing for the future

These objectives were supported by our enabling ambitions:

- **An environment that promotes wellbeing:** Deliver the 2022-23 estates programme including: Emergency Department reconfiguration; multiple wellbeing projects; the SALIX carbon reduction programme
- **Digital transformation to integrate care and improve experience:** Start the process to replace our Electronic Patient Record; Deliver the 2022-23 digital programme including: Luna - Referral To Treatment (RTT) tracking, eRostering, Datix Cloud, Maternity Electronic Patient Record, Somerset (Cancer Tracking), Yorkshire & Humber Care Record
- **Healthcare innovation to improve quality:** Establish a Harrogate Innovation Hub; Deliver our National Institute for Health and Care Research (NIHR) portfolio research activity; Start to develop research into Children's Public Health Services

Overview

Our Values

Over values are a key component of what makes HDFT the organisation it is today. Our values are:

SECTION ONE

Performance Report

Section 1 – Performance Report

1.1 Strategic Risks

The Trust records strategic risks to the organisation in the Board Assurance Framework (BAF) and operational risks to the organisation on the Corporate Risk Register.

The BAF is reviewed on a bi-monthly basis at the Trust Board meeting held in public and the relevant sections are also scrutinised at the responsible Sub-Committee of the Board on a bi-monthly basis. For oversight and assurance, the BAF is also considered at the monthly meetings of the Executive Risk Management Group as well as the Senior Management Team.

The Corporate Risk Register is also reviewed on a bi-monthly basis at the Trust Board meeting held in public. All risks that are scored at 12 or above are reviewed at Directorate Resource Review meetings, Executive Risk Management Group and Senior Management Team each month.

During 2022-23 a wide scale review of risk management practices within the organisation has been undertaken. A revised governance structure, including the embedding of the Executive Risk Management Group has been completed. The Risk Management Policy for the organisation has been revised and a wide scale training package from Board to Ward has been introduced. Risk management within the organisation has moved to being managed digitally, on the electronic Datix system with a dedicated Risk Manager in post for 12 months to oversee the transition.

During 2022-23 the Trust's Strategy was redesigned and as such in November 2022 a revised BAF was developed.

Between April 2022 and November 2022, the strategic risks identified on the BAF included:

- Risk that individual staff engagement and high performing team cultures are compromised because there is an insufficient focus on culture of the Trust
- Risk that individual staff engagement and high performing team cultures are compromised due to a lack of diversity of thinking
- Risk that the Trust does not maximise its contribution to improving population health and reducing health inequalities because of a lack of strategic relationships with primary care and local authorities and an internal focus will impact our strategic ambition to improve population health and wellbeing
- Risk that the Trust's population is not able to fully benefit from being part of an integrated care system (ICS) because our secondary care patient flows are to West Yorkshire and our place population health activities sit within North Yorkshire which are two different ICSs
- Risk to achieving outstanding service quality and patient experience because there is insufficient focus on a systematic organisation-wide approach
- Risk to our clinical and financial sustainability and ability to invest in capital due to the difficulty in generating sufficient internal funds through inward investment or additional cash releasing savings
- Risk that the Trust places insufficient focus on early years services and adult community based services because of the historic dominance of hospital services
- Risk that standards of care are compromised due to the allocation formula not providing sufficient resources to meet the needs of the unique demography of the local area

In November 2022, the Trust Board meeting held in public formally closed the BAF and re-opened the revised BAF in line with the redeveloped Trust strategy.

Performance Report----------

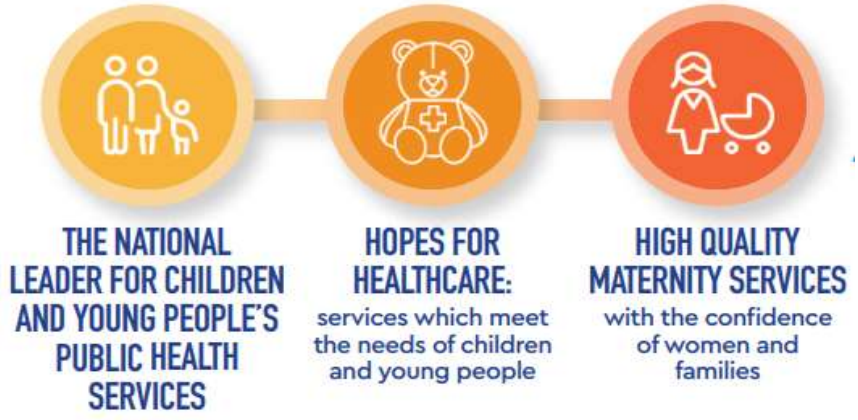
From November 2022 – March 2023 the strategic risks on the BAF were noted as:

- **Best Quality, Safest Care**: The risk of the inability to deliver our ambition to provide the best quality, safest care, where quality is defined by safety, effectiveness and patient experience. There is a risk that we will be unable through continuous learning and improvement make our processes and systems ever safer. There is a risk that we are unable to deliver excellent outcomes for our patients and the children and young people we support which improve their health, wellbeing and quality of life due to being unable to provide effective care based on best practice standards. There is a risk that we will be unable to allow every patient, child and young person to have a positive experience of our care due to being unable to listen and act on their feedback to continuously improve.

- **Person Centred, Integrated Care; Strong Partnerships**: The risk of the inability to deliver our ambition to support person centred, integrated care through strong local partnerships. There is a risk that we are not recognised as an exemplar for person centred, integrated care where we ensure that patients get the right care, from the right staff, in the right place. With an increasingly elderly and frail population, there is a risk that we are unable to prioritise providing the highest quality care and best outcomes for this group, while ensuring that all our patients also benefit from the services and approaches for the elderly and frail.

- **Great Start In Life**: The risk of the inability to deliver our ambition to lead the development of children and young people's public health services, sharing our expertise to benefit children nationally. As a district general hospital we often care for children and young people in our adult services and there is a risk that we will be unable to ensure that every

service meets the needs of children and young people due to the inability to implement the 'Hopes for Healthcare' principles co-designed with our Youth Forum. There is a risk that we will therefore be unable to provide high quality, safe care and a great patient experience for mothers and their babies, and ensure they and their families have confidence in that care due to HDFT being the largest provider of public health services for children and young people in England supporting almost 600,000 children and young people to have a great start in life.

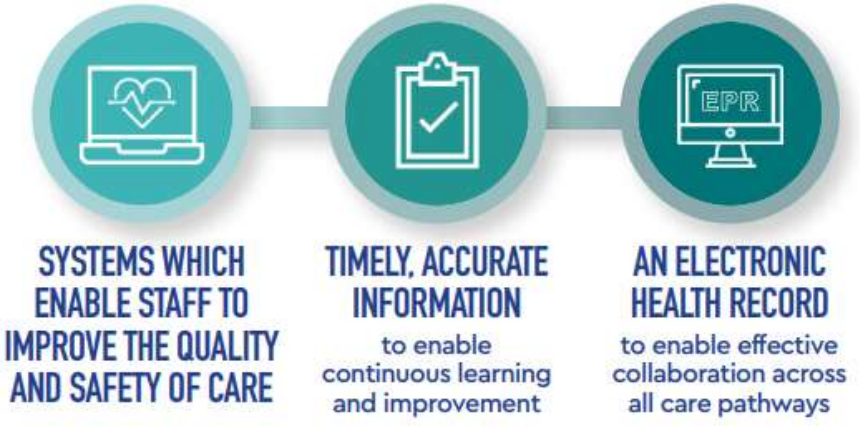


- **At Our Best – Making HDFT The Best Place To Work**: The risk of the inability to deliver our People & Culture Strategy, 'At Our Best'. The strategy follows the NHS People Plan themes and our teamHDFT 'KITE' values and culture. There is a risk that the organisation is unable to achieve its ambition to make HDFT the best place to work. There is a risk that we will be unable to provide physical and emotional support to enable us all to be 'At Our Best'. There is a risk that we will be unable to build strong teams with excellent leadership and promote equality and diversity so everyone is valued and recognised and we are all proud to work for HDFT. There is a risk we will be unable to offer everyone opportunities to develop their career at HDFT through training and education. There is a risk we will be unable to design our workforce, develop our people, recruit and retain, so we have the right people, with the right skills in the right roles to provide care to our patients and to support our children and young people. This is due to the inability to deliver our People & Culture Strategy.

- **An Environment That Promotes Wellbeing:** The risk of the inability to continuously improve our estate and our equipment to promote wellbeing and enable us to deliver the best quality, safest care. Due to the inability to prioritise investments and design new facilities to promote wellbeing and best quality. As the largest employer in Harrogate and

District, and covering a huge footprint across the North East and Yorkshire, we have an important leadership role in reducing our impact on the planet through our buildings, energy use, transport and food. Due to this there is a risk that we will be unable to build on our strong track record to continuously reduce our impact on the environment and achieve net zero carbon by 2040.

- **Digital Transformation To Integrate Care And Improve Patient, Child And Staff Experience:** The risk of the inability to deliver our ambition to provide digital tools and services which make it easier for us to provide the best quality, safest care and which help us provide person centred, integrated care that improves patient experience. There is a risk that we will be unable to collect data about our services through digitisation and this will prevent us from having the ability to create useful information which enables us to learn and continuously improve our services.



- **Healthcare Innovation To Improve Quality and Safety**: The risk that we will have the inability to use our agility to become the first choice for testing healthcare innovations to improve care for patients due to the risk that we will not be able to develop partnerships with industry, academia, government, the voluntary sector and our local system to offer a real-world testbed for healthtech and digital innovations. The risk that we have the inability to use our size and expertise to be the leading NHS trust partner for research in children's public health services due to the inability to access research and clinical trials to improve quality and outcomes for patients and lack of access for our patients through clinical trials at HDFT and through partnerships with our Clinical Research Network.

Performance Report----------

The risks on the Corporate Risk Register at the end of 2022-23 relate to:

- Risk to service delivery and patient care due to potential failure to fill registered nurse vacancies due to the national labour market shortage.
- Organisational risk to compliance with legislative requirements due to a potential failure to make a suitable and sufficient assessment of the risks to the health and safety of employees, patients and others.
- Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and others, and the unauthorised access of persons to restricted areas of the hospital through the loading bay entrance.
- Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatalities, or permanent disability to employees, patients and others, due to the failure to manage the impact of contractors, and construction work at Trust premises.
- Organisational requirements, with the risk of major injuries, fatalities, or permanent disability to employees, patients and others, due to the failure to manage the risk associated with Reinforced Autoclaved Aerated Concrete (RAAC) roofing.
- Insufficient capacity to meet the key national safety standard of a Qualified in Specialty (QIS) staff member on every shift and 70% of the establishment (8.3wte) qualified on Special Care Baby Unit (SCBU).
- Risk to patient care and safety due to current staffing levels and poor morale due to increased workload, post pandemic burn-out and poor working environment. Risk of both short and long term mental health impacts on staff.
- Risk to quality of care by not meeting National Institute for Health and Care Excellence (NICE) guidance in relation to the commencement of autism assessment within 3 months of referral. Risk that children may not get access to the right level of support without a formal diagnosis and that this could lead to deterioration in condition.
- Risk to patient safety, performance, financial performance, and reputation due to increasing waiting times across a number of specialties, including as a result of the impact of COVID-19.
- Risk of increased morbidity / mortality for patients due to failure to meet the four hour target of care in the Emergency Department.
- The Trust is currently in breach of regulatory obligation regarding agency price caps, is incurring premium costs for staffing where vacancies exist, and in some circumstances this

results in an adverse impact to quality and safety. Breach of IR35 regulations and potential fine from HMRC.

- Risk to financial sustainability and regulatory impacts as a result of not achieving breakeven. Risk of providing value for money to taxpayer. Risk to service sustainability as a result of resources available to provide services.

1.2 Going Concern Disclosure

After making enquiries, the Board have a reasonable expectation that the services provided by the NHS Foundation Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the Board have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

1.3 Performance Summary

In line with national requirements, we have continued to place a strong focus on elective recovery. Increasingly moving elective activity to be back in line with 2019/20 levels and reducing the long waiting times for diagnostics and elective admissions whilst delivering improvements in the urgent care pathway to improve timeliness of care and maintain our high performance in ambulance handover.

Over the year, the average referral to treatment (RTT) waiting times remained at a similar level for Harrogate patients of between 10-11 weeks. However the number of patients waiting over 52-weeks reduced from 1176 in March 2022 to 997 in March 2022. By March 2022, the Trust had successfully eliminated any RTT waiting times of more than 104 weeks and, by March 2023, there was no-one waiting more than 78 weeks for referral.

In addition, we were also able to support other providers electively in both Humber and North Yorkshire ICS and West Yorkshire ICS by providing diagnostic (endoscopy) capacity and also by transferring and treating a number of their longer waiting patients. Providers in Humber and North Yorkshire ICS received consistent non-elective support from the Trust through ambulance diversion with an average of provision of 15 inpatient beds.

Safety continues to remain a priority, with all patients clinically triaged and assessed for clinical harm where longer waiting times have occurred.

Our focus is maintaining patient safety. There has continued to be consistently good performance for timely ambulance handover in our Emergency Department.

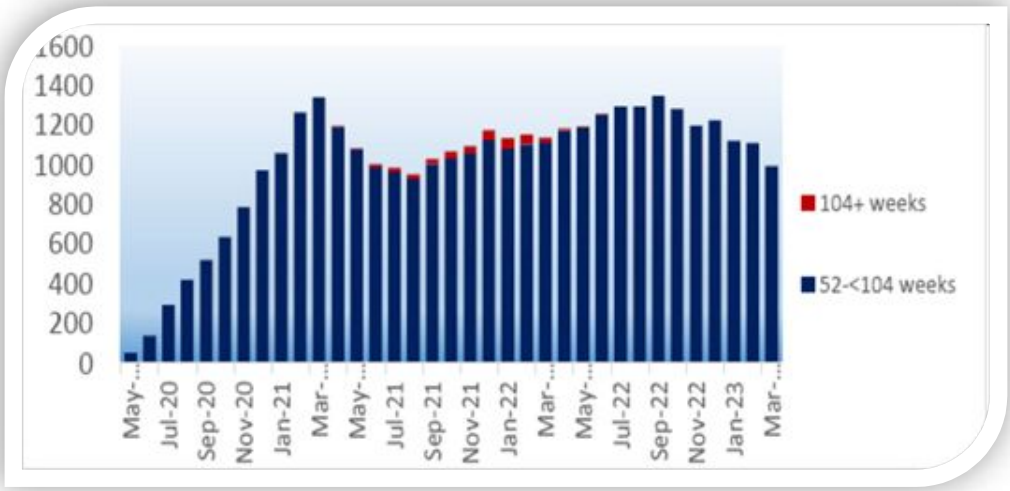
1.4 Operational Performance

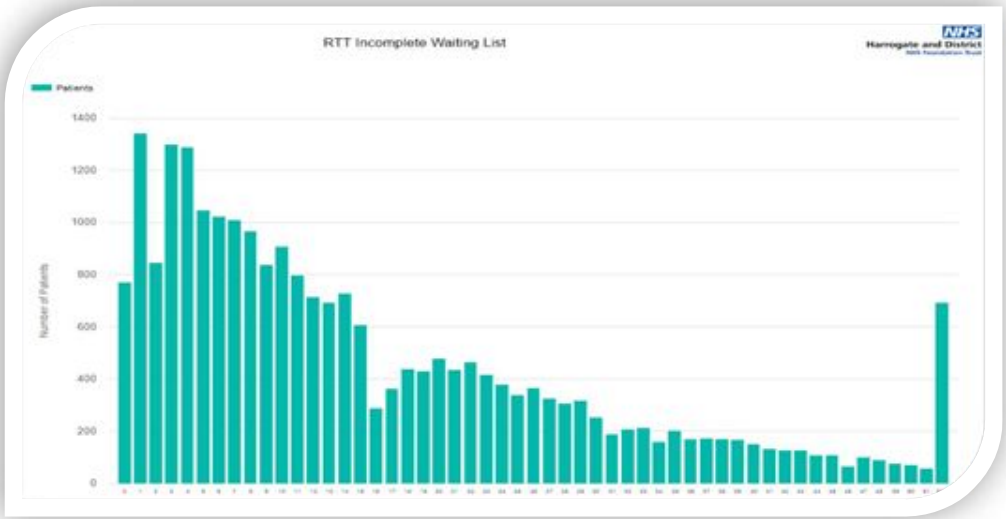
Waiting Times

During 2022-23 the Trust continued to treat the most clinically urgent patients on the elective waiting list alongside patients waiting the longest time. Routine operations were impacted by the ongoing effects of COVID-19 on staff and patient availability as well as industrial action during the final quarter of the year. Routine primary care referrals remained at higher levels than 2019/20 (+5%), impacting on the total number of patients waiting, with the end of the year being at a slightly higher level (1500 patients) than the start of the year. Longer waiting times decreased throughout the year, the 92nd percentile reduced from 44 weeks in March 2022 to 42 weeks in March 2023. The number of patients waiting longer than 52 weeks decreased

again by 15%, from 1176 in March 2022 to 997 in March 2023. Median waiting times remained at a consistent level throughout the year.

Long waiting patient progress and overall waiting list profile





There is ongoing work to further validate the true size of the HDFT waiting list; an AI supported validation tool is close to full implementation alongside text messaging patient validation which is due to commence in April 2023.

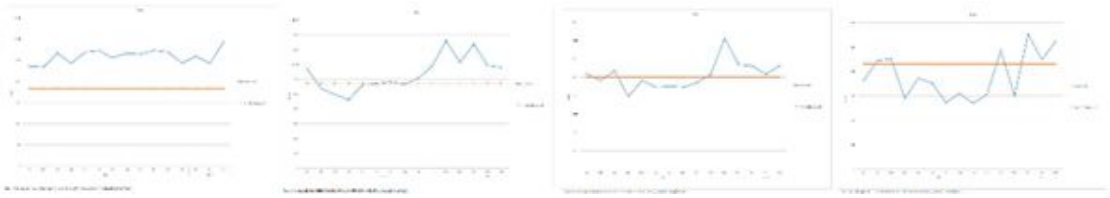
Diagnostic Tests

During 2022-23, diagnostic services have continued to support elective recovery resulting in an increase in activity on the previous years (see charts below). Activity remained relatively consistent throughout the year, despite the challenges relating to staffing absence as a result of COVID-19. Longer waiting times continue to be actively reduced across most modalities. Particular challenges in DEXA, originally due to ageing equipment which has now been replaced, now relate to national challenges in recruiting the skilled workforce – although a recovering trajectory is now on track.

Performance Report----------

Activity versus pre-COVID-19 averages by diagnostic modality(Jan'22-March'23)

CT MRI Ultrasound Dexa



Cancer

Cancer patients continued to be treated throughout the year with increased capacity to help reduce the COVID-19 generated backlog. There was a continued growth in 2 week wait (2WW) referrals with particular spikes in Breast, Skin and Lower Gastrointestinal pathways associated with national campaigns. This increase primarily impacted on waiting times at the beginning of the pathway, however the standard for patients receiving their treatment within 31 days of diagnosis was achieved in all four quarters. The standard for treatment within 62 days of urgent referral was not delivered across the year with shared care cancer pathways contributing to delays. Performance in March 2023 showed significant recovery at 83.2% against a target of 85%.

A cancer summit is planned for April 2023 focusing on the five most challenged pathways to develop sustainable delivery through the next year.

Cancer 31 and 62 day standards

31 day first treatments	Apr-22	May-22	Jun-22	Q1	Jul-22	Aug-22	Sep-22	Q2	Oct-22	Nov-22	Dec-22	Q3	Jan-23	Feb-23	Mar-23	Q4	
Treatments	111	109	114	334	88	91	120	299	94	122	74	290	83	85	74	242	1165
Within 31 days	108	107	111	326	87	90	116	293	93	121	74	288	83	85	73	241	1148
Outside 31 days	3	2	3	8	1	1	4	6	1	1	0	2	0	0	1	1	17
Performance	97.3%	98.2%	97.4%	97.6%	98.9%	98.9%	96.7%	98.0%	98.9%	99.2%	100.0%	99.3%	100.0%	100.0%	98.6%	99.6%	98.5%

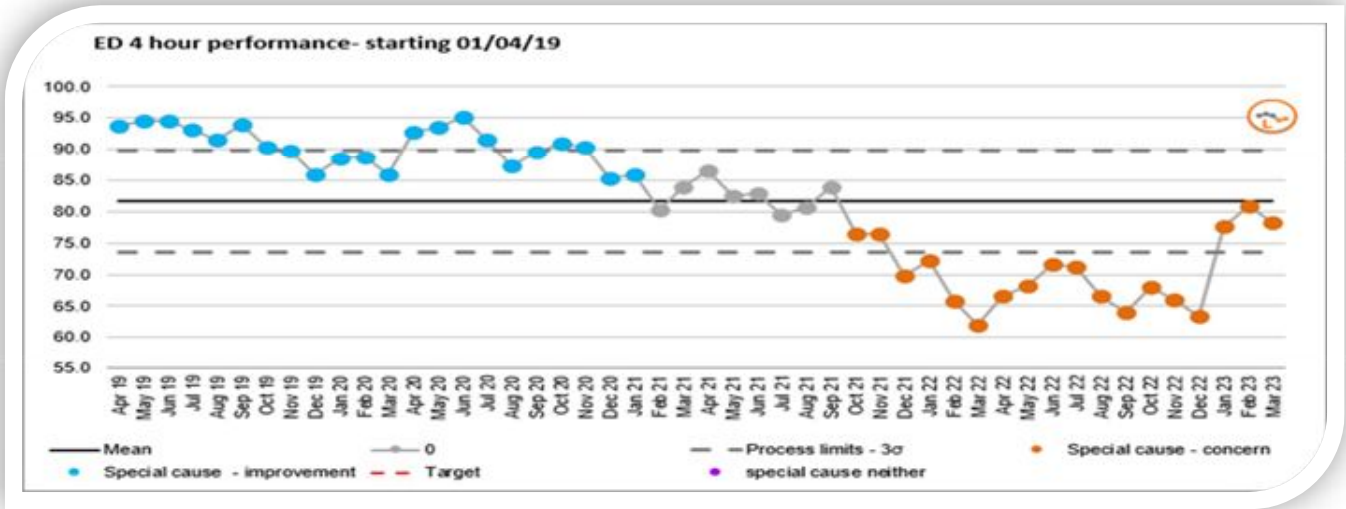
62 day standard	Apr-22	May-22	Jun-22	Q1	Jul-22	Aug-22	Sep-22	Q2	Oct-22	Nov-22	Dec-22	Q3	Jan-23	Feb-23	Mar-23	Q4	2022/3
Treatments	60.0	69.5	70.5	200.0	53.0	51.5	70.0	174.5	66.5	74.0	49.0	189.5	55.5	58.5	53.5	167.5	731.5
Within 62 days	47.0	60.0	57.0	164.0	41.5	42.5	50.0	134.0	53.0	59.0	40.0	152.0	40.5	45.5	44.5	130.5	580.5
Outside 62 days	13.0	9.5	13.5	36.0	11.5	9.0	20.0	40.5	13.5	15.0	9.0	37.5	15.0	13.0	9.0	37.0	151
Performance	78.3%	86.3%	80.9%	82.0%	78.3%	82.5%	71.4%	76.8%	79.7%	79.7%	81.6%	80.2%	73.0%	77.8%	83.2%	77.9%	79.4%

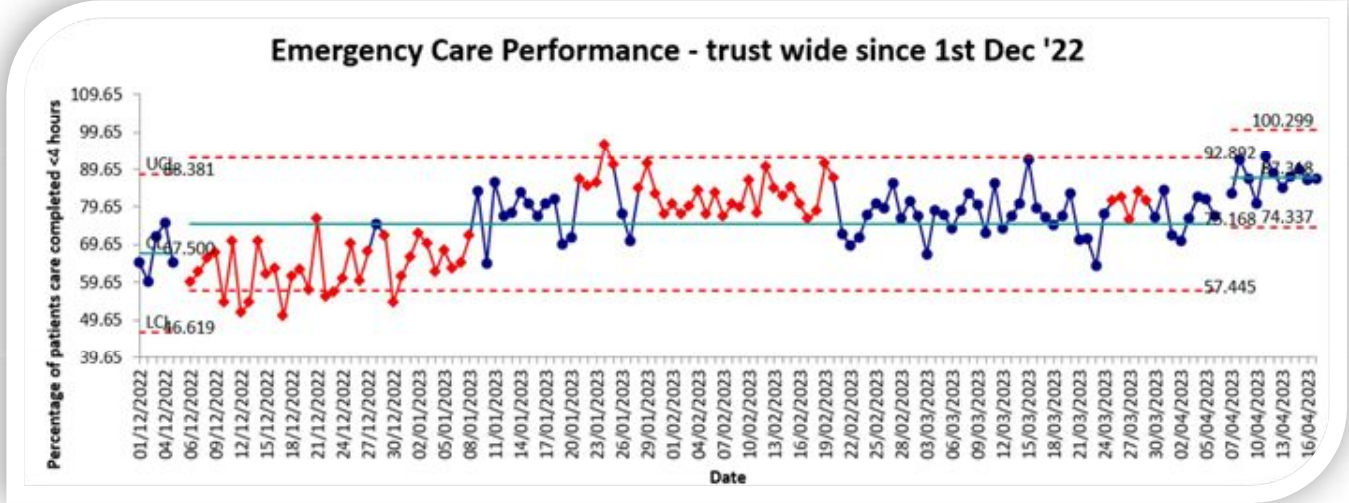
Emergency 4-hour standard and ambulance handover performance

The Trust did not achieve the Emergency Care 4 hour standard (95%) for each quarter of the year. Performance reflects the continuing significant pressures with high bed occupancy relating to discharge challenges and staff absences. The Trust continued to support the wider system during 2022-23 with regular diverts of ambulance patients to Harrogate - this negatively impacted on HDFT's 4 hour performance and length of stay in the department. Emergency Department (ED) attendances have now returned to previous levels experienced in 2019/20.

There has been significant recovery after a deeply challenging winter period when new models of care in the ED (streaming), work across the urgent care and discharge pathways (ward reconfiguration, red to green methodology, virtual wards and the ARCHS model) and redevelopment of the ED footprint have begun to deliver.

Performance Report----------





Ambulance handover has been another key focus nationally and internally, ensuring ambulance service colleagues are able to safely handover patients and be available to respond to the next community emergency. The Trust has maintained its position across the year as one of the top 10 providers. This means that 94% of our ambulance handovers occurred with 30 minutes of arrival at the Emergency Department.

Performance Indicator Description	Q1	Q2	Q3	Q4	YTD
Proportion of ambulance handovers over 30mins	98%	96%	87%	95%	94%

Infection Prevention and Control (IPC)

Infection Prevention and Control (IPC) remains a high priority for the Trust and there is a strong commitment to reducing avoidable harm due to Healthcare Acquired Infections (HCAI). HCAI rates are closely monitored by the IPC committee, chaired by the Director of IPC (DIPC) and reported to the Quality Committee. Actions and recommendations to ensure the Trust HCAI rates remain below the Trust's trajectory level are overseen by the Lead Doctor and Lead Nurse for IPC, reporting directly to the DIPC and the Quality Committee

Performance Report----------

Regulatory Ratings

The HDFT's regulatory performance against key aspects of the NHS Single Oversight Framework is shown below. No formal regulatory action has been taken or is planned. The Trust continues to have robust measures in place to monitor performance and quickly address areas of concern.

RTT, diagnostic, cancer and emergency care performance narrative is covered in the operational performance section above.

Total incomplete RTT pathways	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Under 52 weeks	27414	25384	25134	25629	25564	25490
>52 weeks	23527	24188	23873	24332	24267	24140
>78 weeks	1187	1196	1261	1297	1297	1350
>104 weeks	11	3	1	0	0	0
Total incomplete RTT pathways	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Under 52 weeks	25437	25388	24951	24846	25139	25504
>52 weeks	1285	1201	1228	1124	1112	1061
>78 weeks	112	100	118	99	65	4
>104 weeks	0	0	0	0	0	0

Performance Indicator Description	Q1	Q2	Q3	Q4	YTD
Diagnostic waiting times - maximum wait of 6 weeks	68.7%	50.4%	62.7%	62.9%	62.9%
All Cancers: 14 Days Target	83.2%	54.6%	58.7%	62.7%	65.0%
All Cancers: 31 Day Target - 1st Treatment	97.6%	98.0%	99.3%	99.6%	98.5%
All Cancers: 62 Day Target	82.0%	76.8%	80.2%	77.9%	80.2%
Trust total - Total time in A&E - % within 4 hours	68.7%	67.2%	65.8%	78.8%	69.4%
Type 1 A&E - Harrogate ED - Total time in A&E - % within 4 hours	63.3%	61.0%	60.2%	75.4%	64.0%
Type 1 A&E - Harrogate ED - trolley waits > 12 hours	76	179	292	131	678
Proportion of ambulance handovers over 30mins	98%	96%	87%	95%	94%
Incidence of avoidable hospital acquired MRSA Bacteraemia	0	0	0	0	0
Incidence of hospital acquired C-Difficile (Cumulative)	11	16	21	23	23
Avoidable cases (cumulative)	0	0	2	2	2

Integrated Care Boards

As part of the oversight of ICBs and trusts, NHS England will monitor and gather insights about performance across each of the themes of the framework.

To provide an overview of the level and nature of support required across systems, inform oversight arrangements and target support capacity as effectively as possible, regional teams have allocated all ICBs and trusts to one of four 'segments'

Performance Report----------

	Segment description	
	ICB	Trust
1	Consistently high performing across the six oversight themes Capability and capacity required to deliver on the statutory and wider responsibilities of an ICB are well developed	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place based and overall ICB priorities
2	On a development journey, but demonstrate many of the characteristics of an effective ICB Plans that have the support of system partners are in place to address areas of challenge	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues
3	Significant support needs against one or more of the six oversight themes Significant gaps in the capability and capacity required to deliver on the statutory and wider responsibilities of an ICB	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts)
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	In actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support

HDFT and the ICB (Humber and North Yorkshire) are both allocated to segment 2.

The Trust operates in partnership with colleagues across our ICB as well as those in West Yorkshire. The Trust strategy, delivery, operational and financial plans are developed with regard to the ICB in which we operate.

Performance Report----------

1.5 Operating and Financial Review of the Trust

Income and Expenditure Summary

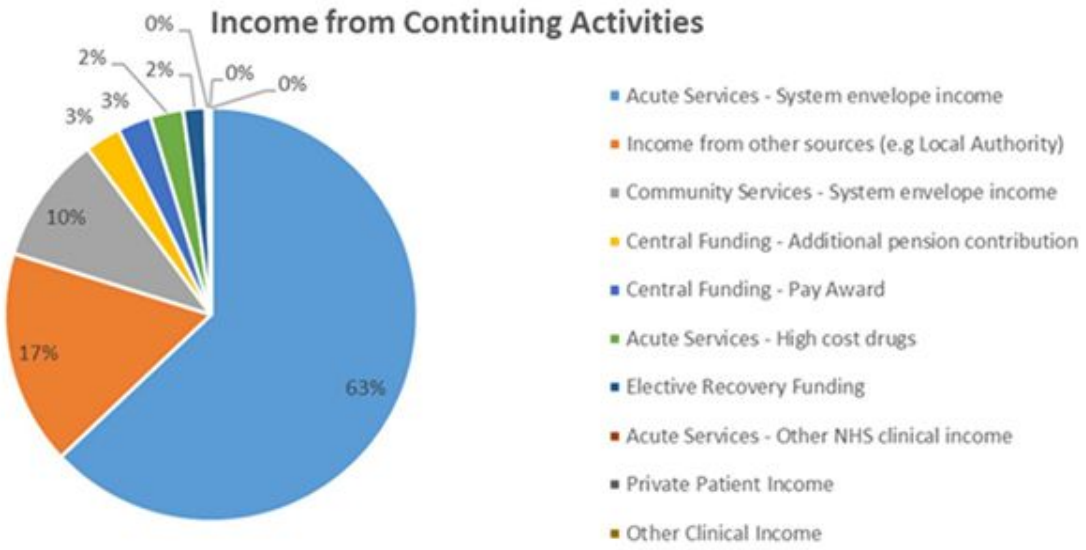
The Income and Expenditure position for the Trust for 2022/23 was a surplus of £652k. The table below provides a high level comparison of the Income and Expenditure account for the year

£000's	2022/23	2021/22
Operating Income	352,270	324,260
Operating Expenditure	-349,004	-312,153
Finance Costs	-2,614	-2,495
Surplus for the year	652	9,612
Remove Capital donations /grants I&E impact	-523	-12,375
Add back all I&E impairments/(reversals)	238	3,181
Remove Charitable Fund Position	299	-349
Performance for monitoring purposes	666	69

The above outlines a small surplus position against the regulatory requirements for the Trust.

Income Generated from Continuing Activities

Total income from continuing activities for the year 2022/23 was £314,906k. This represented 87% of total income for the year. An analysis of this income is shown below:

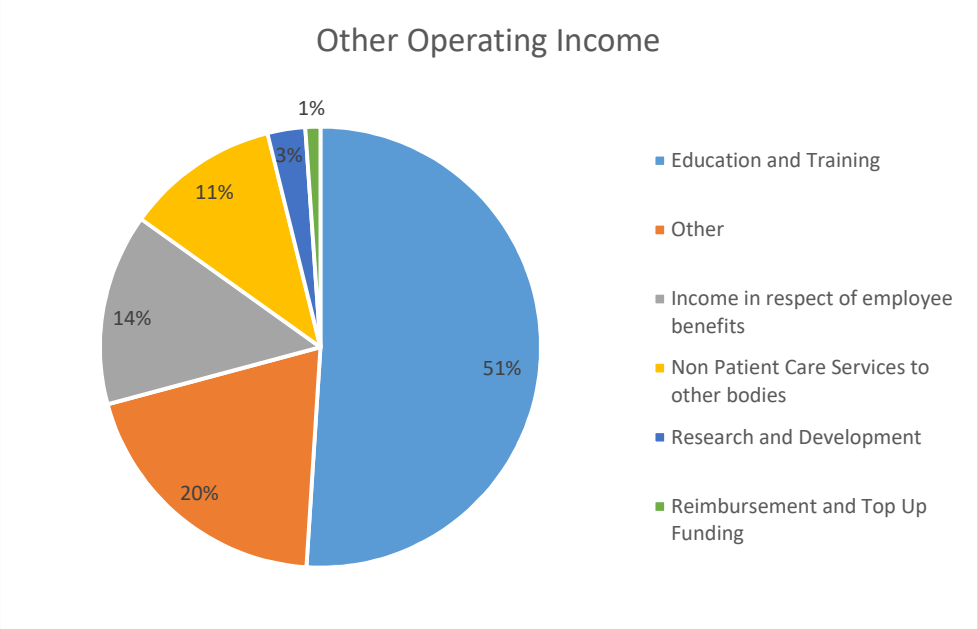


The Trust has met the requirements of section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), in that the income from the provision of goods and services for the purposes of the health service in England (principal) has exceeded income from the provision of goods and services for any other purposes (non-principal). Non-principal income is used to provide additional funding for the Trust. It is directly reinvested in the delivery of high quality NHS Services.

Performance Report----------

Other Operating Income

Other Operating income totalled £37,364k for the Group. This represents 11% of total income.



Cash

The Trust has a cash balance of £35,679k at the close of the financial year.

Use of Resource Metric

This metric measures how effectively the trust manages its financial resources to deliver high quality, sustainable services for patients. The Trust did deliver a small surplus and although agency spend was higher than the ceiling target allocated it was managed within the overall resources available.

Financial Outlook 2023-24

In order to support the wider ICS position and enable the ICS, ICB and therefore the Trust to have signed off operational plans, the Trust has set a financial plan of a £6m surplus for 2023-24. The final £6m of this position was essentially a stretch target, supporting the system to achieve the target financial plan requirement for 2023-24 following a challenging planning round.

This £6m stretch has been phased in equal 12ths across the year. The final adjustment to the plan was made close to the deadline for submission and the phasing is prudent, reflecting the nature and risk of this final agreement.

The Trust has a challenging Cost Improvement Programme to deliver £20.8m for 2023-24.

Key pressures that will need to be negotiated throughout the year include the impact of inflation, as well as the various demands on ensuring the workforce is in place to undertake recovery and provide safe, effective care.

Performance Report----------

Capital Investment Activity

During 2022/23 the Trust undertook another significant capital programme, £22m. There were two large schemes which additional resource was received for including EPR readiness and infrastructure, £7.8m and TIF2 (Support Elective Recovery), £2m.

Scheme	£000's
CDEL	
Digital/IT	1,973
Replacement Clinical Equipment	2,855
Estate Infrastructure incl Backlog	3,915
Health and Wellbeing	763
Total CDEL	**9,506**
PDC	
EPR	7,811
TIF2	2,000
9*Other Schemes (Digital/Estate/Elective Recovery)	3,069
Total PDC	**12,880**
Total Capital	**22,386**

Land Interests

During the financial year ending 31 March 2023, the Trust's land and buildings were re-valued by the Valuation Office Agency (Royal Institute of Chartered Surveyors qualified) which is an Executive Agency of HM Revenue and Customs (HMRC). This valuation, in line with the Trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in a valuation of the Trust's land and buildings of £99,449k, which has been incorporated into the accounts.

Investments

Harrogate Healthcare Facilities Management, which trades as Harrogate Integrated Facilities, is the wholly owned subsidiary of the Trust. The Trust is also a member of a joint venture arrangement for Pathology Services

No financial assistance was given or received by the group in 2022/23.

Details of Activities Designed to Improve Value for Money

The Trust will drive forward the delivery of efficiency through reducing waste and driving forward service improvement. This will be built from Directorate level, incorporating changes that are managed Trust-wide and across the West Yorkshire Association of Acute Trusts.

The Business Development Strategy has continued its success and aims to continue to support the sustainability of the Trust, both financially and clinically.

The Quality Impact Assessment process relating to the efficiency programme continues to play a key role in ensuring quality, safety, and access is not compromised by efficiencies. This process has been further refined to include the impact on as part of these changes.

The Trust CIP target is £20.8m for 2023/24. It is recognised that, at 6%, this represents a challenging target. The Trust has historically met these challenges, and processes are in place to give assurance and confidence that this target will be achieved.

Events since the end of the financial year

The Trust has not identified any events that occurred after the reporting year that would require disclosure as non-adjusting events in accordance with IAS10

Performance Report----------

Oversees Operation

The Trust has no overseas operations.

1.6 Environmental Matters

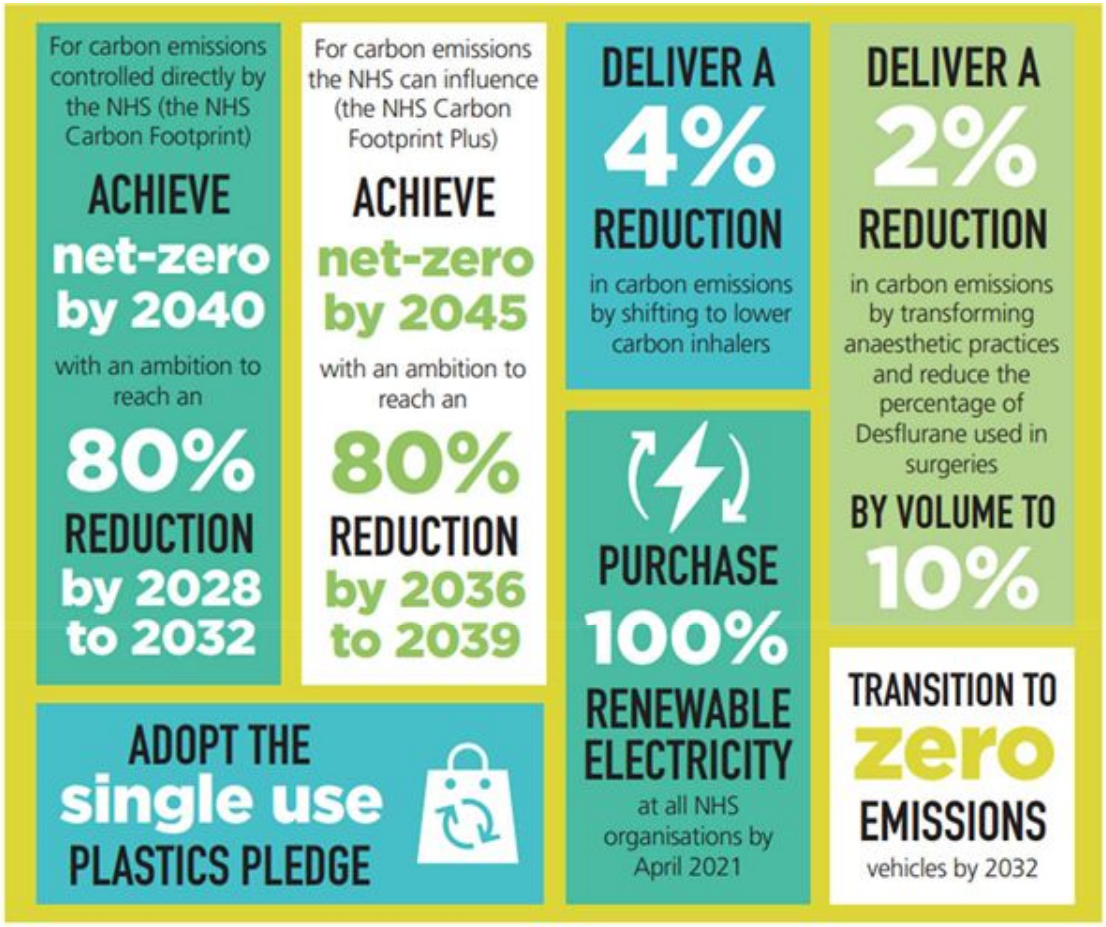
In March 2022 the Trust and its subsidiary company HIF developed and approved the Green Plan 2022-2025. The Plan sets of the key areas we need to focus on for instance, to significantly reduce carbon emissions across our footprint by developing schemes that support walking and cycling, enhance green spaces, reduce pollutants and waste, improve energy and efficiency and increase recycling.

Green Plan
2022-2025

Creating better, more sustainable
healthcare for our community

Performance Report----------

The Trust has committed to being a net-zero organisation by 2040, having reduced our carbon footprint by 80% by the end of this decade. Our intention is to deliver sustainable healthcare for the benefit of the population we serve. Our targets are:



In the first year of our Plan we have achieve our aims and ambitions we set ourselves. These included:

- Developing our People and Leadership with the implementation of a Sustainability Board, Green Working Group, Green Colleague Panel and carbon literacy training.
- Delivering sustainable models of care by increasing our understanding of opportunities to deliver care in a more sustainable way.
- Digital transformation with environmental sustainability as a key driver in our Digital Strategy.
- Travel and transport with a revised travel plan rolled out across the organisation.
- Improved energy usage across our estates and facilities to ensure our refurbishments and new builds are environmentally considerate.
- Impacts of medicine with links into our Scan 4 Safety programme.
- An expectation that our suppliers commit to include carbon reduction in their contracts.
- Ensure food is locally sourced, reviewing our food waste and implement the revised food and drink strategy.

Performance Report----------

1.7 Quality

The Trust continues to be fully committed to the provision of high quality care. The Trust has prepared a Quality Account, which is a requirement of the Health Act 2009 and the Quality Account regulations. The Quality Account is produced in addition to the Annual Report and Accounts. Full details of the 2022-23 quality priorities and their achievements are detailed within the Quality Accounts. The document also details the quality priorities for 2023-2024.

Following extensive review and consultation, the Trust set an ambitious programme of quality priorities. It was acknowledged that this would be a three-year programme and the focus would remain on the following quality priorities between 2022 and 2025.

SAFE: Best Quality, Safest Care: Ever Safer Care through Continuous Learning and Improvement

1. **Theatres Improvement:** Following a number of incidents within our surgical and theatres environment, a wide scale theatres improvement plan was developed. The aim of this project is to improve patient safety and quality of care within this environment. It will focus on a series of enhanced cultural events, training and education, and bespoke pieces of work on the safety checks we undertake.
2. **Emergency Department Improvement:** A wide scale Emergency Department (ED) improvement plan was developed following a number of incidents within our ED. The aim of the project is to review the patient pathways into and out of the department, consider new ways of working, implement an enhanced safety regime and undertake a range of training and development initiatives.
3. **Pressure Ulcers:** The work undertaken in previous years in relation to our pressure ulcers improvement plan continues with an enhanced and dedicated Tissue Viability Team. The work they will do will build on what has already been achieved and will continue to implement new ways of working and ensure care is in line with our national framework.
4. **Inpatient Falls:** Enhanced training and education from our Falls Improvement Lead and Fundamentals of Care Lead will strengthen the work undertaken in previous years in relation to inpatient falls continues with. This work will complement and improve our governance arrangements for reviewing and learning from inpatient falls.

OUTCOMES: Best Quality, Safest Care: Excellent outcomes through effective, best practice

1. **Failure to Act on Results:** The failure to act on test results is a significant patient safety risk across the NHS. Errors and oversights in this area have resulted in delays in diagnosing and treating patients, some with tragic consequences. Following a number of incidents where failure to act on results or a delay in acting on results have been a primary cause of harm to our patients, this area was therefore selected as an area for improvement. The aim of this priority is to reduce the incidents of harm.
2. **Medication Errors:** We are building on the work undertaken in previous years. The focus has moved to improvements in key areas such as insulin errors as well as playing an active part in the national medication improvement programme.

EXPERIENCE: Best Quality, Safest Care: A positive experience for every patient by listening and acting on feedback

1. **Patient Experience:** The organisation has reviewed the national patient experience framework and created a dedication improvement plan to ensure our services are fit for purpose and future proofed.

The Quality Priorities are reviewed within speciality committees and working groups as required. They are overseen at an operational level at our Quality Governance Management Group (QGMG) and at a strategic level at our Quality Committee where a monthly highlight report is received as well as reviewing deep dives of each priority on a rotational basis.

1.8 Social, Community, Anti-bribery, Health-inequalities and Human Rights Issues

The Trust operates seven staff networks:

LGBT+

Disability and Long-Term Conditions

Neurodiversity

Menopause

BAME and Allies

Men's network

Armed Forces

All of these networks help to work towards reducing inequalities between staff who share or do not share their protected characteristic as defined within the Equality Act 2010 and Public Sector Equality Duty (PSED). Each network group is sponsored at the director level and has a chair to drive it forward. Awareness events and promotions are delivered regularly throughout the year using different media platforms to all staff.

Performance Report----------

As part of our recruitment processes, we are guided by the organisational values of **Kindness, Integrity, Teamwork and Equality** which lend themselves to our accreditations. We hold accreditation for being a Menopause-Friendly organisation, Disability Confident Employer which promotes and offers choice of equitable practices and reasonable adjustments for applicants from the induction stage and beyond for our employees. We also hold accreditation for being age-positive, a mindful employer and we are proactive in recruiting ex-military personnel.

In order to evidence the rationale for our decision-making, the Trust employee data is monitored and published on our website using the following mandated reports:

Workforce Race Equality Standard (WRES)

The WRES report captures information regarding our employees who identify as BAME. The report identifies areas where their career trajectory or working practice may be compromised due to their ethnicity in terms of bullying and harassment, and a lack of equity where training, promotion or career opportunities should be available.

The Trust is committed to its action plan which details the governance and leadership sponsors.

Workforce Disability Equality Standard (WDES)

The WDES report captures information regarding our employees who identify as having a disability. The report identifies areas where their career trajectory or working practice may be compromised due to their disability in terms of bullying and harassment, and a lack of equity where training, promotion or career opportunities should be available.

The Trust is committed to its action plan which details the governance and leadership sponsors.

Equality Delivery Standard 2022 (EDS22)

The EDS22 report was completed and published externally by the end of February 2023. This report examined the findings of three separate domains:

- Commissioned or Provided Services
- Workforce Health and Wellbeing
- Inclusive Leadership

The Trust has scored 'Developing' as a minimum in all areas with the exception of outcome 1B - Individual patients' health needs are met. This was due to the Trust failing to introduce the accessible information standard.

Gender Pay-Gap report

The gender pay gap report was published in 2022 and highlights the gaps in pay between men and women. The gap identified was for those medical staff who claim Clinical Excellence Awards which found that women were less likely than their male peers to either achieve the award or to receive equitable monetary value.

Performance Report----------

Ethnicity Pay-Gap report

The ethnicity pay gap report was published in 2022 and is provided as a matter of good practice. It highlights the gaps in pay between staff who identify as Black, Asian, Minority or other Ethnic Group (BAME). The gap identified was for those medical staff who claim Clinical Excellence Awards which found that those employees who identify as BAME were less likely than their White peers to either achieve the award or to receive equitable monetary value.

Rainbow Badge Accreditation

The second iteration of the NHS rainbow badge is facilitated by Stonewall and LGBT Foundation. The revision to this initiative is to enable NHS Trusts to demonstrate how they are inclusive to the LGBT+ community by presenting evidence in the form of policies, procedures, emails and photographs to them in order to score sufficient points to achieve their award. HDFT is currently undergoing their review and will be making their submission in April 2023.

Freedom to Speak Up Guardian

The Freedom to Speak Up Guardian (FtSu) is a conduit for employees to whistle-blow bad practices, abuse or harassment as an alternative route to raising these matters with Human Resources or their line manager. By having this person in the role, they can support the employee, signpost and offer advice to enable them to resolve these issues.

Belonging Sub-Group

The Belonging Sub-Group is where all of the above reports and initiatives converge for discussion and ratification prior to them being escalated to other groups which oversee the governance of the directorate.

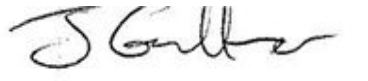
Health Inequalities

Differential waiting times are analysed and reported to board on a bimonthly basis specifically examining ethnicity, deprivation and learning disability status. Currently there is no inequality in waiting times by ethnicity or learning disability but there is a difference in waiting times between those in the highest deprivation quintile compared to middle and lowest- further analysis is being carried out to understand this discrepancy.

The established learning difficulty lead nurse has had a positive impact on waiting times and outcomes for this group of patients.

Approval by the Directors of the Performance Report

This Performance Report has been approved by the Board of Directors of Harrogate and District NHS Foundation Trust.



Jonathan Coulter
Chief Executive Officer
Harrogate and District NHS Foundation Trust
8 September 2023

SECTION TWO

Accountabilty

Section 2 - Accountability Report

The commitment and achievements of our colleagues in HDFT is key to the success of our organisation.

There are over 5,000 colleague working across our acute, community and children and young people services in a variety of different roles. Each of them is vital to the care, safety and quality of the services we deliver.

HDFT is governed by a Trust Board comprising of both Executive Directors, appointed to specific roles in the organisation and Non-executive and Associate Non-executive Directors who offer external expertise and perspective.

2.1 Members of the Trust Board

The Directors of the Trust during the year 2022-23 were:

Non-executive Directors

Sarah Armstrong	Chair
Jeremy Cross	Non-executive Director
Chiara De Biase	Non-executive Director (commenced 3 October 2022)
Andrew Papworth	Non-executive Director and Vice Chair
Laura Robson	Non-executive Director and Senior Independent Director
Wallace Sampson OBE	Non-executive Director
Richard Stiff	Non-executive Director
Maureen Taylor	Non-executive Director (Left post 30 September 2022)
Julia Weldon	Non-executive Director (commenced 7 November 2022)

Associate Non-executive Directors

Azlina Bulmer	Associate Non-executive Director (commenced 10 October 2022)
Kama Melly	Associate Non-executive Director (commenced 3 October 2022)

Executive Directors

Jonathan Coulter	Chief Executive Officer
Jacqueline Andrews	Executive Medical Director
Matthew Graham	Director of Strategy and Transformation
Jordan McKie	Acting Director of Finance
Russell Nightingale	Chief Operating Officer
Emma Nunez	Director of Nursing, Midwifery and Allied Health Professionals (AHPs) and Acting Deputy Chief Executive
Angela Wilkinson	Director of People and Culture

2.2 Company Directorships held by Directors or Governors

There are no company directorships or other significant interests held by Directors or Governors that are considered to conflict with their responsibilities.

Accountability

During the year, Matthew Graham, Director of Strategy and Transformation and Richard Stiff, Non-executive Director were appointed by the Trust as Stakeholder Non-executive Directors of the wholly-owned subsidiary, Harrogate Healthcare Facilities Management Limited (t/a Harrogate Integrated Facilities (HIF)). This was declared at the start of all meetings in which they attended, in both the Trust and HIF.

As part of the Joint Venture Pathology arrangements of which the Trust is a member, Russell Nightingale, Chief Operating Officer and Angela Wilkinson, Director of People and Culture hold Board roles for Integrated Pathology Services (IPS) and Integrated Laboratory Services (ILS).

The Register of Interests for all members of the Board of Directors and the Council of Governors are held within the Trust and are continually updated as required. The Board of Directors' register is received at every Public and Private Trust Board meeting. The Council of Governors' register is received at each Council of Governors meeting. Both registers are available through public papers, pages on the Trust website and on request through the Company Secretary's Office.

2.3 Accounting Policies

The Trust prepares its financial statements under direction from NHS England (NHSE), in accordance with the Government Financial Reporting Manual 2022/23, which is agreed with HM Treasury. The accounting policies follow International Financial Reporting Standards (IFRS) to the extent they are meaningful and appropriate to NHS Foundation Trusts.

2.4 Charitable and Political Donations

During 2022/23 no charitable or political donations were made by the Trust.

2.5 Better Payment Code of Practice

The Better Payment Code of Practice requires the Trust to aim to pay all valid non-NHS invoices within 30 days of receipt, or the due date, whichever is the later. The information below provides an update on the Trust's compliance to this:

Year to 31 March 2022			Numbers	Year to 31 March 2023		
NHS	Non NHS	Total		NHS	Non NHS	Total
2,585	40,508	43,093	No of invoices Paid to Date	2,471	42,899	45,370
1,928	38,613	40,541	No of invoices Paid in 30 Days	1,678	40,591	42,269
74.6%	95.3%	94.1%	% of invoices Paid in 30 Days	67.9%	94.6%	93.2%
Year to 31 March 2022			Values	Year to 31 March 2023		
NHS	Non NHS	Total		NHS	Non NHS	Total
23,733	68,209	91,942	£K Value of invoices Paid to Date	33,437	74,993	108,430
21,121	62,760	83,881	£K Value of invoices Paid in 30 Days	28,550	69,777	98,327
89.0%	92.0%	91.2%	% of invoices Paid in 30 Days	85.4%	93.1%	90.7%

Accountability

2.6 NHS Improvement Well Led Framework

The Trust has arrangements in place to ensure that services are well-led in accordance with the Care Quality Commission (CQC) and the NHS England requirements. Further details of these are included within this Annual Report and Accounts as part of the Annual Governance Statement (AGS).

2.7 Statement as to Disclosure to Auditors and Accounts Prepared under Direction from NHS England

So far as the Directors are aware, there is no relevant audit information of which the External Auditors are unaware, and the Directors have taken all of the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the Auditors are aware of that information. The Trust's accounts have been prepared under the direction of NHS England, in exercising the statutory functions conferred in accordance with the Department of Health and Social Care Group Accounting Manual 2022-23.

2.8 Income Disclosure required by Section 43 (2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012)

Section 43 (2A) of the NHS 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater that the Trust's income from the provision of goods and services for any other purposes. The Trust confirms that it has met this requirement during 2022-23.

2.9 NHS Oversight Framework

The overall purpose of and approach to NHS Oversight was consulted on prior to publication of the 2021-22 System Oversight Framework. This refreshed framework aligns with these key principles. The purpose of the NHS Oversight Framework is to:

a. ensure the alignment of priorities across the NHS and with wider system partners.
b. identify where Integrated Care Boards (ICBs) and/or NHS providers may benefit from, or require, support.
c. provide an objective basis for decisions about when and how NHS England will intervene.

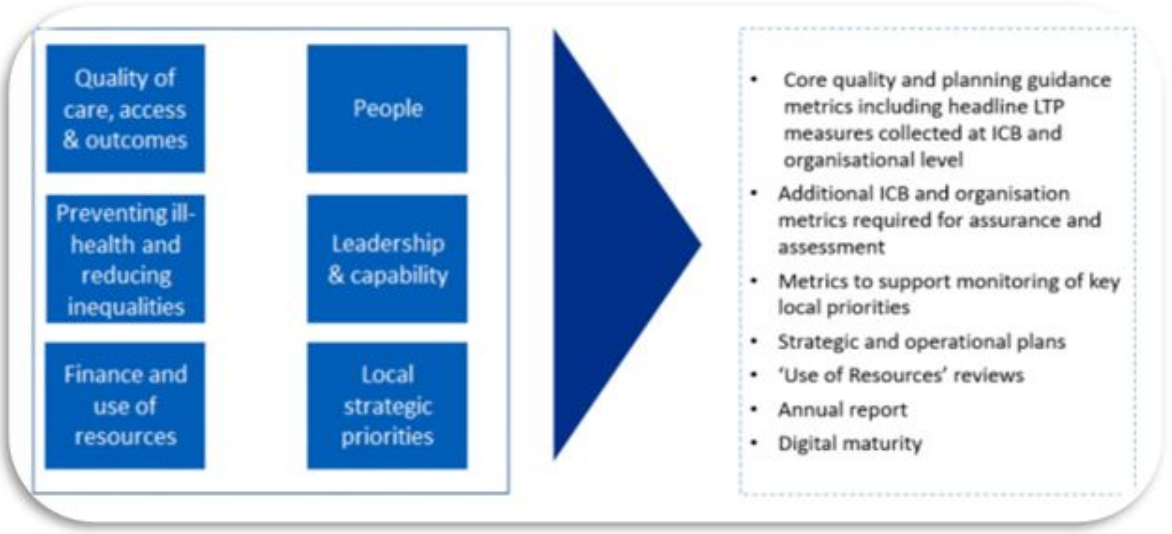
The approach to oversight is characterised by the following key principles:

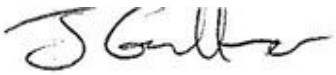
a. working with and through ICBs, wherever possible, to tackle problems.
b. a greater emphasis on system performance and quality of care outcomes, alongside the contributions of individual healthcare providers and commissioners to system goals.
c. matching accountability for results with improvement support, as appropriate.
d. autonomy for ICBs and NHS providers as a default position.
e. compassionate leadership behaviours that underpin all oversight interactions informed by Our Leadership Way (an agreed set of behaviours describing what good leadership should look and feel like), the National Quality Board's (NQB's) Our shared ambition for compassionate, inclusive leadership and the NHS board level competency frameworks.

To achieve this, the NHS Oversight Framework is built around:

a. Five national themes that reflect the ambitions of the NHS Long Term Plan and apply across trusts and ICBs: quality of care, access and outcomes; preventing ill-health and reducing inequalities; people; finance and use of resources; and leadership and capability.

b. A set of high-level oversight metrics, at ICB and trust level, aligned to these themes.





Jonathan Coulter
Chief Executive Officer
Harrogate and District NHS Foundation Trust
8 September 2023

SECTION THREE

Patients, Service Users and Stakeholders

Section 3 – Patients, Service Users and Stakeholders

3. Patient Care Activities

3.1 Complaints Handling

The Trust's aim is to 'get it right first time, every time'. The Trust recognises that listening to feedback from patients and carers can continuously improve services, ensure the patient voice is placed at the centre of care and can actively influence service development, and enhance the public perception of the Trust.

The Trust promotes pro-active, on the spot resolution of problems at a local level, thus reducing the need for patients/carers to raise issues in a more formal way. It is recognised that lessons must be captured from this type of feedback locally to promote sharing of learning and good practice. Quality of Care Teams, which are department-based teams of frontline staff, are encouraged to facilitate the resolution of issues in their own areas and promote learning.

Following a review of our Making Experiences Count Policy, a separate Complaints Policy has been developed and shared for Trust-wide use. Alongside this, a procedure to manage Unreasonable Behaviour has also been developed, to support staff and services when handling habitual or challenging complainants.

In order to publicise the service, leaflets and posters are available in all departments across the Trust and in community locations. Patient Experience Volunteers (PEV), based at the front of Harrogate hospital in the Main Reception during normal working hours, support the team in capturing feedback and signpost any concerns or queries to the team.

The Patient Experience Team (PET) has undergone significant reorganisation during the latter part of 2022. In post now are two Patient Experience Officers, a Patient Experience Co-ordinator, a Patient Engagement Officer and a Patient Experience Manager. The team continue to settle in to their new roles, with a number of developments and projects planned and underway for 2023-24

The Patient Experience Officers act as the first point of contact for patient and carer feedback, and aim to triage all new feedback within three working days of receipt.

For cases agreed as a formal complaint in partnership with the patient/carer/relative, appropriate consent is first obtained and a Triage and Resolution plan is agreed with the patient/complainant. An independent Lead Investigator is appointed by the relevant Directorate and a formal written acknowledgement is sent from the Chief Executive.

Patients, Service Users and Stakeholders----------

Local resolution may, for example, be achieved by means of a written investigation, a meeting with staff or a telephone call. The resolution plan is agreed between the complainant and Trust from the outset and must be proportionate to the issue raised.

Where there are serious risk management implications, the Patient Experience Team will refer to the Deputy Head of Quality and Safety, to ensure appropriate action is taken in relation to any ongoing patient care or incident investigation.

If the complainant is not satisfied by the outcome, the complainant is entitled to request a further investigation by the Health Service Ombudsman. This request must be made within 12 months of the initial concern, unless there are extenuating circumstances.

If the person is not a patient, but is raising issues on behalf of a patient, the PET requests that the patient has given consent to the complainant to bring the complaint on their behalf via a Form of Authority (consent form) or an alternative form of consent such as evidence of Power of Attorney. In exceptional cases, the Patient Experience Team will determine what investigation can proceed without consent and what information can be disclosed.

There is no time limit for giving feedback to the Trust for those issues which fall outside the Complaints Regulations. All feedback will be received and acted upon wherever possible to ensure learning and improvement for the organisation. Where the issue is coded as a complaint, the regulations set a time limit of 12 months from the event or awareness of the event, for making the complaint. The Trust, however, adopts a flexible attitude to complaints about incidents occurring outside this timescale.

Action plans are considered by the Directorates for each complaint which is raised and are required for all issues that have been upheld following investigation and quality assurance by the Directorate. Complaint trends and action plans, including those developed in response to Health Service Ombudsman reviews are reported to the Quality Summit and the Quality Governance Management Group on a regular basis and in turn to the Board of Directors.

3.2 Patient and Public Involvement

Patient and public involvement remains a vital part of our Trust's vision. As part of our revised quality governance structures, we have established the Making Experiences Count (MEC) Forum which will direct and oversee all our patient engagement activity. The MEC Forum reports into the Quality Governance Management Group which has management responsibility for all aspects of quality (safety, effectiveness and patient experience). Each Directorate has developed a detailed action plan to improve patient experience for the gaps identified against the Patient Experience Improvement Framework.

Examples of the Trust's patient and public engagement in 2022-23 include:

- We have continued to develop good relationships with Healthwatch North Yorkshire and other Healthwatch organisations across the North East in the areas where we deliver 0-19

Children's Public Health Services. On behalf of all Healthwatch organisations, Healthwatch North Yorkshire is a member of the MEC Forum, attends monthly meetings and shares regular issues logs with the forum.

- Our Maternity Voices Partnership has continued to expand. It is closely embedded into the governance of our maternity services and its chair works closely with our maternity leadership team.
- Specialist Children's Services (SCS) identified a gap in making sure children and young people with complex communication needs are able to give feedback about their experience of care at HDFT. With commissioning support from the ICB, Specialist Children's Services co-produced three feedback tools, working with children and young people, parents, carers, staff and teachers to develop and evaluate each feedback method.
- Picture menus were developed on elderly care wards for patients with dementia and cognitive impairments to support patient choice at meal times
- New Friends and Family Test collection methods have been introduced to allow patients, carers, children and young people to give feedback in a variety of ways. New paper feedback forms designed using the Trust KITE theme and an easy-read format are available to patients across Harrogate District Hospital (HDH) departments. A children and young people's version was designed with support from the Specialist Children's Services, and an online survey is now available in both easy read and standard formats. This can be accessed via the Trust's website and via posters in HDH wards and departments displaying QR Codes that link to the online FFT survey. So far, over 400 pieces of FFT feedback have been uploaded since initial rollout in February 2023.

More information on patient engagement can be found in the Trust's Quality Account.

3.3 Stakeholder Relations

The Trust does not operate in isolation. We are part of a large and complex health and care system and we will only be successful if we work in collaboration and partnership. Our strategy must align with and support delivery of the national and system strategies, and complement those of our partners.

Due to the wide variety and geographical spread of our services, the Trust works with partners across three Integrated Care Systems:

- **Humber and North Yorkshire Integrated Care System (HNY ICS)** (formerly Humber Coast and Vale Integrated Care System)

  Due to the location of our acute and adult community services in North Yorkshire, HDFT is formally a member of the HNY ICS. With the establishment of Integrated Care Boards as statutory bodies in July 2021, this relationship will become increasingly important because the vast majority of our funding, including capital funding, for our NHS services will flow through the HNY ICB. HDFT has played a leading role in the HNY ICS with, for example, our Chief Executive leading the Workforce Programme, our Medical Director taking an active role in research and innovation and our Director of Strategy and Transformation leading on Community Diagnostics.

  As an acute and community services provider, the Trust is a member of the HNY Collaborative of Acute Providers (CAP) and the HNY Community Collaborative. The HNY CAP also includes Yorkshire and Scarborough Teaching Hospitals NHS Foundation Trust (YSTHFT), Hull University Teaching Hospitals NHS Trust and North Lincolnshire and Goole NHS Foundation Trust. HNY CAP leads on elective care, diagnostics, cancer and

urgent and emergency care for HNY ICS. The Trust is playing an active role in developing the mission, priorities and governance of the CAP.

HNY ICS is made up of six places based on local authority areas. HDFT is part of North Yorkshire Place alongside North Yorkshire Council, Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), Yorkshire Ambulance Service NHS Trust, primary care, the voluntary, community and social enterprise sector and other partners. North Yorkshire Place has identified four key priorities, which are reflected in the Trust's Strategy and objectives:

- A comprehensive and integrated health and social care model
- A high quality care sector with sufficient capacity to meet demand
- A strong workforce
- Prevention and public health: adding life to years and years to life

As the acute and community provider for Harrogate and District, HDFT has important roles as a health care provider and also as an anchor institution for our community. We are working closely with local partners to establish the Harrogate and Rural District Local Care Partnership (HARD LCP) to bring together partners across health, care and beyond to improve the health and wellbeing of the Harrogate and District population. This will build on our well-established partnership for older adult community and social care, the Harrogate and Rural Alliance (HARA). HARA has continued to develop its services and now provides a comprehensive range of community health services and social care services for older adults. We agreed a one year extension to the HARA Section 75 Partnership Agreement with North Yorkshire County Council with the aim of developing a more extensive and ambitious partnership agreement over the next year.

- **West Yorkshire Health and Care Partnership**

Being located only 15 miles to the north, Harrogate has always had strong links with Leeds. HDFT has close links to Leeds Teaching Hospitals NHS Trust (LTHT). Until 2019, Harrogate and District was formally part of the West Yorkshire Health and Care Partnership and HDFT was a founder member of the West Yorkshire Association of Acute Trusts (WYAAT).

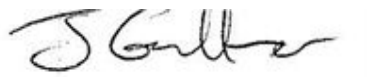
WYAAT is nationally recognised as a leading provider collaborative which brings together the six acute trusts in West Yorkshire and Harrogate: Airedale NHS Foundation Trust, Bradford Teaching Hospitals NHS Foundation Trust, Calderdale and Huddersfield NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust, and Mid Yorkshire Hospitals NHS Trust, as well as HDFT. The WYAAT trusts collaborate on a wide range of programmes and issues including diagnostic imaging, pathology, elective care, non-surgical oncology and procurement. With the majority of our patient pathways for tertiary (specialist) hospital services, such as cancer, cardiothoracic surgery and neurosurgery, going to LTHT, our nearest, and most comprehensive, provider of tertiary services, membership of WYAAT will remain strategically important to us and our patients.

Our links to West Yorkshire have been further strengthened since 1 October 2022 because HDFT has been the provider of Children and Young People's Public Health Services in Wakefield, the first such service we have provided in West Yorkshire.

Patients, Service Users and Stakeholders----------

- **North East and North Cumbria Integrated Care System**

  This ICS includes:
  - Multiple local authorities as commissioners of Children's and Young People's Public Health Services in County Durham, Darlington, Middlesbrough, Stockton-On-Tees, Sunderland, Gateshead and Northumberland.
  - Acute, mental health, primary care and voluntary sector providers in the areas where the Trust provides Children's and Young People's Public Health Services.



Jonathan Coulter
Chief Executive Officer
Harrogate and District NHS Foundation Trust
8 September 2023

SECTION FOUR

Annual Statement on Remuneration

4. Annual Statement on Remuneration – Remuneration Report

4.1 Annual Statement on Remuneration

The Trust recognises that the remuneration policy is important and to ensure that the organisation can attract and retain skilled and experienced leaders. At the same time it is important to recognise the broader economic environment and the need to ensure that we deliver value for money.

The Board of Directors has established a Remuneration Committee with responsibilities which include the consideration of matters in relation to the remuneration and associated terms of service for Executive Directors, including the Chief Executive. The report outlines the approach adopted by the Remuneration Committee when setting the remuneration of the Executive Directors who have authority or responsibility for directing or controlling the major activities of the organisation.

The following posts have been designated as fitting the criteria by the Committee and are collectively referred to as the Executives within this report:

- Chief Executive
- Deputy Chief Executive (not a stand-alone post)
- Director of Finance
- Executive Medical Director
- Director of Nursing, Midwifery and AHPs
- Chief Operating Officer
- Director of Strategy and Transformation
- Director of People and Culture

The Committee is chaired by the Trust Chair and all of the Non-executive Directors are members of the Committee. The Chief Executive, Director of People and Culture and the Associate Director of Quality and Corporate Affairs (Company Secretary) support the workings of the Committee by providing discussions about the Board composition, succession planning, remuneration and performance of the Executive Directors. The Chief Executive and the Director of People and Culture are not present when discussions take place in relation to their own performance, remuneration or terms of service.

4.2 Remuneration Committee

The Remuneration Committee for Executive Directors meets as and when required. In 2022-23 the Committee met three times as per the table below:

Attendance at Remuneration Committee Meetings 2022-23

Board Member	Number of business meetings attended	10 August 2022	11 November 2022	16 February 2023
Sarah Armstrong	3/3	✓*	✓*	✓*
Jeremy Cross	2/3	-	✓	✓
Chiara De Biase	1/2		-	✓
Andrew Papworth	1/3	-	✓	-
Laura Robson	2/3	-	✓	✓

Remuneration----------

Wallace Sampson OBE	1/3	✓	-	-
Richard Stiff	2/3	✓	✓	-
Maureen Taylor	1/1	✓		
Julia Weldon	0/1			-

* indicates Chair of the meeting
- indicates apologies at the meeting

The Committee undertakes periodic reviews of the salary levels of the Executive Directors including the Chief Executive whilst taking into account the overall performance of the Trust as well as individual performance of directors and published benchmarking information.

The Remuneration Committee is a Committee of the Board of Directors and the key outcomes of this Committee are shared with the full Board of Directors.

The Trust's Remuneration Committee has an agreed Terms of Reference, which includes specific aims and objectives. The role of the Remuneration Committee is to make such recommendations to the Board of Directors on remuneration, allowances and terms of service to ensure that Directors are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance to the provision of any national agreements or regulatory requirements where appropriate.

The Committee monitors and evaluates performance and development of the Chief Executive and all Executive Directors and advises on and oversees appropriate contractual arrangements. This includes the proper calculation and scrutiny of termination payments, as appropriate in the light of available guidance, all aspects of salary (including any performance related element) and the provision of other benefits, including pensions.

The Committee follows the Trust diversity and inclusion Policy that links to the revised Trust Strategy. Further details of the work ongoing in relation to equality and diversity and included in the People section of this report.

4.3 Remuneration Policy ----------

The Trust's remuneration policy applies equally to Non-executive Director and Executive Director posts and is based upon open, transparent and proportionate pay decisions. All pay decisions are based on market intelligence and are designed to be capable of responding flexibly to recruitment imperatives to secure high calibre people.

When setting levels of remuneration, the Remuneration Committee takes into account the remuneration policies and practices applicable to other employees, along with any guidance received from the sector regulator and NHS England. The Committee also receives professional independent reports based on objective evidence of pay benchmarking across a range of industry comparators. The conclusions reached in professional independent reports is that "weightings accredited to the various posts in relation to market comparisons had resulted in remuneration that is in line with current pay practices".

The Trust has well-established performance management arrangements. Every year the Chief Executive undertakes an appraisal for each of the Executive Directors. The Chief Executive is appraised by the Chair of the Trust.

The Trust does not have a system of performance related pay and therefore any discussion on remuneration on an individual's performance is considered alongside the performance of the Executive Directors and the organisation as a whole.

Remuneration----------

The Executive Directors are employed on permanent contracts with up to six months' notice period. In any event {where a contract is terminated without the Executive Director receiving full notice, compensation would be limited to the payment of the salary for the contractual notice period. There would be no provision for any additional benefit over and above standard pension arrangements in the event of early retirement. Non-executive Directors are requested to provide six months' notice should they wish to resign before the end of their term of office. They are not entitled to any compensation for early termination. The Trust has no additional service contract obligations.

In accordance with NHS England guidance, the Trust will seek an opinion concerning remuneration of any director who is paid more than £150,000.

Information of the salary and pensions contributions of all Executive and Non-executive Directors are provided in the tables on the following pages. The information in these tables has been subject to audit by the external auditors, Azets Audit Services.

Remuneration----------

4.4 Annual Report on Remuneration (Senior Managers including Pension Disclosure)

Name and Title	2022/23							
	Salary	National Clinical Excellence Awards	Taxable benefits	Annual Performance Related Bonuses	Long Term Performance Related Bonuses	Total Salary and taxable benefits in year	Pension related benefits	Total
	(bands of £5,000) £'000s	(bands of £5,000) £'000s	Rounded to the nearest £100	(bands of £5,000) £'000s	(bands of £5,000) £'000s	(bands of £5,000) £'000s	(bands of £2,500) £'000s	(bands of £5,000) £'000s
Mr. S Russell - Chief Executive (2)	-	-	-	-	-	-	-	-
Mr. J Coulter - Deputy Chief Executive & Finance Director, Acting Chief Executive (3)	180-185	-	-	-	-	180-185	135-137.5	315-320
Dr. J Andrews - Medical Director (4)	150-155	35-40	-	-	-	185-190	27.5-30	215-220
Mrs. E Nunez - Director of Nursing, Midwifery and AHPs (7)	125-130	-	-	-	-	125-130	2.5-5	125-130
Mr. R Nightingale - Chief Operating Officer (10)	120-125	-	-	-	-	120-125	30-32.5	155-160
Ms. A Wilkinson - Director of Workforce and Organisational Development	110-115	-	-	-	-	110-115	65-67.5	175-180
Mr. M Graham - Director of Strategy (12)	115-120	-	-	-	-	115-120	30-32.5	145-150
Mr. J McKie - Acting Director of Finance (13)	120-125	-	-	-	-	120-125	127.5-130	250-255
Ms. A Gillett - Subsidiary Managing Director (14)	50-55	-	-	-	-	50-55	-22.5- -25	25-30
Ms. S Armstrong - Chair (5)	45-50	-	-	-	-	45-50	-	45-50
Mr. M Chamberlain - Subsidiary Chairman (11)	10-15	-	-	-	-	10-15	-	10-15
Mr. R Stiff - Non-Executive Director / Audit Committee Chair	15-20	-	-	-	-	15-20	-	15-20
Mrs. L Hind - Subsidiary Non-Executive Director	0-5	-	-	-	-	0-5	-	0-5
Mr. R Taylor - Subsidiary Non-Executive Director	0-5	-	-	-	-	0-5	-	0-5
Mr. G Barrett - Subsidiary Non-Executive Director (8)	0-5	-	-	-	-	0-5	-	0-5
Ms. L Robson - Non-Executive Director	15-20	-	-	-	-	15-20	-	15-20
Mr. J Cross - Non-Executive Director	15-20	-	-	-	-	15-20	-	15-20
Mr. W Sampson - Non-Executive Director	10-15	-	-	-	-	10-15	-	10-15
Miss. C De Biase - Non-Executive Director (9)	5-10	-	-	-	-	5-10	-	5-10
Mrs. J Weldon - Non-Executive Director (15)	0-5	-	-	-	-	0-5	-	0-5
Mr. A Papworth - Non-Executive Director	15-20	-	-	-	-	15-20	-	15-20

Remuneration----------

Name and Title	2021/22							
	Salary	National Clinical Excellence Awards	Taxable benefits	Annual Performance Related Bonuses	Long Term Performance Related Bonuses	Total Salary and taxable benefits in year	Pension related benefits	Total
	(bands of £5,000) £'000s	(bands of £5,000) £'000s	Rounded to the nearest £100	(bands of £5,000) £'000s	(bands of £5,000) £'000s	(bands of £5,000) £'000s	(bands of £2,500) £'000s	(bands of £5,000) £'000s
Mr. S Russell - Chief Executive (2)	170-175	-	-	-	-	170-175	-	170-175
Mr. J Coulter - Deputy Chief Executive & Finance Director, Acting Chief Executive (3)	160-165	-	-	-	-	160-165	60-62.5	225-230
Dr. J Andrews - Medical Director (4)	155-160	35-40	-	-	-	190-195	82.5-85	270-275
Mrs. E Nunez - Director of Nursing, Midwifery and AHPs (7)	45-50	-	-	-	-	45-50	57.5-60	105-110
Mr. R Nightingale - Chief Operating Officer (10)	120-125	-	-	-	-	120-125	7.5-10	125-130
Ms. A Wilkinson - Director of Workforce and Organisational Development	100-105	-	-	-	-	100-105	32.5-35	135-140
Mr. M Graham - Director of Strategy (12)	60-65	-	-	-	-	60-65	32.5-35	95-100
Mr. J McKie - Acting Director of Finance (13)	5-10	-	-	-	-	5-10	-	5-10
Ms. A Gillett - Subsidiary Managing Director (14)	85-90	-	-	-	-	85-90	125-127.5	210-215
Mrs. A Schofield - Chairman	45-50	-	-	-	-	45-50	-	45-50
Mr. M Chamberlain - Subsidiary Chairman (11)	10-15	-	-	-	-	10-15	-	10-15
Mr. R Stiff - Non-Executive Director / Audit Committee Chair	15-20	-	-	-	-	15-20	-	15-20
Mrs. L Hind - Subsidiary Non-Executive Director	0-5	-	-	-	-	0-5	-	0-5
Mr. R Taylor - Subsidiary Non-Executive Director	0-5	-	-	-	-	0-5	-	0-5
Ms. S Armstrong - Non-Executive Director	15-20	-	-	-	-	15-20	-	15-20
Mrs. M Taylor - Non-Executive Director (6)	15-20	-	-	-	-	15-20	-	15-20
Ms. L Robson - Non-Executive Director	15-20	-	-	-	-	15-20	-	15-20
Mr. J Cross - Non-Executive Director	15-20	-	-	-	-	15-20	-	15-20
Mr. W Sampson - Non-Executive Director	10-15	-	-	-	-	10-15	-	10-15
Mr. A Papworth - Non-Executive Director	10-15	-	-	-	-	10-15	-	10-15

Remuneration----------

(1) The median salary for all staff in 2022/23 was £37,633. The median salary for all staff in 2021/22 was £32,306. The median calculation is the annualised full time remuneration of all staff in the Trust as at 31 March 2023 (excluding agency staff), excluding the highest paid Director. The ratio is based on the total salary and benefits in year. Further details are in section 4.2.4.
(2) Mr S. Russell commenced a secondment with NHS England on 28 February 2022. His earnings have been included for the period he was Chief Executive only.
(3) Mr J. Coulter commenced as Acting Chief Executive from 28 February 2022. Mr J. Coulter subsequently became substantive Chief Executive from 11th May 2023.
(4) Dr J. Andrews commenced as Medical Director on 15 June 2020. Dr Andrews undertakes sessions as a Rheumatologist at the Trust, as well as the Medical Director role.
(5) Ms S. Armstrong commenced as Trust Chair on 1st April 2022.
(6) Mrs M. Taylor left the Trust on 30 September 2022.
(7) Mrs E. Nunez commenced as Director of Nursing, Midwifery and AHPs from 01 November 2021. Prior to this Mrs Nunez was in the role on a secondment basis. Subsequently, Mrs Nunez commenced as Acting Deputy Chief Executive from 28 February 2022. Mrs Nunez became substantive Deputy Chief Executive from 6th June 2023
(8) Mr G. Barrett commenced as Subsidiary Non Executive Director on 24 May 2022
(9) Miss C. De Biase commenced as Non Executive Director on 3 October 2023
(10) Mr R. Nightingale commenced as Chief Operating Officer on 05 April 2021.
(11) Mr M. Chamberlain commenced as Chairman of the Trust's Subsidiary on 01 July 2020.
(12) Mr M. Graham commenced as Director of Strategy from 13 September 2021.
(13) Mr J. McKie commenced as Acting Director of Finance from 28 February 2022.
(14) Ms A. Gillett commenced as Subsidiary Managing Director from 01 April 2021.
(15) Mrs J. Weldon commenced as Non Executive Director on 7 November 2023

Name and title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2023 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2023 £000	Cash Equivalent Transfer Value at 31 March 2022 £000	Real Change in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension to nearest £100
Mr Stephen Russell - Chief Executive	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£Nil
Mr. Jonathan Coulter - Deputy Chief Executive & Finance Director / Acting Chief Executive	7.5-10	10-15	70-75	145-150	1,420	1,220	137	£Nil
Dr Jacqueline Andrews - Medical Director	2.5-5	-2.5-0	55-60	105-110	1,051	969	28	£Nil
Ms Angela Wilkinson - Director of Workforce and Organisational Development	2.5-5	£Nil	50-55	£Nil	799	699	63	£Nil
Mr Russell Nightingale - Chief Operating Officer	0-2.5	£Nil	25-30	£Nil	291	255	11	£Nil
Mr Matthew Graham - Director of Strategy	0-2.5	£Nil	25-30	£Nil	392	342	23	£Nil
Mrs Emma Nunez - Director of Nursing, Midwifery and AHPs & Acting Deputy Chief Executive	0-2.5	-2.5-0	30-35	55-60	449	424	10	£Nil
Miss Angela Gillett - Subsidiary Managing Director	-2.5 - 0	-5 - -2.5	45-50	130-135	206	0	206	£Nil
Mr Jordan McKie - Acting Director of Finance	5-7.5	10-12.5	20-25	35-40	299	202	75	£Nil

4.5 Fair Pay Declaration

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component. The banded remuneration of the highest paid director in Harrogate and District NHS Foundation Trust in the financial year 2022-23 was £185-190k (2021-22, £190-195k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table

2022/23	25th Percentile	Median	75th Percentile
Total Remuneration (£)	28,058	37,633	49,975
Salary Component of total remunerations (£)	28,058	37,633	49,975
Pay Ratio information	6.77	5.05	3.80
2021/22			
Total Remuneration (£)	24,882	32,306	42,121
Salary Component of total remunerations (£)	24,882	32,306	42,121
Pay Ratio information	7.72	5.94	4.56

For context, whilst the salary for the highest earning Board Member reduced by 1%, the median salary at Harrogate and District NHS Foundation Trust increased by 16%. The change in ratio is driven by this movement, with the median salary reflecting the 2022/23 pay award and a movement in the median position.

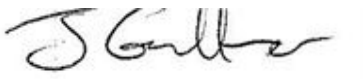
In 2022-23, 13 employees received remuneration in excess of the highest-paid director / member (1 in 2021-22). Remuneration ranged from £3k to £228k (£8k to £204k in 2021-22). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

4.6 Payments to Past Senior Managers, if relevant

As detailed in section 4.4.

4.7 Payments for Loss of Office, if relevant

There have been no payments made for loss of office.



Jonathan Coulter
Chief Executive Officer
Harrogate and District NHS Foundation Trust
8 September 2023

SECTION FIVE

People

5

People

5. Staff Report

5.1 Overview

Our aim is to deliver excellent patient care, every time by having the right number of staff, with the right skills, in the right place at the right time.

To enable this we have a People Plan which is structured under four key pillars:

- Looking After our People
- Belonging in the NHS
- New Ways of Working
- Growing for the Future

Our people management processes are designed to support employees to have a positive experience at work, making the Trust a working environment where they want to be and where they can thrive and grow professionally, and be the best they can be.

5.2 Analysis of Staff Numbers as at 31 March 2023

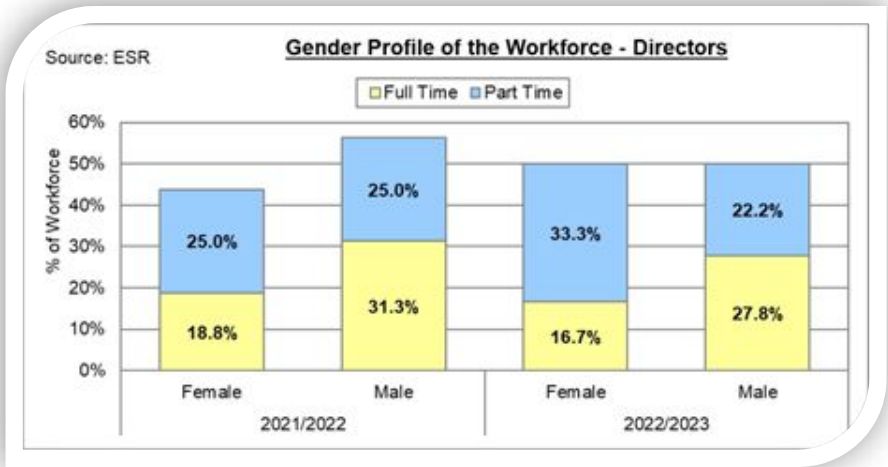
Staff Group	2021/2022		2022/2023	
	Headcount	WTE	Headcount	WTE
Administrative and Clerical	834	718.78	901	783.71
of which Senior Management	*80*	*77.47*	*91*	*89.17*
Allied Health Professionals	348	286.61	405	340.80
Estates and Ancillary	22	15.86	11	6.58
Medical and Dental	426	362.80	448	380.76
Nursing and Midwifery Registered	1,811	1,509.88	1,929	1,621.21
Scientific and Technical	182	154.34	136	116.19
Support Workers	914	743.71	989	808.18
TOTAL	**4,537**	**3,791.98**	**4,819**	**4,057.44**

*Headcount is based on the employee's primary assignment to avoid duplication of headcount.
**Senior Management relates to Administrative and Clerical staff, Band 8a and above.

5.3 Analysis of Male and Female Directors, Other Senior Managers and Employees as at 31 March 2023

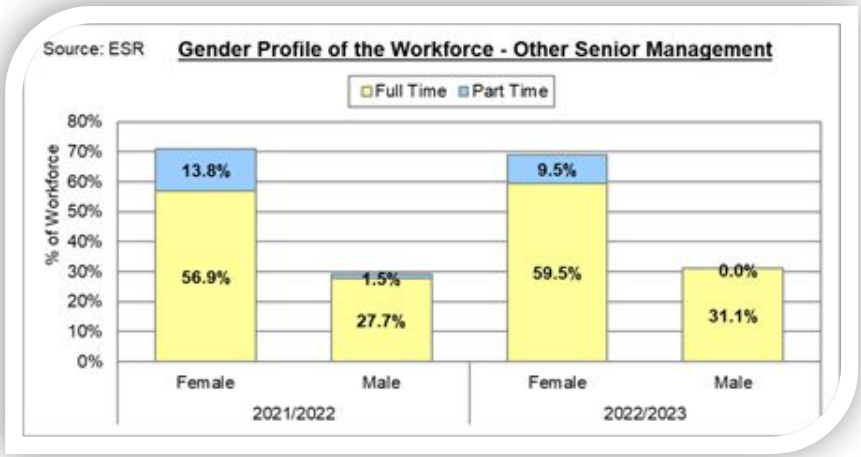
The graph and table below give a breakdown of the number of Directors, including Non-executive Directors, by gender, as at 31 March 2023.

People



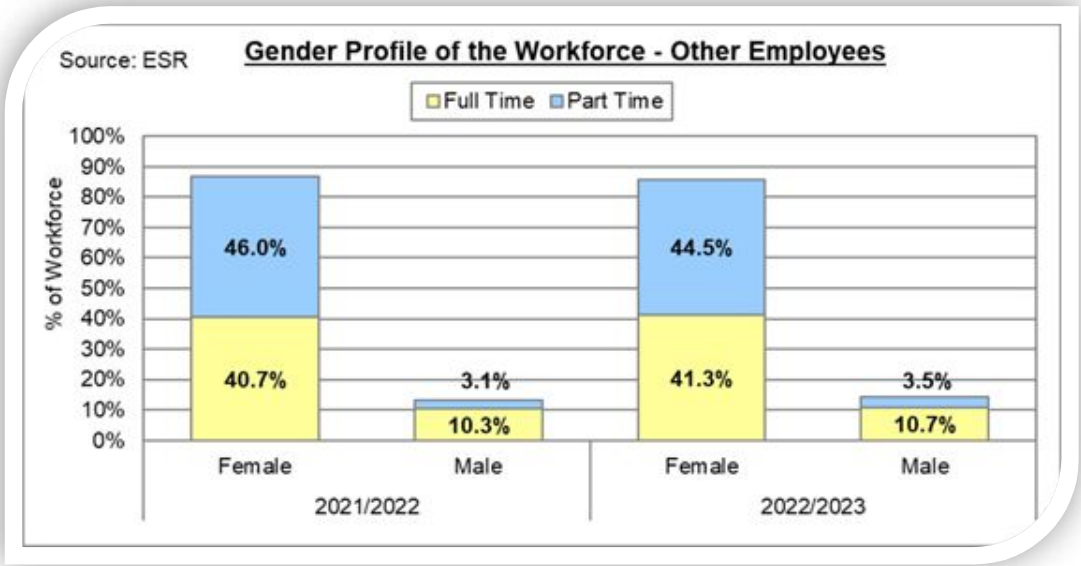
Gender	Category	2021/2022	2022/2023
DIRECTORS		**Headcount**	**Headcount**
Female	Full Time	3	3
	Part Time	4	6
Male	Full Time	5	5
	Part Time	4	4
TOTAL		**16**	**18**

The graph and table below give a breakdown of the number of other senior management, by gender, as at 31 March 2023.



Gender	Category	2021/2022	2022/2023
OTHER SENIOR MANAGEMENT		**Headcount**	**Headcount**
Female	Full Time	37	44
	Part Time	9	7
Male	Full Time	18	23
	Part Time	1	0
TOTAL		**65**	**74**

The graph and table below give a breakdown of the number of other employees, by gender, as at 31 March 2023.



Gender	Category	2021/2022	2022/2023
OTHER EMPLOYEES		**Headcount**	**Headcount**
Female	Full Time	1,814	1,950
	Part Time	2,048	2,104
Male	Full Time	457	508
	Part Time	137	165
TOTAL		**4,456**	**4,727**

5.4 Sickness Absence Data

Directorate	**22/23 Q1**	**22/23 Q2**	**22/23 Q3**	**22/23 Q4**	**Cumulative % Absence Rate**
	% Abs Rate	**% Abs Rate**	**% Abs Rate**	**% Abs Rate**	
Community and Children's	5.51%	5.44%	6.35%	6.02%	**5.85%**
Corporate Services	2.55%	3.25%	3.49%	3.81%	**3.29%**
Long Term and Unscheduled Care	4.58%	5.04%	4.57%	4.28%	**4.62%**
Planned and Surgical Care	5.05%	5.13%	5.02%	4.50%	**4.92%**
TOTAL	**4.82%**	**5.01%**	**5.27%**	**4.97%**	**5.02%**

Key
22/23 Q1 – April 2022 to June 2022
22/23 Q2 – July 2022 to September 2022
22/23 Q3– October 2022 to December 2022
22/23 Q4 – January 2023 to March 2023

People

5.5 Analysis of Disability Profile of the Workforce as at 31 March 2023

The table below gives a breakdown of the number of employees registered as having a disability as at 31 March 2023.

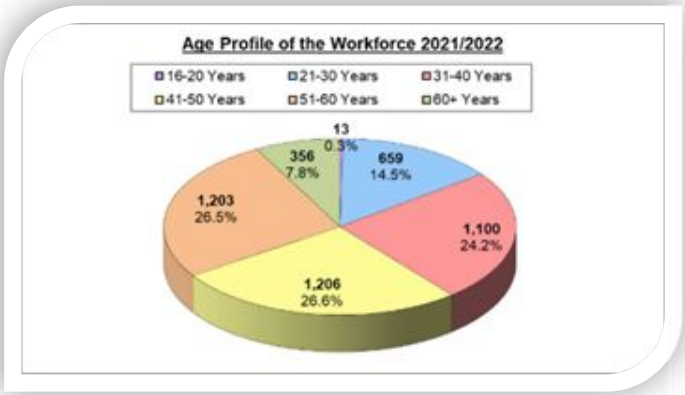
Disabled	2021/2022	2022/2023
	Headcount	**Headcount**
No	3,706	3,984
Yes	207	253
Not Declared	624	582
TOTAL	**4,537**	**4,819**

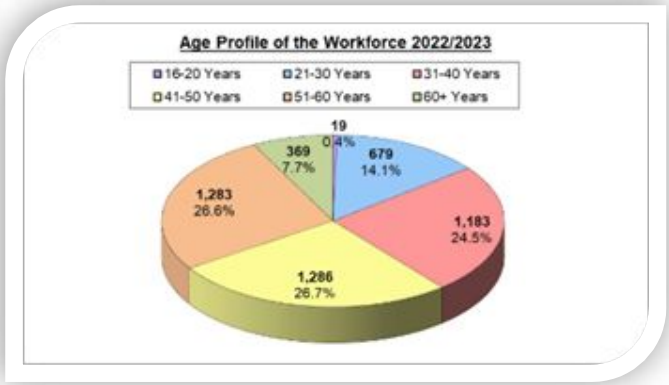
5.6 Analysis of the Age Profile of the Workforce as at 31 March 2023

The table below gives a breakdown of the number of employees, by age, as at 31 March 2023.

	2021/2022		2022/2023	
Age Band	**Headcount**	**% of Workforce**	**Headcount**	**% of Workforce**
16-20 Years	13	0.3%	19	0.4%
21-30 Years	659	14.5%	679	14.1%
31-40 Years	1,100	24.2%	1,183	24.5%
41-50 Years	1,206	26.6%	1,286	26.7%
51-60 Years	1,203	26.5%	1,283	26.6%
60+ Years	356	7.8%	369	7.7%
TOTAL	**4,537**		**4,819**	

People----------





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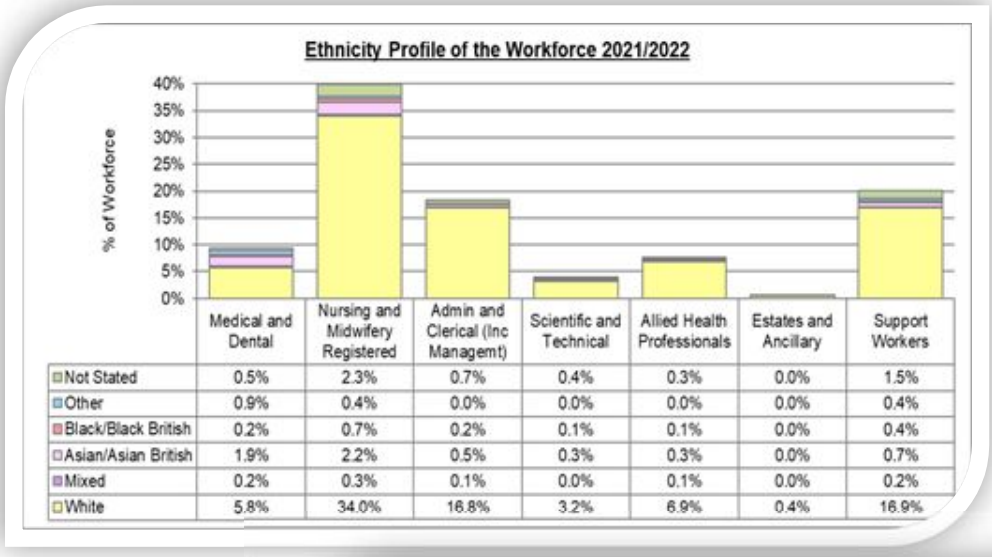
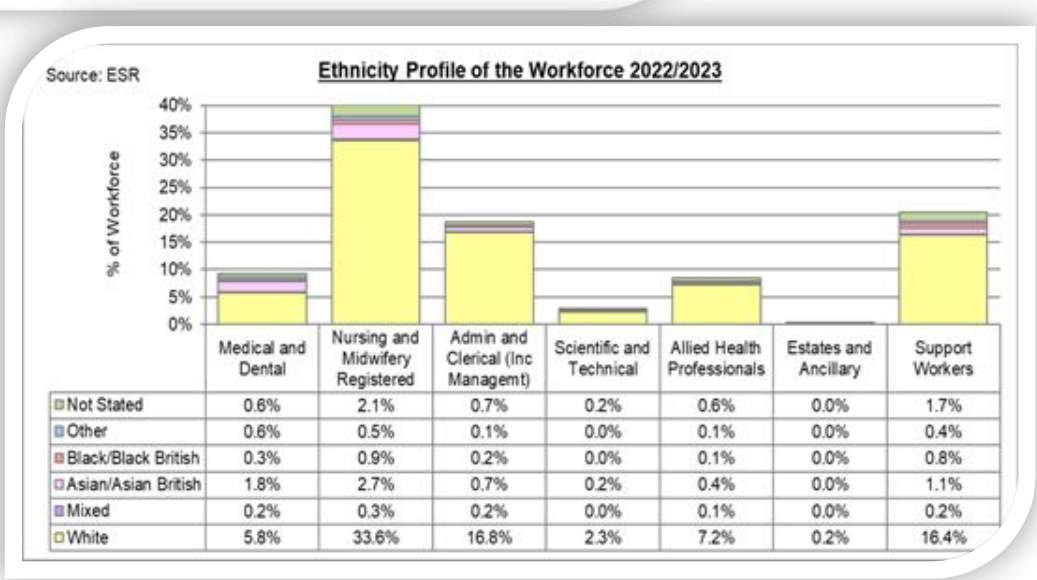
5.7 Analysis of the Ethnicity Profile of the Workforce as at 31 March 2023



	Medical and Dental	Nursing and Midwifery Registered	Admin and Clerical (Inc Managemt)	Scientific and Technical	Allied Health Professionals	Estates and Ancillary	Support Workers
Not Stated	0.5%	2.3%	0.7%	0.4%	0.3%	0.0%	1.5%
Other	0.9%	0.4%	0.0%	0.0%	0.0%	0.0%	0.4%
Black/Black British	0.2%	0.7%	0.2%	0.1%	0.1%	0.0%	0.4%
Asian/Asian British	1.9%	2.2%	0.5%	0.3%	0.3%	0.0%	0.7%
Mixed	0.2%	0.3%	0.1%	0.0%	0.1%	0.0%	0.2%
White	5.8%	34.0%	16.8%	3.2%	6.9%	0.4%	16.9%



	Medical and Dental	Nursing and Midwifery Registered	Admin and Clerical (Inc Managemt)	Scientific and Technical	Allied Health Professionals	Estates and Ancillary	Support Workers
Not Stated	0.6%	2.1%	0.7%	0.2%	0.6%	0.0%	1.7%
Other	0.6%	0.5%	0.1%	0.0%	0.1%	0.0%	0.4%
Black/Black British	0.3%	0.9%	0.2%	0.0%	0.1%	0.0%	0.8%
Asian/Asian British	1.8%	2.7%	0.7%	0.2%	0.4%	0.0%	1.1%
Mixed	0.2%	0.3%	0.2%	0.0%	0.1%	0.0%	0.2%
White	5.8%	33.6%	16.8%	2.3%	7.2%	0.2%	16.4%

People

HEADCOUNT 2021/2022	Medical and Dental	Nursing and Midwifery Registered	Admin and Clerical (incl. Management)	Scientific and Technical	Allied Health Profess-ionals	Estates and Ancillary	Support Workers	Total
White	262	1,543	764	145	312	19	765	**3,810**
Mixed	8	14	6	2	3	1	9	**43**
Asian/Asian British	85	102	24	14	12	0	33	**270**
Black/Black British	10	31	7	4	5	1	20	**78**
Other	39	17	0	1	2	0	20	**79**
Not Stated	22	104	33	16	14	1	67	**257**
TOTAL	**426**	**1,811**	**834**	**182**	**348**	**22**	**914**	**4,537**

HEADCOUNT 2022/2023	Medical and Dental	Nursing and Midwifery Registered	Admin and Clerical (incl. Management)	Scientific and Technical	Allied Health Profess-ionals	Estates and Ancillary	Support Workers	Total
White	279	1,618	809	110	348	10	789	**3,963**
Mixed	9	14	10	2	3	0	8	**46**
Asian/Asian British	88	130	33	9	18	0	51	**329**
Black/Black British	14	41	12	2	6	0	38	**113**
Other	29	26	3	2	3	0	20	**83**
Not Stated	29	100	34	11	27	1	83	**285**
TOTAL	**448**	**1,929**	**901**	**136**	**405**	**11**	**989**	**4,819**

5.8 Starters and Leavers 2022-23

	Headcount	FTE
Starters	660	574.76
Leavers	628	497.25

Exclusions applied

- Retire and Returns
- Locum Medical and Dental staff
- Bank Staff
- Doctors in training
- Fixed Term Contracts
- TUPE Transfers in/out

5.9 Trade Union Facility Time Disclosures

The Trade Union (Facility Time Publication Requirements) Regulations 2017

This is the fifth year that organisations have been required by law to publish Trade Union (TU) facility time information. The data below is for the financial year 1 April 2022 to 31 March 2023.

Relevant union officials

	Full-time equivalent employee number
Number of employees who were relevant union officials during the reporting period	**16.15**

People

Percentage of time spent on facility time

Percentage of time	Number of Employees
0%	10
1-50%	6
51-99%	0
100%	0

Percentage of pay bill spent on facility time

Provide the total cost of facility time	16002.54
Provide the total pay bill	164101327.00
Provide the percentage of the total pay bill spend on facility time, calculated as: (total cost of facility time divided by total pay bill) x 100	0.01

Paid trade union activities

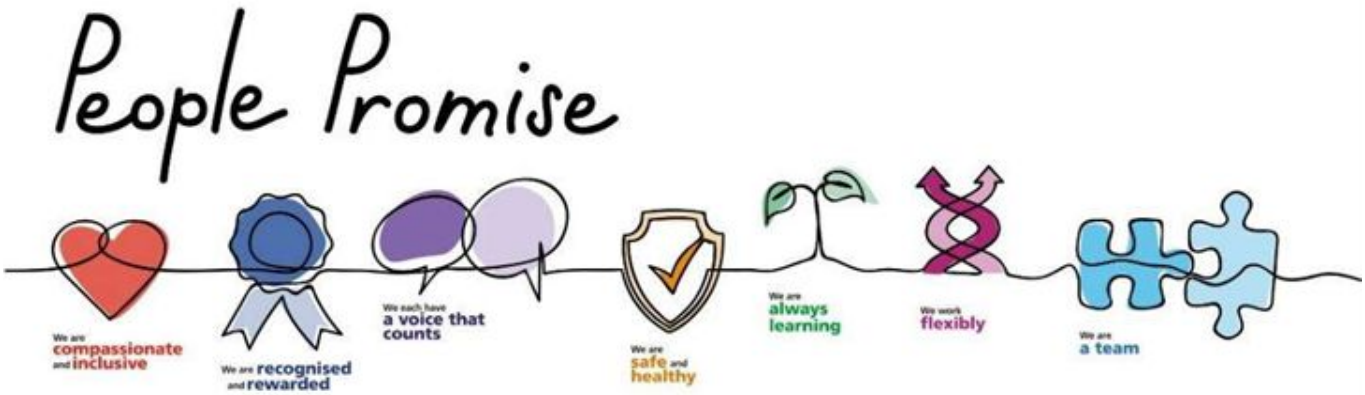
Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	111.68

5

5.10 National Staff Survey

The 2022-23 NHS Staff Survey continued with rating trusts against the seven People Promise elements. This allows us to measure, consistently and robustly, the working experience of our people across the NHS in England. Alongside the seven Promise elements we retain the two themes of Engagement and Morale. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

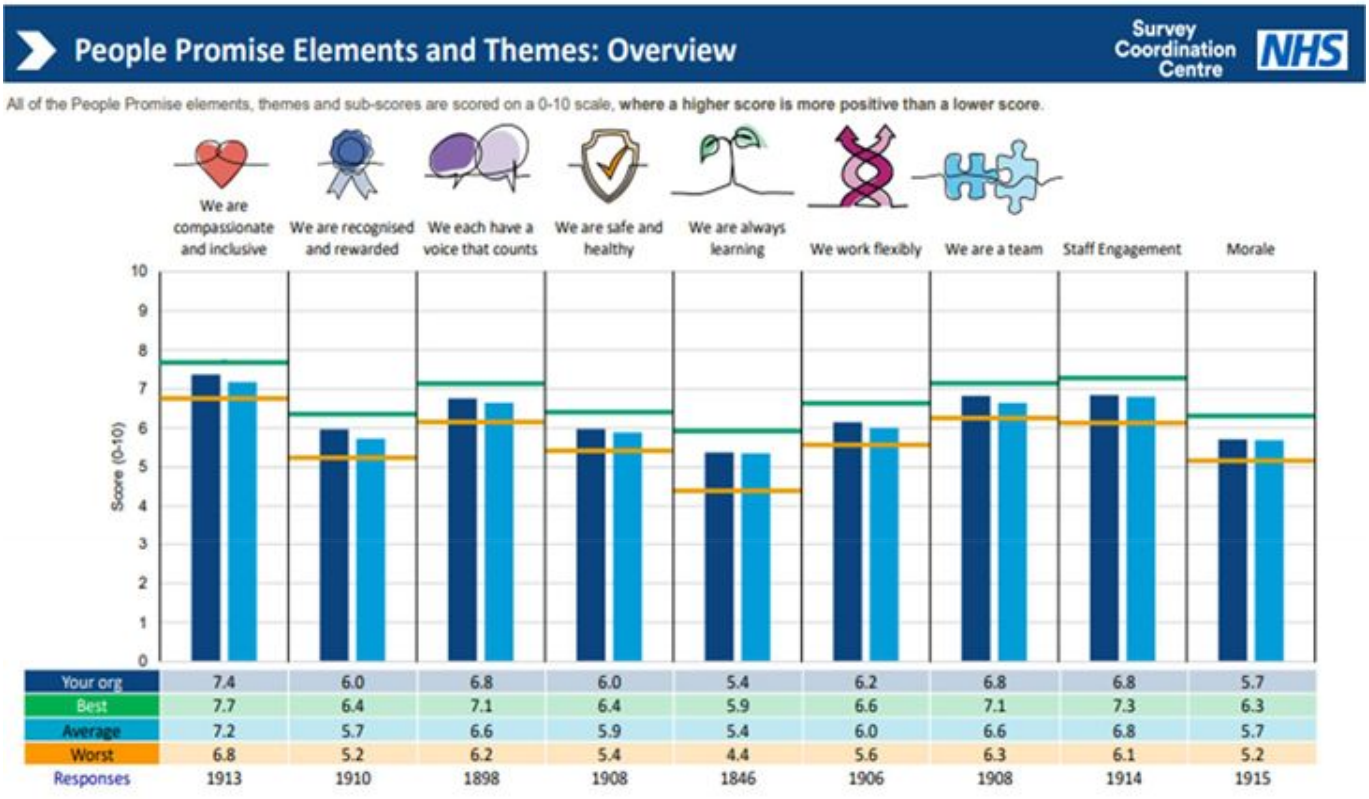
The NHS staff survey is conducted annually. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those. The response rate to the 2022-23 survey among HDFT staff was 43% compared to 39% the previous year.



People

Scores for each People Promise and Theme are presented below alongside the Trusts scores from 2021-22, and those of the survey benchmarking group (Acute and Acute & Community Trusts).

For this period the response rate increased by 4% from last year to 43%. The Trust has improved its ratings against each of the People Promises and the Themes compared to the previous year, and has either scored higher than, or equalled, the average scores of its benchmarked sector, namely Acute and Acute and Community Trusts.



Compared to the previous year's results, our scores have increased in all nine of the People Promise elements and themes.

Areas to Celebrate

- Line management results have all moved upwards and are above average – steady improvements.
- Teamworking results have all shown improvement in 2022.
- Organisational support for home life balance, flexible working and flexible shift patterns have all increased and are above the benchmarking group average.
- All questions related to learning development opportunities have shown improvement since 2021, with many reaching or exceeding the benchmarking group average.
- Appraisals have improved in terms of numbers conducted and benefits of these, but it is worth noting the numbers are still below the levels achieved in 2018 and 2019.

Areas to Focus On

- The percentage of staff who feel able to meet the conflicting demands on their time has improved slightly to 37.8% in 2022 from 35.0% in 2021. However, this is well below the benchmarking group average of 42.9% in 2022.
- The number of staff saying that they have worked additional unpaid hours is significantly higher than the average for comparable organisations (65.1% compared with the average

of 56.3%). This is also notable when viewed against the number of staff saying that they work additional paid hours. The HDFT figures are significantly lower than the comparable average (25.8% compared with the average of 40.4%).

5.11 Off-Payroll Arrangements

The Trust is required to report on its highly paid and/or senior off-payroll engagements. There are no such arrangements to report for 2022-23.

5.12 Consultancy Expenditure

The Trust is required to report on Consultancy expenditure, which in 2022-23 equated to £1,019k.

5.13 Exit Packages

The Trust is required to disclose summary information of staff exit packages which have been agreed in the year. Detail of this can be found within the annual accounts. There was one exit package payment in 2022-2023, totalling £134k.

SECTION SIX

NHS Foundation Code of Governance

6. NHS Foundation Trust Code of Governance

6.1 Overview

The Board of Directors (the Board / the Trust Board) and the Council of Governors (the Council) work closely together in the best interests of the Trust. Detailed below is a summary of the key roles and responsibilities of both the Board of Directors and the Council of Governors.

The Board meets formally with the Council, through the Council of Governors itself on a quarterly basis to seek and consider the views of the Governors in areas such as strategic aims, potential changes to service provision and public perception matters. These meetings are also used as an opportunity to update and inform the Board and the Council of areas of good practice. The Trust Chair chairs both the Board and the Council which proactively ensures a synergy between the two.

The Executive and Non-executive Directors meet regularly with Governors on a formal and informal basis during their day-to-day working through meetings, briefings, consultations, information sessions, ward and department visits. Examples include active discussions on the development of the Trust Strategy. Informal meetings are held on a regular basis (normally bi-monthly). The Chair, Chief Executive and Associate Director of Quality and Corporate Affairs (Company Secretary) attend these meetings to support the Council and to ensure the Board have an opportunity to obtain the views of the Council and their members in the planning of services for the local community.

6.2 Audit Committee

In accordance with best practice and the NHS Audit Committee Handbook, this section of the report has been prepared to provide a summary of the work of the Audit Committee during the 2022-23 financial year.

Work Performance

The Audit Committee met formally on seven occasions during 2022-23.

The Audit Committee has a membership of four Non-executive Directors and during 2022-23 this comprised of:

- Richard Stiff — Non-executive Director (Chair)
- Jeremy Cross — Non-executive Director / Chair of Resource Committee
- Laura Robson — Non-executive Director / Senior Independent Director / Chair of Quality Committee
- Maureen Taylor — Non-executive Director (until 30 September 2022)
- Chiara De Biase — Non-executive Director (from 3 October 2022)

The Committee was supported by:

- Jordan McKie — Acting Director of Finance
- Kate Southgate — Associate Director of Quality and Corporate Affairs (Company Secretary)

Code of Governance----------

As well as when required: The Deputy Director of Finance, the Head of Financial Accounts, Internal Audit (Head of Internal Audit and Internal Audit Manager), External Audit, other Executive Directors of the Trust, and Local Counter Fraud Specialists.

Audit Committee members attendance is set out in the table below.

Committee Member	Number of business meetings attended	4 May 2022	18 May 2022	31 May 2022	7 September 2022	3 October 2022	7 December 2022	1 March 2023
Richard Stiff	8/8	✓	✓	✓	✓	✓	✓	✓
Jeremy Cross	8/8	✓	✓	✓	✓	✓	✓	✓
Laura Robson	7/8	✓	-	✓	✓	✓	✓	✓
Maureen Taylor	3/4	✓	✓	✓	-			
Chiara De Biase	0/2						-	-

Audit Committee members meet in private prior to the start of each Committee meeting. Separate private sessions are held with Internal Audit and External Audit prior to the Audit Committee as required and no less than once a year. Detailed minutes and action logs of each meeting are taken and the Chair of the Committee provides a regular update report to the Board of Directors. On most occasions the meetings have also been observed by at least one member of the Council of Governors.

Governance, Risk Management and Internal Control

The Audit Committee receives the Corporate Risk Register at each of its meetings. The report provides details of the key matters discussed at the Executive Risk Review Group and details the changes in ratings, controls and mitigation in place as well as target review dates. In addition, the Audit Committee receives the minutes of the Quality Committee to further improve the visibility and assurance of clinical risks.

The Board Assurance Framework is also received on a periodic basis to provide a mechanism for reviewing and reporting strategic risks to the organisation.

The Annual Governance Statement and the Head of Internal Audit Opinion were reviewed by the Audit Committee prior to submission to the Board on 26 August 2023.

The Chief Executive (or another designated Executive Director) attends the Audit Committee annually at the year-end to discuss assurance around the Annual Governance Statement.

Clinical Assurance

The revised Quality Governance structure means that the Audit Committee receives assurance on the effectiveness of clinical processes through the meeting minutes and attendance of the Chair of Quality Committee and the Associate Director of Quality and Corporate Affairs (Company Secretary). The Audit Committee's role in this regard focuses on the delivery of the quality assurance process.

Internal Audit and Counter Fraud Service

Internal Audit and Counter Fraud Services are provided to the Trust by Audit Yorkshire. The Acting Director of Finance sits on the Audit Yorkshire Board which oversees Audit Yorkshire at a strategic level. An Internal Audit Charter formally defines the purpose, authority and responsibility of internal audit activity.

The conclusions, including levels of assurance, findings and recommendations of finalised reports are shared with the Audit Committee. The Committee can, and does, challenge Internal Audit on assurances provided, and requests additional information, clarification or follow-up work as required.

A system whereby all Internal Audit recommendations and actions are followed up by Executive Directors is overseen by the Audit Committee.

External Audit

Following a robust procurement exercise, led by Governors, the Trust appointed a new External Audit partner in 2021-22, Azets Audit Services. They remained the Trust external auditors in 2022-2023.

6.3 The Board of Directors and Council of Governors

The Board of Directors is a unitary Board with collective responsibility for all areas of performance of the Trust such as clinical and operational performance, financial performance, governance and management. The Board is legally accountable for the services it provides at the Trust and operates to the highest of corporate governance standards. It has the option to delegate these powers to senior management and other Committees. Its role is to provide active leadership within a framework of prudent and effective controls which enable risk to be assessed and managed. The Board is responsible for the allocation of resources to support the achievement of organisational objectives, ensure clinical services are safe of a high quality, patient focused and effective.

The Board met in public on a bi-monthly basis during 2022-23 and in closed workshops on the intervening months.

The Board ensures high standards of clinical and corporate governance and, along with the Council of Governors, engages members, partners and stakeholders to ensure effective dialogue with the communities it serves.

The Board is accountable to stakeholders for the achievement of sustainable performance and the creation of stakeholder value through the development and delivery of the Trust's vision and strategy. The Board ensures that adequate systems and processes are maintained to deliver the Trust's Annual Plan, provide safe, high quality healthcare as well as seek continuous improvement and innovation.

The Board delegates some of its powers to Board Sub-Committees and Executive Directors, and these matters are set out in our Scheme of Delegation which is available from the office of the Company Secretary on request.

6.4 Balance, Completeness and Appropriateness of the Board of Directors

The balance, completeness and appropriateness of the Board are reviewed as required and the Trust is confident that it has a balance and appropriately skilled Board to enable it to discharge its duties effectively. This applies to Executive Directors, Non-executive Directors and Associate Non-executive Directors.

Decision making and operational management of the Trust is led by the Executive Directors reporting to the Chief Executive as Accountable Officer. The Standing Orders of the Board

detail the decisions reserved for Board and are available on request from the office of the Associate Director of Quality and Corporate Affairs (Company Secretary).

All of the Non-executive Directors and Associate Non-executive Directors of the Trust are deemed to be independent. The information below describes the skills, expertise and experiences of each Board member and demonstrates the independence of the Non-executive Directors.

Code of Governance----------

6.5 Executive Directors

Jonathan Coulter, Chief Executive (Appointed 28 February 2022, previously appointed as Director of Finance 20 March 2006)

Jonathan is a member of the Chartered Institute of Public Finance and Accountancy (CIPFA) having qualified as an accountant in 1993. Since qualifying, he has taken on a number of roles in the NHS, working in various hospital trusts and commissioning organisations across Yorkshire, including being the Director of Finance for North Bradford PCT. During this time, Jonathan also obtained a postgraduate qualification in Health and Social Care Management. Jonathan was appointed as Finance Director at the Trust in March 2006. Since arriving at Harrogate, Jonathan has contributed significantly to the success of the organisation, both within his role as Finance Director, and Deputy Chief Executive. Jonathan took on the role of Chief Executive at the end of February 2022 on an interim basis, and was appointed permanently in May 2023.

Emma Nunez, Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs) and Deputy Chief Executive (Appointed 1 November 2021 as Director of Nursing and 28 February 2022 as Deputy Chief Executive)

Emma joined the Trust from NHS England and NHS Improvement where she was Clinical Quality Director and Director of Nursing in the North East and Yorkshire Region. Emma is passionate about nursing and midwifery and about promoting the profession through demonstration of professional standards, values and behaviours. She focuses on improvements in patient safety and quality by aligning best practice with innovation and improving cultures through behaviours. She is a strong advocate for patients, carers and families and drives improved patient outcomes through compassionate leadership, staff wellbeing and professional standards. Emma took on the role of Acting Deputy Chief Executive at the end of February 2022.

Dr Jacqueline Andrews, Medical Director (Appointed 15 June 2020)

Jacqueline joined HDFT in June 2020, having been Associate Medical Director, Director for Research and Innovation and a Consultant Rheumatologist at Leeds Teaching Hospitals since 2008.

She oversees a broad executive portfolio which includes Clinical Strategy, Professional Standards, Clinical Effectiveness, Clinical Safety, Compliance, Research and Innovation. Jacqueline is also our Director of Infection Prevention and Control.

Jacqueline also oversees our digital services and teams, who work closely with our research, innovation and improvement teams to ensure we deliver our Trust ambition to be a leading organisation for inventing, testing and adopting the best healthcare innovation.

Jacqueline has extensive experience of leading quality improvement programmes and is passionate about developing a safety culture in the NHS, to ensure we all learn when things do not go as we had planned, in a blame free and transparent way.

Code of Governance----------

Russell Nightingale, Chief Operating Officer (Appointed 5 April 2021)

Russell commenced his professional journey within the private sector, subsequently transitioning into the National Health Service (NHS) upon identifying his true professional predilection. His initial roles within the NHS involved managing services in Urgent Care, Acute Medicine, and Theatres for the Taunton and Somerset NHS Foundation Trust. Following this, he made a considerable impact as the General Manager at Bart's Health NHS Trust. Subsequent Russell ascended to the role of Director of Operations at Whittington Trust. In this position, he was entrusted with overseeing Acute, Community, and Inpatient Mental Health services across five boroughs in London.

From 2017, Russell has been a key figure at North Middlesex Trust, holding dual roles as Director of Operations for Surgery and Medicine, and later transitioning into the role of Deputy Chief Operating Officer. His adaptability was particularly evident in his tenure at HDFT, where he assumed the role of Senior Responsible Officer for elective recovery across WYAAT. Moreover, he has recently been entrusted with leading the HNY elective recovery programme. Russell's professional ethos is characterised by an unwavering commitment to continuous improvement and fostering collaborative leadership throughout HDFT.

Matt Graham, Director of Strategy and Transformation (Appointed 13 September 2021)

Matt joined the Trust in September 2021 after four years as Director of the West Yorkshire Association of Acute Trusts (WYAAT), nationally recognised as one of the leading provider collaboratives. During the COVID-19 pandemic, alongside his WYAAT role, Matt was Chief of Staff for the Nightingale Hospital in Harrogate and led the West Yorkshire vaccination programme. Prior to joining the NHS in 2010, Matt served as an army officer in the Royal Signals for 17 years, including on operations in Northern Ireland, Bosnia and Afghanistan.

Matt enjoys supporting teams to solve problems and to seek improvement and innovation. He is passionate about building a culture of continuous improvement throughout the organisation.

Jordan McKie, Director of Finance (Appointed 28 February 2022)

Jordan took on the role of Acting Director of Finance in February 2022, following years working at the Trust in both Finance and Operational Roles. Jordan is a member of the Chartered Institute of Management Accountants, having qualified as an Accountant in 2009.

Jordan began his career in the NHS as a Graduate Management Trainee in 2006. Prior to joining HDFT, Jordan also worked in Financial and Operational Roles in York and Leeds.

Code of Governance----------

Angela Wilkinson, Director of People and Culture (Appointed 5 November 2018)

Angela was appointed the Trust's Director of People and Culture in November 2018, having previously been Deputy Director of Workforce at The Mid Yorkshire Hospitals NHS Trust. Her role includes strategic and operational leadership for the Trusts HR and organisational development agenda supporting the Board of Directors.

Angela has an MA in strategic HR Management and is a Chartered Fellow of the Institute of Personnel and Development (CIPD) with significant senior level experience in multiple sectors including NHS, local government and education.

Code of Governance----------

6.6 Non-executive Directors and Associate Non-executive Directors

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Non-executive Directors are appointed initially for a term of three years in office. Non-executive Directors can be re appointed for up to three terms (ie a maximum of 9 years) with any final three year term subject to annual reappointment in line with the requirements of the Foundation Trust Code of Governance. The Council of Governors carries the responsibility of terminating the contract for a Non-executive Director where this is believed to be appropriate, in accordance with the Trust's Constitution.

In 2022, the Trust made the decision to enhance the Board by the appointment of Associate Non-executive Directors. Whilst the posts do not hold voting rights at the Board, they are integral to supporting our Board succession strategy and achieving a balance of Board level skills.

The table below sets of the names, appointment dates and tenure of the Chair, Non-executive Directors and Associate Non-executive Directors.

Name	Designation	Appointment	End of First Term	End of Second Term	End of Third Term
Sarah Armstrong*	Chair	1 April 2022	31 March 2025	-	-
Jeremy Cross	Non-executive Director	1 January 2020	31 December 2022	31 December 2025	-
Chiara De Biase	Non-executive Director	3 October 2022	2 October 2025	-	-
Andrew Papworth	Non-executive Director / Vice Chair	1 March 2020	29 February 2023	28 February 2026	-
Laura Robson	Non-executive Director / Senior Independent Director	1 September 2017	31 August 2020	31 August 2023	-
Wallace Sampson OBE	Non-executive Director	1 March 2020	29 February 2023	28 February 2026	-
Richard Stiff	Non-executive Director	14 May 2018	13 May 2021	13 May 2024	Left the Trust 31 July 2023
Maureen Taylor	Non-executive Director	1 November 2014	31 October 2017	31 October 2020	Left the Trust 30 September 2022
Julia Weldon	Non-executive Director	7 November 2022	6 November 2025	-	-
Azlina Bulmer	Associate Non-executive Director	10 October 2022	9 October 2025	-	-
Kama Melly	Associate Non-executive Director	3 October 2022	2 October 2025	-	-

* Prior to becoming Trust Chair Sarah Armstrong was appointed as a Non-executive Director on 1 October 2018 and served as such until the 31 March 2022.

Code of Governance----------

Sarah Armstrong, Chair and Non-executive Director (Appointed 1 April 2022)

Sarah Armstrong is an experienced leader in the charity sector, having also been a senior manager for a national charity leading in volunteering policy and practice and a regional lead for a charity raising aspirations for young people with a disability. In a previous role, she was Chief Executive of York CVS, an ambitious social action organisation.

Sarah is passionate about the value of volunteering and the unique contribution volunteers can make, especially within a healthcare setting.

Sarah was appointed to the Trust's Board of Directors in October 2018 and became Chair of HDFT in April 2022.

Chiara De Biase, Non-executive Director (Appointed 3 October 2022)

Chiara is the Director of Support and Influencing at Prostate Cancer UK. She oversees the charity activity for direct services to men and their families and works alongside the clinical community across the UK. Her role includes overseeing the delivery of NHS clinical education, health information, policy and health influencing, peer support, patient and community involvement, advancing racial equity in healthcare, specialist nurses helpline and cancer data specialists. She is also the charity media spokesperson and safeguarding lead.

Chiara was previously Director of Patient Services at Anthony Nolan for nine years, establishing a new team and a whole suite of new services for patients, families and health care professionals working in blood cancer and stem cell transplant. A passionate advocate for palliative and end of life care, Chiara managed the Macmillan Information and Support Centre at King's College Hospital and was involved in several research projects with the Cicely Saunders Institute of Palliative Care. As a clinician, Chiara was a specialist physiotherapist in cancer and palliative care and worked for many years on the oncology wards at St. Bartholomew's Hospital and has first-hand experience of the challenges that people face with a cancer and long-term conditions. Chiara lives in Guiseley with her family, coaches her son's football team and is a passionate Leeds United fan. She is also a clinical trustee for Candlelighters; a Yorkshire based children's cancer charity.

Chiara took on the role of Audit Committee Chair from August 2023.

Laura Robson, Non-executive Director (Appointed 1 September 2017)

Laura Robson had lived in Sunderland all her life before moving to Ripon in 2016 to enjoy the Yorkshire life. She trained as a nurse and midwife in Sunderland before going on to work in clinical and managerial roles for various hospitals in the North East. She is a qualified midwifery teacher and has a Master's Degree in Management and Communication Studies. From 1996 until retiring in 2012, she was Executive Nurse on the Board of County Durham and Darlington NHS Foundation Trust. Laura has worked as a Clinical Advisor to the CQC and the Health Service Ombudsman. With a special interest in the care of people with dementia in acute hospitals, she has a passion for patient safety, midwifery and maternity services.

Laura was a Non-executive Director of North Cumbria University Hospitals NHS Trust from 2014 until 2017, working with the Board to help them come out of special measures by improving the quality and efficiency of their services to the people of Cumbria.

Laura became the Trust's Senior Independent Director in January 2020. She is also Chair of the Quality Committee.

Richard Stiff, Non-executive Director (Appointed 14 May 2018)

Richard Stiff joined the Trust following his retirement from the role of Chief Executive of Angus Council in Scotland in May 2017. Prior to Angus he enjoyed a long career in English local government, mainly in education and children's services departments, holding senior posts with North Lincolnshire, Leeds and Dudley Councils.

Born and raised near Bury St Edmunds in Suffolk, he is Chairman of NCER CIC; a member of the board of the Heart of Yorkshire Education Group including Castleford, Selby and Wakefield Colleges; member of the Association of Directors of Children's Services; member of Society of Local Authority Chief Executives; a Local Government Information Unit Associate and a Fellow of the Royal Society of Arts.

Richard was the Chair of the Audit Committee until end July 2023.

Maureen Taylor, Non-executive Director (Appointed 1 November 2014 – stood down 30 September 2022)

Maureen Taylor is a chartered accountant and, until 31 March 2015, was the Chief Officer for Financial Management at Leeds City Council. She spent over 31 years in Financial Services at Leeds City Council after qualifying as an accountant in 1987. She has extensive experience, working in a wide range of financial disciplines more recently leading the Council's capital programme and treasury management functions and overseeing aspects of the revenue budget.

As part of her Council role, Maureen held three directorship positions being Public Sector Director of Community Ventures Leeds Limited, Director at Norfolk Property Services (Leeds) Limited, and Alternate Director for the Leeds Local Education Partnership. She is also a Resources Committee member at a local Church of England Primary School.

During her tenure at HDFT, Maureen was Trust Vice-Chair, Chair of the Resources Committee and a member of the Audit Committee.

Code of Governance----------

Jeremy Cross, Non-executive Director (Appointed 1 January 2020)

Jeremy Cross is a fellow of Institute of Chartered Accountants. He joined the Trust from Airedale NHS Foundation Trust where he had been a Non-executive Director for five years, and during his time there has was Chairman of the Audit Committee, a member of the Finance and Performance Committee, and the Charity Committee. Jeremy was also Chair of the 100% owned subsidiary company AGH Solutions Limited.

Prior to taking up Non-executive Director positions Jeremy held senior positions at Lloyds Banking Group, Asda and Boots the Chemist.

Outside of the NHS, Jeremy is Chairman of Tipton Building Society; Chairman of Forget Me Not Children's Hospice, Huddersfield; Governor of Grammar School at Leeds; Director of GSAL Transport Ltd; and a Member of Kirby Overblow Parish Council.

Jeremy is the Chair of the Trust's Resource Committee.

Wallace Sampson OBE, Non-executive Director (Appointed 1 March 2020)

Wallace Sampson was chief executive of Harrogate Borough Council between August 2008 and March 2023. He worked in local government for over 35 years in a variety of roles, starting at Doncaster Metropolitan Borough Council in the exchequer function. He also worked at Chesterfield Borough Council, Kirklees MBC, and Bradford MDC where he was Strategic Director Customer Services and Assistant Chief Executive for Regeneration and the Environment.

Wallace is passionate about public service delivery and the need to work within partnerships to join up service delivery. He has devoted his career to public service and over the years he has worked extensively with partners across public, private and the voluntary sector to ensure a strong focus on customers, residents, businesses and visitors. This was reflected in a number of external responsibilities to Harrogate Council. He chaired the Harrogate District Public Services Leadership Board and served on both of North Yorkshire Children's Safeguarding Board and Adults Safeguarding Board. He also served as a Trustee at St Michaels Hospice as well as a Trustee on the Harrogate District Climate Coalition which was established as a not-for-profit charitable incorporated company.

Wallace was also a Director of Bracewell Homes, a wholly owned Harrogate Borough Council housing company; and a Director of Brimhams Active, a wholly owned Harrogate Borough Council leisure company. He was the lead chief executive for net zero across Yorkshire and the Humber and played a leading role in establishing the Yorkshire and Humber Climate Commission. He is an experienced peer challenge reviewer for the Local Government Association and he is a Member of Society of Local Authority Chief Executives.

Wallace is the Chair of the new Innovation Committee.

Code of Governance----------

Andrew Papworth, Non-executive Director (Appointed 1 March 2020)

Andy Papworth is an accomplished leader with over 20 years' experience in financial services, including eight years at executive level, working in regulated environments. He has a deep background in financial management, business leadership and transformation.

He is a current member of the Chartered Management Institute, Global Chartered Management Accountants, and previous member of the Council of Strategic Workforce Planning and Human Capital Analytics.

He is Director of Cost and Productivity at Lloyds Banking Group and is known for being an innovative executive and brings thought-leadership on a range of subjects to the Trust.

Andy is the Chair of the People and Culture Committee and was appointed as Vice Chair in February 2023.

Julia Weldon, Non-executive Director (Appointed 7 November 2022)

Julia has been Corporate Director of Public Health (DPH) and Adult Social Care at Hull City Council since November 2013, and is the authority's lead advisor and champion on all health matters.

Julia is a statutory member of the Health and Wellbeing Board, and a member of the CCG Primary Care Commissioning Board. Prior to joining Hull City Council, Julia held a number of Chief Officer roles including Director of Public Health at Redcar and Cleveland, with responsibility for the Tees Valley Shared Service, Teaching Public Health Director for Yorkshire and Humber and Training Programme Director for the Yorkshire and Humber Deanery.

Julia began her career in nursing as a junior sister at Pinderfields Hospital Trust. Her career includes work as Nursing and Health improvement Health Action Zone Manager, and Head of Public Health in Wakefield PCT with a focus on Development, Intelligence and capacity building.

Julia was a member of the Independent Enquiry looking at Health Equality North (Due North) which was commissioned by Public Health England. Julia represents the Yorkshire and Humber ADSPH at National level, is Educational Supervisor for Yorkshire and Humber, the DPH Mental Health Champion and lead for the intelligence community and Interest Group.

Code of Governance----------

Azlina Bulmer, Associate Non-executive Director (Appointed 10 October 2022)

Azlina Bulmer is currently the Executive Director of Membership & Engagement at the Chartered Insurance Institute (CII) where she has the oversight of CII's membership activities and engagement programmes. She is also responsible for the day to day operations internationally including CII's offices in Dubai and Hong Kong. Additionally, Azlina joined the Board of Personal Finance Society in December 2022.

She was previously the Director of International at the Royal Institute of British Architects (RIBA) where she set up the RIBA's first international directorate in 2019 and led on the expansion of the RIBA's operations and profiling in target markets in Middle East and China. She joined the RIBA in January 2016 as Head of Operations, Nations & Regions managing the operations of the RIBA's 10 UK regions including volunteer network activities and support across England and Wales.

Azlina's early career was in law before moving into economic and community development roles at local authorities. This was followed by seven years working at a social investment bank before the RIBA. She has held a number of non-executive director roles previously including as Chair of Finance & Estate Committee at University College of Osteopathy and Chair of The Works UK, a Special Educational Needs provision in Leeds.

Kama Melly, Associate Non-executive Director (Appointed 3 October 2022)

Kama Melly KC has been a barrister since 1997 and was appointed a King's Counsel in 2016. She is Deputy Head of Chambers at Park Square Barristers, based in Leeds which is the largest set of chambers in the North of England.
Kama also sits part-time as a Judge in the Crown Court and the Family Court and is a Governor of the Inns of Court College of Advocacy and a Bencher of the Honourable Society of the Middle Temple.

Kama has a particular interest in issues of Diversity and Inclusion and facilitating the evidence of vulnerable people.

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6.7 Performance Evaluation of the Board of Directors

Evaluation of the Board of Directors is delivered formally via a number of channels, which can include:

- Appraisal of Executive Director performance by the Chief Executive and Chair on an annual basis.
- Appraisal of Non-executive Director performance by the Chair and Vice Chair/Lead Governor of the Council of Governors on an annual basis.
- Appraisal of the Chair by the Council of Governors, led by the Senior Independent Director of the Board of Directors and the Lead Governor, after seeking views and comments of the full Council of Governors and Board colleagues.
- Appraisal of the Chief Executive by the Chair.
- An annual Board development programme, and
- An annual review of the effectiveness of each Board Sub-Committee.

The Care Quality Commission, at its last inspection carried out in 2018, assessed the Trust as ‘Good’ against its Well-Led standard.

The information below provides details on the Executive Director, Non-executive Director and Associate Non-executive Director attendance at Board of Directors meetings in 2022-23. When the Board of Directors met in public there was also a private meeting.

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6.8 Board of Directors (Trust Board) Attendance 2022-23

	Number of business meetings attended	25 May 2022	27 July 2022	28 September 2022	30 November 2022	25 January 2023	29 March 2023
Sarah Armstrong	6/6	✓	✓	✓	✓	✓	✓
Jeremy Cross	5/6	✓	✓	-	✓	✓	✓
Chiara De Biase *	3/3				✓	✓	✓
Andrew Papworth **	5/6	✓	-	✓	✓	✓	✓
Laura Robson	6/6	✓	✓	✓	✓	✓	✓
Wallace Sampson OBE	5/6	✓	✓	✓	✓	✓	-
Richard Stiff	6/6	✓	✓	✓	✓	✓	✓
Maureen Taylor ***	3/3	✓	✓	✓			
Julia Weldon ****	3/3				✓	✓	✓
Azlina Bulmer *****	3/3				✓	✓	✓
Kama Melly *	2/3				✓	✓	-
Jonathan Coulter	6/6	✓	✓	✓	✓	✓	✓
Jacqueline Andrews	6/6	✓	✓	✓	✓	✓	✓
Matthew Graham	6/6	✓	✓	✓	✓	✓	✓
Jordan McKie	6/6	✓	✓	✓	✓	✓	✓
Russell Nightingale	6/6	✓	✓	✓	✓	✓	✓
Emma Nunez	6/6	✓	✓	✓	✓	✓	✓
Angela Wilkinson	6/6	✓	✓	✓	✓	✓	✓

*** Commenced in post 3 October 2022**
**** Vice Chair from 1 March 2023**
***** Left post on 30 September 2022**
****** Commenced in post 7 November 2022**
******* Commenced in post 10 October 2022**

Code of Governance----------

6.9 Council of Governors Overview

The Council of Governors has positions elected by members of the public constituency (including one position representing the rest of England), positions elected by the staff constituency and members appointed by local partner organisations. Governors are elected to office for terms of up to three years and may seek re-election for further terms.

6.10 Council of Governors Attendance 2022-23

Council of Governors Attendance 2022-23

	Governor Category	Number of business meetings attended	6 September 2022	5 December 2022	7 March 2023	Annual Members' Meeting 5 December 2022
Sarah Armstrong	Chair	4/4	✓	✓	✓	✓
Public Elected Governors						
Ian Barlow	Public	2/4	✓	-	✓	-
Donald Coverdale	Public	3/4	✓	✓	-	✓
Martin Dennys	Public	2/4	-	✓	-	✓
Tony Doveston	Public	4/4	✓	✓	✓	✓
Mike Dunn **	Public	3/4	-	✓	✓	✓
Sue Eddleston	Public	1/4	✓	-	-	-
William Fish	Public	1/4	✓	-	-	-
Kathy Gargan	Public	3/4	-	✓	✓	✓
Jackie Lincoln	Public	4/4	✓	✓	✓	✓
Doug Masterton	Public	1/1	✓			
Richard Owen-Hughes	Public	3/4	✓	-	✓	✓
Rick Sweeney	Public	4/4	✓	✓	✓	✓
Steve Treece **	Public	4/4	✓	✓	✓	✓
Staff Governors						
Andrew Jackson	Staff	0/1	-			
Kathy McClune	Staff	4/4	✓	✓	✓	✓
Stuart Wilson	Staff	3/4	-	✓	✓	✓
Stakeholder Governors						
Claire Illingworth *	Stakeholder	1/4	✓	-	-	-
Cllr Nick Brown	Stakeholder	2/2			✓	✓
Karen Stansfield	Stakeholder	3/4	✓	-	✓	✓
Cllr John Mann	Stakeholder	0/2	-	-		
Cllr Sue Lumby	Stakeholder	0/4	-	-	-	-

*** Lead Governor**
**** Interim Deputy Lead Governors (from 24 January 2023)**

Code of Governance

6.11 Statement of Compliance with the NHS Foundation Trust Code of Governance

Harrogate & District NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a “comply or explain” basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.”

During the year, the Trust considered the Code and considered that it complied with all recommended practice. This included the identification of a Senior Independent Director (SID). The role was filled Laura Robson, Non-executive Director.

The Board conducted a review of the effectiveness of its system of internal control, with details contained within the Annual Governance Statement.

The Board of Directors provides effective and proactive leadership within a framework which enables risk to be assessed and managed appropriately (see the AGS). The Board ensures compliance with the Terms of Authorisation, the constitution, mandatory guidance, relevant statutory requirements and contractual obligations.

It sets out the strategic ambitions for the Trust, taking into account the views of the Council of Governors, and ensures that the necessary resources are in place to meet priorities and objectives. There is periodic review of progress and management performance against the strategy. Principles and standards of corporate and clinical governance are set and overseen by standing committees of the Board. Directors have overall responsibility for the effective, efficient and economical discharge of the functions of the Trust, taking joint responsibility for every decision of the Board, notwithstanding the particular responsibilities of the Chief Executive and Accounting Officer.

Specific mechanisms are in place for the appointment, terms of service and removal of Executive Directors. Non-executive Directors are in the majority on the Board and are independent. They challenge and scrutinise the performance of the Executive Directors to satisfy themselves of the integrity of the financial, clinical and non-clinical information they receive, and to ensure that risk management arrangements are robust and effective.

There is a formal Scheme of Delegation and Reservation of Powers that defines which functions are reserved for the Board and which are delegated to committees and Trust officers.

Members of the Board of Directors have an open invitation to attend all meetings of the Council of Governors. The Trust’s constitution sets out the statutory responsibilities of the Council in relation to the appointment and removal of the Chair and Non-executive Directors, the appointment and removal of external auditors, the approval of the appointment of the Chief Executive, receiving the Annual Audit Letter, and providing input to the Annual Plan and its strategies. The Board determines which of its standing committees and groups may have governors as members or in attendance.

6.12 Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's Responsibilities as the Accounting Officer of Harrogate and District NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS England.

NHS England has given Accounts Directions which require Harrogate and District NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Harrogate and District NHS Foundation Trust and of its income and expenditure, items of other comprehensive income and cash flows for the financial year.

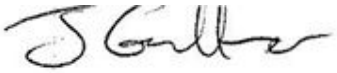
In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy; and

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of Harrogate and District NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the Harrogate and District NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.



Jonathan Coulter
Chief Executive Officer
Harrogate and District NHS Foundation Trust
8 September 2023

SECTION SEVEN

Annual Governance Statement

7. Annual Governance Statement

Annual Governance Statement 2022-23

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of Harrogate and District NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that Harrogate and District NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Harrogate and District NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Harrogate and District NHS Foundation Trust for the year ended 31 March 2023 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

The Board of Directors provides leadership on the overall governance agenda. The Board of Directors is supported by a range of Committees that scrutinise and review assurances on internal control. Our assurance Committees: Audit, Remuneration, Quality, Resources, People and Culture and the newly initiated Innovation Committee build on the controls in place.

As Accounting Officer, and supported by fellow members of the Board of Directors, I have responsibility for the integration of governance systems. I delegate executive lead to the Director of Nursing, Midwifery and AHPs / Deputy Chief Executive for the implementation of quality governance and risk management.

The Board has a number of overarching principles and procedures related to governance that is defined within our policies and procedures with means of monitoring and ongoing assurance. Our approach to risk identification, assessment and control, and the management and investigation of incidents is aligned to the values and behaviours set out in our Strategy through our KITE values.

The Board of Directors recognises that risk management is an integral part of good management practice and to be most effective should be part of the Trust's culture. The Board is, therefore, committed to ensuring that risk management forms a central part of its philosophy, practices and business plans rather than being viewed or practised as a separate programme; responsibility for its implementation is accepted at all levels of the organisation.

The provision of appropriate training is central to the achievement of this aim. Our policy requires staff required to be trained and supported in incident reporting, carrying out risk assessments, mitigating risk and maintaining risk registers.

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The Board Directors, Directorate and departmental managers oversee staff (including those promoted or acting up, contractors, locum, agency and bank staff) corporate, and specific local, induction training appropriate to their area of work; this includes but is not limited to risk management, incident reporting and hazard recognition training. An ongoing training programme has been developed based on a training needs analysis of staff. The programme includes formal training for:

- Staff dealing with specific everyday risks, e.g. basic risk management information including an overview of patient safety, incident reporting and investigation, complaints investigation and development of measures to improve patient experience, fire safety, information governance, health and safety, moving and handling, infection control, and security; and
- Specific staff involved in the maintenance of risk registers at Directorate and department level, investigation and root cause analysis, the investigation of serious incidents (SIs) and risk assessment for health and safety.

This work is being reviewed in light of the forth coming Patient Safety Incident Response Framework (PSIRF) and 2023-24 will see a wide range of updates to our policies, protocols and daily management of patient safety events.

Employees, contractors and agency staff are required to report all incidents and concerns and this is closely monitored. The Trust supports an “open” culture; we are transparent with service users, carers and staff when things go wrong. A significant emphasis is placed upon ensuring that we comply with the requirements of the statutory Duty of Candour that came into force on 27 November 2014. This follows the introduction of a number of new standards with which NHS Boards need to comply; this includes the Duty of Candour, and the Fit and Proper Person’s test. Assurance on these areas is through the Trust’s governance framework.

The Datix system supports our incident reporting process. Guidance on reporting incidents on Datix, grading of incidents, risk assessment, risk registers, undertaking root cause analysis and statement writing, is available for all staff on the Trust intranet. The Trust is in the process of transition to Datix IQ to provide greater support and emphasis on the review, management and learning from patient safety events.

The Trust’s *Freedom to Speak Up* Guardian meets with the Chair and Chief Executive on a regular basis. They report to the People and Culture Committee on a quarterly basis and by exception to the Board. This provides the Board with an opportunity to reflect on themes and learning identified by the Guardian. The Guardian has developed a role for Fairness Champions to support and listen to colleagues, promote fairness, and signpost to resources and options for speaking up.

Quality impact assessments assist the Trust in meeting obligations under the public sector equality duty introduced in April 2011 and in accordance with the National Quality Board guidance produced in 2012 on assessing cost improvement plans.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer’s contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

The organisation has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months as required by the *Managing Conflicts of Interest in the NHS*27 guidance.

Annual Governance Statement----------

The organisation has undertaken risk assessments and *has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme.* The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The risk and control framework

The key objectives regarding risk and control are to achieve:

- Compliance with external regulatory and other standards for quality, governance and risk including Care Quality Commission fundamental standards and regulations;
- A culture of effective risk management at all levels of the organisation;
- Delivery of the Trust's strategic aims and objectives; and
- A robust framework to ensure all controls and mitigations of risks are in place and operating, and can provide assurance to the Board of Directors on all areas of governance, including:
    - Corporate governance
    - Quality governance
    - Financial governance
    - Risk management
    - Information governance, including data security
    - Research governance
    - Clinical effectiveness and audit
    - Performance governance

The Trust has a system of integrated governance described in the Risk Management Policy. This includes:

Determine priorities

The Board of Directors determines corporate objectives annually and these establish the priorities for Executive Directors and clinical services.

Risk Identification

Risk is identified in many ways. We identify risk proactively by assessing corporate objectives, work related activities, analysing adverse event trends and outcomes, and anticipating external possibilities or scenarios that may require mitigation by the Trust.

Risk Assessment

Risk Assessment involves the analysis of individual risks, including analysis of potential risk aggregation where relevant. The assessment evaluates the severity and likelihood of each risk and determines the priority based on the overall level of risk exposure.

Risk Response (Risk Treatment)

For each risk, controls are ascertained (or where necessary developed), understood and documented. Controls are implemented to avoid risk; seek risk (take opportunity); modify risk; transfer risk or accept risk. Gaps in control are subject to mitigating actions that are implemented to reduce residual risk. The Board of Directors has considered its appetite for taking risk and reviewed its risk appetite to guide the management of risk throughout the Trust.

Annual Governance Statement----------

Risk Reporting
Significant risks are reported at each formal meeting of the Board of Directors and the Executive Risk Review Group. In addition, in the event of a significant risk arising, arrangements are in place to escalate a risk to the Chief Executive and Executive Team. The level at which risk must be escalated is clearly set out in the Risk Management Policy, which is reviewed every two years and was last updated and approved in 2022-23. The risk reporting to the Board of Directors also details what actions are being taken, and by whom, to mitigate the risk and monitor delivery.

The Audit Committee and Board of Directors have reviewed assurance on the effective operation of controls to manage potential significant risk as set out in the Corporate Risk Register and supporting report to each Board meeting and regular reviews of the Board Assurance Framework

Risk Review
a. Those responsible for managing risk regularly review the output from the risk register to ensure it remains valid, reflects changes and supports decision making. In addition, risk profiles for all clinical directorates remain subject to detailed scrutiny as part of a rolling programme by the Resource Review Meetings and the Executive Risk Review Group. The purpose of the Trust's risk review is to track how the risk profile is changing over time; evaluate the progress of actions to treat material risk; ensure controls are aligned to the risk; risk is managed in accordance with the Board's appetite; resources are reprioritised where necessary; and risk is escalated appropriately.

b. Incident reporting and investigation is openly encouraged as a key component of risk and safety management to help us learn and take action in response to patient safety incidents. An electronic incident reporting system is operational throughout the organisation and is accessible to all staff. Incident reporting is promoted through induction and training, regular communications, leadership walk rounds or other visits and inspections that take place. A programme to support staff who have been involved in an incident is in place, and a process for sharing lessons across the organisation is established, overseen by the Learning Summit and the Quality Summit.

In addition, arrangements are in place for staff to raise any concerns at work confidentially and anonymously if necessary.

As at 31 March 2023, Harrogate and District NHS Foundation Trust has identified a range of significant risks, which are currently being mitigated, whose impact could have a direct bearing on requirements within the NHS Oversight Framework, CQC registration or the achievement of Trust policies, aims and objectives should the mitigation plans be ineffective. Currently, the significant risks documented on the Corporate Risk Register at 31 March 2023 and described broadly relate to the five CQC Domains and the Use of Resources

Care Quality Commission (CQC) Registration

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

Compliance with the provisions of the Health and Social care Act 2008 (Registration Regulations) 2010 is coordinated by the Executive Director of Nursing, Midwifery and AHPs and the Associate Director of Quality and Corporate Affairs (Company Secretary). Compliance is overseen by:

- Reporting and keeping under review, matters highlighted within the Care Quality Commission's Acute Insights Report and inspections.
- Self-assessments against the Key Lines of Enquiry defined within the criteria of the Well-Led Review and preparing the Trust for an external review.

- Liaising with the Care Quality Commission and Clinical Directorates to address specific concerns where required.
- Engaging with the Care Quality Commission on the inspection process, coordinating the Trust's response to inspections and recommendations and actions arising from this.
- Analysing trends from incident reporting, complaints and surveys to detect potential non-compliance or concerns in Clinical Directorates.
- Reviewing assurance of the effective operation of controls.
- Receiving details of assurances provided by Internal Audit and being notified of any Clinical Audit conclusions which provide only limited assurance on the operation of controls, and
- Challenging assurances or gaps in assurance by attending meetings of the Quality Governance Management Committee, Serious Incident Committee, Quality Committee and the Audit Committee.

The Trust is registered with the Care Quality Commission with full compliance of fundamental standards of care. The overall Trust Rating from 2018 remains as "Good".

During 2022-23 the Care Quality Commission inspected the Safe and Well-Led Domains for the core service of Maternity. Safe Domain was rated as "Requires Improvement" and the Well-Led Domain was rated as "Good".

Risks and challenges

The quality of performance information is the responsibility of the Senior Information Risk Owner (SIRO) who chairs the Data and Information Governance Steering Group and advises the Board of Directors on the effectiveness of information risk management across the organisation. The SIRO for the Trust is the Chief Operating Officer.

The Trust has put in place due processes to ensure information governance and data security in accordance with national recommendations led by the Senior Information Risk Owner at Board level.

The Trust has an Integrated Board Report (IBR) which triangulates key information metrics covering quality, workforce, finance, efficiency and operational performance, presenting trends over time to enable identification of improvements and deteriorations.

The IBR is presented to each Board and Council of Governors meetings, and this is reviewed together with the quality dashboard at each Quality Committee; it is also available to each of the groups responsible for leading work to ensure compliance with CQC standards. The Audit Committee reviews the evidence for compliance with CQC registration requirements annually.

There are no significant risks that have been identified relating to compliance with the NHS Foundation Trust Licence Condition 4 (FT governance). The Trust ensures compliance with the requirements of the Provider Licence in its entirety via annual and in-year submissions as required by NHS Improvement's Oversight Framework. These submissions include detailed information on financial performance, plans and forecasts, and third party information, in order to assess the risk to continuity of services and governance.

This Annual Governance Statement also provides an outline of the structures and mechanisms that the Trust has in place to maintain a sound system of governance and internal control to meet the requirement of the Licence Condition 4, Section 6. It takes assurance from these structures as well as feedback from Internal and External Audit and other internal and external stakeholders regarding the robustness of these governance structures. These same mechanisms are used by the Board to ensure the validity of the annual Corporate Governance Statement.

Annual Governance Statement----------

In order to mitigate any risks to compliance with NHS Improvement's Provider Licence Condition 4, the Trust has in place a governance framework with clear accountability and reporting to ensure integrated governance, to deliver the Trust's objectives and to provide assurance to the Board of Directors. The framework was revised during 2022-23 specifically against the quality governance framework. The review of the quality governance framework included colleagues' participation to ensure integrated governance, to deliver the Trust's objectives and to provide assurance to the Board of Directors. Quality of patient care is at the heart of this framework.

Executive Directors, Non-executive Directors, Governors and other stakeholders are key participators in many of the Trust's Committees.

The Board of Directors is responsible for exercising all of the powers of the Trust; however, it has the option to delegate these powers to senior management and other Committees. The Board:

- sets the strategic direction for the Trust.
- allocates resources.
- monitors performance against organisational objectives.
- ensures that clinical services are safe, of a high quality, patient-focused and effective;
- ensures high standards of clinical and corporate governance, and
- in conjunction with the Council of Governors, engages members and stakeholders to ensure effective dialogue with the communities it serves.

The Board is also responsible for ensuring that the Trust exercises its functions effectively, efficiently and economically and that compliance with the Trust's Licence and Constitution are maintained.

During 2022-23 there have been six formally constituted assurance Committees of the Board:

- the Audit Committee
- the Quality Committee
- the Resource Committee
- the Remuneration Committee
- the People and Culture Committee, and
- the newly formed Innovation Committee (commenced in November 2022).

Review of economy, efficiency and effectiveness of the use of resources

As Accounting Officer, I am responsible for ensuring that the Trust has arrangements in place for securing value for money in the use of its resources. To do this I have maintained systems to:

- Set, review and implement strategic and operational objectives;
- Engage actively with patients, staff, members and other stakeholders to ensure key messages about services are received and acted upon;
- Monitor and improve organisational performance; and
- Establish plans to deliver waste reduction programmes

The five year integrated plan is refreshed each year and used to develop the annual operational plan for the Trust. The Trust actively engages Commissioners, regulators (NHS England), system functions, staff and others as necessary to develop and agree detailed financial and operational plans.

Planning takes account of system initiatives and their impact to ensure that planning within the broader ICS is aligned. These detailed operational plans and budgets are approved by the Trust's Board.

Updates to the plans include revisions to our operational, financial, workforce and strategic plans. These submissions contain a variety of technical documents prepared by members within the Trust and an overall narrative which describes these submissions and their associated risks. This informs the detailed operational plans and budgets which are also approved by the Trust's Board.

NHS England published draft planning guidance for systems on 24th December 2021 and the Trust has reviewed these in relation to our agreed annual plan. The Trust agreed its plan in February 2022.

The Trust is a key member of West Yorkshire Association of Acute Trusts (WYAAT). In the year it has continued to make good progress with the Committee in Common (CiC) meeting four times per year for the governance and accountability of work streams to support transformation across West Yorkshire, reporting and accountable to each sovereign Board. The CiC has membership from each provider organisation with both Executive and Non-executive membership from each, usually by the Chief Executive and Chair. The Trust is also an active participant in the North Yorkshire and Coast Integrated Care Board (ICB) and the development of a CiC is ongoing.

The Board annually agrees a set of corporate objectives which are communicated to colleagues and the public. This provides the basis for performance reviews at directorate level. Operational performance is kept under constant review by the Executive Team, Resource Committee and the Board of Directors. In order to keep under review the delivery of the corporate objectives, the Board scrutinises at each formal meeting an Integrated Board Report covering patient safety, quality, access and experience metrics, as well as a Finance Performance Report.

The Trust continues to operate its Financial Management Framework to ensure that the Trust is meeting its strategic target of financial sustainability. Each quarter a fundamental review takes place of the financial position, and this is reviewed by the Board and relevant action plans developed. Monthly reports are prepared for the Resource Committee on the financial position, alongside the monthly finance reports issued to directorates that show performance against budget. These reports contain both financial and non-financial information.

Assurances on the operation of controls are commissioned and reviewed by the Audit Committee and, where appropriate, other Committees of the Board of Directors as part of their annual cycle of business.

Information governance

Information governance breaches, which include breaches under Data Protection Act 2018/GDPR and Security of Network Information System Regulations 2018 (NIS) are managed in line with the Trust's Events and Serious Incidents Policy. Serious information governance breaches are also managed in line with the NHS Guide to the Notification of Data Security and Protection Incidents.

There have been no incidents at a level which required reporting to the Information Commissioner's Office (ICO) during 2022-23.

The Trust takes the threat of cyber-attacks very seriously and has robust measures and controls in place to improve cyber awareness and resilience of its IT infrastructure and manage the threat of Cyber-attack and other IT vulnerabilities and security threats.

Data quality and governance

The Board is satisfied that steps are in place to assure that data quality and governance processes are in place with appropriate controls to ensure the accuracy of data. The Quality Committee has continued its work to gain assurance in relation to the CQC quality domains ensuring compliance with fundamental standards of care in acute and community services.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the Executive Directors, Clinical Directors and Clinical Leads within Harrogate and District NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, our assurance and management Committees reporting to Board and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust applies a robust process for maintaining and reviewing the effectiveness of the system of internal control. A number of key groups, Committees and feeder Committees make a significant contribution to this process, including:

Board of Directors – the statutory body of the Trust is responsible for strategic and operational management of the organisation and has overall accountability for the risk management frameworks, systems and activities, including the effectiveness of internal controls.

The Terms of Reference of all Board Committees and Groups are reviewed regularly to strengthen their roles in governance to the Board on risks and mitigations in place to the organisation's ability to achieve its key objectives.

Audit Committee – is a statutory Committee that provides an independent contribution to the Board's overall process for ensuring that an effective internal control system is maintained and provides a cornerstone of good governance.

Internal Audit – provides an independent and objective opinion to the Accounting Officer, the Board and the Audit Committee on the organisation's systems for risk management, control and governance to support the achievement of the Trust's agreed priorities.

The Internal Audit team work to a risk based audit plan, which is agreed by the Audit Committee, and covering risk management, governance and internal control processes, both financial and non-financial across the Trust. The work includes identifying and evaluating controls and testing their effectiveness, in accordance with Public Sector Internal Audit Standards.

Following each audit, a report is produced providing a conclusion and, where scope for improvement is found, recommendations are made and appropriate action plans are agreed with management. Reports are issued and followed up with the responsible Executive Directors. The results of audits are reported to the Audit Committee which has a key role to performance manage the action plans to address recommendations from all audits. Internal audits are also made available to the external auditors who may use them as part of their planning. In addition, Internal Audit provides advice and assistance to senior management on

control issues and other matters of concern. Internal Audit work also covers service delivery and performance, financial management and control, human resources, operational and other reviews.

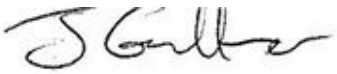
Internal Audit found a number of audit reports received "Limited" assurance in 2022-23 and some included follow-up "Limited" assurance reports from 2021-22. Internal Audit found that responses to these reports had been impacted by the pandemic and the Trust like other organisations across the NHS continues to face a number of challenging issues and wider organisational factors particularly with regards to the ongoing pandemic response and COVID-19 recovery. The COVID-19 pandemic led to changes to the NHS financial framework, the establishment of the control-and-command structures both regionally and within individual organisations, and an ongoing focus on the emergency response. This has required NHS organisations to operate in a different way to previous 'business as usual' practice. Guidance was clear that financial constraints must not stand in the way of taking immediate and necessary action but that there was no relaxation in fiduciary duties.

Based on the work undertaken, including a review of the Board's risk and assurance arrangements, the Head of Internal Audit Opinion concluded in June 2023 that '*Significant assurance*' can be given and there is a good system of governance, risk management and internal control in place designed to meet the organisation's objectives and that controls are generally being applied consistently.

Conclusion

The Annual Governance Statement requires me to consider whether there are any significant internal control issues facing the Trust. Risks and challenges regarding the COVID-19 pandemic are identified above and the Trust has an internal control environment in place to manage the COVID-19 pandemic in line with national guidance.

In summary, I am assured that Harrogate and District NHS Foundation Trust has an overall sound system of internal controls in place, which is designed to manage the key organisational objectives and minimise exposure to risk and that no significant internal control issues have been identified.



Jonathan Coulter
Chief Executive Officer
Harrogate and District NHS Foundation Trust
8 September 2023

SECTION EIGHT

Independent Auditors Report

8. Independent Auditors Statement

Independent Auditor's Report to the Council of Governors of Harrogate and District NHS Foundation Trust

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of Harrogate and District NHS Foundation Trust (the 'Trust') for the year ended 31 March 2023, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards, in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2023 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with UK adopted international accounting standards, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK), applicable law and Practice Note 10 'Audit of Financial Statements and Regularity of Public Sector Bodies in the United Kingdom', as required by the Code of Audit Practice approved by the Comptroller and Auditor General ("the Code of Audit Practice"). Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the Annual Report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Independent Auditors Statement ----------

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- The parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with the requirements set out in the NHS foundation trust annual reporting manual 2022/23; and
- Based on the work undertaken in the course of the audit of the financial statements, the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

Under the Code of Audit Practice, we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS foundation trust annual reporting manual 2022/23 or is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2022/23, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services and functions to another public sector entity. The Accounting Officer is required to comply with the requirements set out in the Department of Health and Social Care Group Accounting Manual 2022-23.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with International Standards on Auditing (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with International Standards on Auditing (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

We obtain and update our understanding of the Trust, its activities, control environment, and likely future developments, including in relation to the legal and regulatory framework applicable and how the Trust is complying with that framework. We determined that the most significant legal and regulatory frameworks that are applicable to the Trust, which are directly linked to specific assertions in the financial statements, are those related to the financial reporting frameworks. These include the National Health Service Act 2006 and international accounting standards, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23.

Based on this understanding, we identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence

that is sufficient and appropriate to provide a basis for our opinion. This includes consideration of the risk of acts by the Trust that were contrary to applicable laws and regulations, including fraud.

In response to the risk of irregularities and non-compliance with laws and regulations, including fraud, we designed procedures which included:

- Enquiry of management, internal audit, and those charged with governance concerning the Trust's operations, the key policies and procedures, and the establishment of internal controls to mitigate risks related to fraud and non-compliance with laws and regulations, together with their knowledge of any actual or potential litigation and claims and actual, suspected and alleged fraud;
- Reviewing minutes of meetings of those charged with governance;
- Assessing the extent of compliance with the laws and regulations considered to have a direct material effect on the Trust's financial statements and the operations of the Trust through enquiry and inspection;
- Reviewing financial statement disclosures and testing to supporting documentation to assess compliance with applicable laws and regulations;
- Performing audit work over the risk of management bias and override of controls, including testing of high risk journal entries and other adjustments for appropriateness, evaluating the rationale of any unusual transactions and reviewing key accounting estimates including property plant and equipment valuations, provisions and accruals and right of use assets and liabilities for indicators of potential bias; and
- Other audit procedures responsive to the risk of fraud, non-compliance with laws and regulation or irregularity including testing the accuracy, occurrence and completeness of income and non-pay expenditure;
- Assessing whether the engagement team collectively had the appropriate competence and capabilities to identify or recognise non-compliance with laws and regulations. We concluded that more experienced audit team members needed to be allocated to perform work on the significant risks identified.

We also communicated potential non-compliance with laws and regulations, including potential fraud risks, to all engagement team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

Because of the inherent limitations of an audit, there is a risk that we will not detect all irregularities, including those leading to a material misstatement in the financial statements or non-compliance with regulations. This risk increases the more that compliance with a law or regulation is removed from the events and transactions reflected in the financial statements, as we will be less likely to become aware of instances of non-compliance. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

Report on other legal and regulatory matters

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves, or would involve, the incurring of unlawful expenditure, or is about to take or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2023.

Our work in this area is not yet complete. Our preliminary assessment is included in our Audit Findings Report and the outcome of our work will be reported in our commentary on the Trust's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in arrangements, these will be reported by exception in our Audit Completion Certificate.

We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2023.

Independent Auditors Statement ----------

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit completion certificate in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice until we have completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Chris Brown

Digitally signed by Chris Brown
DN: cn=Chris Brown, c=GB, o=Azets, email=chris.brown@azets.co.uk
Reason: I am the author of this document

Chris Brown, Key Audit Partner

for and on behalf of Azets Audit Services, Local Auditor
Edinburgh

8 September 2023

Independent Auditors Statement

Independent Auditor's Report to the Council of Governors of Harrogate and District NHS Foundation Trust

In our auditor's report issued on 8 September 2023 we explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2023, in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice, until we had completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2023 issued on 8 September 2023 we reported that, in our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2023 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with UK adopted international accounting standards, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

No matters have come to our attention since 8 September 2023 that would have a material impact on the financial statements on which we gave this opinion.

Report on other legal and regulatory matters - the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2023.

We have nothing to report in this respect.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources . We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Independent Auditors Statement

Certificate of completion of the audit

We certify that we have completed the audit of the financial statements of Harrogate and District NHS Foundation Trust for the year ended 31 March 2023 in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Chris Brown, Key Audit Partner

for and on behalf of Azets Audit Services, Local Auditor

Edinburgh
29 September 2023

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SECTION NINE

Annual Accounts 2022-2023

9. Harrogate and District NHS Foundation Trust – Annual Accounts 2022 – 2023

Foreword to the Accounts

These accounts are prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

The annual accounts submitted under paragraph 25 of Schedule 7 to the 2006 Act shall show, and give a true and fair view of, the NHS foundation trust's income and expenditure, cash flows and financial state at the end of the financial period.

The annual accounts shall follow the requirements as to form and content set out in chapter 1 of the NHS Foundation Trust Annual Reporting Manual (FT ARM) in force for the relevant financial year.

The annual accounts shall comply with the accounting requirements of the Department of Health and Social Care Group Accounting Manual (DHSC GAM) as in force for the relevant financial year.

The Statement of Financial Position shall be signed and dated by the chief executive of the NHS foundation trust.

Jonathan Coulter
Chief Executive Officer
Harrogate and District NHS Foundation Trust
8 September 2023

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CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2023

	Note	Group 2022/23 Total £000	Group 2021/22 Total £000
Operating income from continuing operations	3.1	**352,270**	324,260
Operating expenses of continuing operations	4.1	**(349,004)**	(312,153)
OPERATING SURPLUS		**3,266**	12,107
FINANCE COSTS			
Finance income	6.1	**851**	64
Finance expense - financial liabilities	7	**(365)**	(202)
Finance expense - unwinding of discount on provisions	17.2	**(2)**	(2)
Public Dividend Capital - dividends payable		**(2,952)**	(2,366)
NET FINANCE COSTS		**(2,468)**	(2,506)
Losses on disposal of assets	9.1	**(21)**	(6)
Movement in fair value of investments	11	**(124)**	17
SURPLUS FOR THE YEAR		**652**	9,612
Other comprehensive income			
Revaluations	9.1	**3,618**	6,570
Other reserve movements		**3**	-
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**4,273**	16,182

The notes on pages 115 to 154 form part of these financial statements.

CONSOLIDATED STATEMENT OF FINANCIAL POSITION
as at 31 March 2023

		Group	
		31 March 2023	31 March 2022
	Note	**£000**	£000
Non-current assets			
Intangible assets	8	**6,759**	4,149
Property, plant and equipment	9.1 & 9.3	**145,482**	130,262
Right of use assets	10.1	**9,292**	-
Other Investments	11	**1,685**	1,830
Trade and other receivables	14.1	**832**	1,103
Total non-current assets		**164,050**	137,344
Current assets			
Inventories	13.1	**2,443**	1,931
Trade and other receivables	14.1	**23,607**	10,535
Cash and cash equivalents	15	**35,679**	42,854
Total current assets		**61,729**	55,320
Current liabilities			
Trade and other payables	16	**(49,960)**	(41,959)
Borrowings	19	**(3,089)**	(1,223)
Provisions	17.1	**(104)**	(100)
Other liabilities	18	**(2,840)**	(2,643)
Total current liabilities		**(55,993)**	(45,925)
Total assets less current liabilities		**169,786**	146,739
Non-current liabilities			
Trade and other payables	16	**-**	(187)
Borrowings	19	**(15,274)**	(9,054)
Provisions	17.1	**(662)**	(801)
Total non-current liabilities		**(15,936)**	(10,042)
Total assets employed		**153,850**	136,697
Financed by taxpayers' equity:			
Public Dividend Capital		**116,818**	103,938
Revaluation reserve		**15,166**	11,548
Income and expenditure reserve		**19,622**	18,676
HDFT charitable fund reserves	26	**2,244**	2,535
Total taxpayers' equity (see page 109)		**153,850**	136,697

The notes on pages 115 to 154 form part of these financial statements.

Signed: …… Mr. Jonathan Coulter - Chief Executive

Date: 8 September 2023

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2023

	HDFT charitable fund reserve	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Group Total
	£000	£000	£000	£000	£000
Balance as at 1 April 2022	2,535	103,938	11,548	18,676	136,697
Surplus for the financial year (Page 107)	(459)	-	-	1,112	652
Revaluations (Note 9.1)	-	-	3,618	-	3,618
Public Dividend Capital received	-	12,880	-	-	12,880
Other reserve movements	-	-	-	3	3
Other reserve movements - charitable funds consolidation adjustment	168	-	-	(168)	-
Balance at 31 March 2023	2,244	116,818	15,166	19,622	153,850

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2022

	HDFT charitable fund reserve	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Group Total
	£000	£000	£000	£000	£000
Balance as at 1 April 2021	2,186	98,845	4,978	9,413	115,422
Surplus for the financial year (Page 107)	637	-	-	8,975	9,612
Revaluations (Note 9.3)	-	-	6,570	-	6,570
Public Dividend Capital received	-	5,093	-	-	5,093
Other reserve movements - charitable funds consolidation adjustment	(288)	-	-	288	-
Balance at 31 March 2022	2,535	103,938	11,548	18,676	136,697

The notes on pages 115 to 154 form part of these financial statements.

CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2023

		Group	
		2022/23	2021/22
	Note	**£000**	£000
Cash flows from operating activities			
Operating surplus from continuing operations		**3,266**	12,107
		3,266	12,107
Non-cash income and expense			
Depreciation and amortisation	4.1	**10,574**	7,509
Impairments and reversals	9.1	**(238)**	3,181
Income recognised in respect of capital donations		**(1,033)**	(12,717)
Increase/(Decrease) in trade and other receivables		**(13,058)**	(2,279)
Decrease in inventories	13.1	**(512)**	98
Increase in trade and other payables		**6,451**	12,329
Increase/(Decrease) in other liabilities	18	**197**	1,213
Increase/(Decrease) in provisions		**(138)**	597
HDFT Charitable Funds - net adjustments for working capital		**(3)**	(10)
NHS charitable funds: other movements in operating cash flows		**-**	(148)
NET CASH GENERATED FROM OPERATIONS		**5,507**	21,880
Cash flows from investing activities			
Interest received		**708**	22
Purchase of Intangible assets	8	**(3,885)**	(1,292)
Purchase of Property, Plant and Equipment		**(17,143)**	(22,222)
Receipt of cash donations to purchase capital assets		**572**	12,717
HDFT Charitable funds - net cash flows from investing activities		**74**	44
Net cash used in investing activities		**(19,674)**	(10,731)
Cash flows from financing activities			
Public dividend capital received (please see page 8)		**12,880**	5,093
Movement in loans from the DHSC	19	**(1,180)**	(4,867)
Capital element of lease liability repayments		**(1,744)**	-
Interest paid		**(366)**	(212)
PDC dividend paid		**(2,598)**	(2,507)
Net cash generated/(used) in financing activities		**6,992**	(2,493)
Net increase in cash and cash equivalents	15	**(7,175)**	8,656
Cash and cash equivalents at 1 April 2022	15	**42,854**	34,198
Cash and cash equivalents at 31 March 2023	15	**35,679**	42,854

The notes on pages 115 to 154 form part of these financial statements.

FOUNDATION TRUST STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2023

	Note	Foundation Trust 2022/23 Total £000	Foundation Trust 2021/22 Total £000
Operating income from continuing operations	3.1	**352,166**	324,636
Operating expenses of continuing operations	4.2	**(350,047)**	(309,571)
OPERATING SURPLUS		**2,119**	15,065
FINANCE COSTS			
Finance income	6.2	**1,965**	36
Finance expense - financial liabilities	7	**(139)**	(202)
Finance expense - unwinding of discount on provisions	16.2	**(3)**	(2)
Public Dividend Capital - dividends payable		**(2,952)**	(2,366)
NET FINANCE COSTS		**(1,129)**	(2,534)
Losses on disposal of assets	9.2	**(21)**	(6)
SURPLUS FOR THE YEAR		**969**	12,525
Other comprehensive income			
Impairments charged to Revaluation Reserve	9.4	**-**	-
Revaluations	9.2	**9,705**	6,570
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		**10,674**	19,095

The notes on pages 114 to 154 form part of these financial statements.

FOUNDATION TRUST STATEMENT OF FINANCIAL POSITION
as at 31 March 2023

		Foundation Trust	
		31 March 2023	31 March 2022
	Note	**£000**	£000
Non-current assets			
Intangible assets	8	**6,759**	4,149
Property, plant and equipment	9.2 & 9.4	**127,806**	111,956
Right of Use Asset	10.1	**9,291**	-
Investment in Subsidiary	12	**1,000**	1,000
Loan to Subsidiary	12	**23,155**	20,191
Trade and other receivables	14.1	**832**	1,103
Total non-current assets		**168,844**	138,399
Current assets			
Inventories	13.1	**2,297**	1,816
Loan to Subsidiary	12	**2,649**	1,643
Trade and other receivables	14.1	**22,572**	8,533
Cash and cash equivalents	15	**32,281**	38,846
Total current assets		**59,799**	50,838
Current liabilities			
Trade and other payables	16	**(45,254)**	(37,248)
Borrowings	19	**(2,840)**	(1,223)
Provisions	17.1	**(104)**	(100)
Other liabilities	18	**(2,840)**	(2,643)
Total current liabilities		**(51,038)**	(41,214)
Total assets less current liabilities		**177,605**	148,023
Non-current liabilities			
Trade and other payables	16	**-**	(187)
Borrowings	19	**(15,408)**	(9,054)
Provisions	17.1	**(662)**	(801)
Total non-current liabilities		**(16,070)**	(10,042)
Total assets employed		**161,535**	137,981
Financed by taxpayers' equity:			
Public Dividend Capital		**116,818**	103,938
Revaluation reserve		**21,253**	11,548
Income and expenditure reserve		**23,464**	22,495
Total taxpayers' equity (see page 113)		**161,535**	137,981

The notes on pages 115 to 154 form part of these financial statements.

Signed: …… Mr. Jonathan Coulter - Chief Executive

Date: 8 September 2023

FOUNDATION TRUST STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2023

	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Foundation Trust Total
	£000	£000	£000	£000
Balance as at 1 April 2022	**103,938**	**11,548**	**22,495**	**137,981**
Surplus for the financial year (see page 111)	**-**	**-**	**969**	**969**
Revaluations (Note 9.2)	**-**	**9,705**	**-**	**9,705**
Public Dividend Capital received	**12,880**	**-**	**-**	**12,880**
Balance at 31 March 2023	**116,818**	**21,253**	**23,464**	**161,535**

FOUNDATION TRUST STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2022

	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Foundation Trust Total
	£000	£000	£000	£000
Balance as at 1 April 2021	98,845	4,978	9,970	113,793
Surplus for the financial year (see page 111)	-	-	12,525	12,525
Revaluations (Note 9.4)	-	6,570	-	6,570
Public Dividend Capital received	5,093	-	-	5,093
Balance at 31 March 2022	103,938	11,548	22,495	137,981

The notes on pages 115 to 154 form part of these financial statements.

FOUNDATION TRUST STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2023

	Note	Foundation Trust 2022/23 £000	2021/22 £000
Cash flows from operating activities			
Operating surplus from continuing operations		**2,119**	15,065
		2,119	15,065
Non-cash income and expense			
Depreciation and amortisation	4.2	**10,033**	7,149
Impairments and (reversals)	9.2	**(238)**	(147)
Income recognised in respect of capital donations	3.1	**(571)**	-
(Increase)/Decrease in trade and other receivables		**(5,707)**	(456)
(Increase)/Decrease in inventories	13	**(481)**	97
Increase/(Decrease) in trade and other payables		**(1,749)**	11,912
Increase in other liabilities	18	**197**	1,213
Increase / (Decrease) in provisions		**(147)**	597
NET CASH GENERATED FROM OPERATIONS		**3,456**	35,430
Cash flows from investing activities			
Interest received		**1,875**	36
Purchase of Intangible assets	8	**(3,885)**	(1,292)
Purchase of Property, Plant and Equipment		**(11,279)**	(8,206)
Receipt of cash donations to purchase capital assets		**-**	-
Net cash used in investing activities		**(13,289)**	(9,462)
Cash flows from financing activities			
Public dividend capital received (please see page 12)		**12,880**	5,093
Movement in loans from the DHSC		**(1,180)**	(4,867)
Movement in loans to subsidiary		**(3,970)**	(18,053)
Capital element of lease liability repayments		**(1,721)**	-
Interest paid		**(143)**	(212)
PDC dividend paid		**(2,598)**	(2,507)
Net cash generated/(used) in financing activities		**3,268**	(20,546)
Net increase/(decrease) in cash and cash equivalents	15	**(6,565)**	5,422
Cash and cash equivalents at 1 April 2022	15	**38,846**	33,424
Cash and cash equivalents at 31 March 2023	15	**32,281**	38,846

The notes on pages 115 to 154 form part of these financial statements.

1 GROUP ACCOUNTING POLICIES AND OTHER INFORMATION

NHS England has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC Group Accounting Manual 2022-23, issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC Group Accounting Manual permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS foundation trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the Trust's services in the public sector is normally sufficient evidence of going concern.

After making enquiries, the directors have a reasonable expectation that the services provided by Harrogate and District NHS Foundation Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Consolidation

The NHS foundation trust is the corporate trustee to the Harrogate and District NHS Foundation Trust Charitable Fund (registered charity number 1050008). The NHS foundation trust has assessed its relationship with the charitable fund and determined it to be a subsidiary because the NHS foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable funds statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the NHS foundation trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

The NHS foundation trust launched Harrogate Healthcare Facilities Management Ltd (HHFM) a wholly owned subsidiary with effect from the 1 March 2018 (registered company number 11048040). HHFM trades as Harrogate Integrated Facilities (HIF). The income, expenses, assets, liabilities, equity and reserves of HHFM are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with NHS foundation trust.

Joint ventures are separate entities over which the NHS foundation trust has joint control with one or more other parties. The meaning of control is to exercise control or power to influence so as to gain economic or other benefits. Joint ventures are accounted for under IAS 28 using the equity method. The NHS foundation trust has equity investment in the following joint ventures:

- Integrated Laboratory Solutions LLP
- Integrated Pathology Solutions LLP

1.4 Operating segments

Income and expenditure are analysed in the Operating Segments note (2.1) and are reported in line with management information used within the NHS foundation trust.

1.5 Revenue

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.

1.5 Revenue (continued)

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

- The NHS foundation trust is not required to disclose information regarding performance obligations that are part of a contract that has an original expected duration of one year or less.
- The NHS foundation trust is not required to disclose information where revenue is recognised in line with the practical expedient offered in the Standard, where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in the Standard that requires [the entity] to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of revenue for NHS foundation trust is contracts with commissioners in respect of healthcare services. Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. At the year end, the NHS foundation trust accrues income relating to performance obligations satisfied in that year. Where a patient care spell is incomplete at the year end, revenue relating to the partially complete spell is accrued in the same manner as other revenue.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred. The method adopted to assess progress towards the complete satisfaction of a performance obligation is determined by reviewing key milestones/deliverables determined at inception.

The NHS foundation trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The NHS foundation trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepencies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements or measuring expected credit losses

Income from the sale of non-current assets is recognised only when all material conditions of sales have been met, and is measured as the sums due under the sale contract.

1.6 Expenditure on employee benefits

Short term employee benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including non-consolidated performance pay earned but not yet paid. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Pension costs - NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS foundation trust of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time [the NHS body] commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.6 Expenditure on employee benefits (continued)

Pension costs - National Employment Savings Trust (NEST) Pension Scheme

The Pensions Act 2008 requirements created a duty for the NHS foundation trust to provide a pension scheme for employees who are ineligible to join the NHS Pension Scheme. The NHS foundation trust selected NEST as it's partner to meet this duty. The scheme operated by NEST on the NHS foundation trust's behalf is a defined contribution scheme and employers contributions are charged to operating expenses as and when they become due.

Pension costs - HHFM defined contribution scheme (The People's Pension)

A defined contribution plan is a post employment benefit plan under which the Company pays fixed contributions into a separate entity and will have no legal or constructive obligation to pay further amounts. Obligations for contributions to defined contribution pension plans are recognised as an expense in the profit and loss account in the periods during which services are rendered by employees.

A number of the HHFM employees remain within the NHS Pension Scheme, however HHFM also operates a defined contribution pension scheme, The assets of the scheme are held separately from those of the Group in an independently administered fund. The amount charged to the profit and loss account represents the contributions payable to the scheme in respect of the accounting period.

1.7 Expenditure on other goods and services

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.8 Value Added Tax

Most of the activities of the NHS foundation trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable the amounts are stated net of VAT.

1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if;

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the NHS foundation trust
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and either
- individually has a cost of at least £5,000; or
- collectively has a cost of at least £5,000 and individually has a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their individual useful economic lives.The assessment of the components useful economic life may be adjusted to reflect the wider scheme of work.

1.9 Property, plant and equipment (continued)

Valuation

Land and buildings used for the NHS foundation trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the statement of financial position date. Fair values are determined as follows:

Land and specialised buildings – depreciated replacement cost
Non specialised buildings – existing use value

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. All valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS). The NHS foundation trust had a full valuation of its land and buildings carried out as at 31 March 2017 based on an alternative site in line with HM Treasury's approach. The NHS foundation trust's management having taken advice from professionally qualified valuers, determined that a desktop valuation should be carried out as at 31 March 2020 ensuring that land and buildings are held at fair value. The desktop valuation was also based on an alternative site in line with HM Treasury's approach, this revised valuation has been incorporated in the financial statements.

An item of property, plant and equipment which is surplus with no plan to bring back into use is valued at fair value under IFRS 13.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Costs include professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by International Accounting Standard (IAS) 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as a proxy for fair value.

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income. Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of "Other Comprehensive

In accordance with the DoH GAM, impairments that arise from a clear consumption of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment. Other impairments are treated as revaluation losses. Reversals of other impairments are treated as revaluation gains.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.10 Intangible Assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the NHS foundation trust business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the NHS foundation trust; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it, and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.11 Depreciation, amortisation and impairments

Freehold land, assets under construction or development, investment properties, stockpiled goods, and assets held for sale are not depreciated/amortised

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the NHS foundation trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS foundation trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless the NHS foundation trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

At each financial year end, the NHS foundation trust checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

1.11 Depreciation, amortisation and impairments (cont)

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings*	1	90
Dwellings*	1	90
Plant & machinery	5	16
Transport equipment	5	11
Information technology	5	11
Furniture & fittings	5	11

*Assessed by a RICS qualified valuer when a valuation takes place

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	2	5
Development expenditure	2	5
Websites	2	5
Software licences	2	5
Licences & trademarks	2	5
Patents	2	5
Other (purchased)	2	5
Goodwill	2	5

1.12 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.13 Government grant funded assets

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 0.95% applied to new leases.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

1.14 Leases (cont)

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases
Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Initial application of IFRS 16
IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury has been applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaces IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations.

The standard has been applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 have only been applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments have not been revisited.

The Trust as lessee
For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the statement of financial position immediately prior to initial application. Hindsight has been used in determining the lease term where lease arrangements contain options for extension or earlier termination.

No adjustments have been made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets has a value below £5,000. No adjustments have been made in respect of leases previously classified as finance leases.

The Trust as lessor
Leases of owned assets where the Trust is lessor were unaffected by initial application of IFRS 16. For existing arrangements where the Trust is an intermediate lessor, classification of all continuing sublease arrangements has been reassessed with reference to the right of use asset.

2021/22 comparatives
Comparatives for leasing transactions in these accounts have not been restated on an IFRS 16 basis. Under IAS 17 the classification of leases as operating or finance leases still applicable to lessors under IFRS 16 also applied to lessees. In 2021/22 lease payments made by the Trust in respect of leases previously classified as operating leases were charged to expenditure on a straight line basis.

1.15 Inventories

Inventories are valued at the lower of cost and net realisable value, using the first-in first out cost formula.

1.16 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the NHS foundation trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.17 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2022:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	0.47%	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.70%	0.18%
Long-term	After 10 years up to 40 years	0.95%	1.99%
	Exceeding 40 years	0.66%	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2022:

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95).

1.18 Clinical negligence costs

NHS Resolution (the trading name of the NHS Litigation Authority NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 17. Provisions but is not recognised in the Trust’s

1.19 Non-clinical risk pooling

The NHS foundation trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS foundation trust pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.20 Contingent liabilities and contingent assets

A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS foundation trust, or
- a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation, or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS foundation trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.21 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

1.21 Losses and special payments (cont)

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the NHS foundation trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.22 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.23 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

1.24 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the NHS foundation trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described in note 1.8 above.

Purchase or sales are recognised and derecognised, as applicable, using the trade date.

All other financial assets and financial liabilities are recognised when the NHS foundation trust becomes party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the NHS foundation trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as loans and receivables.

Financial liabilities are classified as other financial liabilities.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The NHS foundation trust's loans and receivables comprise: cash and cash equivalents, NHS receivables and other receivables.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income. Loans from the Department of Health are not held for trading and are measured at historic cost with any unpaid interest accrued separately.

1.24 Financial instruments and financial liabilities (cont)

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from discounted cash flow analysis.

Impairment of financial assets

At the Statement of Financial Position date, the NHS foundation trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the assets carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly or through the use of a bad debt provision. Bad debt provisions are used when there is some uncertainty that the debt will be paid. Bad debts are written off directly only when there is certainty that the debt will not be paid.

1.25 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital is a type of public sector equity finance, which represents the Department of Health and Social Care’s investment in the trust. HM Treasury has determined that, being issued under statutory authority rather than under

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the trust. Relevant net assets are calculated as the value of all assets less all liabilities, except for:

- donated and grant funded assets
- charitable funds
- average daily cash balances held with the Government Banking Service (GBS) and National Loans Fund (NLF) deposits (excluding cash balances held in GBS accounts that relate to a short-term working capital facility)
- approved expenditure on COVID-19 capital assets
- assets under construction for nationally directed schemes
- any PDC dividend balance receivable or payable.

The average relevant net assets are calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health and Social Care, the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts. The PDC dividend calculation is based upon the trust’s group accounts (i.e. including subsidiaries), but excluding consolidated charitable funds.

1.26 Corporation Tax

The NHS foundation trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this but the trust is potentially within the scope of corporation tax in respect of activities where income is received from a non public sector source.

The NHS foundation trust has determined that it has no corporation tax liability, as all activities are either ancillary to healthcare or below the de minimus level of profit at which tax is payable. However Harrogate Healthcare Facilities Management Ltd is a wholly owned subsidiary of NHS foundation trust and is subject to corporation tax on its profits.

1.27 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2022/23.

1.28 IFRS Standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2022-23. These Standards are still subject to HM Treasury FReM adoption.

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 is yet to be adopted by the FReM, therefore early adoption is not permitted.

1.29 Critical estimates and judgements in applying accounting policies

The preparation of financial statements under IFRS requires the foundation trust to make estimates and assumptions that affect the application of policies and reported amounts. Estimates and judgements are continually evaluated and are based on historical experience and other factors that are considered to be relevant.

Revisions to accounting estimates are recognised in the period that the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Although the NHS foundation trust makes estimates within these financial statements such as incomplete patient spells, accrued income, annual leave accrual and provisions e.g. early retirements, the amounts involved would not cause a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

In relation to estimations for uncoded NHS income at the financial yearend, the NHS foundation trust runs a forecast for income relating to March based on the average income received by specialty and point of delivery, all uncoded activity is then priced using an average. This methodology is used throughout the year and has proven to be robust with only very minor variances showing once the activity is coded and then costed. Added to this, there is less variation in this position due to the changes as a result of the funding approach adopted nationally in response to the Covid-19 pandemic.

In addition, a revaluation of the NHS foundation trust's land and buildings was undertaken at a prospective date of 31 March 2022, the valuation excludes the cost of VAT. Since the NHS foundation trust created a subsidiary company "Harrogate Healthcare Facilities Management Ltd". The subsidiary company became responsible for the provision of a Managed Healthcare Facility to the NHS foundation trust, a consequence of this was that VAT became recoverable under an MEA alternative site valuation. The NHS foundation trust relies on the professional services of the Valuation Office for the accuracy of such valuations.

Finally, the NHS foundation trust has made utilised estimates provided by NHS England in relation to the pay award for agenda for change staff, and the settlement of the ongoing pay dispute. These payments have been made in 2022/23 and the figures are accurate for this staff group. It is assumed that any other agreement with other staff groups will be supported with income.

1.30 Climate Change Levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

2 Operating segments

2.1 Group operating segments

The NHS foundation trust's management has reviewed IFRS 8 (Operating Segments) and has determined that the consolidated financial statements consist of two segments "Healthcare" and "Charity".

	Group		Group	
	Healthcare 2022/23 £000	**Charity 2022/23 £000**	Healthcare 2021/22 £000	Charity 2021/22 £000
Operating Surplus/(Deficit)	**3,486**	**(220)**	11,817	290
Net Finance (Costs)/Income	**(2,521)**	**53**	(2,548)	42
Movement in fair value of investments/Loss on disposal of assets/Corporation tax expenses	**(21)**	**(124)**	(6)	17
SURPLUS/(DEFICIT) FOR THE YEAR	**944**	**(291)**	9,263	349
Non-current assets	**162,365**	**1,685**	135,514	1,830
Current assets	**61,136**	**593**	54,585	735
Current liabilities	**(55,959)**	**(34)**	(45,895)	(30)
Non-current liabilities	**(15,936)**	**-**	(10,042)	-
TOTAL ASSETS EMPLOYED	**151,606**	**2,244**	134,162	2,535
Financed by taxpayers' equity:				
Public Dividend Capital	**116,818**	**-**	103,938	-
Revaluation reserve	**15,166**	**-**	11,548	-
Income and expenditure reserve	**19,622**	**-**	18,676	-
HDFT Charitable fund reserves	**-**	**2,244**	-	2,535
TOTAL TAXPAYERS' EQUITY	**151,606**	**2,244**	134,162	2,535

3 Operating Income from continuing operations

3.1 Analysis of operating income

	Foundation Trust & Group	
	2022/23	2021/22
	£000	£000
Income from activities by nature:		
Acute services		
Block contract / system envelope income	**198,262**	194,736
High cost drugs income from commissioners	**8,148**	2,692
Other NHS clinical income	**787**	857
Community services		
Block contract / system envelope income	**31,570**	31,010
Income from other sources (e.g. local authorities)	**53,011**	42,286
All trusts		
Private patient income	**521**	815
Elective recovery fund	**5,431**	3,385
Agenda for change pay offer central funding	**8,325**	-
Additional pension contribution central funding (see below*)	**8,818**	7,934
Other clinical income	**33**	477
Total income from activities	**314,906**	284,192

	Foundation Trust & Group	
	2022/23	2021/22
	£000	£000
Income from activities by source:		
NHS Foundation Trusts	**335**	441
NHS Trusts	**-**	37
NHS England	**41,918**	33,646
Clinical commissioning groups	**48,630**	206,499
Integrated care boards	**166,016**	-
Local Authorities	**53,010**	42,286
Department of Health and Social Care	**20**	-
NHS Other	**4,028**	45
Non NHS: Private Patients	**463**	815
Non-NHS: Overseas patients (chargeable to patient)	**59**	48
NHS injury scheme (see below**)	**335**	275
Non NHS: Other	**92**	100
Total income from activities	**314,906**	284,192

	Group	
	2022/23	2021/22
	£000	£000
Group other operating income:		
Research and development	**1,030**	1,008
Education and training	**19,028**	11,566
Education and training - notional income from apprenticeship fund	**880**	284
Non-patient care services to other bodies	**4,201**	1,855
Reimbursement and top up funding	**414**	1,676
Donated equipment from DHSC for COVID response (non-cash)	**461**	-
Cash donations for the purchase of capital assets - received from other bodies	**572**	12,717
Contributions to expenditure - consumables (inventory) donated from DHSC	**455**	643
Rental revenue from operating leases (see note 3.4)	**-**	162
Staff recharges (secondments)	**5,278**	4,145
HDFT Charitable Funds: Incoming Resources excluding investment income	**604**	879
Other	**4,441**	5,133
Group total other operating income	**37,364**	40,068
Group total operating income	**352,270**	324,260

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

** NHS injury scheme income is subject to a provision for doubtful debts of 22.43% (2021: 22.43%) to reflect expected rates of collection.

3.1 Analysis of operating income (continued)

	Foundation Trust	
	2022/23	2021/22
	£000	£000
Total income from activities	**314,906**	284,192
Foundation Trust other operating income:		
Research and development	**1,030**	1,008
Education and training	**19,028**	11,566
Education and training - notional income from apprenticeship fund	**880**	284
Received from NHS charities: Receipt of grants/donations for capital acquisitions	**-**	148
Non-patient care services to other bodies	**4,988**	2,647
Reimbursement and top up funding	**298**	1,676
Cash donations for the purchase of capital assets - received from other bodies	**571**	12,717
Donated equipment from DHSC/UKHSA for COVID response (non-cash)	**461**	
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies	**455**	643
Rental revenue from operating leases (see note 3.6)	**-**	1,265
Staff recharges (secondments)	**5,378**	4,283
Other	**4,171**	4,207
Foundation Trust total other operating income	**37,260**	40,444
Foundation Trust total operating income	**352,166**	324,636

3.2 Overseas visitors (relating to patients charged directly by the foundation trust)

Income recognised in year relating to overseas visitors was £59k (2022 £48k), payments received in year (relating to invoices raised in current and previous years) was £26k (2022 £21k) and amounts written off in year (relating to invoices raised in current and previous years) was £0k (2022 £5k).

3.3 Analysis of income from activities by Commissioner Requested Services (CRS) and Non-Commissioner Requested Services (Non-CRS).

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Foundation Trust & Group	
	2022/23	2021/22
	£000	£000
Commissioner Requested Services	**179,577**	162,041
Non-Commissioner Requested Services	**135,329**	122,151
Total	**314,906**	284,192

3.4 Additional information on revenue from contracts with customers recognised in the period.

	Foundation Trust & Group	
	2022/23	2021/22
	£000	£000
Revenue recognised in the reporting period that was included in contract liabilities at the previous period end	**-**	-
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	**-**	-

3.5 Operating lease income and future annual lease receipts - Group

This note discloses income generated in operating lease agreements where No trust selected is the lessor.
The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives.
Comparative disclosures in this note are presented on an IAS 17 basis. This includes a different maturity analysis of future minimum lease receipts under IAS 17 compared to IFRS 16.

	Group	
	2022/23	2021/22
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	**-**	162
Variable lease receipts / contingent rents	**-**	-
Other	**-**	-
	-	162
Future minimum lease receipts due on buildings expiring		
- not later than one year;	**-**	162
- later than one year and not later than five years;	**-**	650
- later than five years.	**-**	194
	-	1,006

3.6 Operating lease income and future annual lease receipts - Foundation Trust

	Foundation Trust	
	2022/23	2021/22
Lease receipts recognised as income in year:	**£000**	£000
Minimum lease receipts	**-**	-
Variable lease receipts / contingent rents	**-**	1,265
Other	**-**	-
	-	1,265
Future minimum lease receipts due on buildings expiring		
- not later than one year;	**-**	1,265
- later than one year and not later than five years;	**-**	5,126
- later than five years.	**-**	18,098
	-	24,489

4. Operating Expenses from continuing operations

4.1 Group operating expenses comprise:

	Group	
	2022/23	2021/22
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	**110**	115
Purchase of healthcare from non-NHS and non-DHSC bodies	**229**	105
Staff and executive directors costs	**252,229**	213,770
Non-executive directors	**212**	196
Drug costs (see note 13.2)	**20,168**	18,289
Supplies and services - clinical	**25,731**	24,867
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	**455**	643
Supplies and services - general	**2,318**	8,901
Establishment	**2,552**	2,092
Research and development	**12**	11
Transport (including Patients' travel)	**1,866**	1,238
Premises - business rates payable to local authorities	**371**	1,101
Premises - other	**12,029**	9,883
Increase in provision for irrecoverable debts	**(1,707)**	916
Operating leases expenditure (comparative only)	**-**	4,056
Depreciation on property, plant and equipment	**9,299**	6,728
Amortisation on intangible assets (see note 8)	**1,275**	781
Impairments/(Reversals) of property, plant and equipment	**(238)**	3,181
Audit services- statutory audit	**174**	184
NHS Resolution contribution - Clinical Negligence	**6,529**	7,210
Legal fees	**58**	562
Consultancy costs	**1,018**	799
Internal audit costs	**201**	193
Education and training	**9,414**	2,285
Education and training - notional expenditure funded from apprenticeship fund	**880**	284
Redundancy	**134**	6
Early retirements	**10**	7
Hospitality	**4**	73
Insurance	**30**	369
Losses, ex gratia and special payments (see note 20) - Non Pay	**22**	39
Losses, ex gratia and special payments (see note 20) - Pay	**-**	488
Other	**2,627**	2,480
HDFT Charitable funds: Other resources expended	**992**	301
Group total operating expenses	**349,004**	312,153

4. Operating Expenses from continuing operations (Continued)

4.2 Foundation Trust operating expenses comprise:	**Foundation Trust**	
	2022/23	2021/22
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	**109**	115
Purchase of healthcare from non-NHS and non-DHSC bodies	**229**	105
Staff and executive directors costs	**242,329**	205,004
Non-executive directors	**185**	164
Drug costs (see note 13.2)	**20,168**	18,289
Supplies and services - clinical	**23,163**	22,786
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	**455**	643
Supplies and services - general	**22,683**	25,365
Establishment	**2,227**	1,811
Research and development	**12**	11
Transport (including Patients' travel)	**1,749**	1,193
Premises - business rates payable to local authorities	**371**	1,101
Premises - other	**8,999**	6,559
Increase/(Decrease) in provision for irrecoverable debts	**(1,707)**	916
Operating leases expenditure (comparative only)	**(1,321)**	4,004
Depreciation on property, plant and equipment	**8,758**	6,395
Amortisation on intangible assets (see note 8)	**1,275**	754
Impairments/(Reversals) of property, plant and equipment	**(238)**	(147)
Audit services- statutory audit	**141**	150
NHS Resolution contribution - Clinical Negligence	**6,529**	7,210
Legal fees	**(233)**	562
Consultancy costs	**1,004**	756
Internal audit costs	**182**	173
Education and training	**9,374**	2,234
Education and training - notional expenditure funded from apprenticeship fund	**880**	284
Redundancy	**134**	6
Early retirements	**10**	7
Hospitality	**73**	73
Insurance	**289**	305
Losses, ex gratia and special payments (see note 20) - Non Pay	**22**	39
Losses, ex gratia and special payments (see note 20) - Pay	**-**	488
Other	**2,196**	2,216
Foundation Trust total operating expenses	**350,047**	309,571

4.3 Limitation on external auditor's liability

	Foundation Trust & Group	
	2022/23	2021/22
	£000	£000
Limitation on external auditor's liability	**1,000**	1,000
	1,000	1,000

5. Employee costs and numbers

5.1 Employee costs

	Total 2022/23 £000	**Group Permanently Employed £000**	**Other £000**	Total 2021/22 £000	Group Permanently Employed £000	Other £000
Salaries and wages	**195,389**	**193,056**	**2,333**	167,262	164,613	2,649
Social Security costs (Employers NI costs)	**17,223**	**17,223**	**-**	14,480	14,480	-
Apprenticeship levy	**846**	**846**	**-**	759	759	-
Pension cost - employer contributions to NHS pension scheme	**20,448**	**20,448**	**-**	18,567	18,567	-
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	**8,818**	**8,818**	**-**	7,934	7,934	-
Pension cost - other	**309**	**309**	**-**	240	240	-
Termination benefits	**144**	**144**	**-**	6	6	-
External bank	**46**	**-**	**46**	-	-	-
Agency/contract staff	**10,911**	**-**	**10,911**	12,604	6,302	6,302
Total employee expenses	**254,134**	**240,845**	**13,290**	221,852	212,901	8,951
Less costs capitalised as part of assets	**(1,761)**	**(1,761)**	**-**	(1,286)	(1,286)	-
Total employee costs excluding capitalised costs	**252,373**	**239,084**	**13,290**	220,566	211,615	8,951

5. Employee costs and numbers (continued)

5.2 Employee costs

	Foundation Trust			Foundation Trust		
	Total 2022/23 £000	**Permanently Employed £000**	**Other £000**	Total 2021/22 £000	Permanently Employed £000	Other £000
Salaries and wages	**187,409**	**184,955**	**2,454**	159,820	157,162	2,658
Social Security costs (Employers NI costs)	**16,511**	**16,511**	**-**	13,877	13,877	-
Apprenticeship levy	**805**	**805**	**-**	722	722	-
Employer contributions to NHS Pensions Agency	**20,072**	**20,072**	**-**	18,117	18,117	-
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	**8,818**	**8,818**	**-**	7,934	7,934	-
Pension cost - other	**125**	**125**	**-**	102	102	-
Termination benefits	**144**	**144**	**-**	13	13	-
Agency/contract staff	**10,220**	**-**	**10,220**	5,922	-	5,922
Total employee expenses	**244,104**	**231,430**	**12,674**	206,507	197,927	8,580
Less costs capitalised as part of assets	**(1,631)**	**(1,631)**	**-**	(1,002)	(1,002)	-
Total employee costs excluding capitalised costs	**242,473**	**229,799**	**12,674**	205,505	196,925	8,580

5.3 Average number of employees (WTE basis)

	Group			Group		
	Total 2022/23 Number	**Permanently Employed Number**	**Other Number**	Total 2021/22 Number	Permanently Employed Number	Other Number
Medical and dental	**407**	**378**	**30**	413	386	27
Ambulance staff	**1**	**1**	**-**	1	1	-
Administration and estates	**773**	**751**	**22**	726	706	20
Healthcare assistants and other support staff	**412**	**412**	**-**	412	412	-
Nursing, midwifery and health visiting staff	**2,024**	**1,965**	**59**	1,842	1,806	36
Nursing, midwifery and health visiting learners	**47**	**47**	**-**	43	43	-
Scientific, therapeutic and technical staff	**533**	**533**	**-**	515	515	-
Healthcare science staff	**102**	**101**	**1**	106	97	9
Social care staff	**-**	**-**	**-**	-	-	-
Other	**12**	**12**	**-**	8	8	-
Total	**4,311**	**4,199**	**113**	4,066	3,974	92
Less capitalised employees	**(44)**	**(44)**	**-**	(28)	(28)	-
Total excluding capitalised WTE	**4,267**	**4,155**	**113**	4,038	3,946	92

5.4 Average number of employees (WTE basis)

	Foundation Trust			Foundation Trust		
	Total 2022/23 Number	**Permanently Employed Number**	**Other Number**	Total 2021/22 Number	Permanently Employed Number	Other Number
Medical and dental	**408**	**378**	**30**	413	386	27
Ambulance staff	**1**	**1**	**-**	1	1	-
Administration and estates	**702**	**698**	**4**	667	656	11
Healthcare assistants and other support staff	**200**	**200**	**-**	198	198	-
Nursing, midwifery and health visiting staff	**2,024**	**1,965**	**59**	1,842	1,806	36
Nursing, midwifery and health visiting learners	**47**	**47**	**-**	43	43	-
Scientific, therapeutic and technical staff	**533**	**533**	**-**	515	515	-
Healthcare science staff	**102**	**101**	**1**	106	97	9
Other	**8**	**8**	**-**	5	5	-
Total	**4,024**	**3,930**	**94**	3,790	3,707	83
Less capitalised employees	**(44)**	**(44)**	**-**	(21)	(21)	
Total excluding capitalised WTE	**3,980**	**3,886**	**94**	3,769	3,686	83

WTE = Whole time equivalents

5.5 Pensions costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as at 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

5.6 Retirements due to ill-health

During the year ended 31 March 2023 there were 2 (2022: 4) early retirements from the NHS foundation trust agreed on the grounds of ill-health. The estimated additional pension liability of the ill-health retirement is £68,000 (2022: £142,000). The cost of ill-health retirements are borne by the NHS Business Services Authority Pensions Division.

5.7 Staff exit costs

NHS Improvement requires NHS foundation trusts to disclose summary information regarding redundancy and other departures in staff costs agreed in the financial year.

	Foundation Trust & Group		Foundation Trust & Group	
Exit cost band	**2022/23 Number of compulsory redundancies**	**2022/23 Number of other departures agreed**	2021/22 Number of compulsory redundancies	2021/22 Number of other departures agreed
<£10,000	**-**	**-**	1	-
£10,001 - £25,000	**-**	**-**	-	-
£25,001 - £50,000	**-**	**-**	-	-
£50,001 - £100,000	**-**	**-**	-	-
£100,001 - £150,000	**1**	**-**	-	-
£150,001 - £200,000	**-**	**-**	-	-
>£200,000	**-**	**-**	-	-
Total number of exits by type	**1**	**-**	1	-
Total resource cost	**£134,000**	-	£6,000	-

5.8 Analysis of termination benefits

	Foundation Trust & Group		Foundation Trust & Group	
	2022/23 Number	**2022/23 £000**	2021/22 Number	2021/22 £000
Compulsory redundancies	**1**	**134**	1	6
Contractual payments in lieu of notice	**-**	**-**	-	-
	1	**134**	1	6

6. Finance revenue

6.1 Group finance revenue received during the year is as follows:

Finance revenue received during the year is as follows:	Group	
	2022/23	2021/22
	£000	£000
Interest income:		
Interest on bank accounts	**798**	22
HDFT Charitable funds: investment income	**53**	42
	851	64

6.2 Foundation Trust finance revenue received during the year is as follows:

Finance revenue received during the year is as follows:	Foundation Trust	
	2022/23	2021/22
	£000	£000
Interest income:		
Interest on bank accounts	**794**	22
Interest on loans to HHFM	**1,171**	14
	1,965	36

7. Finance expenses

Finance expenses incurred during the year are as follows:	Foundation Trust & Group	
	2022/23	2021/22
	£000	£000
Interest expense:		
Capital Loans from the Department of Health (formerly ITFF see note 18)	**162**	202
Interest on lease obligations	**203**	-
	365	**202**

8. Current year intangible fixed assets

	Foundation Trust & Group					
	Software Licences	**Development Expenditure**	**Websites**	**Assets Under Construction**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Gross cost at 1 April 2022	1,354	3,720	187	-	1,343	**6,604**
Additions - purchased	43	926	-	2,294	622	**3,885**
Reclassifications	657	502	-	(1,390)	231	**-**
Disposals	-	-	-	-	-	**-**
Gross cost at 31 March 2023	**2,054**	**5,148**	**187**	**904**	**2,196**	**10,489**
Amortisation at 1 April 2022	976	1,119	51	-	309	**2,455**
Provided during the year	263	666	26	-	320	**1,275**
Disposals	-	-	-	-	-	**-**
Amortisation at 31 March 2023	**1,239**	**1,785**	**77**	**-**	**629**	**3,730**
Net book value						
- Purchased at 31 March 2023	815	3,363	110	904	1,567	**6,759**
- Total at 31 March 2023	**815**	**3,363**	**110**	**904**	**1,567**	**6,759**

8.1 Prior year intangible fixed assets

	Foundation Trust & Group					
	Software Licences	**Development Expenditure**	**Websites**	**Assets Under Construction**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Gross cost at 1 April 2021	1,287	2,918	187	-	306	**4,698**
Additions - purchased	54	786	-	-	452	**1,292**
Reclassifications	18	16	-	-	585	**619**
Disposals	(5)	-	-	-	-	**(5)**
Gross cost at 31 March 2022	**1,354**	**3,720**	**187**	**-**	**1,343**	**6,604**
Amortisation at 1 April 2021	868	672	24	-	115	1,679
Provided during the year	113	447	27	-	194	781
Disposals	(5)	-	-	-	-	(5)
Amortisation at 31 March 2022	**976**	**1,119**	**51**	**-**	**309**	**2,455**
Net book value						
- Purchased at 31 March 2022	378	2,601	136	-	1,034	4,149
- Total at 31 March 2022	**378**	**2,601**	**136**	**-**	**1,034**	**4,149**

9. Property, plant and equipment

9.1 Current year property, plant and equipment (group) comprises of the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Group Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2022	3,500	82,770	1,138	20,191	30,598	178	16,279	745	**155,399**
Additions - purchased	-	1,259	-	15,299	203	-	1,103	66	**17,930**
Additions - donations of physical assets	-	197	-	375	-	-	-	-	**572**
Additions - equipment donated from DHSC	-	-	-	-	461	-	-	-	**461**
Impairments charged to operating expenses	-	-	-	-	-	-	-	-	**-**
Transfer to revaluation reserve	-	1,089	79	-	-	-	-	-	**1,168**
Reclassifications	-	9,417	-	(16,375)	3,912	-	2,972	74	**-**
Disposals	-	-	-	-	(138)	(8)	-	-	**(146)**
Cost or valuation At 31 March 2023	**3,500**	**94,732**	**1,217**	**19,490**	**35,036**	**170**	**20,354**	**885**	**175,384**
Depreciation at 1 April 2022	-	-	-	-	15,801	124	8,821	391	**25,137**
Provided during the year (see note 4.1)	-	2,630	58	-	2,977	11	1,836	66	**7,578**
Reversal of impairments charged to operating expenses	-	(238)	-	-	-	-	-	-	**(238)**
Transfer to revaluation reserve	-	(2,392)	(58)	-	-	-	-	-	**(2,450)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Disposals	-	-	-	-	(117)	(8)	-	-	**(125)**
Depreciation at 31 March 2023	**-**	**-**	**-**	**-**	**18,661**	**127**	**10,657**	**457**	**29,902**
Net book value									
- Purchased at 31 March 2023	3,500	81,781	1,217	17,116	13,581	43	9,684	413	**127,335**
- Donated at 31 March 2023	-	12,951	-	2,374	1,939	-	13	15	**17,292**
- Donated (DHSC) at 31 March 2023	-	-	-	-	855	-	-	-	**855**
Net book value at 31 March 2023	**3,500**	**94,732**	**1,217**	**19,490**	**16,375**	**43**	**9,697**	**428**	**145,482**

At 31 March 2023, of the Net Book Value £3,500,000 related to land valued at open market value and £94,732,000 related to buildings valued at open market value and £1,217,000 related to dwellings valued at open market value. The land and buildings (including dwellings) of the trust were revalued by the Valuation Office Agency which is a government agency of Her Majesty's Revenue and Customs (RICS qualified) as at 31 March 2023. This valuation, in line with the NHS foundation trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in an increase in value of £3,856,000.00.

9. Property, plant and equipment

9.2 Current year property, plant and equipment (Trust) comprises of the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Foundation Trust Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2022	3,500	77,202	654	9,439	27,908	25	16,268	686	**135,682**
Additions - purchased	-	1	-	10,719	79	-	1,115	36	**11,950**
Additions - donations of physical assets	-	197	-	375	-	-	-	-	**572**
Additions - equipment donated from DHSC	-	-	-	-	461	-	-	-	**461**
Reversals charged to operating expenses	-	238	-	-	-	-	-	-	**238**
Reclassifications	-	239	-	(6,794)	3,761	-	2,763	31	**-**
Transfer to revaluation reserve	-	7,265	28	-	-	-	-	-	**7,293**
Disposals	-		-	-	(138)		-		**(138)**
Cost or valuation At 31 March 2023	**3,500**	**85,142**	**682**	**13,739**	**32,071**	**25**	**20,146**	**753**	**156,058**
Depreciation at 1 April 2022	-	-	-	-	14,521	4	8,821	380	**23,726**
Provided during the year (see note 4.2)	-	2,383	29	-	2,764	4	1,817	58	**7,055**
Transfer to revaluation reserve	-	(2,383)	(29)	-	-	-	-	-	**(2,412)**
Disposals	-		-	-	(117)	-	-	-	**(117)**
Depreciation at 31 March 2023	**-**	**-**	**-**	**-**	**17,168**	**8**	**10,638**	**438**	**28,252**
Net book value									
- Purchased at 31 March 2023	3,500	80,278	682	13,739	12,964	17	9,508	300	**120,988**
- Donated at 31 March 2023	-	4,864	-	-	1,084	-	-	15	**5,963**
- Donated (DHSC) at 31 March 2023	-	-	-	-	855	-	-	-	**855**
Net book value at 31 March 2023	**3,500**	**85,142**	**682**	**13,739**	**14,903**	**17**	**9,508**	**315**	**127,806**

At 31 March 2023, of the Net Book Value £3,500,000 related to land valued at open market value and £85,115,000 related to buildings valued at open market value and £682,000 related to dwellings valued at open market value. The land and buildings (including dwellings) of the trust were revalued by the Valuation Office Agency which is a government agency of Her Majesty's Revenue and Customs (RICS qualified) as at 31 March 2023. This valuation, in line with the NHS foundation trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in a increase in value of £9,943,000.00.

9. Property, plant and equipment (continued)

9.3 Prior year property, plant and equipment (group) comprises of the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Group Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2021	3,500	75,875	871	3,783	29,425	184	13,729	718	128,085
Additions - purchased	-	5,844	-	19,665	1,669	-	1,115	40	28,333
Additions - donations of physical assets	-	11	-	-	137	-	- 0	-	148
Impairments charged to operating expenses	-	(3,328)	-	-	-	-	-	-	(3,328)
Transfer to revaluation reserve	-	4,085	(23)	-	-	-	-	-	4,062
Reclassifications*	-	284	290	(3,257)	633	(6)	1,435	2	(619)
Disposals	-	(1)	-	-	(1,266)	-	-	(15)	(1,282)
Cost or valuation At 31 March 2022	**3,500**	**82,770**	**1,138**	**20,191**	**30,598**	**178**	**16,279**	**745**	**155,399**
Depreciation at 1 April 2021	-	-	-	-	14,467	112	7,417	344	22,340
Provided during the year (see note 4.1)	-	2,593	66	-	2,589	14	1,404	62	6,728
Reversal of impairments charged to operating expe	-	(147)	-	-	-	-	-	-	(147)
Transfer to revaluation reserve	-	(2,442)	(66)	-	-	-	-	-	(2,508)
Reclassifications	-	(3)	-	-	5	(2)	-	-	-
Disposals	-	(1)	-	-	(1,260)	-	-	(15)	(1,276)
Depreciation at 31 March 2022	**-**	**-**	**-**	**-**	**15,801**	**124**	**8,821**	**391**	**25,137**
Net book value									
- Purchased at 31 March 2022	3,500	74,914	1,138	11,225	12,899	54	7,441	337	111,508
- Donated at 31 March 2022	-	7,856	-	8,966	779	-	17	17	17,635
- Donated (DHSC) at 31 March 2022	-	-	-	-	1,119	-	-	-	1,119
Net book value at 31 March 2022	**3,500**	**82,770**	**1,138**	**20,191**	**14,797**	**54**	**7,458**	**354**	**130,262**

At 31 March 2022, of the Net Book Value £3,500,000 related to land valued at open market value and £82,770,000 related to buildings valued at open market value and £1,138,000 related to dwellings valued at open market value. The land and buildings (including dwellings) of the trust were revalued by the Valuation Office Agency which is a government agency of Her Majesty's Revenue and Customs (RICS qualified) as at 31 March 2022. This desktop valuation, in line with the NHS foundation trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in a decrease in value of £3,389,000.

9. Property, plant and equipment

9.4 Prior year property, plant and equipment comprises (Trust) of the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Foundation Trust Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2021	3,500	72,938	451	3,020	27,104	25	13,728	658	**121,424**
Additions - purchased	-	176	-	9,106	1,510	-	1,105	41	**11,938**
Reversals charged to operating expenses	-	147	-	-	-	-	-	-	**147**
Reclassifications	-	(168)	239	(2,687)	560	-	1,435	2	**(619)**
Transfer to revaluation reserve	-	4,110	(36)	-	-	-	-	-	**4,074**
Disposals	-	(1)	-	-	(1,266)	-	-	(15)	**(1,282)**
Cost or valuation At 31 March 2022	**3,500**	**77,202**	**654**	**9,439**	**27,908**	**25**	**16,268**	**686**	**135,682**
Depreciation at 1 April 2021	-	-	-	-	13,346	-	7,418	339	**21,103**
Provided during the year (see note 4.2)	-	2,458	39	-	2,435	4	1,403	56	**6,395**
Transfer to revaluation reserve	-	(2,457)	(39)	-	-	-	-	-	**(2,496)**
Disposals	-	(1)	-	-	(1,260)	-	-	(15)	**(1,276)**
Depreciation at 31 March 2022	**-**	**-**	**-**	**-**	**14,521**	**4**	**8,821**	**380**	**23,726**
Net book value									
- Purchased at 31 March 2022	3,500	73,080	654	9,439	11,489	21	7,447	289	**105,919**
- Donated at 31 March 2022	-	4,122	-	-	779	-	-	17	**4,918**
- Donated (DHSC) at 31 March 2022	-	-	-	-	1,119	-	-	-	**1,119**
Net book value at 31 March 2022	**3,500**	**77,202**	**654**	**9,439**	**13,387**	**21**	**7,447**	**306**	**111,956**

At 31 March 2022, of the Net Book Value £3,500,000 related to land valued at open market value and £77,202,000 related to buildings valued at open market value and £654,000 related to dwellings valued at open market value. The land and buildings (including dwellings) of the trust were revalued by the Valuation Office Agency which is a government agency of Her Majesty's Revenue and Customs (RICS qualified) as at 31 March 2022. This valuation, in line with the NHS foundation trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in a increase in value of £6,717,000.00.

10. Leases - Harrogate and District NHS Foundation Trust as a lessee

10.1 This note details information about leases for which the Trust is a lessee.
The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis.

Group	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	leased from DHSC group bodies £000
IFRS 16 implementation - reclassification of existing leased assets from PPE or intangible assets	-	-	-	-	-
IFRS 16 implementation - adjustments for existing operating leases / subleases	9,100	96	17	9,213	6,615
Transfers by absorption	-	-	-	-	-
Additions	1,770	-	223	1,992	41
Remeasurements of the lease liability	-	-	-	-	-
Movements in provisions for restoration / removal costs	-	-	-	-	-
Impairments	-	-	-	-	-
Reversal of impairments	-	-	-	-	-
Revaluations	-	-	-	-	-
Reclassifications	-	-	-	-	-
Disposals / derecognition	(193)	-	-	(193)	(193)
Valuation/gross cost at 31 March 2023	**10,677**	**96**	**240**	**11,013**	**6,462**
Accumulated depreciation at 1 April 2022 - brought forward	-	-	-	-	-
IFRS 16 implementation - reclassification of existing leased assets from PPE or intangible assets	-	-	-	-	-
IFRS 16 implementation - adjustments for existing subleases	-	-	-	-	-
Transfers by absorption	-	-	-	-	-
Provided during the year	1,574	41	106	1,721	619
Impairments	-	-	-	-	-
Reversal of impairments	-	-	-	-	-
Revaluations	-	-	-	-	-
Reclassifications	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-
Accumulated depreciation at 31 March 2023	**1,574**	**41**	**106**	**1,721**	**619**
Net book value at 31 March 2023	**9,102**	**56**	**133**	**9,291**	**5,843**
Net book value of right of use assets leased from other NHS providers					1,516
Net book value of right of use assets leased from other DHSC group bodies					4,328
					5,843

Note 10.2 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 19.

	Foundation Trust & Group 2022/23 £000
Carrying value at 31 March 2022	-
IFRS 16 implementation - adjustments for existing operating leases	9,213
Lease additions	1,993
Interest charge arising in year	203
Early terminations	(193)
Financing cash flows - principal	(1,744)
Financing cash flows - interest	(203)
Carrying value at 31 March 2023	**9,269**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 10.3 Maturity analysis of future lease payments at 31 March 2023

	Foundation Trust & Group	
	Total 2022/23 £000	Of which leased from DHSC group bodies: 2022/23 £000
Undiscounted future lease payments payable in:		
- not later than one year;	1,869	671
- later than one year and not later than five years;	5,762	3,652
- later than five years.	1,639	1,521
Net lease liabilities at 31 March 2023	**9,270**	**5,844**
Net lease liabilities at 31 March 2023		
Of which:		
Current	1,869	671
Non-Current	7,401	5,173
	9,270	**5,844**
Of which:		
Leased from other NHS providers		1,516
Leased from other DHSC group bodies		4,328

Note 10.4 Commitments in respect of operating leases at 31 March 2022 (IAS 17 basis)

This note discloses costs incurred in 2021/22 and commitments as at 31 March 2022 for leases the trust previously determined to be operating leases under IAS 17.

	Foundation Trust & Group 2021/22 £000
Lease payments recognised as an expense in year:	
Minimum lease payments	4,056
Contingent rents	-
Less sublease payments received	-
Total	**4,056**

	2021/22 £000
Future minimum lease payments due:	
- not later than one year;	1,063
- later than one year and not later than five years;	1,388
- later than five years.	491
Total	**2,942**

Note 10.5 Initial application of IFRS 16 on 1 April 2022

IFRS 16 as adapted and interpreted for the public sector by HM Treasury has been applied to leases in these financial statements with an initial application date of 1 April 2022.

The standard has been applied using a modified retrospective approach without the restatement of comparatives. Practical expedients applied by the Trust on initial application are detailed in the leases accounting policy in note 15.

Lease liabilities created for existing operating leases on 1 April 2022 were discounted using the weighted average incremental borrowing rate determined by HM Treasury as 0.95%.

Reconciliation of operating lease commitments as at 31 March 2022 to lease liabilities under IFRS 16 as at 1 April 2022

	Foundation Trust & Group 1 April 2022 £000
Operating lease commitments under IAS 17 at 31 March 2022	2,942
IAS 17 operating lease commitment discounted at incremental borrowing rate	**2,942**
Adjustments:	
Public sector leases without full documentation previously excluded from operating lease commitments	2,927
Adjustments for contracts reassessed for being or containing a lease on transition to IFRS 16.	3,344
Total lease liabilities under IFRS 16 as at 1 April 2022	**9,213**

11. Investments

	Group	
	2022/23	2021/22
	£000	£000
Carrying value at 1 April 2022	**1,830**	1,815
Acquisitions in year - other	**156**	408
Movement in fair value of investments	**(124)**	17
Disposals	**(177)**	(410)
Carrying value at 31 March 2023	**1,685**	1,830

Investments held are wholly attributable to the Harrogate and District NHS Foundation Trust Charitable Fund (registered charity number 1050008), for further information please see the charity's Annual Report and Accounts.

12. Subsidiary Undertaking - Harrogate Healthcare Facilities Management Ltd.

	Foundation Trust	
	2022/23	2021/22
	£000	£000
Non-current assets		
Shares in Subsidiary	**1,000**	1,000
Loans to Subsidiary	**23,155**	20,191
	24,155	21,191
Current assets		
Loans to Subsidiary	**2,649**	1,643
	26,804	22,834

The shares in the subsidiary company Harrogate Healthcare Facilities Management Ltd comprises a 100% holding of the share capital. Details of the NHS foundation trust loans to it's Subsidiary as at 31 March 2023 are in the table below.

			Non-current	**Current**
Loan Name - Principal Borrowed	Term	Interest Rate	**£000**	**£000**
Working Capital Loan - £1m - REPAID	5 Years	4.00%	-	-
Capital Loan - £7.5m	10 Years	3.60%	5,625	938
Capital Loan - £14.1m	15 Years	3.75%	12,619	1,009
Capital Loan - £5.6m	10 Years	7.50%	4,911	702
			23,155	**2,649**

There have been no defaults or breaches by the subsidiary in relation to the above loans from the NHS foundation trust.

The principal activity of Harrogate Healthcare Facilities Management Ltd is to provide estate management and facilities services.

13. Inventories

13.1 Analysis of inventories	**Group**		**Foundation Trust**	
	2022/23	2021/22	**2022/23**	2021/22
	£000	£000	**£000**	£000
Drugs	**1,040**	603	**1,040**	603
Consumables	**1,403**	1,328	**1,257**	1,213
Total	**2,443**	1,931	**2,297**	1,816

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2022/23 the Trust received £455k of items purchased by DHSC (2021/22: £643k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses - please see notes 4.1 and 4.2.

13.2 Inventories recognised in expenses

	Foundation Trust & Group	
	2022/23	2021/22
	£000	£000
Drug Inventories recognised as an expense in the year	**20,168**	18,289
Total	**20,168**	18,289

14. Trade and other receivables

14.1 Trade and other receivables are made up of:

	Group	
	2022/23	2021/22
Current	**£000**	£000
Contract receivables (IFRS 15): invoiced	**5,934**	4,563
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	**10,437**	1,279
PDC Dividend receivable (Department of Health)	**40**	394
Deposits and advances	**(12)**	33
Provision for the impairment of contract receivables (see note 14.2)	**(518)**	(1,371)
Prepayments	**4,038**	3,386
Interest receivable (excludes finance lease interest)	**90**	-
VAT receivables	**2,964**	1,775
Other receivables	**634**	476
Total	**23,607**	10,535

	Foundation Trust	
	2022/23	2021/22
Current	**£000**	£000
Contract receivables (IFRS 15): invoiced	**6,012**	4,543
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	**10,498**	1,279
PDC Dividend receivable (Department of Health)	**40**	394
Deposits and advances	**(14)**	31
Provision for the impairment of contract receivables (see note 14.2)	**(518)**	(1,371)
Prepayments	**3,003**	2,496
Interest receivable (excludes finance lease interest)	**90**	**-**
VAT receivables	**2,828**	705
Other receivables	**633**	456
Total	**22,572**	8,533

	Foundation Trust & Group	
	2022/23	2021/22
Non-Current	**£000**	£000
Other receivables	**350**	204
VAT receivables	**-**	303
Provision for the impairment of receivables (see note 14.2)	**(57)**	(44)
Clinician pension tax provision reimbursement funding from NHSE	**539**	640
Total	**832**	1,103
Of which receivable from NHS and DHSC group bodies:	**15,294**	3,919
Current	**539**	640
Non-Current		

The majority of the NHS foundation trust's trade is with Commissioners for NHS patient care services which are funded by the Government to buy NHS patient care services therefore no credit scoring for them is considered necessary.

14. Trade and other receivables (continued)

14.2 Allowances for credit losses (doubtful debts)	Foundation Trust & Group 2022/23 £000	2021/22 £000
Allowance for credit losses at 1 April 2022	**1,415**	499
New allowances arising	**-**	916
Reversals of allowances (where receivable is collected in-year)	**(1,707)**	-
Utilisation of allowances (where receivable is written off)	**867**	-
Balance at 31 March 2023	**575**	1,415

NHS Injury Benefit Scheme income is subject to a provision for impairment of 22.43% (2022: 22.43%) to reflect expected rates of collection. Other debts are assessed by management considering age of debt and the probability of collection.

15. Cash and cash equivalents

	Group 2022/23 £000	2021/22 £000	Foundation Trust 2022/23 £000	2021/22 £000
Balance at 1 April 2022	**42,854**	34,198	**38,846**	33,424
Net change in year	**(7,175)**	8,656	**(6,565)**	5,422
Balance at 31 March 2023	**35,679**	42,854	**32,281**	38,846
Made up of:				
Cash with Government Banking Service	**32,742**	39,508	**32,274**	38,811
Cash at commercial banks and in hand	**2,872**	3,328	**7**	35
Other current investments	**65**	18	**-**	-
Cash and cash equivalents	**35,679**	42,854	**32,281**	38,846

16. Trade and other payables

Current	Group 2022/23 £000	2021/22 £000	Foundation Trust 2022/23 £000	2021/22 £000
Receipts in advance	**47**	48	**47**	48
Trade payables	**6,015**	5,006	**6,197**	4,138
Other trade payables - capital	**8,655**	7,296	**5,725**	4,482
Social Security costs	**3,360**	2,070	**3,269**	2,003
Other tax payable	**2,148**	2,268	**2,059**	2,175
Pension contributions payable	**2,912**	2,660	**2,845**	2,605
Other payables	**511**	1,284	**615**	1,307
Accruals	**26,313**	21,327	**24,497**	20,490
Total	**49,960**	41,959	**45,254**	37,248

Non-Current	Foundation Trust & Group 2022/23 £000	2021/22 £000
Accruals	**-**	187
Total	**-**	187

17. Provisions

17.1 Provisions current and non current

	Foundation Trust & Group Current		Foundation Trust & Group Non current	
	2022/23	2021/22	**2022/23**	2021/22
	£000	£000	**£000**	£000
Pensions relating to the early retirement of staff pre 1995	**33**	33	**105**	135
Legal claims	**54**	50	**(0)**	-
Pensions - Injury benefits	**17**	17	**18**	26
2019/20 Clinicians' pension reimbursement	**-**	-	**539**	640
	104	100	**662**	801

17.2 Provisions by category

	Pensions relating to the early retirement of staff pre 1995	Legal claims	Pensions - Injury benefits	2019/20 Clinicians' pension reimbursement	**Foundation Trust & Group Total 2022/23**
	£000	£000	£000	£000	**£000**
At 1 April 2022	168	50	43	640	**901**
Change in discount rate	-	-	-	(475)	**(475)**
Arising during the year	1	35	1	363	**400**
Utilised during the year	(33)	(8)	(10)	-	**(50)**
No longer required	-	(24)	-	-	**(24)**
Unwinding of discount	2	-	1	11	**13**
At 31 March 2023	**138**	**54**	**35**	**539**	**766**

17.3 Expected timing of cashflows by category:

	Pensions relating to the early retirement of staff pre 1995	Legal claims	Pensions - Injury benefits	2019/20 Clinicians' pension reimbursement	**Foundation Trust & Group Total 2022/23**
	£000	£000	£000	£000	**£000**
Within one year	33	54	17	-	**104**
Between one and five years	102	-	18	-	**120**
After five years	3	-	-	539	**542**
	138	**54**	**35**	**539**	**766**

Pensions relating to the early retirement of staff pre 1995
Provisions for capitalised pension benefits are based on tables provided by the Office for National Statistics, reflecting years to normal retirement age and the additional pension costs associated with early retirement.

Legal claims
Legal claims consist of amounts due as a result of third party and employee liability claims. These values are based on information provided by NHS Resolution (formerly the NHS Litigation Authority).

Pensions - Injury benefits
Permanent Injury Benefits are payable to eligible individuals, and are calculated in the same way as capitalised pension benefits.

2019/20 Clinicians' pension
These consist of the pensions tax costs of clinicians working additional sessions, which the UK Government committed to pay. These values are based on information provided by NHS England.

£129,126,819 is included in the provisions of NHS Resolution (formerly the NHS Litigation Authority) at 31 March 2023 in respect of clinical negligence liabilities of the NHS foundation trust (31 March 2022 - £151,496,000). Please see note 1.15.

18. Other liabilities

	Foundation Trust & Group	
	2022/23	2021/22
Current	**£000**	£000
Deferred income	**2,840**	2,643
Total	**2,840**	2,643

19. Borrowings

	Group	
	2022/23	2021/22
Current	**£000**	£000
Capital loans from DHSC (formerly ITFF)*	**1,220**	1,223
Lease liabilities	**1,869**	-
Total	**3,089**	1,223
Non-Current		
Capital loans from DHSC (formerly ITFF)*	**7,873**	9,054
Lease liabilities	**7,401**	-
Total	**15,274**	9,054

	Foundation Trust	
	2022/23	2021/22
Current	**£000**	£000
Capital loans from DHSC (formerly ITFF)*	**1,220**	1,223
Lease liabilities	**1,620**	-
Total	**2,840**	1,223
Non-Current		
Capital loans from DHSC (formerly ITFF)*	**7,873**	9,054
Lease liabilities	**7,535**	-
Total	**15,408**	9,054

19. Borrowings (Continued)

*During 2012/13, the Trust signed a 10 year loan agreement for £3.4m from the Independent Trust Financing Facility (ITFF) to fund the provision of additional theatre capacity, the loan was drawn down in full during the financial year. During 2013/14, the Trust signed an additional 10 year loan for £1.5m from the ITFF to fund the replacement of an MRI Scanner. The loan was drawn down in full during the financial year. During 2014/15 the NHS foundation trust did not undertake any additional borrowing. During 2015/16 the Trust signed a 25 year loan agreement from the Department of Health for £7.5m to fund a Carbon Efficiency capital scheme and a 10 year loan agreement from the Department of Health for £1.5m to fund the purchase of a Mobile MRI Scanner, both of these loans were drawn down in full during the financial year. The NHS foundation trust did not undertake any additional borrowing during 2016/17. During 2017/18, the Trust signed two loan agreements (both with 10 year terms). Replacement of automatic endoscope reprocessors for £3.8m and a modular build endoscopy suite for £6.9m.

During the 2021/22 financial year the NHS foundation trust repaid in full three of the outstanding loans (please see below).
Additional theatre capacity loan £375k
Replacement MRI loan £166k
Replacement of Automated Endoscope Reprocessors scheme loan £2,401k

The interest rates on the NHS foundation trust's loans are:-
Additional theatre capacity loan originally £3.4m is fixed at 0.93% per annum (10 year term).
Replacement MRI loan originally £1.5m is fixed at 1.75% per annum (10 year term).
Carbon efficiency capital scheme loan originally £7.5m is fixed at 2.5% per annum (25 year term).
Mobile MRI Scanner loan originally £1.5m is fixed at 0.90% per annum (10 year term).

Replacement of Automated Endoscope Reprocessors scheme loan originally £3.8m is fixed at 0.76% per annum (10 year term).
Modular Build Endoscopy Suite loan originally £6.9m is fixed at 0.56% per annum (10 year term).
Working capital loan originally £4.9m is fixed at 1.5% per annum (3 year term - see **above).

Interest accrued is paid every six months see finance expense note 7.

There have been no defaults or breaches in relation to the DHSC (formerly ITFF) loans.

20. Losses and special payments

	Foundation Trust & Group			
	2022/23 Total number of cases	**2022/23 Total value of cases**	2021/22 Total number of cases	2021/22 Total value of cases
		£000		£000
Losses:				
Bad debts private patients	**-**	**-**	4	1
Bad debts overseas visitors	**-**	**-**	5	5
Bad debts other	**188**	**2**	243	3
Total losses	**188**	**2**	252	9
Special payments:				
Ex gratia payment loss of personal effects	**27**	**13**	18	14
Compensation under court order or legally binding arbitration award	**-**	**-**	-	**-**
Ex gratia payment personal injury with advice	**1**	**7**	4	16
Ex gratia payment other employment payments	**-**	**-**	-	-
Overtime corrective payments	**-**	**-**	1	488
Ex gratia payment other	**-**	**-**	3	-
Total special payments	**28**	**20**	26	518
Total losses and special payments	**216**	**22**	278	527

21. Third Party Assets

The NHS foundation trust held £0 cash at bank and in hand at 31 March 2023 which related to monies held by the NHS foundation trust on behalf of patients (31 March 2022: £0).

22. Contractual Capital Commitments

Commitments under capital expenditure contracts at 31 March 2023 were £4,041,000 (31 March 2022: £1,025,000).

23. Related Party Transactions

23.1 Transactions with key management personnel

IAS 24 requires disclosure of transactions with key management personnel during the year. Key management personnel is defined in IAS 24 as "those persons having authority and responsibility for planning, directing and controlling the activities of the entity, directly or indirectly, including any director (whether executive or otherwise) of that entity". The Trust has deemed that its key management personnel are the board members (voting and non-voting directors and non-executive directors) of the NHS foundation trust.

However the DHSC GAM states the requirement in IAS 24 to disclose the compensation paid to management, expenses allowances and similar items paid in the ordinary course of an entity's operations will be satisfied with the disclosures in the Remuneration Report. There were no transactions with board members or parties related to them other than those from the ordinary course the NHS foundation trust's operations.

23.2 Transactions with other related parties

The Department of Health and Social Care is the parent department of Harrogate and District NHS Foundation Trust, paragraph 25 of IAS 24 allows entities which are related parties because they are under the same government control to reduce the volume of detailed disclosures.

The DHSC GAM interprets this as requiring the disclosure of the main entities within the public sector with which the NHS foundation trust has had dealings, but no information needs to be given about these transactions. These entities are listed below:-

County Durham Unitary Authority
Darlington Borough Council
Gateshead Council
Health Education England
HM Revenue & Customs
Leeds Teaching Hospitals NHS Trust
Middlesbrough Council
NHS Humber and North Yorkshire ICB
NHS West Yorkshire ICB
NHS Bradford District and Craven CCG
NHS England
NHS Leeds CCG
NHS North Yorkshire CCG
NHS Pension Scheme
NHS Property Services
NHS Resolution (formerly NHS Litigation Authority)
NHS Vale of York CCG
North Yorkshire County Council
Northumberland Unitary Authority
Stockton-on-Tees Borough Council
Sunderland City Metropolitan Borough Council
Wakefield Council
York Teaching Hospital NHS Foundation Trust

24. Financial instruments.

Disclosure is required under International Accounting Standards of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The Harrogate and District NHS Foundation Trust actively seeks to minimise its financial risks. In line with this policy, the Trust neither buys nor sells financial instruments. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Interest Rate Risk

All of the Trust's financial liabilities carry nil or fixed rates of interest. In addition, the only element of the Trust's assets that are subject to a variable rate are short term cash investments. The Trust is not, therefore, exposed to significant interest-rate risk.

Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

Credit Risk

The Trust operates primarily within the NHS market and receives the majority of its income from other NHS organisations. There is therefore little risk that one party will fail to discharge its obligation with the other. Disputes can arise, however, around how the amounts owed are calculated, particularly due to the complex nature of the Payment by Results regime. For this reason the Trust makes a provision for irrecoverable amounts based on historic patterns and the best information available at the time the accounts are prepared. The Trust does not hold any collateral as security.

Liquidity Risk

The Trust's net operating costs are incurred under three year agency purchase contracts with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust receives such contract income in accordance with Payment by Results (PBR), which is intended to match the income received in year to the activity delivered in that year by reference to the National Tariff procedure cost. The Trust received cash each month based on an annually agreed level of contract activity and there are quarterly payments made to adjust for the actual income due under PBR. This means that in periods of significant variance against contracts there can be a significant cash-flow impact. The Trust has adequate liquidity to deal with these variances.

The Trust finances it's capital expenditure from internally generated funds or funds made available from Government, in the form of additional Public Dividend Capital, under an agreed limit. In addition, the Trust has borrowed from the Department of Health Financing Facility and may also borrow commercially in order to finance capital schemes. Financing is drawn down to match the capital spend profile of the scheme concerned and the Trust is not, therefore exposed to significant liquidity risks in this area.

24. Financial instruments (continued).

	Group		Foundation Trust	
	2022/23	2021/22	**2022/23**	2021/22
	£000	£000	**£000**	£000
Financial assets at amortised cost				
Loans and receivables (including cash and cash equivalents)	**52,495**	47,410	**48,656**	44,097
Investments	**-**	-	**1,000**	1,000
Consolidated NHS Charitable fund financial assets	**2,278**	2,565	**-**	-
	54,773	49,975	**49,656**	45,097
Financial liabilities at amortised cost				
Loans and payables	**59,823**	41,473	**55,282**	36,820
Consolidated NHS Charitable fund financial liabiilities	**34**	30	**-**	-
	59,857	41,503	**55,282**	36,820

Management consider that the carrying amounts of financial assets and financial liabilities recorded at amortised cost in the financial statements approximate to their fair value.

Maturity of Financial Liabilities
The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group	
	31 March 2023	**31 March 2022**
	£000	**£000**
In one year or less	45,232	32,573
In more than one year but not more than five years	11,524	5,107
In more than five years	4,167	5,204
Total	**60,923**	**42,884**

25. Charitable funds reserve.

Unrestricted income funds comprise those funds which the Trustee is free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include designated funds, where the donor has made known their non binding wishes or where the Corporate Trustee, at its discretion, has created a fund for a specific purpose.

Restricted funds are funds which are to be used in accordance with specific restrictions imposed by the donor.

The charity has one permanent endowment fund. The income of the Elsie Sykes Endowment Fund can be used for medical equipment or medical research (excluding transplant or vivisection work).

	Group	
	2022/23	2021/22
	£000	£000
Unrestricted income funds	**504**	745
Restricted funds	**74**	37
Endowment fund	**1,666**	1,753
	2,244	2,535

27. Ultimate parent.

As an entity operating in the National Health Service in England, the ultimate parent holding is considered as the Department of Health and Social Care.

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www.harrogateintegratedfacilities.co.uk

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Harrogate and District NHS Foundation Trust

CONSTITUTION OF HARROGATE AND DISTRICT NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

Updated to reflect the changes to:

- **the NHS England Code of Governance for NHS Provider Trusts (October 2022), effective from 1 April 2023**
- **the Governor Constituencies agreed at the Council of Governors' meeting (7 March 2023)**

Version 4.0 (to be approved by Trust Board on 31 May 2023 and Members' Council on 6 June 2023) Effective from 7 June 2023

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1. Interpretation and definitions

1.1. Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and the Health and Social Care Act 2022.

1.2. Words importing the masculine gender only shall include the feminine gender; words importing the singular shall include the plural and vice-versa.

1.3. In this constitution:

“the 2006 Act”	is the National Health Service Act 2006;
“the 2012 Act”	is the Health and Social Care Act 2012;
“the 2022 Act”	is the Health and Social Care Act 2022;
"Accounting Officer"	means the person who from time to time discharges the function specified in section 25(5) of Schedule 7 to the 2006 Act;
"Annual Members' Meeting"	is defined in paragraph 15 of this constitution;
“area of the Trust”	means the areas specified in Annex A;
“Board of Directors”	means the Board of Directors as constituted in accordance with this constitution;
“CCGs”	means Clinical Commissioning Groups;
“Chair”	means the individual appointed by the Council of Governors to provide leadership to and chair meetings of the Board of Directors and the Council of Governors;
“Company Secretary”	means the individual appointed to perform the duties of the Secretary to the Trust as defined in section 17 of this constitution;
“constitution”	means this constitution and all annexes to it;
“Council of Governors”	means the Council of Governors as constituted in accordance with this constitution;

Lead Governor	means the person appointed to preside over meetings of the Council of Governors in the absence of the Chair and Vice Chair.
“Director”	means a member of the Board of Directors;
“elected Governors”	means those Governors elected by the public constituencies and the classes within the staff constituency;
“financial year”	means each successive period of twelve months beginning with 1 April;
"Governor"	means a member of the Council of Governors and either being a Public Governor, Staff Governor or Stakeholder Governor;
“Licence”	means the Trust’s licence granted by Monitor under the 2012 Act;
"Medical Practitioners' Staff Class"	means the staff class of the staff staff constituency defined in paragraph 7.3.3 of this constitution;
“NHS Improvement” (formally known as Monitor)	is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act;
"Nursing and Midwifery Staff Class"	means the staff class of the staff constituency defined in paragraph 7.3.2 of this constitution;
"Other Clinical Staff Class"	means the staff class of the staff constituency defined in paragraph 7.3.4 of this constitution;
"Non-Clinical Staff Class"	means the staff class of the staff constituency defined in paragraph 7.2.5 of this constitution;
“Local Authority Governor”	means a member of the Council of Governors appointed by one or more local authorities whose area includes the whole or part of the area specified as a public constituency of the Trust;
“member”	means a member of the Trust;

"the Trust"	means Harrogate and District NHS Foundation Trust;
"Public Governor"	means a member of the Council of Governors elected by members of one of the public constituencies;
"Senior Independent Director"	means the individual appointed by the Board to act as the Senior Independent Director in accordance with section 16.5 of the constitution;
"Staff Governor"	means a member of the Council of Governors elected by the members of the relevant class within the staff constituency;
"Stakeholder Governor"	means those members of the Council of Governors appointed by the appointing organisations;
"Vexatious Complainant"	a definition can be found within the Trust's Making Experiences Count Policy;
"Vice Chair"	means the individual appointed by the Council of Governors, to chair in the absence of the Chair, meetings of the Board of Directors and the Council of Governors.

2 Name

2.1 The name of the foundation trust is Harrogate and District NHS Foundation Trust ("the Trust").

3 Principal purpose

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry out activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

3.5 Every trust should be led by an effective and diverse board that is innovative and flexible, and whose role it is to promote the long-term sustainability of the trust as part of the ICS and wider healthcare system in England, generating value for members in the case of foundation trusts, and for all trusts, patients, service users and the public

4 Powers

4.1 The powers of the Trust are set out in the 2006 Act, subject to any restrictions in its Licence.

4.2 In particular it may:

4.2.1 acquire and dispose of property;

4.2.2 enter into contracts;

4.2.3 accept gifts of property (including property to be held on Trust for the purposes of the Trust or for any purposes relating to the health service); and,

4.2.4 employ staff.

4.3 Any power of the Trust to pay remuneration and allowances to any person includes the power to make arrangements for providing, or securing the provision of, pensions or gratuities (including those payable by way of compensation for loss of employment or loss or reduction of pay).

4.4 The Trust may borrow money for the purposes of or in connection with its functions subject to any restrictions imposed by NHS Improvement from time to time.

4.5 The Trust may invest money (other than money held by it as Trustee) for the purposes of or in connection with its functions subject to any guidance provided by NHS Improvement. The investment may include investment by:

4.5.1 forming, or participating in forming bodies corporate;

4.5.2 otherwise acquiring membership of bodies corporate.

4.6 The Trust may give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its functions.

4.7 The Trust may raise charitable funds and in doing so, appeal for any contribution, donation, grant, gift money or property.

5 Commitments

5.1 The Trust shall exercise its functions effectively, efficiently and economically.

5.2 Representative membership

5.2.1 The Trust shall at all times endeavour to procure membership that, taken as a whole, is representative of those eligible for membership, and in deciding which areas are to be areas of the Trust, have regard to the need for those eligible for such membership to be representative of those to whom the Trust provides goods and services. The Trust shall at all times have in place and pursue a Membership Development Strategy which shall be approved by the Council of Governors, and which shall be reviewed by them from time to time, and in any event, at least every three years.

5.2.2 The Council of Governors shall present to each Annual Members' Meeting:

5.2.2.1 a report on steps taken to procure that, taken as a whole, the actual membership of its constituencies is representative of those eligible for such membership;

5.2.2.2 the progress of a Membership Development Strategy; and,

5.2.2.3 any changes to the Membership Development Strategy.

5.3 Co-operation with external organisations

5.3.1 In exercising its functions the Trust shall co-operate with other NHS bodies (as defined in Section 275 of the 2006 Act) including the National Institute for Health and Clinical Excellence, NHS Digital, Local Authorities, NHS England, Integrated Care Board, the Care Quality Commission and

with other non-health organisations, both statutory and voluntary.

5.4 Respect for rights of people

5.4.1 In conducting its affairs, the Trust shall respect the rights of members of the community it services, its employees and people dealing with the Trust as set out in the Charter of Fundamental Rights of the European Union and the NHS Constitution.

5.5 Openness

5.5.1 In conducting its affairs, the Trust shall have regard to the need to provide information to members and conduct its affairs in an open and accessible way.

6 Framework

6.1 The affairs of the Trust are to be conducted by the Board of Directors, the Council of Governors and the members in accordance with this constitution. The members, the Council of Governors and the Board of Directors are to have the roles and responsibilities set out in this constitution.

7 Membership and constituencies

7.1 The members of the Trust are those individuals whose names are entered in the membership database. Every member is either a member of one of the public constituencies or a member of one of the classes of the staff constituency. Subject to this constitution, membership is open to any individual who:

7.1.1 is 16 years of age and over; and

7.1.2 is entitled under this constitution to be a member of a public constituency or a member of the appropriate class within the staff constituency as applicable; and

7.1.3 if applying to be a member of a public constituency, has completed a public membership application form; or

7.1.4 if applying to be a member of a class within the staff constituency, chooses to opt in to the staff membership scheme.

7.2 Public constituencies

7.2.1 There are six public constituencies covering the area of the Trust as set out in Annex A. Membership of each of the public constituencies is open to individuals:

7.2.1.1 who live in an area of the Trust;

7.2.1.2 who are not eligible to be members of the staff constituency;

7.2.1.3 who meet the criteria and have completed the application referred to in paragraph 7.1 above; and

7.2.1.4 who are not otherwise disqualified from membership under paragraph 8 of this constitution.

7.2.2 The minimum number of members in each of the public constituencies is:

200 in Harrogate and surrounding villages;

120 in Ripon and West District;

120 in Knaresborough and East District;

120 in Wetherby and Harewood including Otley and Yeadon, Adel and Wharfedale and Alwoodley Wards;

100 in the rest of North Yorkshire and York; and

50 in the Rest of England.

7.2.3 Those individuals who live in an area of the Trust are referred to collectively as a public constituency.

7.3 Staff constituency

7.3.1 The staff constituency is to be divided into six classes of individuals as follows:

The Nursing, Midwifery and Allied Health Professionals (AHPs) Staff Class;

The Medical Practitioners' Staff Class;

0-19 Services Staff Class;

Community Services Staff Class;

The Other Clinical Staff Class; and

The Non-Clinical Staff Class.

The classes are collectively referred to as the staff constituency. In the case of employment covering a dual role, the primary appointment will determine the relevant class of the staff constituency.

7.3.2 The members of the Nursing, Midwifery and AHPs Staff Class are individuals who are members of the staff constituency whose regulatory body falls within the remit of the Council for Healthcare Regulatory Excellence established by section 25 of the NHS Reform and Health Care Professions Act 2002 and who are registered with the Nursing and Midwifery Council, and unregistered nursing staff who are employed by the Trust, and registered with the Health and Care Professions Council (HCPC) or the General Osteopathic Council (GOC).

7.3.3 The members of the Medical Practitioners' Staff Class are individuals who are members of the staff constituency who are fully registered persons within the meaning of the Medical Act 1983 or the Dental Act 1984.

7.3.4 The members of the 0-19 Services Staff Class are individuals who provide services via the 0-19 function. These can be individuals from any discipline.

7.3.5 The members of the Community Services Staff Class are individuals who provide services via the Community Services function. These can be individuals from any discipline.

7.3.6 The members of the Other Clinical Staff Class are individuals who are members of the staff constituency (other than nurses or midwives referred to in paragraph 7.3.2 above) whose regulatory body falls within the remit of the Council for Healthcare Regulatory Excellence established by section 25 of the NHS Reform and Health Care Professions Act 2002, or are employed by the Trust to carry out associated clinical duties to support clinical staff.

7.3.7 The members of the Non-Clinical Staff Class are individuals who are members of the staff constituency who do not come within paragraphs 7.3.2, 7.3.3, 7.3.4, 7.3.5 and 7.3.6 above.

7.3.8 Members of the staff constituency are to be individuals who:

7.3.8.1 are employed by the Trust under a contract of employment which has no fixed term or a fixed term of at least 12 months; or,

7.3.8.2 have been continuously employed by the Trust for at least 12 months; and,

7.3.8.3 are not disqualified from membership under paragraph 8 below; and,

7.3.8.4 have been invited by the Trust to become a member of the relevant class of the staff constituency and have informed the Trust they wish to be a member.

7.3.9 The minimum number of members in each class of the staff constituency is:

150 will be registered in the Nursing Midwifery and Allied Health Professionals Staff Class;

30 in the Medical Practitioners' Staff Class;

50 in the 0-19 Services Staff Class;

50 in the Community Services Staff Class;

50 in the Other Clinical Staff Class; and

100 in the Non-Clinical Staff Class.

7.3.10 A person who is eligible to be a member of one of the classes of the staff constituency may not become or continue as a member of the public constituencies and may not become or continue as a member of more than one staff class.

8 Disqualification from membership

8.1 A person may not be a member of the Trust:

8.1.1 If, in the opinion of the Council of Governors after following proper procedures as required by the Trust's Standing Orders, there are reasonable grounds to believe that they are likely to act in a way detrimental to the interests of the Trust;

8.1.2 If within the last five years they have perpetrated a serious incident of violence towards any of the Trust's facilities, employees or volunteers in association with their employment as defined in the Trust's Violence and Aggression Policy; or

8.1.3 If they are not eligible to be a member in accordance with paragraphs 7.2 and 7.3 of this constitution.

9 Termination of membership

9.1 A member shall cease to be a member if:

9.1.1 they resign by notice to the Foundation Trust Office;

9.1.2 they die;

9.1.3 they are disqualified from membership by paragraph 8;

9.1.4 being a member of a public constituency, they cease to fulfil the requirements of paragraph 7.2; or,

9.1.5 being a member of the staff constituency, they cease to fulfil the requirements of paragraph 7.3.

9.2 Upon ceasing to be a member, any benefits attaching to membership cease immediately.

10 The role of members

10.1 The role of members is to demonstrate their support to the Trust and should they wish to, and be eligible, stand for election to be a Public Governor or Staff Governor on the Council of Governors.

10.2 To vote on whether to approve amendments to the constitution in relation to the powers and duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust) and to take such other part in the affairs of the Trust as is provided in this constitution.

10.3 The surpluses or any profits of the Trust are not to be distributed either directly or indirectly in any way at all among members of the Trust.

10.4 Members will receive treatment by the Trust on exactly the same basis as any other NHS patient.

11 The Council of Governors

11.1 The Trust is to have a Council of Governors. It is to consist of elected Public and Staff Governors and appointed Stakeholder Governors.

11.2 The Council of Governors of the Trust is to comprise:

11.2.1 Thirteen Public Governors, which must be more than half the total membership of the Council of Governors, are to be elected by the public constituencies as follows:

Area 1 – Harrogate and surrounding villages (five Governors);

Area 2 – Ripon and West District (two Governors);

Area 3 – Knaresborough and East District (two Governors);

Area 4 – Wetherby and Harewood wards and Alwoodley, Adel and Wharfedale and Otley and Yeadon wards (two Governors);

Area 5 – The Rest of North Yorkshire and York (one Governor); and

Area 6 – the Rest of England (one Governor).

11.2.2 Six Staff Governors from each of the following staff classes are to be elected as follows:

- Medical Practitioners' Staff Class (one Governor);
- Nursing, Midwifery and Allied Health Professionals (AHPs) Staff Class (one Governor);
- 0-19 Services Staff Class (one Governor);
- Community Services Staff Class (one Governor);
- Other Clinical Staff Class (one Governor); and,
- Non-Clinical Staff Class (one Governor).

11.2.3 Six Stakeholder Governors from each of the following classes are to be appointed as follows:

- Patient Experience Stakeholder (one Governor);

To be appointed by relevant Stakeholder Organisations:

- Local Authority (two Governors);
- Further Education (one Governor);
- A Voluntary Organisation (one Governor); and,
- Harrogate Healthcare Facilities Management Limited (one Governor).

11.3 Composition of the Council of Governors, subject to the 2006 Act, shall seek to ensure that:

11.3.1 the interests of the community served by the Trust are appropriately represented; and,

11.3.2 the level of representation of the public constituencies, the staff constituency and the appointed Stakeholder Governors strikes an appropriate balance having regard to their legitimate interest in the Trust's affairs.

11.4 Elected Governors

11.4.1 Subject to the composition of the Council of Governors, members of the public constituencies may elect any of their number to be Public Governors for that constituency. Members of each of the classes in the staff constituency may elect any of their number to be Staff Governors for that class.

11.4.2 If contested, the elections will take place by secret ballot in accordance with the Trust's election rules using the single transferable vote system.

11.4.3 The model election rules for the Council of Governors, which govern the elections for elected Governors, are set out in Annex B to this constitution. Any subsequent variation of the model election rules shall not constitute a variation of the terms of this constitution for the purposes of paragraph 27 of this constitution.

11.5 Appointed Stakeholder Governors

11.5.1 The organisations set out in 11.2.3 above shall, on request, furnish the Trust the names of Governors appointed to serve and be responsible for replacement as necessary.

11.6 Council of Governors – tenure

11.6.1 Elected Governors:

11.6.1.1 shall normally hold office for a period of three years;

11.6.1.2 subject to the next sub-paragraph, are eligible for re-election after the end of that period;

11.6.1.3 may not hold office for more than nine years in total or three terms of office; and

11.6.1.4 An elected Governor who has fulfilled their term of office may not return as a Stakeholder Governor without a break of one term (three years).

cease to be a Governor if they:

11.6.1.5 cease to hold office;

11.6.1.6 cease to be a member of the public constituency to which they were elected, or;

11.6.1.7 cease to be a member of the class of the staff constituency to which they were elected.

11.6.2 Appointed Stakeholder Governors:

11.6.2.1 shall normally hold office for a maximum period of three years commencing from the date of their appointment;

11.6.2.2 subject to the next sub-paragraph, are eligible for re-appointment after the end of that period;

11.6.2.3 may not hold office for longer than nine years in total or three terms of office; and

11.6.2.4 shall cease to hold office if the appointing organisation terminates their appointment.

11.7 Lead and Deputy Lead Governors of the Council of Governors

11.7.1 The Council of Governors shall elect a Lead Governor and a maximum of two Deputy Lead Governors from amongst the elected Governors.

11.7.2 The Lead Governor shall preside in the absence of the Chair and Vice Chair.

11.7.3 The Council of Governors shall operate its own procedure for electing the Lead and Deputy Lead Governors.

11.7.4 The Deputy Lead Governor(s) shall be from the publicly elected governors.

11.7.5 The Lead and Deputy Lead Governors shall represent different constituencies or staff classes.

11.8 Ineligibility to be a Governor

11.8.1 A person may not become a Governor of the Trust, and if already holding such office will immediately cease to do so if:

11.8.1.1 they have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out regulated activity or providing a service elsewhere which, if provided in England would be a regulated activity;

11.8.1.2 they are a Director of the Trust, or a Governor or Director of another NHS Foundation Trust;

11.8.1.3 they are a member who shares the same household as a member of the Board of Directors of the Trust;

11.8.1.4 they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

11.8.1.5 they have made a composition or arrangement with, or granted a trust deed for, their creditors and have not been discharged in respect of it;

11.8.1.6 they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them;

11.8.1.7 they have within the preceding two years been dismissed from any paid employment with a health service body;

11.8.1.8 they are a person whose tenure of office as the Chair or as a member or Director of a health

service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

11.8.1.9 they have had their name removed, by a direction under paragraph 10 of the National Health Service (Performers Lists) Regulations 2004 or Section 151 of the 2006 Act (or similar provision elsewhere), and has not subsequently had their name included in such a list;

11.8.1.10 they are not by reason of their health capable of properly performing tasks which are intrinsic to the office for which they are elected or appointed;

11.8.1.11 they are a vexatious complainant of the Trust, as defined by Trust policy;

11.8.1.12 they are a vexatious litigant of the Trust as defined by Trust policy;

11.8.1.13 they are a family relation or occupant of the same household of a person who is an existing Governor of the Trust;

11.8.1.14 any amount properly owing to the Trust by them remains outstanding without good cause;

11.8.1.15 they do not, or cease to, fulfil the eligibility requirements as set out in this constitution.

11.9 Termination of office and removal of Governors

11.9.1 A person holding office as a Governor shall immediately cease to do so if:

11.9.1.1 they resign by notice in writing to the Chair;

11.9.1.2 they fail to attend half of the Council of Governor meetings in any financial year, unless the other Governors are satisfied that:

11.9.1.2.1 the absences were due to reasonable causes; and

11.9.1.2.2 they will start attending meetings of the Trust again within such a period as the Council of Governors consider reasonable,

11.9.1.3 in the case of an elected Governor, they cease to be a member of the constituency or class of the constituency by whom they were elected.

11.9.1.4 in the case of an appointed Stakeholder Governor the appointing organisation terminates their appointment;

11.9.1.5 without good reason they have failed to undertake any training which the Council of Governors or Trust requires Governors to undertake;

11.9.1.6 they have failed to sign and deliver to the Foundation Trust Office a statement in the form required by the Council of Governors confirming acceptance of the code of conduct for Governors;

11.9.1.7 they refuse to sign the declaration form that they are a member of one of the public constituencies or one of the classes of the staff constituency as the case may be and are not prevented from being a member of the Council of Governors;

11.9.1.8 their name has been placed on a register of Schedule 1 offenders pursuant to the Sex Offences Act 2003 and/or the Children and Young Persons Act 1933 and the conviction is not spent under the Rehabilitation of Offenders Act 1974;

11.9.1.9 they are removed from the Council of Governors by a resolution approved by a majority of 75% (of the remaining Governors) at a quorate meeting of the Council of Governors . The Governor would be permitted to address the Council of Governors in person if they wish to do so but must withdraw from the discussion, decision and voting on the resolution. The Council of Governors would consider a resolution to remove a Governor on the grounds that:

11.9.1.9.1 they have committed a serious breach of the code of conduct, or;

11.9.1.9.2 they have acted in a manner

detrimental to the interests of the Trust which would undermine public confidence; and,

11.9.1.9.3 the Council of Governors considers that it is not in the best interests of the Trust for them to continue as a Governor.

11.9.2 Special Provisions relating to Termination of Governors' Tenure

11.9.2.1 Any complaint or concern made in respect of a Governor on any of the grounds set out in the Constitution shall be dealt with in line with the Procedure for Management of Governor Conduct Concerns.

11.9.2.2 At any time, the Chair is authorised to take such interim measures as may be immediately required, including the exclusion of the Governor concerned from a meeting or suspension from duties, on the basis that such measures are necessary to:

11.9.2.2.1 Enable an effective investigation to be undertaken into any concern or complaint about a Governor;

11.9.2.2.2 Address or prevent any significant disruption to the effective operation of any part of the Trust;

11.9.2.2.3 Manage risk to the health or wellbeing of a Governor, employee, volunteer or patient of the Trust;

11.9.2.2.4 Protect the reputation of the Trust or safeguard

public confidence in the Trust;

11.9.2.2.5 Give effect to a proposal by the Council to impose a sanction on a Governor.

11.10 Vacancies amongst Governors

11.10.1 Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply:

11.10.1.1 where the vacancy arises amongst the appointed Stakeholder Governors, the Chair shall request that the appointing organisation appoint a replacement to hold office for the remainder of the term of office;

11.10.1.2 where the vacancy arises amongst the elected Governors, the Council of Governors shall be at liberty either:

11.10.1.2.1 to call an election within six months, provided that the period of the vacancy exceeds six months; or,

11.10.1.2.2 to invite the next highest polling eligible candidate for that seat at the most recent election, who is willing to take office to fill the seat until the next annual election, at which time the seat will become vacant and subject to election for any un-expired period of the term of office.

11.10.1.3 If no-one is available under 11.10.1.2.2, and the vacancy is for three months or less, the seat will remain vacant until the next scheduled election.

11.11 Expenses and remuneration of Governors

11.11.1 The Trust may pay travelling and other expenses to Governors at such rates as it decides.

11.11.2 Governors are not to receive remuneration.

11.11.3 The Chair will agree separate arrangements with each appointing organisation in 11.2.3 to cover the reimbursement costs of the appointed Stakeholder Governor.

11.12 Disclosure of interests

11.12.1 Any Governor who has a material interest in a matter as defined in Annex E and below shall declare such interest to the Council of Governors and it shall be recorded in a register of interests. Further guidance is also available from the Trust's Conflicts of Interest Policy. The Governor in question:

11.12.1.1 shall not be present except with the permission of the Council of Governors in any discussion of the matter; and,

11.12.1.2 shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

11.12.2 Any Governor who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Governors, in accordance with section 11.9.1.

11.12.3 A material interest, as defined in Annex E, is a matter of any interest held by a Governor, their spouse or partner, or member of their immediate family, in any firm or company or business which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust. The exceptions which shall not be treated as material interests are as follows:

11.12.3.1 shares not exceeding 1% of the total shares in issue held in any company whose shares are listed on any public exchange;

11.12.3.2 an employment contract held by Staff Governors;

11.12.3.3 an employment contract with a Local Authority;

11.12.3.4 an employment contract with an educational establishment (a university or research institute) and

11.12.3.5 a contract held with a voluntary organisation.

11.12.4 An elected Governor may not vote at a meeting of the Council of Governors unless, before attending their first meeting, they have made a declaration in the form specified by the Council of Governors that they are a member of a public constituency or a member of the classes of the staff constituency and are not prevented from being a Governor of the Council of Governors. An elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors.

12 Roles and responsibilities of the Council of Governors

12.1 The general duties of the Council of Governors are:

12.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors;

12.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public;

12.1.3 to appoint or remove the Chair and the other Non-Executive Directors;

12.1.4 to approve an appointment (by the Non-Executive Directors) of the Chief Executive;

12.1.5 to appoint the Lead Governor and Deputy Lead Governor(s) of the Council of Governors;

12.1.6 to decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and Non-Executive Directors;

12.1.7 to appoint or remove the Trust's external auditor selected from an approved list put forward by the Board of Directors;

12.1.8 to consider the annual accounts, any report of the external auditor on them and the annual report;

12.1.9 to provide their views to the Board of Directors when the Board of Directors is preparing the document containing information about the Trust's forward planning;

12.1.10 to respond as appropriate when consulted by the Board of Directors in accordance with this constitution;

12.1.11 to undertake such functions as the Board of Directors shall from time to time request and which the Council of Governors shall agree;

12.1.12 to prepare, and from time to time to review, the Membership Development Strategy, its policy for the composition of the Council of Governors and of the Non-Executive Directors;

12.1.13 to require one or more Directors to attend a meeting of the Council of Governors for the purpose of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust or Directors' performance);

12.1.14 to approve any merger, acquisition, separation or dissolution application in respect of the Trust before the application is made to NHS Improvement and the entering into of any significant transactions;

12.1.15 to vote on whether to approve the referral of a question by a Governor to any panel appointed by NHS Improvement; and

12.1.16 to approve any proposals to increase by 5% or more of the Trust's proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England. The proposal may be implemented only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

12.2 The Council of Governors will conduct its business at meetings held in accordance with this constitution.

12.3 All Governors will adhere to the policies and procedures of the Trust, acting in the best interest of the Trust at all times.

12.4 The Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such.

12.5 Any amendments to the constitution in relation to the powers or duties of the Council of Governors (or otherwise in respect of the role that the Council of Governors has as part of the Trust) must be put to the vote of the members and approved at the Annual Members' Meeting in accordance with paragraphs 27.3 and 27.4 of this constitution.

13 Meetings of the Council of Governors

13.1 The Chair of the Trust, or in his absence, the Vice Chair of the Trust, or in exceptional circumstances in the absence of both the Chair and Vice Chair, the Lead Governor of the Council of Governors shall preside at a meeting of the Council of Governors.

13.2 Where a conflict of interest arises for the Chair and Vice Chair, the Lead Governor of the Council of Governors shall chair that element of the meeting. In the absence of the Lead Governor, one of the Deputy Lead Governor's shall chair that element of the meeting. If no duly elected individual is available, the Governors shall elect from their members a Governor to chair that element of the meeting. In acting as the Chair, a Governor shall have a casting vote on that issue.

13.3 Meetings of the Council of Governors are to be open to members of the public except in the following circumstances:

13.3.1 during the consideration of any material or discussion in relation to a named person employed by or proposed to be employed by the Trust;

13.3.2 during the consideration of any material or discussion in relation to a named person who is, or has been, or is likely to become a patient of the Trust, or a carer in relation to such a patient; and,

13.3.3 during the consideration of any matter which, by reason of its nature, the Council is satisfied should be dealt with on a confidential basis.

13.4 The Chair may exclude any person present from a meeting of the Council of Governors if they are interfering or preventing proper conduct of a meeting. In addition the Chair may exclude any person present from a meeting of the Council of Governors for a breach of the Standing Orders relating to the conduct of meetings.

13.5 For the purposes of obtaining information about the Trust's performance of its functions, or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

13.6 The Council of Governors is to meet at least four times per year, three of which will be general meetings and one the Annual Members' Meeting.

13.7 At an Annual Members' Meeting, within six months of the end of the financial year, the Council of Governors are to receive and consider the annual accounts, any report of the external auditor on them and the annual report, see 12.1.8.

13.8 The Council of Governors is to adopt its own Standing Orders for its practice and procedure, in particular for its procedure at meetings, and these shall be in accordance with Annex D.

13.9 A Governor, whether elected to the Council of Governors by a public constituency, elected by one of the classes of the staff constituency or nominated as a Stakeholder Governor, may not vote at a meeting of the Council of Governors unless, within one month of election or appointment, he has made a declaration of eligibility in the form set out at Annex C stating which constituency or section he is a member of and is not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 to the 2006 Act or under this constitution.

14 Council of Governors – referral to the Panel

14.1 In this paragraph, the Panel means a panel of persons appointed by NHS Improvement to which a governor of an NHS Foundation Trust may refer a question as to whether the Trust has failed or is failing:

14.1.1 to act in accordance with its constitution; or

14.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

14.2 A Governor may refer a question to the Panel only if more than half of the members of the Council of Governors in attendance at a quorate meeting vote to approve the referral.

15 Annual Members' Meeting

15.1 The Trust is to hold an annual meeting of its members (Annual Members' Meeting) within six months of the end of each financial year. The Annual Members' Meeting shall be open to members of the public.

15.2 At the Annual Members' Meeting the Council of Governors shall present to the members (and in respect of presenting the documents referred to in sub-paragraphs 15.2.1 to 15.2.4, at least one member of the Board of Directors must be in attendance):

15.2.1 the annual accounts;

15.2.2 any report of the external auditor;

15.2.3 any report of any other external auditor of the Trust's affairs;

15.2.4 the annual report;

15.2.5 forward planning information for the next financial year;

15.2.6 subject to 15.5 below, any proposed changes to the constitution for the composition of the Council of Governors and of the Non-Executive Directors;

15.2.7 a report on the activities of the Remuneration, Nominations and Conduct Committee within the previous year; and

15.2.8 the results of elections and appointment to the Council of Governors.

15.3 The Council of Governors will invite the external auditor to the Annual Members' Meeting.

15.4 Minutes of every Annual Members' Meeting, of every meeting of the Council of Governors and of every meeting of the Board of Directors are to be kept. Minutes of meetings will be taken at the next meeting and signed by the Chair of that meeting. The signed minutes will be conclusive evidence of the events of the meeting.

15.5 Any amendments to the constitution in relation to the powers or duties of the Council of Governors (or otherwise in respect of the role that the Council of Governors has as part of the Trust) must be put to the vote of the members and approved at the Annual Members' Meeting in accordance with paragraphs 27.3 and 27.4 of this constitution.

16 Board of Directors

16.1 The Trust shall have a Board of Directors. It shall comprise of Executive and Non-Executive Directors.

16.1.1 Non-Executive Directors:

16.1.1.1 a Chair, who is to be appointed by the Council of Governors; and,

16.1.1.2 a minimum of six Non-Executive Directors who are to be appointed by the Council of Governors.

16.1.2 Executive Directors:

16.1.2.1 a Chief Executive who is to be appointed by the Non-Executive Directors, subject to the approval of the Council of Governors;

16.1.2.2 the Chief Executive shall be the Accounting Officer;

16.1.2.3 a Finance Director;

16.1.2.4 a registered medical practitioner or a registered dentist (within the meaning of the Dentists' Act 1984);

16.1.2.5 a registered nurse or a registered midwife;

16.1.2.6 Two Executive Directors.

16.1.2.7 a Deputy Chief Executive who will be one of the above.

16.1.3 The Non-Executive Directors and Chief Executive will establish and set the Terms of Reference for a Remuneration and Nominations Committee for the appointment of Executive Directors. The committee should consist of the Chair, the Chief Executive and other Non-Executive Directors. The removal of an Executive Director is subject to the application of the appropriate Trust policies and procedures.

16.1.4 Only members of the public constituencies who are not disqualified by virtue of paragraph 11.8.1 are eligible for appointment as a Non-Executive Director.

16.2 Appointment and removal of Non-Executive Directors

16.2.1 Non-Executive Directors (including the Chair) are to be appointed by the Council of Governors. Removal of the Chair and other Non-Executive Directors shall require the approval of 75% of the members of the Council of Governors at a quorate meeting.

16.2.2 The Council of Governors will establish and set the terms of reference for a Remuneration, Nominations and Conduct Committee. The Committee will normally be chaired by the Chair. Where the Chair has a conflict of interest, for example when the Committee is considering the Chair's re-appointment or remuneration, the Committee will normally be chaired by the Lead Governor.

16.2.3 That committee will recommend to the full Council of Governors no more than one individual per Non-Executive vacancy for appointment to the Board of Directors.

16.2.4 The Board of Directors will identify the skills, experience and knowledge required from time to time of any vacant post of Non-Executive Directors (including the Chair). The Board of

Directors will draw on advice from external sources as necessary.

16.2.5 The Council of Governors will have responsibility for the handling of all further aspects of the recruitment process, including any appointment.

16.2.6 The Trust shall publicly advertise the posts to be filled where determined by the Remuneration, Nominations and Conduct Committee on the basis of performance or when a Non-Executive Director is approaching their final term of office.

16.2.7 A long list for consideration will be identified by the Remuneration, Nominations and Conduct Committee. Only those candidates meeting the skills and experience agreed by the Board of Directors will be eligible for appointment.

16.2.8 For the purpose of considering the appointment of Non-Executive Directors the interview panel will include the Chair, three Governors, at least one of whom will be a Public Governor, an independent external assessor and the Chief Executive, acting in an ex-officio capacity. The Chief Executive and the independent external assessor have no vote.

16.2.9 For the purpose of considering the appointment of the Chair of the Trust, the interview panel will include four Governors, two of whom will be Public Governors, an independent external assessor and the Chief Executive, acting in an ex-officio capacity. The Chief Executive and the independent external assessor have no vote.

16.3 Terms of office of Non-Executive Directors

16.3.1 The Chair and the Non-Executive Directors are to be appointed for a period of office in accordance with the terms and conditions of office decided by the Council of Governors at a general meeting. Non-Executive Directors will serve a three year period and will not normally exceed a maximum of three terms of office except in exceptional circumstances.

16.3.2 Any terms beyond two terms (six years) should be subject to annual endorsement of the continued appointment by the Council of Governors.

16.4 Board of Directors – roles and responsibilities

16.4.1 The general duty of the Board of Directors, and of each Director individually, is to act with a view to promoting the

success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

16.4.2 The business of the Trust shall be managed by the Board of Directors who, subject to this constitution, shall exercise all the powers of the Trust including:

16.4.2.1 to act as the critical decision making body of the Trust and to be accountable for the subsequent risks and liabilities that rest with this responsibility;

16.4.2.2 to set the strategic direction of the Trust within the overall limits detailed in the Licence by NHS England;

16.4.2.3 to define its annual and longer-term objectives and agree plans to achieve them;

16.4.2.4 to oversee the delivery of its plan by monitoring performance against objectives and ensuring that corrective action is taken when necessary;

16.4.2.5 to ensure effective financial stewardship through value for money, financial control, financial planning and strategy;

16.4.2.6 to ensure high standards of corporate governance and personal behaviour are maintained in the conduct of business of the Trust;

16.4.2.7 to ensure appropriate mechanisms for the appointment, appraisal and remuneration of staff;

16.4.2.8 to endeavour to ensure effective dialogue between the Trust and the local community on its plans and performance and that these are responsive to the needs of the community; and,

16.4.2.9 to work collaboratively with the Council of Governors to ensure that each body understands their respective roles and responsibilities and develop practical ways of engaging and interacting with each other.

16.4.3 A third party dealing in good faith with the Trust shall not be affected by any defect in the process by which Directors are appointed or any vacancy on the Board of Directors.

16.4.4 All Directors will adhere to the policies and procedures of the Trust and shall act in the best interests of the Trust at all times.

16.4.5 The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and section 44 of the Code of Governance for NHS provider trusts (October 2022) effective from 1 April 2023.The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action.

16.5 Appointment of the Vice Chair and Senior Independent Director

16.5.1 For the purposes of enabling the proceedings of the Trust to be conducted in the absence of the Chair, the Council of Governors will appoint by simple majority, following a recommendation from the Chair, a Non-Executive Director to be Vice Chair for such a period, not exceeding the remainder of their term as a Non-Executive Director of the Trust.

16.5.2 The Board of Directors, following a recommendation from the Chair and in consultation with the Council of Governors, will appoint a Non-Executive Director to be Senior Independent Director for such a period, not exceeding the remainder of their term as a Non-Executive Director of the Trust.

16.6 Remuneration and Nominations Committees

16.6.1 The Remuneration and Nominations Committee of Non-Executive Directors shall decide the terms and conditions of office, including remuneration and allowances, of the Executive Directors (including the Chief Executive). The Company Secretary shall be the secretary to this Committee. The Chief Executive shall be in attendance at the request of the Committee. Neither the Director of Workforce and Organisational Development nor the Chief Executive shall be present to the discussion of their own remuneration.

16.6.2 The Remuneration, Nominations and Conduct Committee of Governors shall recommend to the Council of Governors the terms and conditions of office, including remuneration and

allowances, of the Non-Executive Directors, including the Chair.

16.6.3 The remuneration for Directors is to be disclosed in the annual report.

16.7 Disqualification

16.7.1 A person may not become or continue as a Director of the Trust if:

16.7.1.1 they are not of good character;

16.7.1.2 they do not have the qualifications, competence, skills and experience which are intrinsic for the work for which they are to be appointed, or have been appointed;

16.7.1.3 they have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out a regulated activity or providing a service which, if provided in England, would be a regulated activity;

16.7.1.4 they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

16.1.7.5 they have made a composition or arrangement with, or granted a trust deed for, their creditors and have not been discharged in respect of it;

16.7.1.6 they are the subject of a bankruptcy restriction order or an interim bankruptcy restriction order or an order to like effect made in Scotland or Northern Ireland;

16.7.1.7 they are a person to whom a moratorium period under a debt relief order applied under Part VIIA (Debt Relief Order) of the Insolvency Act 1986;

16.7.1.8 they are included on the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;

16.7.1.9 they are prohibited from holding the relevant office or position or from carrying on the regulated activity, by or under enactment;

16.7.1.10 they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them;

16.7.1.11 any amount properly owing to the Trust by them remains outstanding without good cause;

16.7.1.12 they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

16.7.1.13 in the case of a Non-Executive Director, they are no longer a member of a public constituency;

16.7.1.14 they are a person whose tenure of office as a Chair or as a member or Director of a health service body has been terminated on the grounds that their appointing is not in the interests of the health service, for non-attendance at meetings or for non-disclosure of a pecuniary interest;

16.7.1.15 they have had their name removed by a direction under paragraph 10 of the National Health Service (Performers Lists) Regulations 2004 or Section 151 of the 2006 Act (or similar provision elsewhere) and have not subsequently had their name included on such a list;

16.7.1.16 they have within the preceding two years been dismissed, for reasons considered to be inappropriate by the Trust, from any paid employment with a health service body;

16.7.1.17 in the case of a Non-Executive Director they have without good reason failed to fulfil any training requirement established by the Board of Directors;

16.7.1.18 in the case of a Non-Executive Director they have failed to sign and deliver to the Company Secretary, a statement in the form required by the Board of Directors, confirming acceptance of the code of conduct for Directors.

16.8 Meetings of the Board of Directors

16.8.1 Meetings of the Board of Directors shall be open to members of the public unless the Board of Directors decides otherwise in relation to all or part of such meetings having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. The Chair may exclude any member of the public and representatives of the press from any meeting or part of meeting of the Board of Directors if they are interfering with or preventing the proper conduct of the meeting.

16.8.2 Before holding a meeting in public, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors.

16.8.3 The Board of Directors shall meet at the direction of the Chair. Standing Orders govern the proceedings and business of meetings. The proceedings shall not however be invalidated by any vacancy of its membership, or defect in a Director's appointment.

16.9 Committees and delegation

16.9.1 The Board of Directors shall have a schedule of delegation. Any of the powers of the Board may be delegated, whether to a committee, group of Directors, or to an Executive Director, subject to the Board maintaining a list of powers reserved to itself.

16.9.2 The Board of Directors shall appoint an Audit Committee of Non-Executive Directors to monitor the exercise of the external auditor's functions and perform such monitoring, reviewing and other functions as the Board of Directors shall consider appropriate. The Audit Committee shall function pursuant to its terms of reference.

16.10 Conflicts of interest

16.10.1 The duties that a Director has by virtue of being a Director include in particular:

16.10.1.1 a duty to avoid a situation in which the Director has (or can have) a direct or indirect interest

that conflicts (or possibly may conflict) with the interests of the Trust;

16.10.1.2 a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

16.10.2 The duty referred to in sub-paragraph 16.10.1.1 of this constitution is not infringed if:

16.10.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or

16.10.2.2 the matter has been authorised in accordance with this constitution.

16.10.3 The duty referred to in sub-paragraph 16.10.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

16.10.4 In sub-paragraph 16.10.1.2 of this constitution. "third party" means a person other than:

16.10.4.1 the Trust; or

16.10.4.2 a person acting on its behalf.

16.10.5 If a Director has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, which includes a relevant and material interest in a matter as defined in Annex E and at 16.10.10 below, the Director must declare the nature and extent of that interest to the other Directors and it shall be recorded at the earliest opportunity and before the next meeting of the Board of Directors in a register of interests. Further guidance is also available from the Trust's Conflicts of Interest Policy. The Director in question:

16.10.5.1 shall not be present except with the permission of the Board of Directors in any discussion of the matter; and,

16.10.5.1 shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

16.10.5.3 It shall be a disciplinary offence on the part of a Director wilfully to fail to disclose any interest required to be disclosed under the preceding paragraph.

16.10.6 Any declaration required by this paragraph 16.10 must be made before the Trust enters into the transaction or arrangement.

16.10.7 If a declaration under this paragraph 16.10 proves to be, or becomes inaccurate or incomplete, a further declaration must be made.

16.10.8 This paragraph 16.10 of the constitution does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

16.10.9 A Director need not declare an interest:

16.10.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

16.10.9.1 If, or to the extent that, the Directors are already aware of it;

16.10.9.2 If, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered:

16.10.9.2.1 By a meeting of the Board of Directors; or

16.10.9.2.2 By a committee of the Directors appointed for the purpose under this constitution.

16.10.10 A material interest in a matter, as defined in Annex E, is any interest held by a Director, their spouse or partner, or a member of immediate family, in any firm or company or business which in connection with the matter is trading with the Trust or is likely to be considered as a potential trading partner with the Trust. The exceptions which shall not be treated as material interests are as follows:

16.10.10.1 shares not exceeding 1% of the total shares in issue held in any company whose shares are listed on any public exchange; and,

16.10.10.2 an employment contract with an appointing organisation held by a Non-Executive Director.

16.11 Expenses

16.11.1 The Trust may pay travelling and other expenses to Executive Directors and Non-Executive Directors at such rates as it decides.

17 Roles and responsibilities of the Company Secretary of the Trust

17.1 The Trust shall have a Company Secretary. The Company Secretary shall not be a member of the Council of Governors or the Chief Executive or the Finance Director. The Company Secretary's functions shall include responsibility for:

17.1.1 acting as secretary to the Council of Governors and the Board of Directors and such committees as may from time to time be required by either the Board or Council;

17.1.2 summoning and attending all meetings of the Council of Governors and the Board of Directors and keeping the minutes of those meetings;

17.1.3 keeping the register of members and other registers required by this constitution to be kept;

17.1.4 publishing to members, in appropriate form, information about the Trust's affairs; and

17.1.5 preparing and sending to NHS Improvement, and any other statutory body, all returns which are required to be made.

18 Registers

18.1 The Trust is to have:

18.1.1 a register of members showing, in respect of each member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

18.1.2 a register of the Council of Governors;

18.1.3 a register of interests of the Council of Governors;

18.1.4 a register of Directors; and

18.1.5 a register of interests of the Board of Directors.

18.2 The Corporate Affairs Office shall remove from the register of members the name of any member who ceases to be entitled to be a member under the provisions of this constitution, and will add the name of anyone who applies to be and becomes a member.

18.3 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if the member so requests.

18.4 So far as the registers are required to be made available:

18.4.1 they are to be available for inspection free of charge at all reasonable times; and

18.4.2 a person who requests a copy of, or extract from, the registers is to be provided with a copy or extract.

18.5 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

19 Public documents

19.1 The following documents of the Trust are to be available for inspection by members of the public at all reasonable times and shall be available on the Trust's website, in line with the Trust's Freedom of Information Policy:

19.1.1 a copy of the current constitution;

19.1.2 a copy of the latest annual accounts and of any report of the external auditor on them;

19.1.3 a copy of the report of any other external auditor of the Trust's affairs appointed by the Council of Governors;

19.1.4 a copy of the latest annual report;

19.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

19.2.1 a copy of any order made under section 65D (appointment of Trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (Trusts coming out of administration) or 65LA (Trusts to be dissolved) of the 2006 Act;

19.2.2 a copy of any report laid under section 65D (appointment of Trust special administrator) of the 2006 Act;

19.2.3 a copy of any information published under section 65D (appointment of Trust special administrator) of the 2006 Act;

19.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act;

19.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act;

19.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (NHS Improvement's decision), 65KB (Secretary of State's response to NHS Improvement's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;

19.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

19.2.8 a copy of any final report published under section 65I (administrator's final report) of the 2006 Act;

19.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act; and,

19.2.10 a copy of any information published under section 65M (replacement of Trust special administration) of the 2006 Act.

19.3 Any person who requests a copy of, or extract from any of the above documents, is to be provided with a copy. If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

20 External auditor

20.1 The Trust is to have an external auditor and is to provide the auditor with every facility and all information which he may reasonably require for the purposes of his functions under Schedule 10 to the 2006 and paragraph 23 of Schedule 7 to the 2006 Act.

20.2 A person may only be appointed as the external auditor if he (or in the case of a firm of each of its members) is a member of one or more of the bodies referred to in paragraph 23 (4) of Schedule 7 to the 2006 Act.

20.3 The Council of Governors at a general meeting shall appoint or remove the Trust's external auditors.

20.4 The external auditor is to carry out his duties in accordance with Schedule 15 to the 2006 Act and in accordance with any directions

given by NHS Improvement on standards, procedures and techniques to be adopted.

20.5 The Board of Directors shall nominate a list of external auditors to be considered for appointment by the Council of Governors and may resolve that external auditors be appointment to review any other aspect of the Trust's performance. Any such external auditors are to be appointed by the Council of Governors.

21 Accounts

21.1 The Trust must keep proper accounts and proper records in relation to the accounts.

21.2 NHS England may, with the approval of the Secretary of State, give directions to the Trust as to the content and form of the accounts.

21.3 The accounts are to be audited by the Trust's external auditor.

21.4 The Trust shall prepare in respect of each financial year annual accounts in such form as NHS England may with the approval of the Secretary of State direct.

21.5 The annual accounts, any report of the external auditor on them, and the annual report are to be presented and considered at a Council of Governors meeting. The Trust may combine a meeting of the Council of Governors convened for the purposes of this paragraph with the Annual Members' Meeting.

21.6 The Trust shall lay a copy of the annual accounts, and any report of the external auditor on them, before Parliament and send copies of those documents to NHS England within such period as NHS Improvement may direct.

22 Annual reports, forward plans and non-NHS work

22.1 The Trust is to prepare annual reports and send them to NHS England.

22.2 The Trust shall give information as to its forward planning in respect of each financial year to NHS England. The document containing this information is to be prepared by the Directors, and in preparing the document, the Board of Directors must have regard to the views of the Council of Governors.

22.3 Each forward plan must include information about:

22.3.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on; and.

22.3.2 the income it expects to receive from doing so.

22.4 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 22.3.1, the Council of Governors must:

22.4.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions; and

22.4.2 notify the Directors of the Trust of its determination.

22.5 A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

23 Presentation of the annual accounts and reports to the Governors and members

23.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors for consideration:

23.1.1 the annual accounts;

23.1.2 any report of the external auditor on them; and

23.1.3 the annual report.

23.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting with at least one member of the Board of Directors in attendance.

23.3 The Trust may combine a meeting with the Council of Governors convened for the purposes of sub-paragraph 23.1 with the Annual Members' Meeting.

24 Indemnity

24.1 The Council of Governors and the Board of Directors and officers of the Trust, acting honestly and in good faith, will be indemnified against personal liability incurred in the execution or purported execution of

their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust. The Trust may purchase and maintain insurance against this risk.

25 Execution of documents

25.1 The Trust is to have a seal, but this is not to be affixed except under the authority of the Board of Directors.

25.2 A document purporting to be duly executed under the Trust's seal, or to be signed on its behalf, is to be received in evidence and, unless the contrary is proved, taken to be so executed or signed.

26 Dispute resolution procedures

26.1 Other than where specified in the constitution or the Standing Orders of the Council of Governors, questions of eligibility, procedure and administrative matters in relation to governorship or meetings of members or Governors shall be determined by the Company Secretary, with the right of appeal to a committee of the Council of Governors convened for the purpose of this, whose decision shall be final and binding except in the case of manifest error.

26.2 Other than where specified in the constitution or the Standing Orders for the Board of Directors, questions of procedure and administrative matters in relation to directorship or meetings of Directors shall be determined by the Company Secretary, with the right of appeal to the Board of Directors convened for the purpose of this, whose decision shall be final and binding except in the case of manifest error.

27 Amendment of the constitution

27.1 No amendment shall be made to this constitution unless:

27.1.1 More than half of the members of the Council of Governors of the Trust voting approve the amendments; and,

27.1.2 More than half of the members of the Board of Directors of the Trust voting approve the amendments.

27.2 Amendments made under paragraph 27.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a results of the amendment, not accord with schedule 7 of the 2006 Act.

27.3 Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors, or otherwise with respect to the role that the Council of Governors has as part of the Trust:

27.3.1 at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment; and,

27.3.2 the Trust must give the members an opportunity to vote on whether they approve the amendment.

27.4 If more than half of the members voting approve the amendment, the amendment continues to have effect, otherwise it ceases to have effect and the Trust must take such steps as are necessary as a result.

27.5 Amendments by the Trust of its constitution are to be notified to NHS Improvement. For the avoidance of doubt, NHS England's functions do not include a power or duty to determine whether or not the constitution as a result of the amendments accords with Schedule 7 of the 2006 Act.

28 Mergers etc. and significant transactions

28.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

28.2 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

28.3 Significant transaction means a transaction which would not otherwise require the approval of the Council of Governors under paragraph 28.1 above which meets any one of the criteria below:

Assets:
The gross assets subject to the transaction are greater than 25% of the Trust's existing gross assets.

Income:
The income attributable to the assets or the contract associated with the transaction is greater than 25% of the Trust's overall income.

Consideration to total Trust capital
The gross capital of the company or business being acquired/divested, is greater than 25% of the total capital of the Trust following completion, or the effects on the total capital of the Trust resulting from a transaction.

28.4 For the purposes of this paragraph:

28.4.1 "gross assets" is the total of fixed assets and current assets;

28.4.2 "gross capital" is the market value of the target's shares and debt securities, plus the excess of current liabilities over current assets; and

28.4.3 "total capital" is the taxpayers' equity.

28.5 Material transaction means:

28.4.1 If a transaction meets the criteria above, but the details are greater than 10% of the assets, income or total capital of the Trust, it is considered to be a material transaction. Material transactions do not require more than half of the Council of Governors to vote to approve entering into the transaction however, the Trust would undertake consultation with the Council of Governors prior to entering into a material transaction.

29 Head office and website

29.1 The Trust's head office is at:

29.1.1 Harrogate and District NHS Foundation Trust, Lancaster Park Road, Harrogate, HG2 7SX.

29.2 The Trust maintains a website, the current address of which is:

29.2.1 www.hdft.nhs.uk

29.3 The Trust will display its name on the outside of its head office and at every other place at which it carries on business, and on its business letters, notices, advertisements and other publications.

29.4 Changes to the address and website will require a change to the constitution and will need to be approved by the Board of Directors and Council of Governors.

Annex A

1 Area of the Trust

Eligibility to become a public member will be available to people living within the defined catchment area of the Trust. This includes residents from the following Local Authority electoral areas (as defined for the purposes of local government elections):

- Harrogate and surrounding villages
- Ripon and West District
- Knaresborough and East District
- Wetherby and Harewood
- Alwoodley
- Otley and Yeadon
- Adel and Wharfedale
- The Rest of North Yorkshire and York
- The Rest of England

Membership will remain valid whilst ever a person resides in the above catchment areas.

Public constituencies with minimum numbers as described in 7.2.2:

Public constituency area 1 – Harrogate and surrounding villages is defined by the following electoral wards of Harrogate District Council:

Killinghall, Ripley, Washburn and Harrogate (including: Stray, Hookstone, Rossett, Pannal, Harlow Moor, Saltergate, New Park, Low Harrogate, High Harrogate, Bilton, Woodfield, Granby and Starbeck).

Public constituency area 2 - Ripon and West District is defined by the following electoral wards of Harrogate District Council:

Pateley Bridge, Mashamshire, Kirkby Malzeard, Nidd Valley, Lower Nidderdale, Bishop Monkton, Wathvale and Ripon (including Spa, Minster and Moorside).

Public constituency area 3 – Knaresborough and East District is defined by the following electoral wards of Harrogate District Council:

Newby, Boroughbridge, Claro, Ouseburn, Ribston, Marston Moor, Spofforth with Lower Wharfedale and Knaresborough (including Scriven Park, East and King James).

Public constituency area 4 – Wetherby, and Harewood including Otley and Yeadon, Adel and Wharfedale and Alwoodley Wards are defined by the Wetherby and Harewood electoral Wards of Leeds City Council.

Public Constituency Area 5 – rest of North Yorkshire and York is defined as those areas not served by public constituency areas 1 – 3.

Public Constituency Areas 6 and 7 – the rest of England is defined as those areas not served by public constituency areas 1 – 5.

2 Staff constituency as defined in 7.3.1, with minimum numbers as described in 7.3.7

The Nursing, Midwifery and Allied Health Professionals (AHPs) Staff Class;

The Medical Practitioners' Staff Class;

0-19 Services Staff Class;

Community Services Staff Class;

The Other Clinical Staff Class; and,

The Non-Clinical Staff Class.

Annex B

MODEL ELECTION RULES

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PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (NHS Improvement, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*NHS Improvement*" means the corporate body known as NHS Improvement as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-

mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until

the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, and constituency or class within a constituency of each

candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-

voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:
(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the

returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter’s voter ID number;

(ii) the voter’s declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text

messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the

unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for

replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to

make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form “disqualified”,

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as “disqualified” all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"ballot document" means a ballot paper, internet voting record, telephone voting record or text voting record.

"continuing candidate" means any candidate not deemed to be elected, and not excluded,

"count" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"deemed to be elected" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"mark" means a figure, an identifiable written word, or a mark such as "X",

"non-transferable vote" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"preference" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"quota" means the number calculated in accordance with rule STV46,

"surplus" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"stage of the count" means:

(a) the determination of the first preference vote of each candidate,

(b) the transfer of a surplus of a candidate deemed to be elected, or

(c) the exclusion of one or more candidates at any given time,

"transferable vote" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"transferred vote" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"transfer value" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no

person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value (“the transfer value”) which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents

on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the

transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule

STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled, the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub-parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV49.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this

rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chair of the NHS Trust, or

(ii) in any other case, to the chair of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chair of the NHS Trust, or

(ii) in any other case, to the chair of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chair of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with “rejected in part”,

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chair of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that NHS Improvement has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chair of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to NHS Improvement under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to NHS Improvement for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to NHS Improvement by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. NHS Improvement will refer the application to the independent election arbitration panel appointed by NHS Improvement.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 NHS Improvement shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

Annex C

Fit and Proper Person Declaration

Harrogate and District NHS Foundation Trust ("the Trust")

1. The Care Quality Commission (CQC) Regulation 5: Fit and Proper Person Test for those holding Board level posts came into effect in November 2014. Those persons are required to provide confirmation in writing, on appointment and thereafter on request, of their fitness to hold such posts. Fitness to hold such a post is determined in a number of ways including (but not exclusively) by the Trust's Provider Licence, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("The Regulated Activities Regulations") and the Trust's Constitution.

Provider Licence

2. Condition G3(1) of the Trust's Provider Licence ("the Licence") provides that the Licensee must ensure that a person may not become or continue as a Governor of the Licensee if that person is:
   a. a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
   b. a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);
   c. a person who has made a composition or arrangement with, or granted a trust deed for, that person's creditors and has not been discharged in respect of it;
   d. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person.

Regulated Activities Regulations

3. The intention of Regulation 5 of the Regulated Activities Regulations is to ensure that people who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards, are fit and proper to carry out this important role. Regulation 5(2) states that unless the individual satisfies all the requirements set out in paragraph (3), the service provider must not appoint or have in place an individual as a director of the service provider, or performing the functions of, or functions equivalent or similar to the functions of, such a director.

4. The requirements of paragraph (3) of Regulation 5 of the Regulated Activities Regulations are that:

   e. the individual is of good character, which should include those listed in Part 2 of Schedule 4;

f. the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed;
g. the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;
h. the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; and
i. none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

5. The grounds for unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:

a. The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;
b. The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;
c. The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(16);
d. The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;
e. The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;
f. The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

6. The criteria for determining if a person is of "good character" are set out in Part 2 of Schedule 4 of the Regulated Activities Regulations. These are:

a. Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence;
b. Whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.

Constitution

7. Paragraph 11.8 of the Trust's constitution places a number of restrictions on an individual's ability to become or continue as a Governor as follows:

a. they have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out regulated activity or providing a service elsewhere which, if provided in England would be a regulated activity;
b. they are a Director of the Trust, or a Governor or Director of another NHS Foundation Trust;
c. they are a member who shares the same
d. household as a member of the Board of Directors of the Trust;
e. they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;
f. they have made a composition or arrangement with, or granted a trust deed for, their creditors and have not been discharged in respect of it;
g. they have within the preceding five years been
h. convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them;
i. they have within the preceding two years been dismissed from any paid employment with a health service body for reasons considered to be inappropriate by this Trust;
j. they are a person whose tenure of office as the Chairman or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;
k. they have had their name removed, by a direction under paragraph 10 of the National Health Service (Performers Lists) Regulations 2004 or Section 151 of the 2006 Act (or similar provision elsewhere), and has not subsequently had their name included in such a list;
l. they are not by reason of their health capable of properly performing tasks which are intrinsic to the office for which they are elected or appointed;
m. they are a vexatious complainant of the Trust, as defined by Trust policy;
n. they are a vexatious litigant of the Trust as defined by Trust policy;
o. they are a family relation or occupant of the same household of a person who is an existing Governor of the Trust;
p. any amount properly owing to the Trust by them remains outstanding without good cause;
q. they do not, or cease to, fulfil the eligibility requirements as set out in this constitution.

Declaration

8. By signing the declaration below, you are confirming that you are a fit and proper person to carry out your role, that you do not fall within the definition of an “unfit person”, and that you are not aware of any pending proceedings or matters which may call such a declaration into question.

I acknowledge the extracts from the Trust’s Provider Licence, the Health and Social Care Act 20085 (regulated Activities) Regulations 2014 and the Trust’s Constitution outlined in this document.

I confirm that I do not fit within any definition of an “unfit person” as set out in the Provider Licence, the Health and Social Care Act 20098 (Regulated Activities) Regulations 2014 or the Trust’s Constitution; that I meet all the criteria for being a fit and proper person as defined in the Social Care Act 2008 (Regulated Activities) Regulations 2014; and that there are no other grounds under which I would be ineligible to continue in post.

I undertake to notify the Company Secretary immediately when it comes to my attention if I no longer satisfy the criteria to be a “fit and proper person” or if there are other grounds under which I would be ineligible to continue in post.

I confirm that I am a member of the staff constituency/public constituency/have been nominated by a partner organisation as detailed below.

The information I have provided is accurate and truthful to the best of my knowledge and I understand that providing a false declaration may result in my immediate dismissal from post.

Name:	.....	Signed:	.....
Date:	.....	Constituency/ Stakeholder:	.....

June 2023

Annex D

Council of Governors

Standing Orders

1. NOTICE

1.1 The Council of Governors is to meet at least three times in each financial year in addition to the Annual Members' Meeting. Save in the case of emergencies or the need to conduct urgent business, the Company Secretary shall give at least seven days written notice of the date and place of every meeting of the Council of Governors to all Governors.

1.2 Meetings of the Council of Governors will normally be called at the direction of the Chair. A meeting may also be held if ten Governors give written notice to the Company Secretary specifying the business to be carried out. The Company Secretary shall send a written notice to all Governors as soon as possible after receipt of such a request. The Company Secretary shall issue notice of a meeting on at least seven but not more than twenty-eight days' notice to discuss the specified business.

1.3 Notice of the meetings of the Council of Governors is to be given:

1.3.1 by notice sent by post, or by electronic mail where the Governor has provided an email address for service, to all Governors;

1.3.2 by notice prominently displayed at the registered office;

1.3.3 by notice on the Trust's website;

1.3.4 by any other method approved by the Council of Governors at least seven clear days before the date of the meeting.

1.4 The notice must:

1.4.1 be given to the Council of Governors and the Board of Directors, and to the external auditors;

1.4.2 state whether the meeting is an Annual Members' Meeting or a Council of Governors meeting;

1.4.3 give the time, date and place of the meeting; and

1.4.4 indicate the business to be dealt with at the meeting

2. QUORUM

2.1 Before a Council of Governors meeting can do business there must be a quorum present. Except where these rules say otherwise, a quorum is one third of Governors in post and entitled to vote at the meeting, with the majority of Governors from the public constituencies.

2.2 If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Council of Governors determine and notice of the adjourned meeting shall be circulated to members of the Council of Governors. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of Governors present during the meeting is to be a quorum.

3. CONDUCT OF MEETING

3.1 It is the responsibility of the Council of Governors, the Chair of the meeting and the Company Secretary to ensure that at any meeting:

3.1.1 the issues to be decided are clearly explained;

3.1.2 sufficient information is provided to Governors to enable rational discussion to take place; and

3.1.3 where appropriate, experts in relevant fields or representatives of special interest groups are invited to address the meeting.

3.2 The Chair of the Trust, or in their absence, the Vice Chair of the Trust, or in exceptional circumstances in the absence of both the Chair and Vice Chair, the Lead Governor of the Council of Governors shall preside at a meeting of the Council of Governors.

Where a conflict of interest arises for the Chair and Vice Chair, the Lead Governor of the Governors shall chair that element of the meeting. In these circumstances and in the absence of the Lead Governor, the Governors shall elect from their members, a Governor to chair that element of the meeting. In acting as the Chair a Governor shall have a casting vote on that issue.

3.3 Where a Governor wishes to formally pose a question at the public Council of Governors meeting, they should supply this question in writing to the Company Secretary or the Corporate Affairs Office no less than five working days prior to the meeting. If a query arises during the

meeting that is not resolved through the discussions at the meeting, any questions to be formally posed should be supplied in writing to the Company Secretary or the Chair.

4. VOTING

4.1 Subject to the constitution, a resolution put to the vote at a meeting of the Council of Governors shall, except where a poll is demanded or directed, be decided upon by a show of hands.

4.2 On a show of hands or on a poll, every Governor present is to have one vote. On a poll, votes may be given either personally or by proxy under arrangements laid down by the Council of Governors, and every Governor is to have one vote. In the case of an equality of votes the Chair of the meeting is to have a casting vote, unless there is a conflict of interest as set out in 3.2. in which case the acting chair will have both a primary and a casting vote.

4.3 Unless a poll is demanded, the result of any vote will be declared by the Chair and entered in the minutes of the meeting. The minutes will be conclusive evidence of the result of the vote.

4.4 A poll may be directed by the Chair or demanded either before or immediately after a vote by show of hands by not less than one-tenth of the Governor present at the meeting. A poll shall be taken immediately.

4.5 Subject to the following provisions of this paragraph, questions arising at a meeting of the Council of Governors shall be decided by a majority of votes.

4.5.1 no resolution of the Council of Governors shall be passed if all the Public Governors present unanimously oppose it.

4.5.2 the removal of the Chair or another Non-Executive Director requires the approval of three-quarters of the full membership of the Council of Governors.

4.6 Save as set out in 4.2 the Chair of the Council of Governors or Vice Chair shall not have a vote at a meeting of the Council of Governors.

5 PERSONS ENTITLED TO ATTEND MEETINGS

5.1 All meetings of the Council of Governors are to be open to the public unless the Council of Governors decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other

proper grounds as set out in the constitution. The Chair may exclude any member of the public from a meeting of the Council of Governors if they are interfering with or preventing the proper conduct of the meeting.

5.2 The Council of Governors may invite the Chief Executive or any other representatives of the Board of Directors, or a representative of the Trust's external auditors or other advisors to attend a meeting of the Council of Governors.

5.3 The Chief Executive and any other Director shall have the right to attend any meeting of the Council of Governors provided that they shall not be present for any discussion of their individual relationship with the Trust.

6. MEANS OF ATTENDANCE

6.1 The Council of Governors may agree that its Governors can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

7. COMMITTEES

7.1 The Council of Governors may form advisory sub committees under written terms of reference to the Council of Governors which may include members of the Board of Directors and appropriate people (paid or unpaid) nominated by the Board of Directors and having relevant skills or experience. Those powers shall be exercised in accordance with any written instructions given by the Council of Governors. The Council of Governors will appoint the Chair of any committee and shall specify the quorum. All acts and proceedings of any committee shall be reported to the Council of Governors.

7.2 The Council of Governors will establish a Remuneration, Nominations and Conduct Committee for the purpose of making recommendations to the Council of Governors for the appointment of the Chair and Non-Executive Directors. In addition this committee will consider the remuneration of the Chair and Non-Executive Directors, and decisions will be taken at a meeting of the Council of Governors.

7.4 The Council of Governors may, through the Company Secretary, request that advisors assist them on any committee they appoint in carrying out their functions.

8. VALIDITY OF DECISIONS

8.1 Decisions taken in good faith at a meeting of the Council of Governors or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Council of Governors attending the meeting

Annex E

In accordance with the Constitution of the Trust, the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and Health and Social Care Act 2022) and Monitor's (referred to in this paper as NHS England / Improvement) Code of Governance for Foundation Trusts, and in recognition of the Codes of Conduct and Accountability issued by the Department of Health and the UK Corporate Governance Code produced by the Financial Reporting Council, the Trust is required to maintain a Register of Interests of Directors. The Trust is also required, under the new fundamental standard regulations set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to ensure its Directors meet fit and proper person requirements, which came into force on 1 October 2014

1. Declaration of Interests By Directors and Governors

1.1. All existing Directors (including for the purposes of this document, Non-Executive Directors) and Governors should declare relevant and material interests. Any Directors or Governors appointed or elected subsequently should do so on appointment or election.

1.2. Interests which should be regarded as "relevant and material" and which, for the avoidance of doubt, should be included in the register, are:

(a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies).

(b) Ownership, part-ownership or directorship of private companies, business or consultancies likely or possibly seeking to do business with the NHS.

(c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

(d) A position of Authority in a charity or voluntary organisation in the field of health and social care.

(e) A position of Authority in a local council or Local Authority, for example, a Councillor.

(f) Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services.

(g) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks.

1.3. If Directors or Governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair.

1.4. At the time the interests are declared, they should be recorded in the Board of Director minutes or Council of Governor minutes as appropriate. Any changes in interests should be officially declared at the next Board meeting or Council of Governors meeting as appropriate following the change occurring. It is the obligation of the Director or Governor to inform the Company Secretary of the Trust in writing within 7 days of becoming aware of the existence of a relevant or material interest. The Company Secretary will amend the register upon receipt within 3 working days.

1.5. During the course of a Board of Director meeting or Council of Governor meeting, if a conflict of interest is established, the Directors or Governors concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, the majority will resolve the issue with the Chair having the casting vote.

1.6. There is no requirement for the interests of Directors' or Governors' spouses or partners to be declared.

2. Register of Interests

2.1. The details of Directors and Governors interests recorded in the register will be kept up to date by means of a monthly review of the register by the Company Secretary of the Trust, during which any changes of interests declared during the preceding month will be incorporated.

2.2. Subject to contrary regulations being passed, the register will be available for inspection by the public free of charge. The Chair will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it. Copies or extracts of the register must be provided to members of the Trust free of charge and within a reasonable time period of the request.

ANNUAL MEMBERS' MEETING
21 NOVEMBER 2023

Title:	Annual Report & Accounts 2021-22
Responsible Director:	Trust Chair
Author:	Company Secretary

Purpose of the report and summary of key issues:	To formally present the Trust's **combined** annual report and accounts for 2021-2022.	
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	
	Person Centred, Integrated Care; Strong Partnerships	
	Great Start in Life	
	At Our Best: Making HDFT the best place to work	
	An environment that promotes wellbeing	
	Digital transformation to integrate care and improve patient, child and staff experience	
	Healthcare innovation to improve quality	
Corporate Risks	n/a	
Report History:	Report reviewed and approved at: • Audit Committee on 3 October 2022 • Trust Board on 5 October 2022 • Laid before Parliament on 18 May 2023	
Recommendation:	To confirm the publication of the Trust's combined Annual Report & Accounts 2021-22.	

Harrogate and District NHS Foundation Trust

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
ANNUAL REPORT AND ACCOUNTS

1 April 2021 to 31 March 2022

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
Annual Report and Accounts – 1 April 2021 to 31 March 2022

Presented to Parliament pursuant to Schedule 7 paragraph 25 (4) (a) of the National Health Service Act 2006

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CONTENTS

1. CHAIR'S WELCOME

As the new Chair for Harrogate and District NHS Foundation Trust (HDFT), it is both a pleasure and a privilege to introduce the Annual Report and Accounts for the financial year 1 April 2021 to 31 March 2022.

Following the start of the Covid-19 pandemic, it has continued to be another challenging period for the National Health Service and our patients, service users and colleagues. The Board of Directors and Council of Governors are most grateful and full of admiration for the way in which teams throughout HDFT have continued to adapt their ways of working. This is a fantastic tribute to the great commitment and flexibility of our colleagues, however, we all recognise this has been extraordinarily challenging and difficult in so many ways.

As the challenges of the pandemic remained, our colleagues continued to find ways to care for patients and services users, and at the same time, tackle the backlog of people waiting to access our services. This has been a difficult balance, and we continue to work towards achieving this.

We are so grateful for the kindness and support shown by others, too. For example, the hundreds of volunteers who have provided support in so many ways, from helping to feed patients on wards when visiting was restricted, to distributing food to weary colleagues after a very long shift. The Trust also received thousands of donations during this period. We are incredibly grateful for all the items received and continued to distribute these with care, and recognise all donations within our annual charity report.

We are proud to state that our 0-19 Services grew during this period and we welcome new colleagues from Northumberland. This also means we are now the largest provider of 0-19 services nationally. Something we are extremely proud of, and we will continue to work towards our ambition of providing the best start in life for children, young people and their families.

We learned of Donna Ockenden's initial emerging findings report into the failings in maternity care in Shrewsbury and Telford Hospitals which resulted in deaths and harming of mothers and babies from 2000-2019 (1,862 Serious Incidents) which was published in December 2020. We were saddened and distressed as a Board of Directors to hear this, and immediately began our own work to implement the actions identified in this report, and also to think about how we apply these principles usefully to other services. This work was reinforced when the final report was published in March 2022. Our commitment to this continues into the next year, and beyond.

Working with our subsidiary company; Harrogate Healthcare Facilities Management, trading as Harrogate Integrated Facilities (HIF), we are growing our 'green' awareness and ambition, and I am delighted to report we received grants totalling over £14 million to realise our ambition. This funding will address some of the long-standing backlog maintenance matters relating to the hospital building including repairing and replacing flat roofs that leak and old windows, both of these have impacted on the experience of patients and staff. The programme will also see HDFT embracing new technologies through the installation of a Ground Source Heat Pump, state of the art Air Handling Unit, and the addition of Solar Panels to the building. In addition to the benefits that this work will bring to the hospital and the overall climate change challenge, it is worth noting the benefits that it will bring to the local economy in terms of local businesses being involved in the construction phase of the project.

Our Annual Report and Accounts is our opportunity to present the details of HDFT's performance in 2021/22. You will see that, the Trust performance has been positive in year, reporting a surplus position and meeting all regulatory requirements during the response to Covid-19. As the report describes, we are focused on the challenges moving forward, as well as looking to embrace the opportunities to provide best value for the tax payer.

Work has begun on developing our new strategy, and as a Board of Directors and Council of Governors, alongside our colleagues, patients, service users and partners, we are asking some very tough questions… what is our ambition for the period ahead? What should our priorities be? How can we continue to meet present and future need, whilst making sure the backlog of patients waiting for our services is cleared? I will report on this next year, and in the meantime, please do visit our website where our new strategy will be launched.

I hope that you find this Annual Report interesting and informative. It is an important part of our accountability to our Members and to the wider public we serve. We will be arranging our Annual Members Meeting to take place later in 2022 and would warmly welcome the opportunity to see you, talk about our work from this period, and the period ahead. As always, your views and experiences are extremely important to us, and helps us shape our priorities.

Sarah Armstrong
Chair
Harrogate and District NHS Foundation Trust
5th October 2022

2. CHIEF EXECUTIVE'S INTRODUCTION

As I write this introduction to our annual report 2021/22, I reflect on another amazing year in the life of the NHS in general and HDFT in particular. Our role in the health and care sector is to improve health and wellbeing and provide support and care for our patients and our communities, often at times of great need and personal stress, and to do this with compassion, kindness, skill, and positivity. This role has not fundamentally changed since the start of the NHS in 1948, and it is important to remember what a fantastic thing we have in the NHS, and how important what we collectively do is for the population we serve.

Whilst our key purpose remains consistent, the environment within which we operate continues to present challenges. In the last year we have continued to manage the provision of our services within the context of the Covid-19 pandemic, which has resulted in challenges for all of us; both in work and out of work, both in our hospital services and in our community services, and has put a strain on colleagues as we seek to deliver care and support to the best of our ability.

As you will read through this report though, we have continued to deliver great services to our patients and services users. We have begun the work of recovery from the pandemic, from strengthening our child safeguarding provision to delivering catch-up initiatives for people who have waited too long on our waiting lists for care, and we have taken some of the lessons learnt over the past year to improve how we deliver services using technology. We have also supported the continued roll-out of the Covid-19 vaccination programme, both through our staff vaccination programme and through our school-aged child vaccination and immunisation service that we deliver.

The Pandemic has also served to highlight the benefit of working more closely with partner organisations and HDFT is proud to be a partner in many health systems across Yorkshire and the North-East of England. We are an active partner within the local Harrogate place, within the West Yorkshire Association of Acute Trusts, within the Humber & North Yorkshire Integrated Care System, and with our many Local Authority partners in the north east as we strive to deliver the best children's services for those that need our support. During 2021/22, we also had the delight of welcoming colleagues from Northumberland into HDFT, as we entered into a partnership with the local authority for the provision of children's services. This builds upon the successful delivery of children's services across the North East and North Yorkshire.

I could highlight a number of developments and improvements across the Trust during last year, but they would be many and I'd encourage you to read through the report to get the full flavour of what we have been doing. I would though like to highlight the work undertaken by Harrogate Integrated Facilities (our subsidiary partner) in relation to improving our environmental credentials, and the investment of £14m in energy efficiency that has reduced our carbon footprint by over 25%. This will greatly benefit everybody over the years to come as we continue on our journey to become carbon neutral over the coming years.

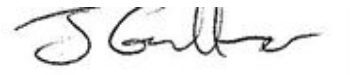
Of course, whilst we do a lot of things well, we don't always get things right, and through our report you will see information in respect of times when we haven't got things right and we have reported incidents or received complaints. What we have tried to do over the last year, and which we will continue to do, is to be open about our mistakes, learn from them, and ensure that we have a culture that is focused on continuous improvement to minimise the risk of future harm to patients. As we take a look forward, we will continue this focus on improvement as we seek to deliver ever safer and better services.

You will read in the report a lot about what we have been doing. This is really important to understand and is hopefully interesting to you all as readers of the report and users of the

NHS. For me, whilst *what* we do is important, *how* we do it is equally significant. During last year we engaged colleagues across the Trust to develop a consistent view of what we as an organisation and group of people collectively working together really value. And following these discussions we have developed our KITE values – which represent Kindness, Integrity, Teamwork, and Equality. It is these values that we will continue to support and encourage, as our way of working together to deliver the best care and support we can.

My last comments will touch on the most important – our colleagues who work in HDFT. Health and Care services are largely services delivered to people, by people, and without a fantastic team of colleagues working across HDFT, we would be unable to do anything. The last couple of years in particular have been tricky times for everyone, and colleagues in the NHS have been impacted in the same way as other parts of the population. The dedication, the commitment, the optimism, and the sense of collective teamwork from those that deliver care alongside those that support the delivery of care, has been truly outstanding and humbling.

So my final words are to my colleagues here at HDFT – Thank you!



Jonathan Coulter
Acting Chief Executive Officer
Harrogate and District NHS Foundation Trust
5th October 2022

3. PERFORMANCE REPORT

3.1 Overview of Performance

3.1.1 Introduction

The Performance Report provides information about Harrogate and District NHS Foundation Trust (HDFT), HDFT's objectives, strategies and the principal risks that the organisation faces. This overview section aims to help readers to understand the Trust, its purpose, key risks to achievement of objectives and details about how the organisation performed during 2021/22.

During 2021/22 the Trust's control environment continued to quickly adapt and respond to the significant change in circumstances that Covid-19 created. The Trust focused its response by providing safe care for its patients, redeploying and re-training our colleagues to support patients that required respiratory support and maximising the availability of colleagues. Added to this was a greater focus on the recovery of services during 2021/22, in particular addressing the care of patients who had been waiting significantly longer periods as a result of Covid-19.

Despite the Covid-19 pandemic, and the necessary changes made to the control environment, the Trust maintained a process of risk management and strong governance processes internally. Focus on the Trust's long term strategy to address the clinical, operational and financial challenges continued throughout the year.

3.1.2 Brief History of Harrogate and District NHS Foundation Trust and its Statutory Background

Harrogate and District NHS Foundation Trust (the Trust) was founded under the Health and Social Care (Community Health and Standards) Act 2003 and authorised as an NHS Foundation Trust from 1 January 2005.

The Trust is the principal provider of hospital services to the population of Harrogate and surrounding district, and also provides services to North and West Leeds - representing a catchment population for the acute hospital of approximately 720,000. In addition, the Trust provides some community services across North Yorkshire (with a population of 400,000) and provides Children's Services between birth and up to 19 years of age in North Yorkshire, County Durham, Darlington, Middlesbrough, Stockton-On-Tees, Sunderland, Gateshead, and Northumberland. The Trusts 0-19 Services look after over 500,000 children across these localities.

Harrogate District Hospital has an Emergency Department, extensive outpatient facilities, an Intensive Therapy Unit and a High Dependency Unit, a Coronary Care Unit, plus five main theatres and a Day Surgery Unit with three further theatres. The Sir Robert Ogden Macmillan Centre (SROMC) provides assessment and treatment, for the diagnosis and treatment of patients with cancer. Dedicated purpose built facilities are also provided on site for Cardiology, Endoscopy, Pathology, Pharmacy, Radiology and Therapy Services, as well as a Child Development Centre, Stroke Unit and Women's Unit. The Trust provides Maternity Services with an Antenatal Unit, central Delivery Suite, Special Care Baby Unit (SCBU) and Post Natal ward, together with an Early Pregnancy Assessment Unit. The Lascelles Neurological Rehabilitation Unit provides care for inpatients with a range of neurological conditions and brain injuries.

Ripon Community Hospital has an inpatient ward and Minor Injuries Unit, and offers a range of outpatient services to the communities of Ripon and the surrounding area.

The Trust also acts as the first contact for access to more specialist services through alliance-based working with neighbouring hospitals. These extended services are provided by visiting consultants, or alternatively by the patient travelling to hospitals in York or Leeds. The range

of hospital services that are provided in partnership with York Teaching Hospital NHS Foundation Trust (YTHFT) include Breast and Cervical Screening, Dermatology, Ear Nose and Throat (ENT), Neurophysiology, Non-Surgical Oncology, Ophthalmology, Oral and Maxillofacial Surgery, Orthodontics, Renal Medicine, Rheumatology, Urology, Vascular and Renal Services. The renal unit is provided at a facility on the Harrogate District Hospital site but managed by YTHFT.

In addition, the Trust has a number of established clinical links with the Leeds Teaching Hospitals NHS Trust (LTHT). These include Coronary Heart Disease, Neurology, Plastic Surgery, Specialist Paediatrics and access to specialist Cancer Services. Links have also been strengthened with commissioners in Leeds, providing further services in Orthopaedics and General Surgery and an outpatient clinic for ENT services at Chapeltown Health Centre.

Additional outpatient outreach clinics are held at Wetherby Primary Care Centre and Yeadon Health Centre for the specialities of Dermatology, Gastroenterology, General Surgery, Gynaecology, Maternity, Neurology, Paediatrics, Respiratory, Rheumatology, Urology, and Vascular clinics. Endoscopy and Gastroenterology services are provided at Wharfedale General Hospital. An outreach clinic facility also operates at Alwoodley Medical Centre and includes clinics for the specialties of Audiology, ENT, General Surgery, Gynaecology, Orthopaedics, Rheumatology and Urology. There is also a dedicated Radiology service providing plain film x-ray and ultrasound services to support the clinics listed above, as well as providing GP Direct Access for the surrounding practices.

Patient choice is an important part of the NHS Constitution and patients from surrounding areas frequently choose Harrogate for their care. The Trust will continue working in partnership with the local Integrated Care Systems (ICSs) to expand secondary care services and meet this demand.

The Trust also provides a range of community services in Harrogate and the local area as well as across North Yorkshire and Leeds. Our dedicated and experienced staff, who are based in the communities they serve, offer expertise across a variety of disciplines and work closely with GPs, hospital-based staff and other healthcare professionals to provide high quality care. Services include:

- Community Podiatry Services;
- District and Community Nursing;
- Health Visitors;
- GP Out of Hours Services;
- Infection Prevention and Control/Tuberculosis Liaison Services;
- Minor Injury Units;
- Older People and Vulnerable Adults Services;
- Safeguarding Children Services;
- Salaried Dental Services and
- Specialist Community Services.

The Trust provides Children's Services in County Durham, Darlington, Middleborough, Stockton-On-Tees, Gateshead, Sunderland, and Northumberland, making it the largest provider by geographical area of such services in the country. These are universal services where the needs and voice of children, young people and families are at the core of the service designed to identify and address their needs at the earliest opportunity, and to recognise and build on the strengths that are within individuals. This enables them to be part of the solution to overcome challenges and identify and develop resources within communities so that children, young people and families have access to support when and where they need it.

3.1.3 Purpose and activities of the Trust

The Trust's vision is to achieve 'Excellence Every Time' for patients and service users, with the organisation's mission statement to be an exceptional provider of healthcare for the benefit of our communities, our staff and our partners.

In order to achieve our vision and mission the Trust has set out four key strategic objectives:

- To be an outstanding place to work
- To deliver high quality care
- To work with our partners to deliver integrated care
- To ensure clinical and financial sustainability

The Trust recognises that to deliver our Vision we will continue to work with partner organisations across the footprint through alliances and networks to achieve these key strategic objectives. The Trust's primary partners include:

- Humber and North Yorkshire Integrated Care Board and System (formally Humber Coast and Vale NHS Partnership;
- West Yorkshire Integrated Care Board and System
- West Yorkshire Association of Acute Trusts (WYAAT);
- Clinical Alliances with York Teaching Hospitals NHS Foundation Trust (YTHFT), Airedale NHS Foundation Trust and Leeds Teaching Hospitals NHS Trust (LTHT);
- Commissioners of Children's Services across North Yorkshire, County Durham, Darlington, Middlesbrough, Stockton-On-Tees, Sunderland and Gateshead;
- Local Provider collaboration with other providers including Tess Esk and Wear Valley NHS Foundation Trust (TEWV) North Yorkshire County Council (NYCC), and the local GP Federation; and,
- Harrogate Healthcare Facilities Management Limited (the Trust's wholly owned subsidiary company providing estates and facilities services), trading as Harrogate Integrated Facilities (HIF)

Whilst working in co-operation with other Trusts and organisations as part of each Integrated Care System/Board (ICS/ICB), and a member of the WYAAT Committee-in-Common. The Trust retains full control and governance and has not delegated any decision-making powers to any other organisation.

3.1.4 Strategic Risks

The Trust records strategic risks to the organisation in the Board Assurance Framework (BAF) and operational risks to the organisation on the Corporate Risk Register, both of which are reviewed monthly by the Board in detail.

During 2021/22 the strategic risks identified on the BAF included risk of:

- Risk that individual staff engagement and high performing team cultures are compromised because there is an insufficient focus on the culture of the Trust and the health and wellbeing of staff which will impact on the Trust's ambition to be an outstanding place to work and in turn will impact on the quality of patient experience.
- Risk that individual staff engagement and high performing team cultures are compromised because there is lack of diversity of thinking due to recruitment and promotion practices that make it more difficult for colleagues with protected characteristics to flourish in the organisation.
- Risk that the Trust does not maximise its contribution to improving population health and reducing health inequalities because of a lack of strategic relationships with primary care and local authorities and an internal focus which will impact on our

strategic ambition to improve population health and wellbeing, provide integrated care and to support primary care.

- Risk that the Trust's population is not able to fully benefit from being part of an integrated care system because our secondary care patient flows are to West Yorkshire and our place based population health activities sit within North Yorkshire which are in two different ICSs and there is insufficient management bandwidth to participate in both. This will impact on our ambition to be an active partner in population health and the transformation of health inequalities.
- Risk to achieving outstanding service quality and patient experience because there is insufficient focus on an systematic organisation-wide approach to and culture of quality improvement which will impact on the Trust's ambition to continuously address the underlying barriers to excellence every time and to provide outstanding care.
- Risk that some of our secondary care based services are not clinically and financially sustainable because of the size of population we serve and our ability to respond to subspecialisation and to recruit and retain staff which will impact on our ambition to provide high quality services.
- Risk that due to a prolonged recovery from Covid-19 the Trust's strategic ambitions are compromised, which will Impact upon service transformation and underlying financial improvement.
- Risk to long term financial sustainability and ability to invest in capital due to the difficulty of generating sufficient internal funds through inward investment or additional cash releasing savings, which will impact upon the quality of care that can be provided.
- Risk that the Trust places insufficient focus on early year's services and adult community based services because of the historic dominance of hospital services which will impact on the transformation opportunities and miss opportunities for long term outcomes and integrated care.
- Risk that standards of care are compromised due to the allocation formula not providing sufficient resources to meet the needs of the unique demography of the local area, which will impact on the Trust's ambition to provide outstanding care and its reputation for quality.

The risks on the Corporate Risk Register at the end of 2021/22 relate to the:

- A risk to service delivery and patient care due to failure to fill registered nurse vacancies due to the national labour market shortage.
- A risk of both short and long term mental health impacts on staff due to ongoing Covid-19 pandemic. Risk includes;
  a) Staff having to manage increased pressures of caring for acutely unwell and dying patients.
  b) Staff managing increased work pressures alongside concerns for their own health and safety, increased workload and hours due to staff absence, potential childcare concerns, family health concerns and potential bereavement.
  c) Once the Covid-19 peak has passed and HDFT returns to BAU services, further pressure will be put on staff to manage an increase in BAU caseload pressures and patients presenting with higher acuity due to delays.
  d) Risk of further Covid-19 peaks emerging
  e) Longer term impacts include the potential to develop PTSD.
- A risk that Systems and Processes within the Childhood Immunisation Service could lead to duplicate vaccines being given and vaccination without consent.
- A risk to quality of care by not meeting NICE guidance in relation to the commencement of autism assessment within 3 months of referral.
- A risk that children may not get access to the right level of support without a formal diagnosis and that this could lead to deterioration in condition.
- A risk to patient safety, performance, financial performance, and reputation due to increasing waiting times across a number of specialties, including as a result of the impact of Covid-19

- A risk to patient and staff safety due to long delays in response from mental health services for patients at high risk - time taken to undertake a MHA assessment and locate a bed for patients requiring detention is invariably between 8 and 12 hours meaning Emergency Department (ED) staff are attempting to manage high risk patients in the ED.ED Environment not suitable for a prolonged stay for patients who present a risk to themselves or others.
- A risk of increased morbidity/ mortality for patients experiencing prolonged stay in the emergency department. Risk of failure to meet the 4 hour standard and resultant poor patient experience leading to increased concerns and complaints.
- Increasing number of incidents relating to violence or threat of violence to staff in our acute services with a risk of physical and/or psychological harm to staff or other patients
- A risk that legal requirements for health and safety at work are not in place due to the absence of a Health and Safety Manager in the organisation. Further, there is a risk to employees and visitors to the Trust estates for adverse incidents to occur.
- A risk to service delivery that the trust is not able to provide some cancer and other treatments because we have to close the Aseptic Unit due to inability to maintain IPC standards. A risk to patient safety because IPC standards for aseptic production of medicines may not be met. A risk to staff safety due to exposure to substances harmful to health. A financial risk from external provision of medicines at increased cost to replace those previously produced in the Aseptic Unit

The BAF is reviewed by the Board and the Audit Committee. The Corporate Risk Register is reviewed by the Board, Senior Management Team and the Executive Risk Management Group to ensure appropriate triangulation of issues across the organisation. The Board's Committees carry out 'deep dives' into individual areas of responsibility to ensure that the strategic risks are mitigated as far as possible, and that gaps in assurance and control are identified.

3.1.5 Going Concern Disclosure

After making enquiries, the Board have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the Board have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

3.2 Performance Summary of 2021/22

In line with national requirements, we have continued to place a strong focus on elective recovery in the second year of the pandemic. Increasing elective activity to be back in line with 2019/20 levels and reducing the long waiting times for diagnostics and elective admissions were key elements of our plan.

Over the year, the average referral to treatment (RTT) waiting times remained at a similar level for Harrogate patients, however the number of longer waiting patients waiting over 52-weeks reduced from 1,345 in March 2021 to 1,140 in March 2022. In addition, we were also able to support other providers in both Humber and North Yorkshire ICS and West Yorkshire ICS by providing diagnostic (endoscopy) capacity and also by transferring and treating a number of their longer waiting patients. Safety continues to remain a priority, with all patients clinically triaged and assessed for clinical harm where long waits have occurred.

Whilst the Trust is focused on delivering timely access to services for our patients, our performance has been reflective of the national and regional performance with the national waiting times standards underachieved in the year.

Our focus is maintaining patient safety. There has continued to be consistently good performance for timely ambulance handover in our Emergency Department.

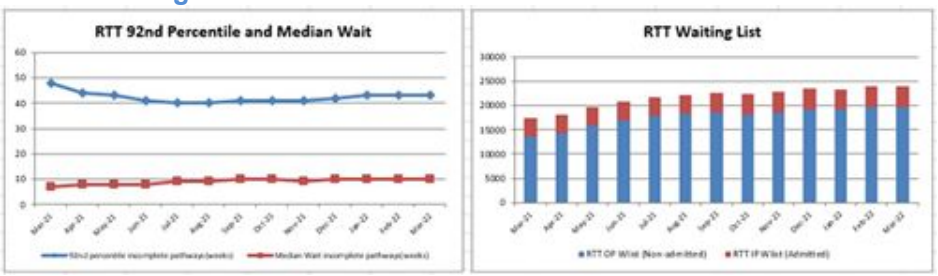
3.2.1 Operational Performance

3.2.1.1. Waiting Times

During 2021/22 the Trust continued to treat the most clinically urgent patients on the elective waiting list alongside patients waiting the longest time. Throughout the year, and particularly in the last quarter (Jan-Mar), routine operations were impacted by the reduced capacity in response to Covid-19 and the Omicron variant. Routine primary care referrals remained at higher levels than 2019/20 (+10%), impacting on the total number of patients waiting, with the end of the year being at a higher level than the start of the year. Longer waiting times improved throughout the year with the 92nd percentile reducing from 49 weeks in March 21 to 44 weeks in March 22. The number of patients waiting longer than 52 weeks reduced by 15%, from 1,345 in March 2021 to 1,140 in March 2022. Median waiting times remained at a consistent level throughout the year.

The information included within the reports is as reported in 2021-22. It is acknowledged, however, that further validation work is required and will be undertaken in 2022-23 to better reflect the true size of the HDFT waiting list.

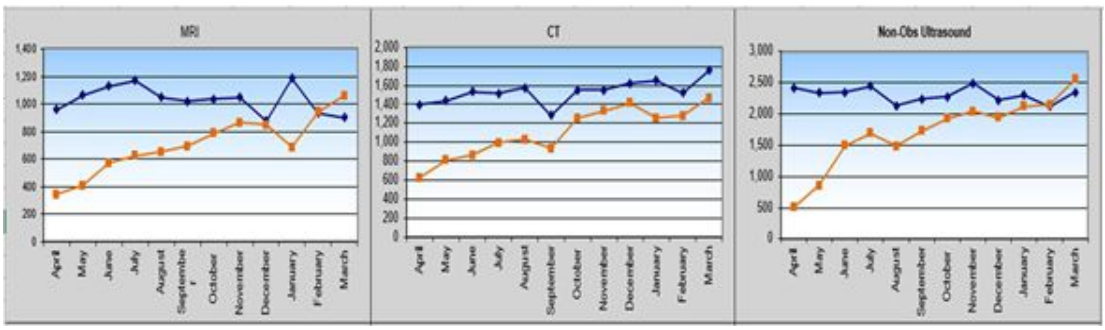
Figure 1: RTT Waiting times



3.2.1.2. Diagnostic Tests

During 2021/22 diagnostic services were stepped up to support elective recovery, resulting in an increase in activity on the previous year (see charts below). Activity remained relatively consistent throughout the year, despite the challenges relating to staffing absence as a result of COVID-19 (Omicron) and staff having to isolate. Longer waiting times continue to be actively reduced as we head into 2022/23.

Figure 2: Diagnostic Activity 2020/21 vs 2021/22



3.2.1.3. Cancer

Cancer patients continued to be treated throughout the year with increased capacity to help reduce the backlog as a result of the previous year. In addition, as anticipated 2 week wait (2WW) referrals increased as patients once again started to access their GP surgeries. This increase impacted on waiting times at the beginning of the pathway, however the standard for patients receiving their treatment within 31 days of diagnosis was achieved in all four quarters and the standard for treatment within 62 days of urgent referral was delivered in quarter 1 and quarter 2 of the year, along with the year overall.

Figure 3: Cancer – 31-day and 62-day standards

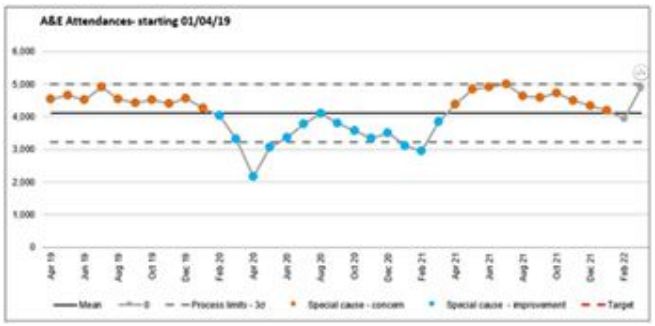
31 day first treatments	Apr-21	May-21	Jun-21	Q1	Jul-21	Aug-21	Sep-21	Q2	Oct-21	Nov-21	Dec-21	Q3	Jan-22	Feb-22	Mar-22	Q4	2021/22
Treatments	99	87	125	311	135	95	112	342	106	122	120	348	101	103	97	301	1,302
Within 31 days	96	84	125	305	135	94	106	335	105	122	117	344	99	101	95	295	1,279
Outside 31 days	3	3	0	6	0	1	6	7	1	0	3	4	2	2	2	6	23
Performance	97.0%	96.6%	100.0%	98.1%	100.0%	98.9%	94.6%	98.0%	99.1%	100.0%	97.5%	98.9%	98.0%	98.1%	97.9%	98.0%	98.2%

62 day standard	Apr-21	May-21	Jun-21	Q1	Jul-21	Aug-21	Sep-21	Q2	Oct-21	Nov-21	Dec-21	Q3	Jan-22	Feb-22	Mar-22	Q4	2021/22
Treatments	62.0	66.0	84.5	212.5	88.0	60.5	71.5	220.0	66.0	72.5	70.0	208.5	52.0	55.0	56.0	163.0	804.0
Within 62 days	53.0	57.5	79.0	189.5	74.0	55.5	63.5	193.0	54.0	58.5	59.5	172.0	41.5	45.0	49.5	136.0	690.5
Outside 62 days	9.0	8.5	5.5	23.0	14.0	5.0	8.0	27.0	12.0	14.0	10.5	36.5	10.5	10.0	6.5	27.0	113.5
Performance	85.5%	87.1%	93.5%	89.2%	84.1%	91.7%	88.8%	87.7%	81.8%	80.7%	85.0%	82.5%	79.8%	81.8%	88.4%	83.4%	85.9%

3.2.1.4. Accident & Emergency Performance and Activity

The Trust did not achieve the A&E 4 hour standard for each quarter of the year. Performance reflects the continuing significant pressures with high bed occupancy relating to discharge challenges and staff absences. The Trust continued to support the Humber and North Yorkshire Integrated Care System during 2021/22 with regular diverts of ambulance patients to Harrogate - this negatively impacts on HDFT's 4 hour performance and length of stay in the department. A&E attendances have now returned to previous levels experience in 2019/20.

Figure 4: A&E Type 1 Attendances



3.2.1.5. Delayed Transfer of Care

A discharge strategy is being progressed to reduce the number of long stay patients in the hospital and reduce the number of patients in beds that do not meet the 'criteria to reside'.

The historical requirement to monitor the number of patients whose transfer of care was delayed was replaced by the requirement to report every day on the 'criteria to reside' of every adult patient in an acute bed. The Covid-19 pandemic initially introduced a large discharge acceleration as patient choice was removed from the discharge policy and funded care for 6 and then 4 weeks was given to all patients to support discharge.

The funded care has now stopped and choice reintroduced and there is a significant increase in delays due to shortages in care provision in the community. This is mainly driven by staff shortages in domiciliary care and closure of care homes due to Covid-19 outbreaks. However, the ARCH's (Acute Response & Rehabilitation in the Community and Hospital) service, which

is the amalgamation of supported discharge service, acute and frailty inpatient therapy services, community therapy and bed based rehabilitation expands the cohort of patients who can be identified to leave the hospital sooner to their home environment. The ARCH service had been expanded to deliver 35 beds worth of inpatient activity away from the hospital. A community discharge hub has been set up in the hospital as part of the HARA (Harrogate and Rural Alliance) model bringing together health and social care staff involved in discharge under a newly appointed Service Manager and there are daily meetings to work through plans for those that have been identified as requiring support on discharge. A new system called vital hub has been purchased that increases the visibility of the criteria to reside status of patients in hospital beds and the next steps required to progress their care.

We are currently progressing plans to implement a 2 hour urgent response team in the community to support admission avoidance and to further increase the reduction of patients being discharged away from their own home.

3.2.2 Infection Prevention and Control

Infection Prevention and Control (IPC) remains a high priority for the Trust and there is a strong commitment to reducing avoidable harm due to Healthcare Acquired Infections (HCAI). HCAI rates are closely monitored by the IPC committee, chaired by the Director of IPC (DIPC) and reported to the Quality Committee. Actions and recommendations to ensure the Trust health care acquired infection rates remain below the Trust's trajectory level are overseen by the Lead Doctor and Lead Nurse for IPC, reporting directly to the DIPC and the Quality Committee.

3.2.3 Regulatory Ratings

The HDFT's regulatory performance against NHS Single Oversight Framework were green in all quarters for one of the seven standards, green in three of the four quarters for one standard, green in two of the four quarters for one standard, and red in all four quarters for four of the standards. No formal regulatory action has been taken or is planned. The Trust continues to have robust measures in place to monitor performance and quickly address areas of concern. The table below outlines the key performance indicators as part of this framework.

Performance Indicator Description	Q1	Q2	Q3	Q4	YTD
RTT - incomplete - % in 18 weeks	74.2%	73.7%	69.5%	68.9%	71.4%
Diagnostic waiting times - maximum wait of 6 weeks	79.2%	80.5%	82.4%	81.9%	81.0%
Trust total - Total time in A&E - % within 4 hours	83.6%	81.1%	73.6%	66.1%	76.3%
All Cancers: 14 Days Target	85.4%	87.2%	84.4%	88.4%	86.3%
All Cancers: 14 Days Target All Breast Referrals	11.0%	49.3%	63.3%	87.4%	53.8%
All Cancers: 31 Day Target - 1st Treatment	98.1%	98.0%	98.9%	98.1%	98.2%
All Cancers: 31 Day Target - Subsequent Treatment - Surgery	88.7%	97.1%	94.8%	89.8%	92.8%
All Cancers: 31 Day Target - Subsequent Treatment - Drug treatment	100.0%	99.3%	100.0%	99.2%	99.6%
All Cancers: 62 Day Target	89.2%	87.8%	82.4%	83.8%	86.0%
All Cancers: 62 Day Target Screening	48.1%	35.8%	53.4%	78.7%	51.3%
All Cancers: 62 Day Target Cons Upgrade	92.4%	87.1%	87.2%	83.7%	87.7%
Incidence of hospital acquired C-Difficile (Cumulative)	8	19	29	36	36
Incidence of hospital acquired C-Difficile (Cumulative cases due to a lapse in care)	1	2	5	5	5

3.2.4 Operating and Financial Review of the Trust

The Income and Expenditure position for the Trust for 2021/22 was a surplus of £9,612k. The table below provides a high level comparison of the Income and Expenditure account for the year.

£'000s	2021/22	2020/21
Operating Income	324,260	297,379
Operating Expenditure	(312,153)	(293,907)
Finance Costs	(2,495)	(2,348)
Surplus for the year	9,612	1,124
Remove capital donations/grants I&E impact	(12,375)	(1,250)
Add back all I&E impairments/(reversals)	3,181	705
Remove Charitable Fund Position	(349)	(538)
Control Total Position	69	41

The above outlines a small surplus position against the regulatory requirements for the Trust, essentially living within the resources available to the organisation. The material change in capital donations/grants relates to the grant income received to support the Salix project. This is the works described in the Chair's Introduction to support the green agenda.

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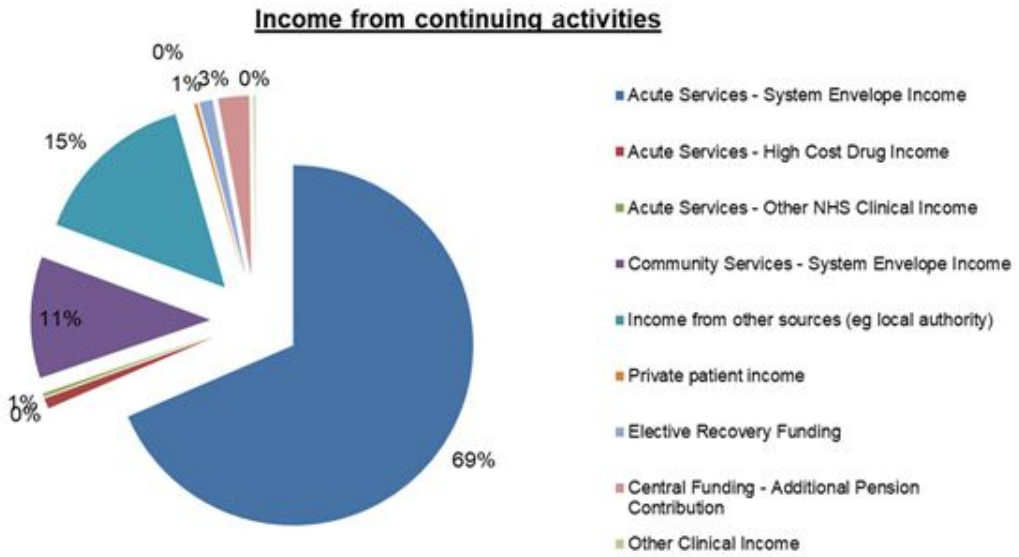
3.2.4.1. Income Generated from Continuing Activities

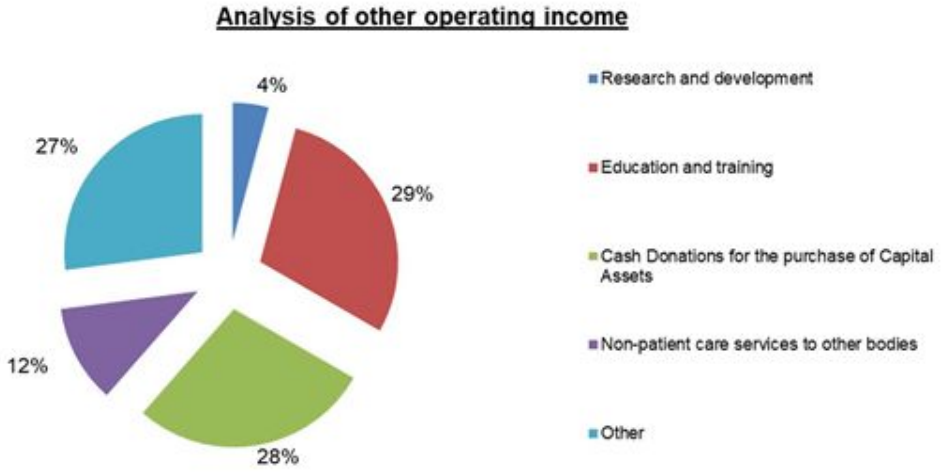
Total income from continuing activities for the year 2021/22 was £284,192k. This represented 87.6% of total income for the year. An analysis of this income is shown below:



The Trust has met the requirements of section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), in that the income from the provision of goods and services fo the purposes of the health service in England (principal) has exceeded income from the provision of goods and services for any other purposes (non-principal). Non-principal income is used to provide additional funding for the Trust. It is directly reinvested in the delivery of high quality NHS Services.

3.2.4.2. Other Operating Income

Other operating income totalled £40,068k during 2021/22. This represented 12.4% of total income for the year and an analysis of this income is shown below:



3.2.4.3. Cash

The Trust has a cash balance of £42,139k at the close of the financial year.

3.2.4.4. Use of Resource Metric

As part of the national response to Covid-19, the formal oversight from the Use of Resource rating was not monitored by regulators. The Trust would have reported a Use of Resource Rating of 1 at the end of 2021/22. Financial Risk is assessed on a scale of 1 (low risk) to 4 (high risk).

3.2.4.5. Financial Outlook 2022/23

After previous years where focus has been on the response and management of the Covid-19 pandemic, the Trust recognises the financial challenges faced by the NHS and wider economy that are part of “living with Covid”. The need for recovery of services is clear, and impacts on the Acute and Community services of the Trust. Added to that is the need to reduce Covid-19 expenditure and meet more challenging savings requirements. Within this backdrop, there is a number of opportunities to take forward service development and improvement, embedding positive changes from the Covid-19 response, as well as taking the opportunity to reshape inefficient pathways that existed pre-pandemic. As well as the exciting work happening within the Trust, there is the opportunity to use our position within both Humber and North Yorkshire ICB, and as a partner of West Yorkshire ICB to take forward financial opportunities which also support sustainable clinical services.

The Board is committed to delivering the financial plan and living within the resources available for 2022/23, as well as working through the necessary efficiency requirements for this year and the following. In 2022/23 the Cost Improvement Programme (CIP) required is £8.3m.

Key pressures that will need to be negotiated throughout the year include the impact of inflation, in particular energy prices, as well as the various demands on ensuring the workforce is in place to undertake recovery and provide safe, effective care.

3.2.4.6. Capital Investment Activity

During 2021/22, the Trust undertook a significant capital programme, investing £29.8m as part of the programme. The breakdown of the investment is show in the table below:

Scheme	£'000
Salix Scheme (Energy Efficiency of HDH site)	12,717
Replacement of Clinical Equipment	3,163
Replacement of IT Equipment	2,766
Other	11,127
Total	**29,773**

3.2.4.7. Land Interests

During the financial year ending 31 March 2022, the Trust's land and buildings were re-valued by the Valuation Office Agency (Royal Institute of Chartered Surveyors qualified) which is an Executive Agency of HM Revenue and Customs (HMRC). This valuation, in line with the Trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in a valuation of the Trust's land and buildings of £87,408k, which has been incorporated into the accounts.

3.2.4.8. Investments

Harrogate Healthcare Facilities Management, which trades as Harrogate Integrated Facilities, is the wholly owned subsidiary of the Trust. The Trust is also a member of a joint venture arrangement for Pathology Services.

No financial assistance was given or received by the Group in 2021/22.

3.2.4.9. Details of Activities Designed to Improve Value for Money

The Trust will drive forward the delivery of efficiency through reducing waste and driving forward service improvement. This will be built from Directorate level, incorporating changes that are managed Trustwide and across the West Yorkshire Association of Acute Trusts.

The Business Development Strategy has continued its success and aims to continue to support the sustainability of the Trust, both financially and clinically.

The Quality Impact Assessment process relating to the efficiency programme continues to play a key role in ensuring quality, safety, and access is not compromised by efficiencies. This process has been further refined to include the impact on as part of these changes.

The Trust CIP target is £8.3m for 2022/23. It is recognised that, at 3%, this represents a challenging target. The Trust has historically met these challenges, and processes are in place to give assurance and confidence that this target will be achieved.

3.2.4.10. Further Details of the Trust's Strategic Plans

A range of actions are planned over the next few years to deliver the Trusts strategy. These are contained within HDFT's Operational Plan for 2022/23 which can be found on the Trust website ().

3.2.4.11. Approval by the Directors of the Performance Report

This Performance Report has been approved by the Board of Directors of Harrogate and District NHS Foundation Trust.

3.2.5 Environmental Matters

The Trust recognises the huge challenges we face in terms of climate change, air pollution and waste. Furthermore, it is now mandatory for NHS Organisations and Regional ICS to have a Green Plan approved by their organisations board or governing body. This is to reflect the national priorities, strategies and plans that need to be implemented to achieve our Net Zero by 2040 obligations and minimise our contribution to climate change at a global, national and local level.

Delivering a 'Net Zero' NHS has two main targets:

- For the emissions we control directly (our NHS Carbon Footprint), we strive to be Net Zero by 2040 with a reduction in carbon emissions of 80% by 2028-2032. HDFT has further ambitions of meeting this target by 2035 in line with our regional ICS Green Plan.
- For the emissions we can influence (our NHS Carbon Footprint Plus) we aim to be net zero by 2045 with an 80% reduction in emissions by 2036-2039

To respond to these challenges, we have now signed off at board our Green Plan for 2022-2025. Which builds upon the successes of our previous Carbon Management Plan. The new Plan will stand as an organisation-wide strategy which will guide the implementation of a collection of actions to improve our sustainability credentials and meet NHS targets. The Green Plan 2022-2025 will act as the core document pertaining to sustainable development within the Trust which we will use to reduce our environmental impact and improve the health of our community.

It will be updated annually and outlines our focus over the next 12 months, highlights include:

- The setting up of the sustainability board
- Green working group to deliver the programme of work
- Green "college panel" to engage and generate ideas
- Develop a new travel plan
- Develop further proposals via the Public Sector Decarbonisation scheme to reduce or completely remove our reliance on gas
- Ensure we have the right energy procurement strategies that aim to purchase electricity from renewable sources only where possible

3.2.6 Quality

The Trust is fully committed to high quality care. The Trust has prepared a quality account, which is a requirement of the Health Act 2009 and the quality account regulations. The Quality Account is produced in addition to the Annual Report and Accounts. Full details on the 2021-22 Quality Priorities and delivery against them is detailed in the Quality Accounts, alongside the priorities for the forth coming year (2022-23).

In 2021-22 the Trust focused on delivery of the following quality priorities:

1. To develop an integrated clinical service for inpatient unplanned care - ensuring patients see the right clinician at the right time in the right place 7 days a week.

2. To improve the responsiveness and effectiveness of our communication with external partners and our patients by delivering a paper-light system in outpatients

3. To embed the Medical Examiner system and refresh our learning from deaths framework

4. To ensure quality, safety and confidentiality in virtual consultations

5. Ensuring we provide a high quality and developmentally appropriate service for our children and young people up to the age of 18 years across services within the acute setting.

6. To enhance the service offered to our patients and colleagues with autism and autism spectrum disorders, by appointing an autism champion, embedding learning and training, and agreeing a Trust-wide approach.

The priorities for quality improvement are agreed with staff and stakeholders and will have clear and measurable targets, with performance against these monitored regularly at an

operational level at Quality Governance Management Group and strategically through the Trust's Quality Committee.

The 2022-23 priorities are:

Safe

1. Theatres Improvement – following a number of incidents within our surgical and theatres environment, a theatres improvement plan has been developed. The aim of this project is to improve patient safety and quality of care within this environment. It will focus on a series of enhanced cultural events, training and education and bespoke pieces of work on the safety checks we undertake.

2. Emergency Department Improvement – following a number of incidents within our Emergency Department, an improvement plan has been developed. The aim of the project is to review the patient pathways into the department, consider new ways of working, implement an enhanced safety regime and undertake a range of training and development initiatives.

3. Pressure Ulcers – the work undertaken in previous years in relation to our pressure ulcers improvement programme will continue into 2022-23. This will build on the work achieved in previous years as well as continue to implement new ways of working and ensure care is in line with our national framework.

4. Falls – the work undertaken in previous years in relation to our Falls Improvement Programme will continue into 2022-23. This will build on the work achieved in previous years as well as continue with the implementation of our falls action plan.

Effective

1. Failure to Act on Results - The failure to act on tests results is a significant patient safety issue across the NHS; errors and oversights in this area have resulted in delays in diagnosing and treating patients, some with tragic consequences. Following a number of incidents where failure to act on results or a delay in acting on results has been a primary cause of harm to our patients, this area has been selected as an improvement priority. The aim of this priority is to reduce the incidents of harm where failure to act or delaying in acting on results has contributed to patient harm.

2. Medication - the work undertaken in previous years in relation to our medication improvement programme will continue into 2022-23. This will build on the work achieved in previous years as well as continue to implement new ways of working and ensure care is in line with our national framework.

Experience

Patient Experience – the organisation has recently reviewed the national patient experience framework. This improvement plan will focus on the implementation of the actions noted following this review.There are governance and reporting frameworks in place to ensure that the Trust continues to deliver its operational plans and targets, which include other quality initiatives and indicators.

3.2.7 Social, community, anti-bribery and human rights issues

The Trust has a significant profile in the local areas it serves and sees its community role as important both as a health care provider and potential local employer.

We have a number of policies in place which cover social, community and human rights matters. A process is in place to ensure that none of our policies have an adverse or discriminatory effect on patients or staff. We continue to provide positive support to people with a disability who wish to secure employment with the Trust through the guaranteed

interview scheme and comply with the two ticks requirements. There are policies in place which support staff who may become disabled during their employment.

The Trust's anti bribery and counter fraud arrangements are in compliance with the NHS Counter Fraud Authority's Counter Fraud Standards for Providers. These arrangements are underpinned by the appointment of accredited Local Counter Fraud Specialists and the introduction of a Trust-wide Anti-Fraud, Bribery and Corruption Policy.

The Trust's Audit Committee reviews and approves an annual counter fraud plan identifying the actions to be undertaken to create an anti-fraud culture, deter prevent, detect and, where not prevented, investigate suspicions of fraud. The counter fraud team also produces an annual report and regular progress reports for the review and consideration of the Director of Finance and Audit Committee.

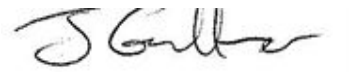
The Counter Fraud Team also facilitates an annual self-assessment of compliance against the Counter Fraud Standards for Providers, which is reviewed and approved by the Director of Finance prior to submission to NHS Counter Fraud Authority. The 2021-22 assessment was completed with an overall assessment of green, confirming the Trust was compliant against the majority of standards.

3.2.8 Events since the end of the financial year

The Trust has not identified any events that occurred after the reporting year that would require disclosure as non-adjusting events in accordance with IAS10.

3.2.9 Overseas Operations

The Trust has no overseas operations.



Jonathan Coulter
Acting Chief Executive Officer
Harrogate and District NHS Foundation Trust
5th October 2022

4. ACCOUNTABILITY REPORT

4.1. Director's Report

4.1.1 Directors 2021-22

The Directors of the Trust during the year 2021-22 were:

Non-executive Directors

Angela Schofield	Chairman (Non-Executive Director) to 31st March 2022.
Sarah Armstrong	Chair (Non-Executive Director 2021-22) from 1st April 2022.
Jeremy Cross	Non-executive Director.
Andrew Papworth	Non-executive Director.
Laura Robson	Non-Executive Director/Senior Independent Director.
Wallace Sampson OBE	Non-executive Director.
Richard Stiff	Non-Executive Director.
Maureen Taylor	Non-Executive Director and Vice Chair.

Executive Directors

Steve Russell	Chief Executive (Currently on Secondment with NHS England, Commenced 28th February 2022).
Jonathan Coulter	Acting Chief Executive, previously Director of Finance and Deputy Chief Executive, commenced 28th February 2022.
Emma Nunez	Executive Director for Nursing, Midwifery & Allied Health Professionals, Acting Deputy Chief Executive, commenced 28th February 2022.
Jordan McKie	Acting Director of Finance, commenced 28th February 2022.
Jacqueline Andrews	Executive Medical Director.
Russell Nightingale	Chief Operating Officer.
Matthew Graham	Director of Strategy, commenced 13th September 2021.
Angela Wilkinson	Director of Workforce and Organisational Development.

4.1.2. Company Directorships held by Directors or Governors

There are no company directorships or other significant interests held by Directors or Governors that are considered to conflict with their responsibilities.

During the majority of the year, Jonathan Coulter and Sarah Armstrong were appointed by the Trust as Non-Executive Board members of the wholly-owned subsidiary, Harrogate Healthcare Facilities Management Limited (t/a Harrogate Integrated Facilities (HIF)). This was declared at the start of all meetings which they attend (in both the Trust and HIF). Following the changes to the Trust Board, Jonathan and Sarah have stood down from these roles, being replaced by Matthew Graham and Richard Stiff as Non-Executive Board Members of HIF.

As part of the Joint Venture Pathology arrangements that the Trust is a member of, Russell Nightingale and Angela Wilkinson hold Board roles for Integrated Pathology Services (IPS) and Integrated Laboratory Services (ILS)

Registers of Interests for all members of the Board of Directors and the Council of Governors are held within the Trust and continually updated. The Board of Directors' register is received at every public Board of Directors' meeting. The Council of Governors' register is received at every Council of Governor meeting on a quarterly basis. Both registers are available on the Trust website and available on request from the Company Secretary's Office.

4.1.3 Accounting Policies

The Trust prepares its financial statements under direction from NHS Improvement (NHSI), in exercising the statutory functions conferred on Monitor, in accordance with the Department of Health Group Accounting Manual 2021/22, which is agreed with HM Treasury. The accounting policies follow International Financial Reporting Standards (IFRS) to the extent they are meaningful and appropriate to NHS Foundation Trusts.

4.1.4. Charitable and Political Donations

During 2021/22 no charitable or political donations were made by the Trust.

4.1.5. Better Payment Code of Practice

The Better Payment Code of Practice requires the Trust to aim to pay all valid non-NHS invoices within 30 days of receipt, or the due date, whichever is the later. The information below provides an update on the Trust's compliance to this:

Year to 31 March 2021	Numbers	Year to 31 March 2022
35,259	No of invoices Paid to Date	40,508
27,649	No of invoices Paid in 30 Days	38,613
78.4%	% of invoices Paid in 30 Days	95.3%

Year to 31 March 2021	Values	Year to 31 March 2022
61,999	£K Value of invoices Paid to Date	68,209
44,045	£K Value of invoices Paid in 30 Days	62,760
71%	% of invoices Paid in 30 Days	92%

The Board recognises that compliance with this code has improved greatly in recent years.

4.1.6. NHS Improvement Well Led Framework

The Trust has arrangements in place to ensure that services are well led in accordance with the Care Quality Commission and NHS England/Improvement's requirements. Further details about these arrangements are included within this Annual Report within the Annual Governance Statement.

4.1.7. Statement as to Disclosure to Auditors and Accounts Prepared under Direction from NHSI

So far as the Directors are aware, there is no relevant audit information of which the External Auditors are unaware, and the Directors have taken all of the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the Auditors are aware of that information. The Trust's accounts have been prepared under direction from NHSI, in exercising the statutory functions conferred on Monitor, in accordance with the Department of Health Group Accounting Manual.

4.1.8. Income Disclosures required by Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012)

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than the Trust's income from the provision of goods and services for any other purposes. The Trust confirms that it has met this requirement during 2021/2022.

4.1.9. Patient Care Activities

4.1.9.1. Improvements in patient/carer Information

The Trust website delivers clear information and reflects the Trust's vision and values. There is a clear focus given to the key information that people want the most – how to find us, contact details, car parking, and visiting hours, service pages and an area about our consultants which features a short biography and photograph of all the consultants working at the Trust.

The Trust continues to provide a more consistent approach to the Accessible Information Standard (AIS) which aims to improve the lives of people who need information to be communicated in a specific way. The AIS is based on the following requirements:

1. Identification of needs;
2. Recording needs as part of patient / service user records and PAS systems;
3. Flagging of needs using e-flags or alerts to indicate that an individual has a recorded information and/or communication need and to prompt staff to take appropriate action;
4. Sharing of needs as part of existing data-sharing processes and as routine part of referral, discharge and handover; and,
5. Meeting of needs.

We have made further progress in relation to people with learning difficulties, and are progressing systems and processes to enable us to support all patients with information and communication needs.

The Trust has continued to develop its social media presence through several channels of dialogue with patients, members of the public, and other stakeholders. The Trust's main corporate Facebook and Twitter accounts have shown strong growth in follower numbers/likes over the year, as well as overall levels of engagement. These channels have been particularly useful for sharing information at times when urgent communication is required, such as when the Trust has faced winter pressures.

Patient information leaflets continue to be developed with the assistance of volunteer readers who evaluate the content and presentation. This enhances the readability of the leaflets which in turn helps ensure patients are better informed regarding appointments, procedures, treatment and self-care. Internal processes to ensure high standards are maintained with regular review of leaflets have been reviewed and updated during the year.

4.1.9.2. Complaints Handling

The Trust's aim is to 'get it right first time, every time'. The Trust recognises that managing patient feedback well can both improve services and enhance the public perception of the Trust.

The Trust promotes pro-active, on the spot resolution of problems at a local level, thus reducing the need for patients/carers to raise issues in a more formal way. It is recognised that lessons must be captured from this type of feedback locally to promote sharing of learning and good practice. Quality of Care Teams, which are department based teams of frontline staff, are encouraged to facilitate the resolution of issues in their own areas and promote learning.

In order to publicise the service, leaflets and posters are available in all departments across the Trust and in community locations. Patient Experience Volunteers (PEV), based at the front of Harrogate hospital in the Main Reception during normal working hours, work to publicise the Making Experiences Count Policy and the process by which the public can share feedback regarding the Trust services.

The Patient Experience Team (PET) is made up of Patient Experience Officers who receive and make an assessment of all new feedback within three working days. To assist this assessment the issue is graded to identify the severity of the concern being raised and the level of investigation that is necessary as well as the internal and external reporting requirements.

For those cases graded as a complaint, an Investigating Officer is appointed by the Directorate with the most involvement and a formal written acknowledgement is sent from the Chief Executive. An individual resolution plan will be developed with the complainant, via the Investigating Officer, which identifies the nature of the issue and how this will be dealt with.

Local resolution may, for example, be achieved by means of a written investigation, a meeting with staff or a telephone call. The resolution plan is agreed between the complainant and Trust from the outset and must be proportionate to the issue raised.

Where a complaint is graded as amber or red (the most serious levels of concern) or where there are serious risk management implications, the Patient Experience Officer will refer to the Head of Risk Management to ensure appropriate action is taken in relation to any ongoing patient care or incident investigation. For serious complaints, a root cause analysis of the case will be carried out by the Investigating Officer.

Failure by the Trust to satisfy the complainant entitles the complainant to request a further investigation by the Health Service Ombudsman. This request must be made within 12 months of the initial concern, unless there are extenuating circumstances.

If the person is not a patient, but is raising issues on behalf of a patient, the PET checks that the patient knows about this and has given consent. In exceptional cases, where the complaint is graded yellow, amber or red, the Trust will determine what investigation can proceed without consent and what, if anything is disclosed.

There is no time limit for giving feedback to the Trust for those issues which fall outside the Complaints Regulations. All feedback will be received and acted upon wherever possible to ensure learning and improvement for the organisation. Where the issue is coded as a complaint, the regulations set a time limit of 12 months from the event or awareness of the event, for making the complaint. The Trust, however, adopts a flexible attitude to complaints about incidents occurring outside this timescale.

Action plans are considered by the Directorates for each complaint which is raised. Action plans are required for all issues that have been upheld following investigation and quality assurance by the Directorate. Complaint trends and action plans, including those developed in response to Health Service Ombudsman reviews are reported to the Quality Summit and the Quality Committee on a regular basis and in turn to the Board of Directors.

4.1.10 Stakeholder Relations

4.1.10.1. Partnerships and Alliances/Relationship Management

HDFT has a long history of partnership working which has served us well over the last few years as the NHS has increasingly focused on the importance of collaboration and systems approaches. Due to the wide range and large geographic spread of the services we provide, the Trust is a member of multiple health and care systems and has partnerships with many different organisations, as set out below:

West Yorkshire Association of Acute Trusts (WYAAT)

HDFT is one of the original members of WYAAT, a nationally recognised leading provider collaborative which brings together the six acute trusts in West Yorkshire and Harrogate. WYAAT collaborate on a wide range of programmes and issues including diagnostic imaging, pathology, elective care, non-surgical oncology and procurement. In 21/22 WYAAT has continued to roll out further enhancements to radiology technology and is progressing the delivery of a single pathology Laboratory Information Management System to link the laboratories of all six trusts. With the majority of our patient pathways for tertiary services going to Leeds Teaching Hospitals NHS Trust, membership of WYAAT will remain strategically important to us and our patients.

Humber and North Yorkshire Integrated Care System (HNY ICS)

Due to the location of our acute and adult community services in North Yorkshire, HDFT is formally a member of the HNY ICS. With the establishment of Integrated Care Boards as statutory bodies in July 2021, this relationship will become increasingly important because the vast majority of our funding, including capital funding, for our NHS services will flow through the HNY ICB. HDFT has played a leading role in the HNY ICS with, for example, our Chief Executive leading the Workforce Programme, our Medical Director taking an active role in research and innovation and our Director of Strategy leading on Community Diagnostics.

HNY Collaborative of Acute Providers (HNY CAP)

Alongside our membership of WYAAT, the Trust is also a member of the HNY CAP, which also includes York and Scarborough Teaching Hospitals NHS FT, Hull University Teaching Hospitals NHS Trust and North Lincolnshire and Goole NHS FT. HNY CAP leads on elective care, diagnostics, cancer and urgent and emergency care for HNY ICS. The Trust is playing an active role in developing the mission, priorities and governance of the CAP.

North Yorkshire Place

HNY ICS is made up of six places based on local authority areas. HDFT is part of North Yorkshire Place alongside North Yorkshire County Council, Tees, Esk and Wear Valleys NHS FT, Yorkshire Ambulance Service NHS Trust, primary care, the voluntary, community and social enterprise sector and other partners. North Yorkshire Place has identified four key priorities, which are reflected in the Trust's Strategy and objectives:

- A comprehensive and integrated health and social care model
- A high quality care sector with sufficient capacity to meet demand
- A strong workforce
- Prevention and public health: adding life to years and years to life

Harrogate Local Care Partnership (including the Harrogate and Rural Alliance)

As the acute and community provider for Harrogate and District, HDFT has important roles as a health care provider and also as an anchor institution for our community. We are working closely with local partners to establish the Harrogate Local Care Partnership to bring together partners across health, care and beyond to improve the health and wellbeing of the Harrogate and District population. This will build on our well established partnership for older adult community and social care, the Harrogate and Rural Alliance (HARA). HARA has continued to develop its services and now provides a comprehensive range of community health services and social care services for older adults. We agreed a one year extension to the HARA Section 75 Partnership Agreement with North Yorkshire County Council with the aim of developing a more extensive and ambitious partnership agreement over the next year.

0-19 Children's Services Partnerships

HDFT is the largest provider of 0-19 Children's Services in England, providing care and support to over 500,000 children in the North East and Yorkshire across 8 local authorities. We work closely with other trusts, the local authority and other organisations to be a strong partner. We are part of the local governance and system working for children's services and we tailor our services to the strengths and challenges of the local population. Due to our strong reputation, during 2021/22, we were asked to take on delivery of Children's Services for Northumberland and agreed a long term partnership agreement with Northumberland County Council. We have agreed several other partnership agreements with local authorities and this is a strategy we are keen to replicate in other areas because it enables long term investment and development of the services.

Over the last 12 months we have engaged with YTHFT to explore opportunities for greater collaboration. Discussions have also continued with LTHT with a number of new initiatives introduced, including providing Endoscopy sessions at Wharfedale General Hospital in Otley. Work will continue between both organisations to scope options for further collaborations across a range of specialties, including paediatric medicine and maternity services.

1.1.11. Patient & Public Engagement

During 2021/22 the Trust refreshed its Strategy. As part of its ambition to provide "Best Quality, Safest Care", the new Strategy includes a specific strategic goal to deliver:

"A positive experience for every patient by listening and acting on their feedback"

To achieve this goal the Trust has extensively reviewed and updated its approach to patient and public engagement. We have undertaken work to review our position against the NHS England Patient Experience Improvement Framework and, as part of our revised quality governance structures, established the Making Experiences Count (MEC) Forum which will direct and oversee all our patient engagement activity. MEC Forum reports into the Quality Governance Management Group which has management responsibility for all aspects of quality (safety, effectiveness and patient experience). Each Directorate has developed a detailed action plan to improve patient experience for the gaps identified against the Patient Experience Improvement Framework.

Examples of the Trust's patient and public engagement in 2021/22 include:

- During 2021/22 the Trust undertook a refresh of its Strategy. Supported by Healthwatch the trust asked patients and the public to complete a survey about their experience of the Trust's services and how they should develop in future. The Trust received over 150 responses which were used to inform the development of the Strategy, including the strategic goal above.
- Building on the strong links with Healthwatch North Yorkshire, we have developed good relationships with Healthwatch organisations across the North East in the areas where we deliver 0-19 Children's Public Health Services. On behalf of all Healthwatch organisations, Healthwatch North Yorkshire is a member of the MEC Forum.
- Our Maternity Voices Partnership has continued to expand. It is closely embedded into the governance of our maternity services and its chair works closely with our maternity leadership team.
- 307 patients responded to the National Cancer Patient Experience Survey for Harrogate and District (across all services not just HDFT), a 66% response rate compared to a national average of 55%. We were rated as one of the very top providers for cancer care, scoring 9.2 out of 10.
- Education for cancer patients on a wide range of subjects related to their diagnoses and treatment including: healthy eating, managing fatigue, mindfulness, physical

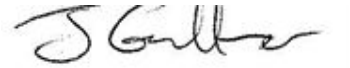
health and activity, hormone therapy, “Thinking Ahead” programme for patients and carers with incurable cancer.
- Our Active Against Cancer service supports cancer patients to remain active, while also offering opportunities for social and peer-to-peer interaction at what can be a challenging time.
- The Oesophageal Patient Association Support Group holds monthly meetings to support patients and carers affected by cancer of the oesophagus

More information on patient engagement can be found in the Trust’s Quality Account.

Approval by the Directors of the Accountability Report

This Accountability Report has been approved by the Board of Directors of Harrogate and District NHS Foundation Trust.

Signed



Jonathan Coulter
Acting Chief Executive Officer
Harrogate and District NHS Foundation Trust
5th October 2022

4.2 Remuneration Report

4.2.1. Annual Statement on Remuneration

The Trust recognises that the remuneration policy is important to ensure that the organisation can attract and retain skilled and experienced leaders. At the same time it is important to recognise the broader economic environment and the need to ensure we deliver value for money.

The Board of Directors has established a Remuneration Committee with responsibilities which include consideration of matters in relation to the remuneration and associated terms of service for Executive Directors including the Chief Executive. The report outlines the approach adopted by the Remuneration Committee when setting the remuneration of the executive directors who have authority or responsibility for directing or controlling the major activities of the organisation.

The following posts have been designated as fitting the criteria by the committee and are collectively referred to as the executives within this report:

- Chief Executive
- Deputy Chief Executive
- Director of Finance
- Executive Medical Director
- Director of Nursing, Midwifery and AHPs
- Chief Operating Officer
- Director of Strategy
- Director of Workforce and Organisational Development

The Committee is chaired by the Chairman of the Trust and all of the Non-executive Directors are members of the Committee. The Chief Executive, Director of Workforce and Organisational Development and Company Secretary support the working of the Committee by providing discussions about the Board composition, succession planning, remuneration and performance of Executive Directors. The Chief Executive and Director of Workforce and Organisational Development are not present when discussions take place in relation to their own performance, remuneration or terms of service are discussed.

4.2.1.1. Remuneration committee

The Remuneration Committee for Executive Directors meets as and when required. In 2021-22 the Committee met twice as per the table below:

Remuneration Committee Meetings 2021/22

Board Member's Name	25 August 2021	01 February 2022
A Schofield	√	√
S Armstrong	√	√
J Cross	√	√
A Papworth	√	√
W Sampson OBE	√	√
R Stiff	√	√
M Taylor	√	√

The Committee undertakes periodic reviews of the salary levels of the Executive Directors including the Chief Executive whilst taking into account the overall performance of the Trust as well as individual performance of directors and published benchmark information.

The Remuneration Committee is a Committee of the Board of Directors and the key outcomes from this Committee are shared with the full Board of Directors.

The Trust's Remuneration Committee has agreed Terms of Reference, which includes specific aims and objectives. The role of the Remuneration Committee is to make such recommendations to the Board of Directors on remuneration, allowances and terms of service to ensure that Directors are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national agreements or regulatory requirements where appropriate.

The Committee monitors and evaluates the performance and development of the Chief Executive and all Executive Directors and advises on and oversees appropriate contractual arrangements for the Chief Executive and all Executive Directors. This includes the proper calculation and scrutiny of termination payments, as appropriate in the light of available guidance, all aspects of salary (including any performance-related element) and the provisions for other benefits, including pensions.

4.2.2. Remuneration Policy

The Trust's remuneration policy applies equally to Non-Executive Director and Executive Director posts and is based upon open, transparent and proportionate pay decisions. All pay decisions are based on market intelligence and are designed to be capable of responding flexibly to recruitment imperatives to secure high calibre people.

When setting levels of remuneration, the Remuneration Committee takes into account the remuneration policies and practices applicable to other employees, along with any guidance received from the sector regulator and the Department of Health. The Committees also receive professional independent reports based on objective evidence of pay benchmarking across a range of industry comparators. The conclusion reached in professional independent reports is that 'weightings accredited to the various posts in relation to market comparisons had resulted in remuneration that is in line with current pay practice.'

The Trust has well established performance management arrangements. Each year the Chief Executive undertakes an appraisal for each of the Executive Directors and the Chief Executive is appraised by the Chairman.

The Trust does not have a system of performance-related pay and therefore in any discussion on remuneration an individual's performance is considered alongside the performance of the Executive Directors and the organisation as a whole.

The Executive Directors are employed on permanent contracts with up to six-month's notice period. In any event where a contract is terminated without the Executive Director receiving full notice, compensation would be limited to the payment of the salary for the contractual notice period. There would be no provision for any additional benefit over and above standard pension arrangements in the event of early retirement. Non-Executive Directors are requested to provide six months' notice should they wish to resign before the end of their term of office. They are not entitled to any compensation for early termination. The Trust has no additional service contract obligations.

In accordance with NHS Improvement guidance the Trust will seek an opinion concerning remuneration of any director who is paid more than £150,000.

Information on the salary and pensions contributions of all Executive and Non-Executive Directors are provided in the tables on the following pages. The information in these tables has been subject to audit by the external auditors, Azets Audit Services.

4.2.3. Annual Report on Remuneration (Senior Managers' Remuneration)

Name and Title	2021/22						
	Salary	Taxable benefits	Annual Performance Related Bonuses	Long Term Performance Related Bonuses	Total Salary and taxable benefits in year	Pension related benefits	Total
	(bands of £5,000) £'000s	Rounded to the nearest £100	(bands of £5,000) £'000s	(bands of £5,000) £'000s	(bands of £5,000) £'000s	(bands of £2,500) £'000s	(bands of £5,000) £'000s
Mr. S Russell - Chief Executive (2)	170-175	-	-	-	170-175	-	170-175
Mr. J Coulter - Deputy Chief Executive & Finance Director, Acting Chief Executive (3)	160-165	-	-	-	160-165	60-62.5	225-230
Dr. J Andrews - Medical Director (4)	190-195	-	-	-	190-195	82.5-85	270-275
Mrs. E Nunez - Director of Nursing, Midwifery and AHPs (7)	45-50	-	-	-	45-50	57.5-60	105-110
Mr. R Nightingale - Chief Operating Officer (10)	120-125	-	-	-	120-125	7.5-10	125-130
Ms. A Wilkinson - Director of Workforce and Organisational Development	100-105	-	-	-	100-105	32.5-35	135-140
Mr. M Graham - Director of Strategy (12)	60-65	-	-	-	60-65	32.5-35	95-100
Mr. J McKie - Acting Director of Finance (13)	5-10	-	-	-	5-10	-	5-10
Ms. A Gillett - Subsidiary Managing Director (14)	85-90	-	-	-	85-90	125-127.5	210-215
Mrs. A Schofield - Chairman	45-50	-	-	-	45-50	-	45-50
Mr. M Chamberlain - Subsidiary Chairman (11)	10-15	-	-	-	10-15	-	10-15
Mr. R Stiff - Non-Executive Director / Audit Committee Chair	15-20	-	-	-	15-20	-	15-20
Mrs. L Hind - Subsidiary Non-Executive Director	0-5	-	-	-	0-5	-	0-5
Mr. R Taylor - Subsidiary Non-Executive Director	0-5	-	-	-	0-5	-	0-5
Ms. S Armstrong - Non-Executive Director	15-20	-	-	-	15-20	-	15-20
Mrs. M Taylor - Non-Executive Director	15-20	-	-	-	15-20	-	15-20
Ms. L Robson - Non-Executive Director	15-20	-	-	-	15-20	-	15-20
Mr. J Cross - Non-Executive Director	15-20	-	-	-	15-20	-	15-20
Mr. W Sampson OBE - Non-Executive Director	10-15	-	-	-	10-15	-	10-15
Mr. A Papworth - Non-Executive Director	10-15	-	-	-	10-15	-	10-15

Name and Title	2020/21						
	Salary	Taxable benefits	Annual Performance Related Bonuses	Long Term Performance Related Bonuses	Total Salary and taxable benefits in year	Pension related benefits	Total
	(bands of £5,000) £'000s	Rounded to the nearest £100	(bands of £5,000) £'000s	(bands of £5,000) £'000s	(bands of £5,000) £'000s	(bands of £2,500) £'000s	(bands of £5,000) £'000s
Mr. S Russell - Chief Executive (2)	190-195	-	-	-	190-195	-	190-195
Mr. J Coulter - Deputy Chief Executive & Finance Director, Acting Chief Executive (3)	165-170	-	-	-	165-170	102.5-105	270-275
Dr. J Andrews - Medical Director (4)	145-150	-	-	-	145-150	-	145-150
Dr. D Scullion - Medical Director (5)	45-50	-	-	-	45-50	-	45-50
Mrs. J Foster - Chief Nurse (6)	120-125	-	-	-	120-125	12.5-15	135-140
Mr. R Harrison - Chief Operating Officer (8)	60-65	-	-	-	60-65	-	60-65
Ms. A Wilkinson - Director of Workforce and Organisational Development	100-105	-	-	-	100-105	247.5-250	345-350
Mrs. A Schofield - Chairman	45-50	-	-	-	45-50	-	45-50
Mr. M Chamberlain - Subsidiary Chairman (11)	10-15	-	-	-	10-15	-	10-15
Mr. R Stiff - Non-Executive Director / Audit Committee Chair	15-20	-	-	-	15-20	-	15-20
Mrs. L Hind - Subsidiary Non-Executive Director	0-5	-	-	-	0-5	-	0-5
Mr. R Taylor - Subsidiary Non-Executive Director	0-5	-	-	-	0-5	-	0-5
Ms. S Armstrong - Non-Executive Director	15-20	-	-	-	15-20	-	15-20
Mrs. M Taylor - Non-Executive Director	15-20	-	-	-	15-20	-	15-20
Ms. L Robson - Non-Executive Director	15-20	-	-	-	15-20	-	15-20
Mr. J Cross - Non-Executive Director	15-20	-	-	-	15-20	-	15-20
Mr. W Sampson OBE - Non-Executive Director	10-15	-	-	-	10-15	-	10-15
Mr. A Papworth - Non-Executive Director	10-15	-	-	-	10-15	-	10-15

(1) The median salary for all staff in 2021/22 was £32,306. The median salary for all staff in 2020/21 was £30,615. The median calculation is the annualised full time remuneration of all staff in the Trust as at 31 March 2022 (Including agency staff), excluding the highest paid Director. The ratio is based on the total salary and benefits in year. Further details are in section 4.2.4.
(2) Mr S. Russell commenced a secondment with NHS England on 28 February 2022. His earnings have been included for the period he was Chief Executive only.
(3) Mr J. Coulter commenced as Acting Chief Executive from 28 February 2022.
(4) Dr J. Andrews commenced as Medical Director on 15 June 2020. Dr Andrews undertakes sessions as a Rheumatologist at the Trust, as well as the Medical Director role.
(5) The Medical Director remuneration for Dr Scullion includes both this role and his clinical post as Consultant Radiologist. The Medical Director proportion of his salary equated to 25% of the salary outlined above. Dr Scullion ceased his role as Medical Director on 14 June 2021
(6) Mrs J. Foster left the position of Chief Nurse on 31 March 2021
(7) Mrs E. Nunez commenced as Director of Nursing, Midwifery and AHPs from 1 November 2021. Prior to this Mrs Nunez was in the role on a secondment basis. Subsequently, Mrs Nunez commenced as Acting Deputy Chief Executive from 28 February 2022.
(8) Mr R. Harrison left the position of Chief Operating Officer on 31 August 2020
(9) Mr T. Gold joined the Trust as interim Chief Operating Officer from 1 September 2020 to 31 March 2021. His position was on a secondment basis and has therefore not been included within the above.
(10) Mr R. Nightingale commenced as Chief Operating Officer on 05 April 2021.
(11) Mr M. Chamberlain commenced as Chairman of the Trust's Subsidiary on 1 July 2020
(12) Mr M. Graham commenced as Director of Strategy from 13 September 2021
(13) Mr J. McKie commenced as Acting Director of Finance from 28 February 2022
(14) Ms A. Gillett commenced as Subsidiary Managing Director from 01 April 2021

Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2022 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2022 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2022 £000	Cash Equivalent Transfer Value at 31 March 2021 £000	Real Change in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension to nearest £100
Mr Stephen Russell - Chief Executive	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£Nil
Mr. Jonathan Coulter - Deputy Chief Executive & Finance Director / Acting Chief Executive	2.5-5	0-2.5	60-65	130-135	1,220	1,127	63	£Nil
Dr Jacqueline Andrews - Medical Director	5-7.5	5-7.5	50-55	105-110	969	867	73	£Nil
Ms Angela Wilkinson - Director of Workforce and Organisational Development	0-2.5	£Nil	45-50	£Nil	699	647	35	£Nil
Mr Russell Nightingale - Chief Operating Officer	0-2.5	£Nil	25-30	£Nil	255	239	-2	£Nil
Mr Matthew Graham - Director of Strategy	0-2.5	£Nil	25-30	£Nil	342	308	23	£Nil
Mrs Emma Nunez - Director of Nursing, Midwifery and AHPs & Acting Deputy Chief Executive	2.5-5	2.5-5	30-35	50-55	424	377	39	£Nil
Miss Angela Gillett - Subsidiary Managing Director	5-7.5	17.5-20	40-45	130-135	0	948	-965	£Nil
Mr Jordan McKie - Acting Director of Finance*	N/A	N/A	15-20	25-30	202	N/A	N/A	£Nil

* Note - no comparator information was available for Mr McKie

4.2.4. Fair Pay Declaration

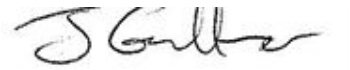
Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director/member in their organisation against the 25th percentile, median and 75th percentile remuneration of the organisation's workforce. The banded remuneration of the highest paid director in Harrogate District NHS Foundation trust in the financial year 2021-22 was £190-195k (2020-21, £190-195k). This is a reduction of 1% between years.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. For employees of the Trust as a whole, the range of remuneration in 2021/22 was from £8k to £315k. The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is a 3% increase. 8 employees received remuneration in excess of the highest-paid director in 2021/22.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

Pay ratio Information Table

2021/22	25th Percentile	Median	75th Percentile
Total Remuneration (£)	24,882	32,306	42,121
Salary Component of total remunerations (£)	24,882	32,306	42,121
Pay Ratio information	7.72	5.94	4.56
2020/21			
Total Remuneration (£)	N/A	30,615	N/A
Salary Component of total remunerations (£)	N/A	30,615	N/A
Pay Ratio information	N/A	6.33	N/A



Jonathan Coulter
Acting Chief Executive Officer
Harrogate and District NHS Foundation Trust
5th October 2022

4.3. Staff Report

All of the data profiles of the Trust's staff in the charts below have been collated from the Trust's Electronic Staff Record (ESR) system and provides a comparison between 2020-21 and 2021-22. All figures are taken for the end of the financial year and include all staff employed by the Trust, with the exception of bank only contracts.

4.3.1. Analysis of staff numbers as at 31 March 2022

Staff Group	2020/2021		2021/2022	
	Headcount	WTE	Headcount	WTE
Administrative and Clerical	789	678.38	834	718.78
of which Senior Management	*75*	*73.15*	*80*	*77.47*
Allied Health Professionals	374	308.15	348	286.61
Estates and Ancillary	27	19.57	22	15.86
Medical and Dental	473	401.33	426	362.80
Nursing and Midwifery Registered	1,630	1,371.37	1,811	1,509.88
Scientific and Technical	118	98.96	182	154.34
Support Workers	899	729.75	914	743.71
TOTAL	**4,310**	**3,607.51**	**4,537**	**3,791.98**

*Headcount is based on the employee's primary assignment to avoid duplication of headcount.
**Senior Management relates to Administrative and Clerical staff, Band 8a and above.

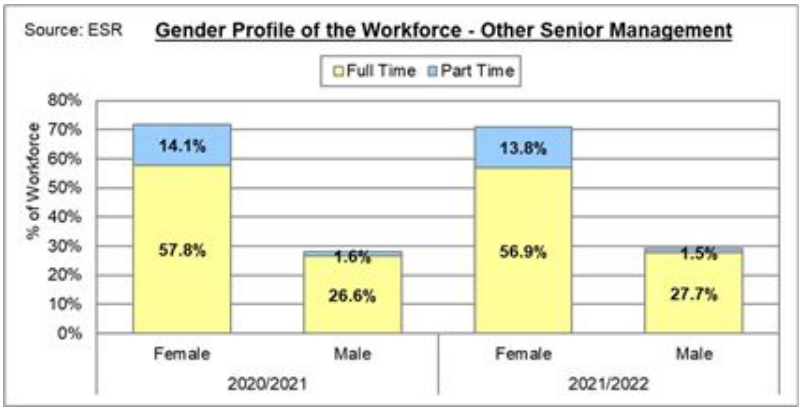
8

4.3.2. Analysis of the Male and Female Directors, Other Senior Managers and Employees as at 31 March 2022

The table below gives a breakdown of the number of Directors, including Non-Executive Directors, by gender, as at 31 March 2022.

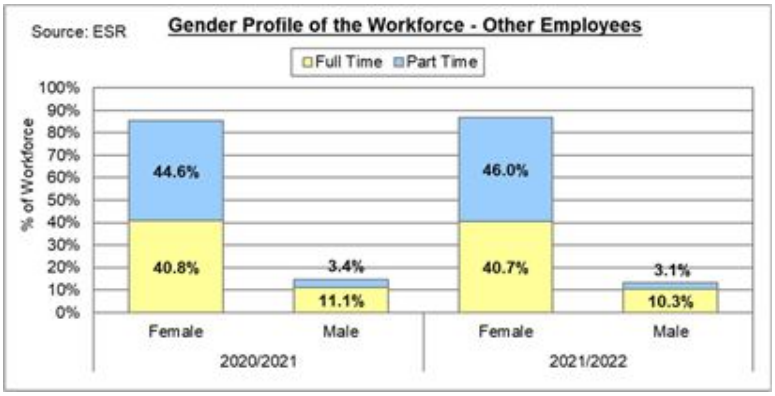
Gender	Category	2020/2021	2021/2022
DIRECTORS		**Headcount**	**Headcount**
Female	Full Time	3	3
	Part Time	4	4
Male	Full Time	3	5
	Part Time	4	4
TOTAL		**14**	**16**

*For the purpose of the above data, Steve Russell, Chief Executive has been included in the Directors headcount, however he is currently on an external secondment as at 31 March 2022.



The table below gives a breakdown of the number of other senior management, by gender, as at 31 March 2022.

Gender	Category	2020/2021	2021/2022
OTHER SNR MANAGEMENT		**Headcount**	**Headcount**
Female	Full Time	37	37
	Part Time	9	9
Male	Full Time	17	18
	Part Time	1	1
TOTAL		**64**	**65**



The table below gives a breakdown of the number of other employees, by gender, as at 31 March 2022.

Gender	Category	2020/2021	2021/2022
Other Employees		**Headcount**	**Headcount**
Female	Full Time	1,726	1,814
	Part Time	1,890	2,048
Male	Full Time	471	457
	Part Time	146	137
TOTAL		**4,233**	**4,456**

4.3.3 Sickness absence data

The table below shows the Trust's sickness absence data for each quarter during the 2021-22 financial year.

Directorate	21/22 Q1 % Absence Rate (FTE)	21/22 Q2 % Absence Rate (FTE)	21/22 Q3 % Absence Rate (FTE)	21/22 Q4 % Absence Rate (FTE)	Cumulative % Absence Rate
Community and Children's	4.49%	5.96%	6.52%	6.41%	**5.89%**
Corporate Services	1.99%	3.10%	3.30%	3.78%	**3.06%**
Long Term and Unscheduled Care	3.51%	4.33%	4.73%	5.09%	**4.41%**
Planned and Surgical Care	4.57%	4.99%	5.78%	5.66%	**5.25%**
TOTAL	**3.97%**	**4.95%**	**5.54%**	**5.61%**	**5.03%**

Key
21/22 Q1 – April 2021 to June 2021
21/22 Q2 – July 2021 to September 2021
21/22 Q3– October 2021 to December 2021
21/22 Q4 – January 2022 to March 2022

4.3.4 Analysis of the Disability Profile of the Workforce as at 31 March 2022

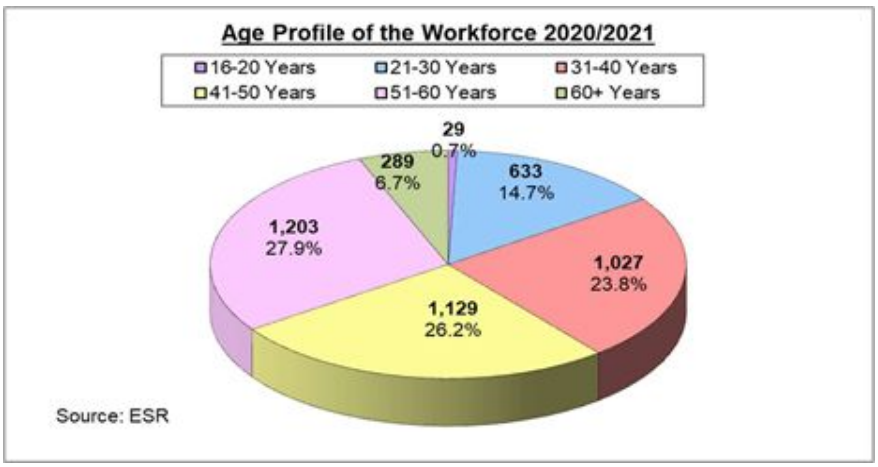
The table below gives a breakdown of the number of employees registered as having a disability as at 31 March 2022.

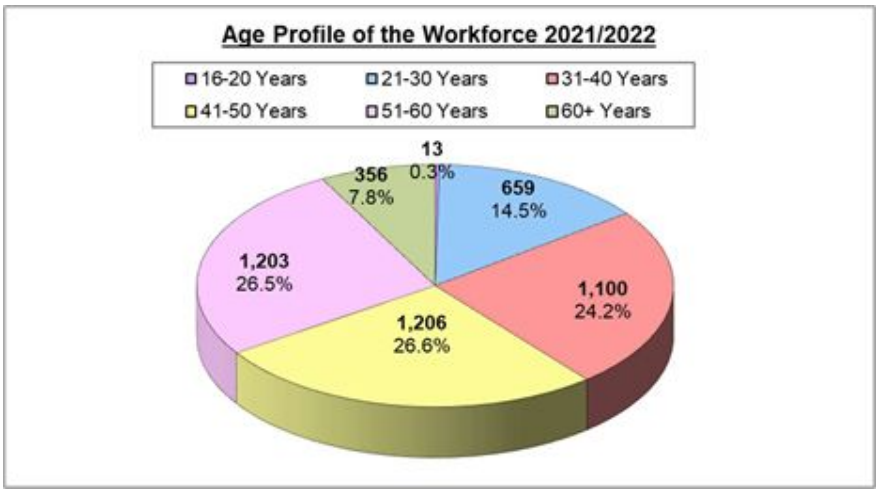
Disabled	2020/2021 Headcount	2021/2022 Headcount
No	3,483	3,706
Yes	152	207
Not Declared	675	624
TOTAL	**4,310**	**4,537**

4.3.5 Analysis of the Age Profile of the Workforce as at 31 March 2022

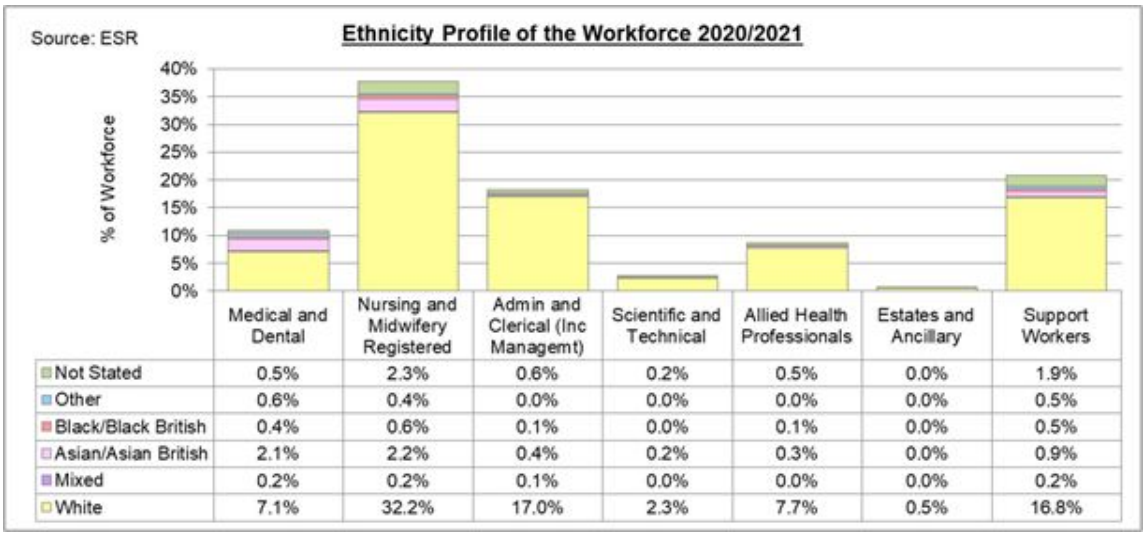
The table below gives a breakdown of the number of employees, by age, as at 31 March 2022.

	2020/2021		2021/2022	
Age Band	Headcount	% of Workforce	Headcount	% of Workforce
16-20 Years	29	0.7%	13	0.3%
21-30 Years	633	14.7%	659	14.5%
31-40 Years	1,027	23.8%	1,100	24.2%
41-50 Years	1,129	26.2%	1,206	26.6%
51-60 Years	1,203	27.9%	1,203	26.5%
60+ Years	289	6.7%	356	7.8%
TOTAL	**4,310**		**4,537**	

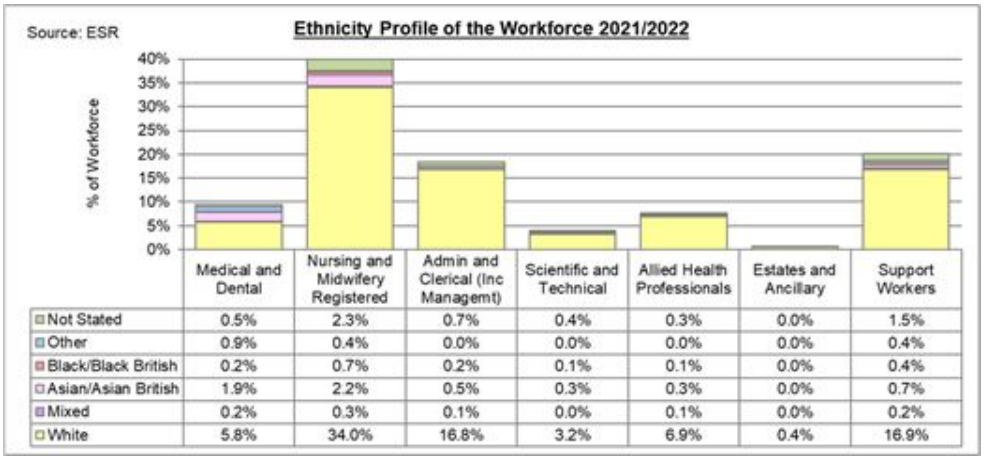




4.3.6 Analysis of the Ethnicity Profile of the Workforce as at 31 March 2022



	Medical and Dental	Nursing and Midwifery Registered	Admin and Clerical (Inc Managemt)	Scientific and Technical	Allied Health Professionals	Estates and Ancillary	Support Workers
Not Stated	0.5%	2.3%	0.6%	0.2%	0.5%	0.0%	1.9%
Other	0.6%	0.4%	0.0%	0.0%	0.0%	0.0%	0.5%
Black/Black British	0.4%	0.6%	0.1%	0.0%	0.1%	0.0%	0.5%
Asian/Asian British	2.1%	2.2%	0.4%	0.2%	0.3%	0.0%	0.9%
Mixed	0.2%	0.2%	0.1%	0.0%	0.0%	0.0%	0.2%
White	7.1%	32.2%	17.0%	2.3%	7.7%	0.5%	16.8%



HEADCOUNT 2020/2021	Medical and Dental	Nursing and Midwifery Registered	Admin and Clerical (incl Manage-ment)	Scientific and Technical	Allied Health Profess-ionals	Estates and Ancillary	Support Workers	Total
White	304	1,386	731	97	331	22	724	**3,595**
Mixed	9	7	5	1	2	1	9	**34**
Asian/Asian British	92	95	18	9	12	1	39	**266**
Black/Black British	18	26	5	1	6	2	21	**79**
Other	28	16	2	0	1	0	22	**69**
Not Stated	22	100	28	10	22	1	84	**267**
TOTAL	**473**	**1,630**	**789**	**118**	**374**	**27**	**899**	**4,310**

HEADCOUNT 2021/2022	Medical and Dental	Nursing and Midwifery Registered	Admin and Clerical (Incl Manage ment)	Scientific and Technical	Allied Health Professi-onals	Estates and Ancillary	Support Workers	Total
White	262	1543	764	145	312	19	765	**3,810**
Mixed	8	14	6	2	3	1	9	**43**
Asian/Asian British	85	102	24	14	12	0	33	**270**
Black/Black British	10	31	7	4	5	1	20	**78**
Other	39	17	0	1	2	0	20	**79**
Not Stated	22	104	33	16	14	1	67	**257**
TOTAL	**426**	**1,811**	**834**	**182**	**348**	**22**	**914**	**4,537**

Starters and Leavers during 2021-22

	Headcount	FTE
Starters	543	477.43
Leavers	591	472.24

Exclusions applied:

- Retire and Returns
- Locum Medical and Dental staff
- Bank Staff
- Doctors in training
- Fixed Term Contracts
- TUPE Transfers in/out

4.3.7 Trade Union Facility Time Disclosure

The Trade Union (Facility Time Publications Requirements) Regulations 2017 implement the requirement introduced by the Trade Union Act 2017 for specified public-sector employers, including NHS Trust's to report annually a range of data in relation to their usage and spend on trade union facility time.

Facility time generates benefits for employees, managers and the wider community from effective joint working between union representatives and employers. Whether in providing support to individual members of Trust staff at a departmental level, or by playing a valuable role in contributing to Trust-wide agendas for example (Partnership Forum, Local negotiating Committee, Health and Safety Committee) the Trust recognises that the participation of trade union representatives supports the partnership process and contributes to delivering improved services to patients and users.

At a time when the whole public sector needs to ensure it delivers value for money, the Trust will continue to monitor and evaluate the amount of money spent on facility time, in the interests of transparency and accountability. The Trust's data for the first reporting period 1 April 2021 to 31 March 2022 is listed below:

The Trade Union (Facility Time Publication Requirements) Regulations 2017

This is the fourth year that organisations have been required by law to publish Trade Union (TU) facility time information. The data below is for the financial year 1 April 2021 to 31 March 2022

Relevant union officials

Number of employees who were relevant union officials during the reporting period	Full-time equivalent employee number
	16.15

Percentage of time spent on facility time

Percentage of time	Number of Employees
0%	10
1-50%	6
51-99%	
100%	

Percentage of pay bill spent on facility time

Provide the total cost of facility time	13751.98
Provide the total pay bill	198797027.86
Provide the percentage of the total pay bill spend on facility time, calculated as:	0.01
(total cost of facility time divided by total pay bill) x 100	

Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	90.74

4.3.8 National Staff Survey

The 2021/22 NHS Staff Survey underwent important changes since the 2020/21 iteration. This involved extending the inclusion criteria as well as making some changes to the content of the questionnaire. Among these improvements, and perhaps the most significant, has been the realignment of the survey questions to the seven People Promise elements, where previously these were aligned to themes. This allows us for the first time to measure, consistently and robustly, the working experience of our people across the NHS in England. Alongside the seven Promise elements we have retained the two themes of Engagement and Morale. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The NHS staff survey is conducted annually. From 2021/22 the survey questions align to the seven elements of the NHS 'People Promise', and retains the two previous themes of engagement and morale. These replace the ten indicator themes used in previous years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those. The response rate to the 2021/22 survey among trust staff was 39%.

2021/22

Scores for each indicator together with that of the survey benchmarking group (Acute and Acute & Community Trusts) are presented below.

Indicators ('People Promise' elements and themes)	**2021/22**	
	Trust score	Benchmarking group score
People Promise:		
We are compassionate and inclusive	7.2	7.2
We are recognised and rewarded	5.9	5.8
We each have a voice that counts	6.6	6.7
We are safe and healthy	5.7	5.9
We are always learning	4.8	5.2
We work flexibly	6.0	5.9
We are a team	6.6	6.6
Staff engagement	6.7	6.8
Morale	5.5	5.7

2019/20 and 2020/21

Scores for each indicator together with that of the survey benchmarking group (Acute and Acute & Community Trusts) are presented below.

	2020/21		2019/20	
	Trust score	Benchmarking group score	Trust score	Benchmarking group score
Equality, diversity & inclusion	8.2	8.1	9.1	9.1
Health & wellbeing	50.4%	56.4%	5.9	6.1
Immediate managers (Compassionate & inclusive)	7.2	7.2	6.7	6.8
Morale	5.5	5.7	6.1	6.2
Quality of care	66.6%	66.9%	7.3	7.5
Safe environment – bullying and harassment	46.1%	46.5%	8.1	8.1
Safe environment – violence from patients / service users, their relatives or other members of the public	9.0%	14%	9.7	9.5
Safety culture	4.8	5.2	6.7	6.8
Staff engagement	6.7	6.8	6.9	7.0
Team working	6.5	6.5	6.5	6.5

For this period the response rate increased by 8% from last year to 39%. The Trust has improved its rating as a safe place to work (violence from patients / service users, their relatives or other members of the public) since last year and has made good progress by maintaining its ratings across the other indicators in line with other Acute and Community Trusts.

4.4. Off-payroll arrangements

The Trust is required to report on its highly paid and/or senior off-payroll engagements. There are no such arrangements to report for 2021/22.

4.5. Consultancy Expenditure

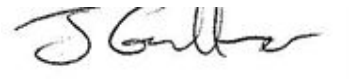
The Trust is required to report on consultancy expenditure, which in 2021/22 equated to £799k.

4.6. Exit Packages

The Trust is required to disclose summary information of staff exit packages which have been agreed in the year. Detail of this can be found within the annual accounts.

Approval by the Directors of the Accountability Report

This Accountability Report has been approved by the Board of Directors of Harrogate and District NHS Foundation Trust.



Jonathan Coulter
Acting Chief Executive Officer
Harrogate and District NHS Foundation Trust
5th October 2022

4.7. NHS Foundation Trust Code of Governance

The Board of Directors (the Board) and Council of Governors (the Council) work closely together in the best interests of the Trust. Detailed below is a summary of the key roles and responsibilities of both the Board of Directors and the Council of Governors.

The Board meets formally with the Council on a six monthly basis to seek and consider the views of the Governors in agreeing, for example, strategic aims, potential changes in service provision, and public perception matters. These meetings are also used as an opportunity to update and inform the Board and Council of particular examples of good practice. The joint Chairman of both the Board of Directors and the Council of Governors proactively ensures synergy between the Board and Council through regular meetings and written communications.

The Directors (both Executive and Non-Executive) meet regularly with Governors during their day to day working through meetings, briefings, consultations, information sessions, directorate inspections and patient safety visits. Examples include membership of Governor working groups and consultations about the development of the Trust's Operational Plan and Quality Account. Informal meetings are also held with the Council three times a year. The Chairman attends these meetings to support the Council and to ensure the Board have an opportunity to obtain the views of the Council and their members in the planning of services for the local community.

Informal meetings between the Non-Executive Directors and the Council have been introduced to further extend the Governors' knowledge of the role of the Non-Executive Directors in response to the Health and Social Care Act 2012 and the Governors' statutory responsibility to hold the Non-Executive Directors to account.

4.7.1. Audit Committee

4.7.1.1. Introduction

In accordance with best practice and the NHS Audit Committee Handbook, this report has been prepared to provide the Board with a summary of the work of the Audit Committee during the period April 2021 – March 2022, and in particular how it has discharged its responsibilities as set out in its Terms of Reference.

Meetings & Attendance

The Audit Committee met formally on six occasions during 2021/22. Audit Committee members attendance is set out in the table below. In addition, all Audit Committee members attended an informal meeting in late April 2021 to undertake a detailed review of the draft accounts (relating to the 2020/21 financial year). Members of the Committee also attended relevant Audit Committee training events during the course of the year.

Audit Committee Members' Attendance:

	4 May 2021	4 June 2021	7 Sept 2021	7 Dec 2021	1Feb 2022	8Mar 2022
Mr Richard Stiff	Y	Y	Y	N	Y	Y
Mrs Maureen Taylor	Y	Y	Y	Y	Y	Y
Mr Jeremy Cross	Y	Y	Y	Y	Y	Y
Ms Laura Robson	Y	Y	Y	Y	Y	Y

The Audit Committee had a membership of four Non-Executive Directors and during the 2021/22 financial year this comprised of:

- Mr Richard Stiff (Chair)
- Mrs Maureen Taylor
- Mr Jeremy Cross
- Ms Laura Robson

The Committee was supported, at all of its meetings by:

- The Deputy Chief Executive / Finance Director
- The Deputy Director of Finance
- The Head of Financial Accounts
- The Associate Director of Quality and Corporate Affairs
- Internal Audit (Head of Internal Audit and Internal Audit Manager)
- External Audit (Director and Senior Manager)

Other representatives (e.g. Chief Nurse, Local Counter Fraud Specialist and Local Security Management Specialist) attended the Audit Committee as and when required.

The attendance details of all attendees at Audit Committee Meetings during 2021/22 are set out in the attached appendix.

The Committee received secretarial and administrative support from Miss Kirstie Anderson who is employed by the Trust's Internal Audit providers but has no managerial responsibility for the HDFT Internal Audit Plan.

Audit Committee members meet in private prior to the start of each Committee meeting. Separate, private sessions are held with Internal Audit and External Audit prior to Audit Committee meetings as required, and no less than once a year. Both Internal and External Audit colleagues have access to the Chair of the Committee and other Committee meetings should they require it outside of the meetings cycle.

There is a documented Audit Committee timetable which schedules the key tasks to be undertaken by the Committee over the course of a year and which is reviewed at each meeting.

Detailed minutes are taken of all Audit Committee meetings and are reported to the Board of Directors both in the form of the Committee's approved minutes and a written report from the Committee Chair to the Board after each Committee meeting

Action lists are prepared after each meeting and details of cleared actions and those carried forward are presented at the following meeting.

On most occasions meetings have been observed by a member of the Council of Governors.

4.7.1.2. Duties of the Audit Committee

Following a review of the Audit Committee's terms of reference in January 2021, the key duties of the Audit Committee could be categorised as follows:

• Governance, Risk Management & Internal Control	Review of the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives, primarily through the assurances provided by internal and external audit and other assurance functions.

• Financial Management & Reporting	Review of the Foundation Trust's Financial Statements and Annual Report, including the Annual Governance Statement, before submission to the Board of Directors. Review of the Charitable Trust's Financial Statements and Annual Report before submission to the Board of Directors acting in its role as Corporate Trustee. Ensuring that systems for financial reporting are subject to review to ensure completeness and accuracy of information and compliance with relevant legislation and requirements. Review of the Trust's Treasury Management Policy, Standing Financial Instructions and systems in place to ensure robust financial management.
• Internal Audit & Counter-Fraud Service	Ensuring an effective internal audit and counter-fraud service that meets mandatory standards and provides appropriate, independent assurance to management and the Audit Committee. Review of the conclusion and key findings and recommendations from all Internal Audit reports and review of regular reports from the Local Counter Fraud Specialist. Monitoring of the implementation of Internal Audit and Counter Fraud recommendations.
• Local Security Management Services (LSMS)	Ensuring an effective LSMS service that meets mandatory standards and provides appropriate assurance to management and the Audit Committee. Review the annual report and plan for the following year.
• External Audit	Ensuring that the organisation benefits from an effective external audit service. Review of the work and findings of external audit and monitoring the implementation of any action plans arising.
• Clinical & Other Assurance Functions	Review of the work of the Quality Committee within the organisation, whose work provides relevant assurance over clinical practice and processes. Review of the findings of other significant assurance functions, both internal and external to the organisation, and consideration of the implications for the governance of the organisation.

4.7.1.3. Work Performed

The Committee has organised its work under five headings "Financial Management", "Governance", "Clinical Assurance", "Internal Audit and Counter Fraud" and "External Audit".

4.7.1.4. Governance, Risk Management and Internal Control

The Audit Committee receives the minutes of the Corporate Risk Review Group for part of the year. The CRRG ceased meeting from the autumn of 2021 and its role was subsumed within

the remit of a new Executive Risk Group. From February 2022 the Audit Committee have received a summary report of the key matters discussed at the Executive Risk Group meetings since the last Audit Committee meeting. These summary reports and the minutes provided previously detail the changes to the Corporate Risk Register and new risks considered. In addition the Audit Committee receives the minutes of the Quality Committee, which is a formal sub-committee of the Board of Directors and the Chair of the Quality Committee is now a member of the Audit Committee further improving ability of the committee to receive assurance in this area.

The Board Assurance Framework, Corporate Risk Register and mechanisms for reporting strategic risks to the Board are reviewed on a periodic basis alongside the review of the Corporate Risk Review Group minutes and Executive Risk Group summary reports.

Additionally the Staff Registers of Interests and Gifts and Hospitality were reported to the Audit Committee in June 2021 and has been subject to ongoing monitoring by the Committee.

The Annual Governance Statement and the Head of Internal Audit Opinion were reviewed by the Audit Committee prior to submission to the Board. The Chief Executive (or another designated Executive Director) attends the Audit Committee annually at year-end (usually held in May but for 2021/22 the meeting was held in October 2022) to discuss assurance around the Annual Governance Statement.

In relation to the governance of the Audit Committee itself, the Committee undertook the following tasks during 2021/22:

- Assessment of Audit Committee Effectiveness in December 2021, the findings of which were presented to the Board of Directors.
- Review and approval of Audit Committee Terms of Reference in December 2021 which were presented to the Board of Directors for approval.
- Ongoing review and revision of the Audit Committee's timetable.

4.7.1.5. Clinical Assurance

The revised Quality and Governance structure means that the Audit Committee receives assurance on the effectiveness of clinical processes through the meeting minutes and Annual Report of the Quality Committee. Within the revised process the Audit Committee's role focuses on the delivery of the quality assurance process.

4.7.1.6. Internal Audit and Counter Fraud Service

Internal Audit and Counter Fraud Services are provided to the Trust by Audit Yorkshire. The Finance Director sits on the Audit Yorkshire Board which oversees Audit Yorkshire at a strategic level. The Board met on four occasions during 2021/22.

An Internal Audit Charter formally defines the purpose, authority and responsibility of internal audit activity. This document was updated, reviewed and approved by the Audit Committee in September 2021.

The Audit Committee approved the planning methodology to be used by Internal Audit to create the Internal Audit Plan for 2021/22, and gave formal approval of the Internal Audit Operational Plan in March 2021.

The conclusions (including the assurance level and the corporate importance and corporate risk ratings) as well as all findings and recommendations of finalised Internal Audit reports are shared with the Audit Committee. The Committee can, and does, challenge Internal Audit on assurances provided, and requests additional information, clarification or follow-up work if considered necessary. All Internal Audit reports are discussed individually with the Audit Committee.

A system whereby all internal audit recommendations are followed-up on a quarterly basis is in place. Progress towards the implementation of agreed recommendations is reported (including full details of all outstanding recommendations) to the Executive Team and the Audit Committee on a quarterly basis. This has been an area of focus by the Committee during the year and Trust management have worked hard to ensure that the process for responding to internal audit recommendations has been improved.

The Counter Fraud Plan was reviewed and approved by the Audit Committee and the Local Counter-Fraud Specialist (LCFS) presented bi-annual reports detailing progress towards achievement of the plan, as well as summaries of investigations undertaken.

The effectiveness of Internal Audit was reviewed by HDFT staff and the Audit Committee in December 2021, resulting in a satisfactory evaluation.

4.7.1.7. External Audit

KPMG's contract was extended to cover the external audit services up until 31st March 2022. The effectiveness of External Audit was reviewed by HDFT staff and the Audit Committee in September 2021 resulting in a satisfactory evaluation which was reported to the Council of Governors.

The Trust undertook a procurement exercise, led by governors, to appoint an auditor for 2021/22 well before the end of the year, however, this process was unsuccessful. After support from NHS England, as well as work by the Finance team to support the Governors, Azets Audit Services were appointed as the provider of External Audit services to the Trust.

During the 2021/22 financial year the Audit Committee reviewed External Audit's Annual Governance Report and Management Letter in relation to the 2020/21 financial statements.

External Audit regularly updated the Committee on progress against their agreed plan, on any issues arising from their work and on any issues or publications of general interest to Audit Committee members.

4.7.1.8. Specific Significant Issues discussed by the Audit Committee during 2021/22

The following additional significant issues have been discussed by the Audit Committee during 2021/22:

- Impact of the Covid-19 pandemic on Risk Management processes and governance arrangements at the Trust
- Impact of the above and availability of staff to support the delivery of the Internal Audit programme.
- Follow up of Limited Assurance Internal Audit reports. The timeliness of response by management to internal audit draft reports and the implementation of outstanding internal audit recommendations.

4.7.1.9. Audit Committee Effectiveness Survey

It is recommended corporate governance best practice for Committees of the Board of Directors to undertake annual self-assessment of effectiveness. A survey of Audit Committee members and regular attendees at the Committee meetings was undertaken during 2021/22. The Annual Audit Committee Effectiveness Survey found that the Committee had conducted itself in accordance with its Terms of Reference and work plan during and that this summary report is consistent with the Annual Governance Statement and the Head of Internal Audit Opinion.

4.7.2 The Board of Directors and Council of Governors

The Board of Directors (the Board) and Council of Governors (the Council) work closely in the best interests of the Trust. Detailed below is a summary of the key roles and responsibilities of both the Board of Directors and the Council of Governors.

The Board meets formally with the Council on a six-monthly basis to seek and consider the views of the Governors in agreeing, for example, strategic aims, potential changes in service provision, and public perception matters. These meetings are also used as an opportunity to update and inform the Board and Council of particular examples of good practice. The Trust's Chairman is the Chairman for the Board of Directors and the Council of Governors and she proactively ensures synergy between the Board and Council through regular meetings and written communications.

The Directors (Executive and Non-Executive) meet regularly with Governors during their day to day working through meetings, briefings, consultations, information sessions, directorate inspections and patient safety visits. Informal meetings are also held with the Council three times a year. The Chairman attends these meetings to support the Council and to ensure the Board have an opportunity to obtain the views of the Council and their members in the planning of services for the local community.

Informal meetings between the Non-Executive Directors and the Council have been introduced to further extend the Governors' knowledge of the role of the Non-Executive Directors in response to the Health and Social Care Act 2012 and the Governors' statutory responsibility to hold the Non-Executive Directors to account.

4.7.2.1. The Board of Directors

The Board of Directors is a unitary Board with collective responsibility for all areas of performance of the Trust such as clinical and operational performance, financial performance, governance and management. The Board is legally accountable for the services it provides at the Trust and operates to the highest of corporate governance standards. It has the option to delegate these powers to senior management and other Committees. Its role is to provide active leadership within a framework of prudent and effective controls which enable risk to be assessed and managed. The Board is responsible for the allocation of resources to support the achievement of organisational objectives, ensure clinical services are safe, of a high quality, patient focused and effective.

The Board had agreed to meet in public bi-monthly during 2021/22. In intervening months the Board of Directors held closed workshops. As part of this, the Board members had extended visits to services in the local area. These proved to be mutually beneficial to Directors and staff alike.

The Board ensures high standards of clinical and corporate governance and, along with the Council of Governors, engages members and stakeholders to ensure effective dialogue with the communities it serves.

The Board is accountable to stakeholders for the achievement of sustainable performance and the creation of stakeholder value through development and delivery of the Trust's long term Vision, Mission, and strategy. The Board ensures that adequate systems and processes are maintained to deliver the Trust's Annual Plan, deliver safe, high quality healthcare, measure and monitor the Trust's effectiveness and efficiency as well as seeking continuous improvement and innovation.

The Board delegates some of its powers to Board Committees or to an Executive Director and these matters are set out in the Trust's scheme of delegation which is available from the Company Secretary's Office on request. The Terms of Reference for the Board of Directors and its sub-committees are available on the Trust's website (www.hdft.nhs.uk).

Balance, Completeness and Appropriateness of the Board of Directors

The balance, completeness and appropriateness of the Board of Directors are reviewed as required and the Trust is confident that it has a balanced and appropriately skilled Board of Directors to enable it to discharge its duties effectively. This applies to both Executive and Non-Executive Directors.

Decision making and operational management of the Trust is led by the Executive Directors, reporting to the Chief Executive as Accountable Officer. The Standing Orders of the Board detail the decisions reserved for the Board and are available on request.

All of the Non-Executive Directors of the Trust are deemed to be independent. The information below describes the skills, expertise and experience of each Board member and demonstrates the independence of the Non-Executive Directors.

Executive Directors

- ***Steve Russell, Chief Executive - Appointed 1 April 2019 (commenced secondment to NHS England 28 February 2022)***

Steve Russell joined the Trust with a decade's worth of board level experience with NHS organisations. His previous post as Executive Regional Managing Director for NHS Improvement in London required him to work across the provider and commissioner sectors. Steve established personal credibility and has a strong reputation throughout the National Health Service.

Prior to his time with NHS Improvement, Steve had spent two years as Chief Operating Officer at South London Healthcare NHS Trust, a year as London Programme Director (A&E) and Improvement Director at the NHS Trust Development Authority, and two years as Deputy Chief Executive at Barking, Havering & Redbridge University Hospitals NHS Trust.

Before this, he was Executive Director of Medicine & Emergency Care at Northumbria Healthcare NHS Foundation Trust for seven years.

As Chief Executive, Steve was responsible for ensuring that our services are safe, effective, responsive, well led and provided with care and compassion at all times as well as ensuring the highest standards of financial management. Working closely with the Board of Directors, Governors, staff and partner organisations, Steve shapes the Trust's strategy, contributes to whole systems transformation and ensures the long-term sustainability of the Trust.

Steve was Chief Executive of NHS Nightingale Hospital Yorkshire and Humber; a Member of NHS England and Improvement North East and Yorkshire Regional People Board; and Lead Chief Executive for Workforce in Humber Coast and Vale ICS.

- ***Jonathan Coulter, Deputy Chief Executive and Finance Director - Appointed 20 March 2006, (appointed as Acting Chief Executive 28 February 2022)***

Jonathan Coulter is a member of the Chartered Institute of Public Finance and Accountancy (CIPFA) having qualified as an accountant in 1993. After beginning his career in Local Government, he has taken on a number of roles in the NHS, working in various hospital Trusts, where his work included the merger of Pontefract and Pinderfields Hospitals. During this time, he has also obtained a post graduate qualification in Health and Social Care Management.

Jonathan became Finance Director for North Bradford Primary Care Trust (PCT) in 2000, gaining valuable experience of leadership and management of community-based services. Following a successful period in North Bradford, during which time he undertook additional responsibility in the role of Finance Director for Airedale PCT, Jonathan was appointed as Finance Director at the Trust in March 2006.

Since arriving at Harrogate, he has contributed significantly to the success of the organisation over the past sixteen years, both within his role as Finance Director, and, since 2010, as Deputy Chief Executive.

Jonathan was appointed Acting Chief Executive on 28th February 2022.

- ***Jackie Andrews, Medical Director - Appointed 15 June 2020***

Jackie Andrews is a Consultant Rheumatologist. Prior to joining the Trust, she was an Associate Medical Director and Director of Research and Innovation at Leeds Teaching Hospital from 2008 and prior to that she worked in London, Auckland and Edinburgh.

Jackie is passionate about local NHS services and the wider children's services across North Yorkshire and the North East.

In addition to the traditional aspects of the Medical Director portfolio such as professional standards, clinical risk management and research and development, Jackie has a focus on helping to improve the safety culture of the organisation and the culture of innovation, to ensure continuous improvement. She is passionate about speaking up to ensure learning can be achieved when things do not go as planned, in a blame free and transparent way.

The role of the Medical Director is many and varied but includes providing clinical advice to the Board of Directors, leading on clinical standards including the formation and implementation of policy, providing clinical leadership and acting as a bridge between the medical workforce and the Board, and dealing with disciplinary matters involving doctors.

- ***Angela Wilkinson, Director of Workforce and Organisational Development - Appointed 5 November 2018***

Angela Wilkinson became the Director of Workforce and Organisational Development following her previous appointment as Deputy Director of Workforce and Organisational Development at Mid-Yorkshire NHS Hospitals Trust, where she had latterly been the Interim Executive Director of Workforce and Organisational Development for a period of five months.

Prior to taking up that role in 2013, Angela had spent three years as Director of Organisational Development and Human Resources at Leeds City College, following almost two years as head of Human Resources and Organisational Development at City of York Council. She started her career as a graduate hotel manager in the hospitality industry before joining the NHS through her first role in the now defunct NHS Purchasing and Supplies Agency, based in Harrogate, and subsequently working in Bradford and Leeds.

Angela's role includes strategic and operational human resources leadership for the Trust and supporting the Board of Directors in decisions in respect of workforce policy, planning and organisational development.

Angela is also a Director of ILS and IPS Pathology Joint Venture.

- ***Russell Nightingale, Chief Operating Officer - Appointed 5 April 2021***

Russell enjoys working through operational challenges, and is passionate about enabling teams and supporting colleagues to excel while challenging the status quo and always seeking improvement.

Russell started his career in Taunton & Somerset undertaking service manager roles in Urgent Care, Acute Medicine and Theatres and Outpatients before joining Bart's Health NHS Trust as General Manager for Women & Children's services. After becoming Director of Operations for Children's services at Whittington Trust he was responsible for Acute Paediatrics at Whittington Hospital, community children's services across five London boroughs and community and inpatient Child and Adolescent Mental Health Services. Since 2017, Russell

has worked at North Middlesex Trust as both Director of Operations for Surgery and Medicine and has most recently been the Trust's Deputy Chief Operating Officer.

Russell enjoys working through operational challenges, and is passionate about enabling teams and supporting colleagues to excel while challenging the status quo and always seeking improvement. He is a graduate of the NHS' Aspirant Chief Operating Officer programme and is excited to move to Yorkshire with his family.

- ***Emma Nunez, Director of Nursing, Midwifery and AHPs - Appointed 1 November 2021***

Emma is passionate about nursing and midwifery and about promoting the profession through demonstration of professional standards, values and behaviours. Emma took on the role of Acting Deputy Chief Executive in March 2022.

Emma joined the Trust from NHS England and NHS Improvement where she was Clinical Quality Director and Director of Nursing in the North East and Yorkshire Region.

Emma is passionate about nursing and midwifery and about promoting the profession through demonstration of professional standards, values and behaviours. She focuses on improvements in patient safety and quality by aligning best practice with innovation and improving cultures through behaviours. She is a strong advocate for patients, carers and families and drives improved patient outcomes through compassionate leadership, staff wellbeing and professional standards. Emma took on the role of Acting Deputy Chief Executive in March 2022.

- ***Matthew Graham, Director of Strategy – Appointed 13 September 2021***

Matt joined the Trust in September 2021 after four years as Director of the West Yorkshire Association of Acute Trusts (WYAAT), nationally recognised as one of the leading provider collaboratives. During the Covid-19 pandemic, alongside his WYAAT role, Matt was Chief of Staff for the Nightingale Hospital in Harrogate and led the West Yorkshire vaccination programme. Prior to joining the NHS in 2010, Matt served as an army officer in the Royal Signals for 17 years, including on operations in Northern Ireland, Bosnia and Afghanistan.

Matt enjoys supporting teams to solve problems and to seek improvement and innovation. He is passionate about building a culture of continuous improvement throughout the organisation.

- ***Jordan McKie, Acting Director of Finance - Appointed 28 February 2022***

Jordan is a member of the Chartered Institute of Management Accountants, having qualified as an Accountant in 2009. He took on the role of Acting Director of Finance in February 2022, following years working at the Trust in both Finance and Operational Roles.

Jordan began his career in the NHS as a Graduate Management Trainee in 2006. Prior to joining the Trust, Jordan also worked in Financial and Operational Roles in York and Leeds.

Non-Executive Directors

Non-Executive Directors are appointed initially for a term of three years. Non-Executive Directors can be re-appointed for up to three terms of office (i.e. a maximum of nine years) with any final term of three years subject to annual reappointment in line with the requirements of the NHS Foundation Trust Code of Governance. The Council of Governors carries the responsibility of terminating the contract for a Non-Executive Director where this is believed to be appropriate, in accordance with the Trust Constitution and Foundation Trust Code of Governance.

The table below sets out the names, appointment dates and tenure of the Chairman, Vice Chairman, Senior Independent Director, and Non-Executive Directors of the Trust.

Name and Designation	Appointment	End of first Term	End of second Term	End of third Term
Mrs A Schofield	1 November 2017	31 October 2020	31 October 2023	N/A
Mrs S Armstrong	1 October 2018	30 September 2021	N/A	N/A
Ms L Robson	1 September 2017	31 August 2020	31 August 2023	N/A
Mr R Stiff	14 May 2018	13 May 2021	13 May 2024	N/A
Mrs M Taylor	1 November 2014	31 October 2017	31 October 2020	30 September 2022
Mr J Cross	1 January 2020	31 December 2022	N/A	N/A
Mr W Sampson OBE	1 March 2020	29 February 2023	N/A	N/A
Mr A Papworth	1 March 2020	29 February 2023	N/A	N/A

Angela Schofield (Concluded her Chairmanship on 31 March 2022)

Angela Schofield has worked in the NHS and with the NHS for over 40 years. Initially she was a health service administrator in her home town of Sheffield and became a general manager in the mid 1980's. After working in the NHS in Sheffield, North Derbyshire and Manchester, she went to work for the University of Manchester undertaking development work in quality of care and integrated care. Angela Schofield was then appointed Chief Executive of the NHS Trust in Calderdale. Following a move to Dorset she was appointed Head of the Institute for Health and Community Services at Bournemouth University.

Angela became Chairman of Bournemouth and Poole Primary Care Trust in 2006 and Chairman of Poole Hospital NHS Foundation Trust in 2011. She moved to Harrogate in 2017.

Angela is a Member of WYAAT Committee in Common, Vice-Chair, West Yorkshire and Harrogate ICS Partnership, Volunteer with Supporting Older People charity, Chair of NHS England Northern Region Talent Board and a Member of Humber Coast and Vale ICS Partnership.

Sarah Armstrong, Non-Executive Director - Appointed 1 October 2018 (appointed as Chair 1 April 2022)

Sarah Armstrong is an experienced leader in the charity sector, having also been a senior manager for a national charity leading in volunteering policy and practice and a regional lead for a charity raising aspirations for young people with a disability. In a previous role, she was Chief Executive of York CVS, an ambitious social action organisation. She is now the Chief Executive of a national charity concerned with children's health and is a Director of Harrogate Integrated Facilities, the Trust's wholly owned subsidiary company.

Sarah is passionate about the value of volunteering and the unique contribution volunteers can make, especially within a healthcare setting.

- ***Laura Robson, Non-Executive Director - Appointed 1 September 2017***

Laura Robson had lived in Sunderland all her life before moving to Ripon in 2016 to enjoy the Yorkshire life. She trained as a nurse and midwife in Sunderland before going on to work in clinical and managerial roles for various hospitals in the North East. She is a qualified midwifery teacher and has Master's Degree in Management and Communication Studies. From 1996 until retiring in 2012, she was Executive Nurse on the Board of County Durham and Darlington Foundation Trust. Laura has worked as a Clinical advisor to the CQC and the Health Service Ombudsman. With special interest in the care of people with dementia in acute hospitals she has a passion for patient safety, midwifery and maternity services.

Laura was a Non-executive Director of North Cumbria University Hospitals from 2014 until 2017, working with the Board to help them come out of special measures by improving the quality and efficiency of their services to the people of Cumbria.

Laura became the Senior Independent Director in January 2020. She is also Chairman of the Quality Committee.

- ***Richard Stiff, Non-Executive Director - Appointed 14 May 2018***

Richard Stiff joined the Trust following his retirement from the role of Chief Executive of Angus Council in Scotland in May 2017. Prior to Angus he enjoyed a long career in English local government, mainly in education and children's services departments, holding senior posts with North Lincolnshire, Leeds and Dudley Councils.

Born and raised near Bury St Edmunds in Suffolk, He is Chairman of NCER CIC; Director and Trustee of TCV (The Conservation Volunteers); Chairman of the Corporation of Selby College until February 2021; Member of the Association of Directors of Children's Services; Member of Society of Local Authority Chief Executives; Local Government Information Unit Associate; Local Government Information Unit (Scotland) Associate and is a Fellow of the Royal Society of Arts.

Richard is the Chair of the Audit committee.

- ***Maureen Taylor, Non-Executive Director - Appointed 1 November 2014***

Maureen Taylor is a chartered accountant and until 31 March 2015 was the Chief Officer for Financial Management at Leeds City Council. She has spent over 31 years in Financial Services at Leeds City Council, qualifying as an accountant in 1987. She has extensive experience, working in a wide range of financial disciplines more recently leading the Council's capital programme and treasury management functions and overseeing aspects of the revenue budget.

As part of her council role Maureen held three directorship positions being public sector Director of Community Ventures Leeds Limited, Director at Norfolk Property Services (Leeds) Limited, and Alternate Director for the Leeds Local Education Partnership.

Maureen is a Vice-Chairman of Governors, Chairman of the Resources Committee and is a member of the Audit Committee. She is also a Resources Committee member at a local Church of England Primary School.

- ***Jeremy Cross, Non-executive Director - Appointed 1 January 2020***

Jeremy Cross is a fellow of Institute of Chartered Accountants. He joined the Trust from Airedale NHS Foundation Trust where he had been a Non-Executive Director for five years, and during his time there has was Chairman of the Audit Committee, and a member of the Finance and Performance Committee, and the Charity Committee. Jeremy was also Chair of the 100% owned subsidiary company AGH Solutions Limited.

Prior to taking up Non-executive Director positions Jeremy held senior positions at Lloyds Banking Group, Asda and Boots the Chemist.

Outside of the NHS, Jeremy is Chairman of Tipton Building Society; Chairman of Forget Me Not Children's Hospice, Huddersfield; Governor of Grammar School at Leeds; Director of GSAL Transport Ltd; and a Member of Kirby Overblow Parish Council.

- ***Wallace Sampson OBE, Non-executive Director - Appointed 1 March 2020***

Wallace Sampson has been with Harrogate Borough Council since August 2008 and has worked in local government for over 35 years. He started at Doncaster Metropolitan Borough Council and has also worked at Chesterfield Borough Council, Kirklees MBC, and Bradford MDC where he was Strategic Director Customer Services and Assistant Chief Executive for Regeneration and the Environment.

Wallace is passionate about public service delivery and the need to work within partnerships to join up service delivery. He has devoted his career to public service and over the years he has worked extensively with partners to ensure a strong focus on customers, residents, businesses and visitors to the district. This is reflected in a number of external responsibilities to Harrogate Council. He chairs the Harrogate District Public Services Leadership Board and is a member of the North Yorkshire Children's Safeguarding Board.

Wallace is Chief Executive of Harrogate Borough Council; Director of Bracewell Homes, a wholly owned Harrogate Borough Council housing company; Chair of Harrogate Public Services Leadership Board; Member of North Yorkshire Safeguarding Children Partnership Executive; Member of Society of Local Authority Chief Executives; and a Director of Brimhams Active, a wholly owned Harrogate Borough Council leisure company.

- ***Andrew Papworth, Non-executive Director - Appointed 1 March 2020***

Andy Papworth is an accomplished leader with over 20 years' experience in financial services, including six years at executive level, working in regulated environments. He has a deep background in financial management, business leadership and transformation.

He is a member of the Chartered Management Institute, Global Chartered Management Accountants, and the Council of Strategic Workforce Planning and Human Capital Analytics.

He is Director of People Insight and Cost at Lloyds Banking Group and is known for being an innovative executive and brings thought-leadership on a range of subjects to the Trust.

Performance Evaluation of the Board of Directors

Evaluation of the Board of Directors is delivered formally via a number of channels, which can include:

- Appraisal of Executive Director performance by the Chief Executive and Chairman on an annual basis;
- Appraisal of Non-Executive Director performance by the Chairman and Vice Chairman/Lead Governor of the Council of Governors on an annual basis;
- Appraisal of the Chairman by the Council of Governors, led by the Senior Independent Director of the Board of Directors and the Vice Chair of the Council of Governors, after seeking views and comments of the full Council of Governors and Board colleagues;
- Appraisal of the Chief Executive by the Chairman;
- An annual Board development programme; and
- An annual review of the effectiveness of each Board Committee.

The Care Quality Commission, at its last inspection carried out in 2018, assessed the Trust as 'Good' against its Well-Led standard.

The information below provides details on the Executive and Non-Executive Director attendance at Board of Directors meetings in 2021/22. When the Board of Directors met in public there was also a private meeting.

Board of Directors Meeting Attendance (held in Public) 2021/22

Individual Attendance	26/05/2021	28/07/2021	29/09/2021	24/11/2021	26/01/2022	30/03/2022
A Schofield	✓	✓	✓	✓	✓	✓
S Armstrong	✓	✓	✓	✓	✓	✓
L Robson	✓	✓	✓	✓	✓	✓
R Stiff	✓	✓	✓	X	✓	✓
M Taylor	✓	✓	✓	✓	✓	✓
J Cross	✓	X	✓	✓	✓	✓
A Papworth	✓	✓	✓	✓	✓	✓
W Sampson	✓	✓	✓	X	✓	✓
S Russell *	✓	✓	✓	✓	✓	N/A
J Coulter	✓	✓	✓	✓	✓	✓
J Andrews	✓	✓	✓	✓	✓	✓
A Wilkinson	✓	✓	✓	✓	✓	✓
E Nunez **	✓	✓	✓	✓	✓	✓
R Nightingale ***	✓	✓	0	✓	✓	0
M Graham ****	N/A	N/A	✓	✓	✓	✓
J Mckie *****	N/A	N/A	N/A	N/A	N/A	✓

*Steve Russell was Chief Executive until 28th February 2022 before going on secondment with NHS England
Jonathan Coulter stepped into Chief Executive Role 28th February 2022.
**Emma Nunez commenced as Director of Nursing, Midwifery and AHP in April 21 & became Deputy Chief Executive on 28th February 2022.
***Russell Nightingale commenced as Chief Operating Officer in April 2021.
**** Matt Graham commenced as Director of Strategy in September 2021.
***** Jordan Mckie commenced as Acting Director of Finance in February 2022.

Council of Governor meetings 2021/2022					
Non - Executive Director individual attendance	Position	Jun-21	Sep-21	Dec-21	Mar-22
Angela Schofield	Chairman	✓	✓	✓	✓
Sarah Armstrong	Non-Executive Director	✓	✓	✓	✓
Laura Robinson	Non-Executive Director	✓	✓	✓	✓
Richard Stiff	Non-Executive Director	✓	✓	X	✓
Maureen Taylor	Non-Executive Director	✓	✓	✓	✓
Jeremy Cross	Non-Executive Director	✓	✓	✓	X
Andy Papworth	Non-Executive Director	✓	✓	✓	✓
Wallace Sampson	Non-Executive Director	X	✓	✓	X

Council of Governor meetings 2021/2022					
Executive Director individual attendance	Position	Jun-21	Sep-21	Dec-21	Mar-22
Steve Russell	Chief Executive	✓	✓	✓	
Jonathan Coulter	Deputy Director of Finance/Acting Chief Executive	✓	X	✓	✓
Angela Wilkinson	Director of Workforce & Organisational Development	✓	✓	✓	X
Jackie Andrews	Medical Director	✓	✓	✓	✓
Russell Nightingale	Chief Operating Officer	✓	✓	✓	✓
Emma Nunez	Director of Nursing, Midwifery & Allied Health Professionals/Acting Deputy Chief Executive	✓	✓	X	✓
Matt Graham	Director of Strategy			X	✓
Jordan Mckie	Acting Director of Finance				✓

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4.7.3 Statement of Compliance with the NHS Foundation Trust Code of Governance

Harrogate and District NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The Trust has applied the principles of the NHS Foundation Trust Code of Governance (2006) which was updated in July 2014.

Information relating to quality governance systems and process is detailed throughout the Annual Report, but in particular in the Annual Governance Statement and Quality Account.

NHS Foundation Trusts are required to provide a specific set of disclosures in relation to the provisions within schedule A of the NHS Code of Governance. The Trust has applied the principles of the NHS Foundation Trust Code of Governance on a '*comply and explain'* basis and has complied with the Code during 2021/22. Evidence to support compliance is included below:

Compliance with the NHS Foundation Trust Code of Governance

The Board of Directors and Council of Governors are committed to continuing to operate according to the highest corporate governance standards. Whilst doing this the Board:

- Meets formally at least bi-monthly in order to discharge its duties effectively. Systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy as well as the quality, of its healthcare delivery.

- Reviews the performance of the Trust against regulatory and contractual obligations and approved plans and objectives. Metrics, measures and accountabilities have been developed to assess progress and delivery of performance.

- All Directors are responsible to constructively challenge the decisions of the Board. Non-Executive Directors scrutinise the performance of the Executive Directors in meeting agreed goals and objectives and monitor the reporting of performance. If a Board member disagrees with a course of action it is minuted accordingly. The Chairman would then hold a meeting with the Non-Executive Directors. If the concerns cannot be resolved this should be noted in the Board minutes.

- Non-executive Directors are appointed for a term of three years by the Council of Governors. The Council of Governors has the authority to appoint or remove the Chairman or the Non-executive Directors at a general meeting. Removal of the Chairman or another Non-Executive Director requires the approval of three-quarters of the members of the Council of Governors.

- At least half of the Board, excluding the Chairman comprises Non-executive Directors determined by the Board to be independent.

- No individual on the Board of Directors or Council of Governors holds positions at the same time of Director and Governor of any NHS Foundation Trust.

- Operates a code of conduct that builds on the values of the Trust to reflect high standards of probity and responsibility.

- In discussion with the Council of Governors a Non-executive Director covers the role of Senior Independent Director.

- The Chairman ensures that the Board of Directors and the Council of Governors work together effectively and that Directors and Governors receive timely and clear information that is appropriate to carry out their duties.

- The Chairman holds regular meetings with Non-executive Directors without the Executive Directors present.

- No independent external adviser has been a member of or had a vote on the Remuneration Committee or the Nomination Committee.

- Independent professional advice is accessible to the Non-executive Directors and the Company Secretary via the appointed independent External Auditors.

- There is no full-time Executive Director that takes on more than one Non-executive Director role of another NHS Foundation Trust or another organisation of comparable size and complexity.

- All Board meetings and Board Committee meetings receive sufficient resources and support to undertake their duties.

The Council of Governors:

- Represents the interests of the Trust's members and partner organisations in the local health economy.

- Has a code of conduct in place to ensure Governors adhere to the best interests and values of the Trust.

- Holds the Board of Directors to account for the performance of the Trust and receives appropriate assurance and risk reports on a regular basis.

- Governors are consulted on the development of forward plans for the Trust and arrangements are in place for them to be consulted on any significant changes to the delivery of the Trust's business plan if so required.

- The Council of Governors meet on a regular basis in order for them to discharge their duties.

- The Governors elected a Lead Governor, Clare Illingworth. As a Lead Governor the main function is to act as a point of contact with NHSI the Trust's independent regulator.

- The Directors and Governors continually update their skills, knowledge and familiarity with the Trust and its obligations, to fulfil their role on various Boards and Committees.

- The Trust's Constitution is available at https://www.hdft.nhs.uk which outlines the clear policy and fair process for the removal from the Council of Governors of any Governor who consistently and unjustifiably fails to attend the meetings of the Council of Governors or has an actual or potential conflict of interest which prevents the proper exercise of their duties.

- The performance review process of the Chairman and Non-executive Directors involves the Governors. The Senior Independent Director and Lead Governor supports the Governors through the evaluation of the Chairman. Each Executive Director's performance is reviewed by the Chief Executive. The Chairman reviews the performance of the Chief Executive.

- The Chief Executive ensures that the Board of Directors and the Council of Governors act in accordance with the requirements of propriety or regularity. If the Board of Directors, Council of Governors or the Chairman contemplates a course of action involving a transaction which the Chief Executive considers infringes these requirements, he will follow the procedures set by NHSI for advising the Board and Council for recording and submitting objections to decisions. During 2021/22 there have been no occasions on which it has been necessary to apply the NHSI procedure.

- Trust staff are required to act in accordance with NHS standards and accepted standards of behaviour in public life. The Trust ensures compliance with the Fit and Proper Person (FPP) requirement for the Board of Directors. All existing Directors completed a self-declaration. All new appointments are also required to complete the self-declaration and the full requirements of the FPP test have been integrated into the pre-employment checking process.

- The Trust holds appropriate litigation insurance to cover the risk of legal action against its Directors in their roles as directors and as trustees of the Trust's Charity.

- Going Concern assessment is undertaken annually.

In summary, the Trust has applied the principles of the NHS Foundation Trust Code of Governance and departed from this on one occasion due to it having alternative arrangements in place for: *A.5.6: 'The Council should establish a policy for engagement with the Board of Directors for those circumstances when they have concerns'*. The alternative arrangement provides the Council of Governors to liaise with the Lead Governor, Senior Independent Director or Company Secretary to raise any concerns they may have in relation to the Board of Directors. The Council of Governors has worked very closely with the Lead Governor over the reporting period. The Lead Governor has regular one to one meetings with the Chairman and relays any areas of concerns with any meetings arranged with Non-executive and Executive Directors as necessary.

4.8 NHS Single Oversight Framework

NHS's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care, access and outcomes
- Preventing ill health and reducing inequalities
- Finance and use of resources
- People
- Leadership and improvement capability (well led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Trust is recognised as being in segment two as at 31 March 2022. This equates to a Targeted Support Offer. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

4.9 Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's Responsibilities as the Accounting Officer of Harrogate and District NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Harrogate and District NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Harrogate and District NHS Foundation Trust and of its income and expenditure, items of other comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS*

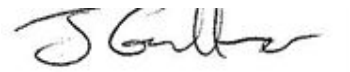
Foundation Trust Annual Reporting Manual (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements;

- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy;
- assess the Group and parent Trust's ability to continue as a going concern, disclosing, as applicable, matters relating to going concern: and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of Harrogate and District NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the Harrogate and District NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.



Jonathan Coulter
Acting Chief Executive Officer
Harrogate and District NHS Foundation Trust
5th October 2022

4.10 Annual Governance Statement

4.10.1 Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of Harrogate and District NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that Harrogate and District NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

4.10.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Harrogate and District NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Harrogate and District NHS Foundation Trust for the year ended 31 March 2022 and up to the date of approval of the Annual Report and Accounts.

4.10.3 Capacity to handle risk

As Accounting Officer, and supported by fellow members of the Board of Directors, I have responsibility for the integration of governance systems. I delegate executive lead to the Director of Nursing, Midwifery and AHPs for the implementation of quality governance and risk management.

The Board of Directors recognises that risk management is an integral part of good management practice and to be most effective should be part of the Trust's culture. The Board is, therefore, committed to ensuring that risk management forms a central part of its philosophy, practices and business plans rather than being viewed or practised as a separate programme; responsibility for its implementation is accepted at all levels of the organisation. The provision of appropriate training is central to the achievement of this aim. Our policy requires staff required to be trained and supported in incident reporting, carrying out risk assessments, mitigating risk and maintaining risk registers.

The Board Directors, Directorate and departmental managers oversee staff (including those promoted or acting up, contractors, locum, agency and bank staff) corporate, and specific local, induction training appropriate to their area of work; this includes but is not limited to risk management, incident reporting and hazard recognition training. An ongoing training programme has been developed based on a training needs analysis of staff. The programme includes formal training for:

- Staff dealing with specific everyday risks, e.g. basic risk management information including an overview of patient safety, incident reporting and investigation, complaints investigation and development of measures to improve patient experience, fire safety, information governance, health and safety, moving and handling, infection control, and security; and
- Specific staff involved in the maintenance of risk registers at Directorate and department level, investigation and root cause analysis, the investigation of serious incidents (SIs) and risk assessment for health and safety.

The Trust's Workforce and Organisational Development department monitors all mandatory and essential training and reports to the Board of Directors. Completion of training is included in staff performance monitoring, appraisals and revalidation. This process was strengthened

by linking pay progression to the completion of essential and mandatory training, and completion of staff appraisals for managers, however, this was paused during the Covid-19 pandemic

Employees, contractors and agency staff are required to report all incidents and concerns and this is closely monitored. The Trust supports an "open" culture; we are transparent with service users, carers and staff when things go wrong. A significant emphasis is placed upon ensuring that we comply with the requirements of the statutory Duty of Candour that came into force on 27 November 2014. This follows the introduction of a number of new standards with which NHS Boards need to comply; this includes the Duty of Candour, and the Fit and Proper Person's test. Assurance on these areas is through the Trust's governance framework.

The Datix system supports our incident reporting process. Guidance on reporting incidents on Datix, grading of incidents, risk assessment, risk registers, undertaking root cause analysis and statement writing, is available for staff on the Trust intranet.

The Trust's *Freedom to Speak Up* Guardian meet with the Chairman and Chief Executive on a regular basis. They report to the People and Culture Committee and to the Board on a quarterly basis. This provides the Board with an opportunity to reflect on themes and learning identified by the Guardian. The Guardian has developed a role for Fairness Champions to support and listen to colleagues, promote fairness, and signpost to resources and options for speaking up.

Quality impact assessments assist the Trust in meeting obligations under the public sector equality duty introduced in April 2011 and in accordance with the National Quality Board guidance produced in 2012 on assessing cost improvement plans.

4.10.4 The risk and control framework

The key objectives regarding risk and control are to achieve:

- Compliance with external regulatory and other standards for quality, governance and risk including Care Quality Commission fundamental standards and regulations;
- A culture of effective risk management at all levels of the organisation;
- Delivery of the Trust's strategic aims and objectives; and A robust framework to ensure all controls and mitigation of risks are in place and operating, and can provide assurance to the Board of Directors on all areas of governance, including:

    - Corporate governance
    - Quality governance
    - Clinical governance
    - Financial governance
    - Risk management
    - Information governance including data security
    - Research governance
    - Clinical effectiveness and audit
    - Performance governance

The Trust has a system of integrated governance described in the Risk Management Policy.

Risk identification and assessment is the process that enables the Trust to understand the range of existing risks, their likelihood of occurrence and their potential impact(s) and the ability of the Trust to mitigate those risks,. Risk assessment is a continuous process with the Trust's policy requiring risks to be assessed at ward, team and departmental level in line with risk assessment guidance and carried out proactively as part of health and safety processes, as well as reactively when risks are identified from, for example, incidents, complaints, local reviews and patient feedback.

Risks are scored based on the likelihood of the risk materialising (score 1-5) multiplied by the impact or consequence of that risk (score 1-5). The risk scoring matrix evaluates the level of risk as low (1-5), medium (6-10) or high (12-25), and therefore the priority for action, and must be used for all risk scoring within the Trust in order to ensure a consistent and standardised approach. This allows the organisation to gain an appreciation of the magnitude of each risk, set targets for improvement based on its risk appetite, and track progress against an agreed, timed action plan. The Board of Directors decides what level of risk is reported to them. The threshold for 2021-22 was a risk score of 12.

A risk register is a specific tool for recording and managing risk in a standard format to allow comparison and aggregation. Taking each risk in turn, the risk register records the controls (the things we do to mitigate that risk) already in place, the original risk score and the current risk score based on those controls. Gaps in controls can then be identified and actions agreed to close these gaps. Targets based on an acceptable level of risk can be agreed, and progress towards achieving the target risk score can be tracked. Assurances (the evidence that controls are effective) are also recorded.

The identification and management of risk documented in risk registers aids decision-making and resource prioritisation. It produces information by which the Trust can reassure the public, patients and stakeholders that it is effective and efficient to deliver the objectives of the organisation.

Risk assessment and management is addressed using risk registers at four levels across the Trust:

a) **Departmental**

Risk assessments are carried out routinely as part of the health and safety process as well as from incidents, complaints, local reviews, patient feedback and information contained in relevant quality, safety, workforce and financial dashboards. The departmental risk registers will reflect these risk assessments, including all residual medium and high risks from the health and safety control books.

It is the responsibility of Directorate leads for governance to review and where appropriate, challenge scores applied to risks on departmental registers at least quarterly. All risks that are scored 9 or above on departmental risk registers are escalated to Directorate risk registers.

b) **Directorate**

The Directorate risk registers and corporate functions risk registers are key management tools which are scrutinised monthly within management meetings to ensure effective oversight of risk management. Clinical Directors, Operational Directors, Corporate Directors and Deputy Directors are responsible for the risk registers.

The Directorate risk register will reflect departmental risk registers where relevant by including risks that are scored 9 or above or form a trend across more than one departmental register. At this level risk assessment is performed alongside objective setting and business planning.

All risks that are scored 12 or more are discussed at the Executive Risk Management Group, together with any other risks that the risk register owner is concerned about.

c) **Corporate**

The Corporate Risk Register is a live document, reviewed and updated as circumstances change, new risks arise and established risks are mitigated or removed. Risks are escalated up to the Corporate Risk Register, or back down to clinical directorate or corporate functions

risk registers, based on the agreed threshold of 12 for designating corporate risk.

The Corporate Risk Register therefore identifies key organisational risks and is reviewed at the monthly Executive Risk Management Group meeting, with a focus on progress of actions to achieve the target risk score for existing risks. Risks from clinical Directorates and corporate functions risk registers are discussed and are included on the Corporate Risk Register if the agreed risk score is 12 or above.

The Senior Management Team, chaired by the Chief Executive Officer, reviews the updated Corporate Risk Register every month following scrutiny at the Executive Risk Review Group. The Audit Committee receives a detailed report on the Corporate Risk Register Group at its meetings and the Board of Directors receives an update at every meeting.

d) **Board Assurance Framework**

The Board Assurance Framework (BAF) is an essential tool which brings together the key strategic objectives, the requirements of licensing and regulatory bodies and provides detail and assurance on the systems of control which underpin delivery of the strategic objectives. It offers visible assurance on the Board's overall governance responsibilities.

The BAF aims to bring together all of the essential elements for achieving the Trust's goals and ambitions, to maintain regulatory compliance and compliance with the Foundation Trust Licence. It systematically evaluates the risks to achieving these. It asks:

- What are the things we have agreed as strategic priorities?
- What are the essential prerequisites to confidently maintaining regulatory compliance?
- What are the essential prerequisites for compliance with the terms of our Foundation Trust Licence?
- What are the risks to these prerequisites?

Taking each risk in turn, the BAF records the controls and the assurances already in place. Gaps in controls and assurances can then be identified and actions agreed to close the gaps. By focusing on gaps in controls and assurances, the Board can be confident that all necessary steps are being taken to assure delivery of the Trust's overall objectives and obligations as above, and that resources can be allocated in the right place. The BAF is a live document which is reviewed by Executive Directors. The Audit Committee receives regular updates on the BAF and the Board of Directors receives a detailed reports. As a Foundation Trust, we also inform our Council of Governors of proposed changes including how any potential risks to patients will be minimised. The Chief Executive regularly reports to the Governors on the position against Trust risks scored at 12 and above.

An audit of the Governance Framework, operation of the assurance Framework and associated Risk Management processes was undertaken in 2021/22. The audit confirmed that the Trust has a clearly defined approach to the management of risk and well established risk reporting and monitoring procedures.

Details of BAF and Corporate Risk are included at section 3.1.4

Risks and challenges

The Trust's control environment quickly adapted to respond to the significant change in circumstances that Covid-19 created. The Trust focused its response by providing safe care for its patients, redeploying and re-training our colleagues to support patients that required respiratory support and maximising the availability of colleagues. Operational command structure was introduced, the operational risk register system was used to identify and report

on Covid-19 risks and their management and business continuity arrangements were enacted upon. Urgent decision-making arrangements required revising our governance arrangements and the use of schemes of reservation and delegation were revised in response.

Despite the Covid-19 pandemic, and the necessary changes made to the control environment, the Trust maintained an internal audit programme, a process of risk management, and strong governance processes internally.

Staff also continued to focus on the Trust's long term strategy to address the clinical, operational and financial challenges.

In 2021-22 the Board of Directors ensured that detailed controls were in place to mitigate risks and support assurance and will ensure that detailed controls will continue to be in place to support assurance and mitigate risks going forward into 2022-23. All risks, mitigation and progress against actions are monitored formally at Directorate, Corporate and Board level.

The quality of performance information is the responsibility of the Senior Information Risk Owner (SIRO) who chairs the Data and Information Governance Steering Group and advises the Board of Directors on the effectiveness of information risk management across the organisation. The SIRO is the Chief Operating Officer.

The Trust has put in place due processes to ensure information governance and data security in accordance with national recommendations led by the Senior Information Risk Owner at Board level.

The Trust has an Integrated Board Report (IBR) which triangulates key information metrics covering quality, workforce, finance and efficiency and operational performance, presenting trends over time to enable identification of improvements and deteriorations. During 2020/21 the IBR and the quality dashboard has been reviewed and further developed to ensure the Board can receive the information required to function effectively. This work will continue into 2022/23.

The IBR is presented to each Board and Council of Governors meetings, and this is reviewed together with the quality dashboard at each Quality Committee; it is also available to each of the groups responsible for leading work to ensure compliance with CQC standards. The Audit Committee reviews the evidence for compliance with CQC registration requirements annually.

There are no significant risks that have been identified to compliance with the NHS Foundation Trust Licence Condition 4 (FT governance). The Trust ensures compliance with the requirements of the Provider Licence in its entirety via annual and in-year submission as required by NHS Improvement's Single Oversight Framework. These submissions include detailed information on financial performance, plans and forecasts, and third party information, in order to assess the risk to continuity of services and governance.

This Annual Governance Statement also provides an outline of the structures and mechanisms that the Trust has in place to maintain a sound system of governance and internal control to meet the requirement of the Licence Condition 4, Section 6. It takes assurance from these structures as well as feedback from Internal and External Audit and other internal and external stakeholders regarding the robustness of these governance structures. These same mechanisms are used by the Board to ensure the validity of the annual Corporate Governance Statement.

In order to mitigate any risks to compliance with Monitor's Licence Condition 4, the Trust has in place a governance framework with clear accountability and reporting to ensure integrated governance, to deliver the Trust's objectives and to provide assurance to the Board of Directors. The framework was revised during 2020/21 specifically against the

clinical/quality governance framework. The review of the clinical/quality governance framework included colleague's participation to ensure integrated governance, to deliver the Trust's objectives and to provide assurance to the Board of Directors. Quality of patient care is at the heart of this framework.

Executive Directors, Non-Executive Directors, Governors and other stakeholders are key participators in many of the Trust's Committees.

The Trust was inspected by the Care Quality Commission (CQC), as part of its routine programme of inspections, in November 2018. The rating of the Trust remained as 'Good'. It was rated as good because:

- Effective, Responsive and Well-Led were rated as 'Good', Safe as 'Requires Improvement' and Caring as 'Outstanding';
- The current ratings of the six core services across one acute location and three community services not inspected at this time remained unchanged. Hence, five acute services across the Trust are rated overall as 'Good' and three are rated as 'Outstanding; three community services are rated as 'Good' and two are rated as 'Outstanding';
- The overall rating for the Trust's acute location remained the same Harrogate District Hospital was rated as 'Good';
- Community services improved and were rated as 'Outstanding';
- The Use of Resources was rated as 'Good'.

The CQC undertook a Well-Led assessment of the Trust during its inspection in late 2018.

The CQC review did not highlight any material areas of concern in relation to the Board and the governance arrangements in place at the Trust. The areas identified for further progress and improvement were:

- There was a lack of diversity at senior level, specifically BME. The Executive and Non-Executive Board members acknowledged this and had strategies in place to help address it;
- Senior leaders were aware that they needed to undertake more work in relation to the Workforce Race Equality Standard and an action plan, with appropriate monitoring at Board level, was in place; and
- Although there was a comprehensive complaints policy, the average time taken to close complaints was not in line with this policy.

Significant work has taken place during 2021/22 on the Trust's journey to address these recommendations. The CQC Action Plan was closed down by the Senior Management Team in August 2021 and the Trust had in place a number of Staff Networks: BAME, Disability and Long-term illness and LGBT+.

In addition to this, the Board continues to work towards the CQC and NHS Improvement well-led framework. During the year the Trust introduced a peer review processes and ward based reviews on fundamental standards.

The Board of Directors is responsible for exercising all of the powers of the Trust; however, it has the option to delegate these powers to senior management and other Committees. The Board:

- sets the strategic direction for the Trust;
- allocates resources;
- monitors performance against organisational objectives;

- ensures that clinical services are safe, of a high quality, patient-focused and effective;
- ensures high standards of clinical and corporate governance; and
- in conjunction with the Council of Governors, engages members and stakeholders to ensure effective dialogue with the communities it serves.

The Board is also responsible for ensuring that the Trust exercises its functions effectively, efficiently and economically and that compliance with the Trust's Licence; and Constitution are maintained.

During 2021-22 there have been six formally constituted assurance Committees of the Board; the Audit Committee, the Quality Committee, the Resource Committee, the Remuneration Committee; and the People and Culture Committee.

The Audit Committee

Non-Executive Directors comprise membership of the Audit Committee. The Deputy Chief Executive/Finance Director and the Associate Director of Quality and Corporate Affairs had a standing invitation to meetings during 2021-22 and the Chief Executive attends one meeting per year, when considering the Annual Report and Accounts and Annual Governance Statement. Other Executive Directors attend meetings when the Committee discusses areas of risk or operations that are the responsibility of those individual Directors.

The key responsibilities of the Audit Committee is to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

The Committee ensures that there is an effective Internal Audit function that meets mandatory NHS Internal Audit Standards. Internal Audit's primary role is to provide an opinion and assurances on the adequacy and effectiveness of the systems of internal control and provide appropriate independent assurance to the Audit Committee, Chief Executive and Board.

The Committee also reviews the work and findings of the External Auditors appointed by the Council of Governors and considers the implications and management's responses to their work. The Audit Committee reviews the work of the Quality Committee, which provides assurance on clinical practice and processes and also receives reports from Internal and External Audit and the Executive Risk Review Group which enable it to provide independent assurance on governance and controls to the Board. The Committee also responsible for overseeing the Internal Audit programme of the HIF, a subsidiary of the HDFT. This also enables triangulation of key issues to enhance the Board and Committee's oversight and assurance role.

The annual audit plans for Internal Audit are approved by the Audit Committee and are prioritised to focus on areas of risk and concern. Governor representatives attend the Audit Committee as observers.

The Quality Committee

The Quality Committee is the principal mechanism to provide assurance to the Board regarding safety and quality of services. It is chaired by a Non-Executive Director, and has Non-executive Director membership from other Board Committees, including the Audit Committee. During 2021-22 there was senior representation from the clinical Directorates and corporate functions including the Director of Nursing, Midwifery and AHPs, Executive Medical Director and the Associate Director of Quality and Corporate Affairs. On behalf of

the Board, it seeks assurance on the systems and processes in place to deliver high quality care and provides scrutiny of the outcomes of these systems and processes in relation to quality. It also provides direction regarding the delivery of the Trust's quality improvement priorities and strategic objectives in respect of quality, and provides oversight and seeks assurance on regulatory compliance. The annual clinical audit plans are approved and monitored by the Quality Committee. Governor representatives attend the Quality Committee as observers.

The Resources Committee

During 2021-22 the key responsibilities of the Resources Committee were to ensure appropriate oversight of resource planning and utilisation The Committee assessed the finance, workforce, and activity plan for the Trust and recommended such plan to the Board of Directors. The Committee reviewed significant projects ensuring appropriate due diligence is undertaken. The Committee also provides assurance to the Board on in-year financial performance, including budget-setting and progress against cost improvement plans, where applicable, as well as oversight of workforce plans and activity and performance delivery. Governor representatives attend the Resource Committee as observers.

The Remuneration Committee

The key responsibilities of the Remuneration Committee is to make recommendations to the Board of Directors on the remuneration, allowances and terms of service for the Executive Directors and to ensure that they are fairly rewarded for their individual contribution to the organisation, having proper regard to the organisation's circumstances and performance, as well as the national position of the NHS as a whole. The Committee is comprised of the Trust's Chairman and all Non-Executive Directors. The Chief Executive, Director of Workforce and Organisational Development and Associate Director of Quality and Corporate Affairs support the workings of this Committee and attend by invitation and in an advisory capacity only.

Remuneration, Nominations and Conduct Committee

The Remuneration, Nominations and Conduct Committee (the Committee) was formed following a review, and approval, of the Trust's Constitution on 1 August 2018. The Lead Governor supports this Committee by meeting with the Governors separately to gain their views and consults and engages with them on such things as annual appraisals before meeting with the Senior Independent Director and Chairman. The Senior Independent Director in association with the Lead Governor makes recommendations to the Council of Governors on the remuneration and terms of service for the Non-executive Directors. The Lead Governor carries out this role on behalf of the Council of Governors.

The People and Culture Committee

The People and Culture Committee was formed in June 2020 to oversee the development and ongoing implementation of the Trust's Fair, Safe and Just Culture in order that all staff can enjoy a positive working experience and improved health and wellbeing. The Committee monitors, reviews and provides assurance to the Board on the culture and organisational development of the Trust. Its main areas of work include driving performance improvement against key elements of the People Plan including: Equality, Diversity and Inclusion Plans, NHS Staff Survey Results and Action Plans; Freedom to Speak Up Reports; Guardian of Safe Working and GMC/HEE Surveys; Recruitment and Retention practices and processes; and oversight on the Trust's values and appropriate standards of behaviour.

The Senior Management Team

The Senior Management Team meeting is the principal forum for ensuring and assuring the

delivery of the Trust's business, including annual operating and financial plans. It exists to ensure that the Trust's strategic and operational objectives are met. The group maintains oversight of operational performance and management of risk in a systematic and planned way. The group is the most senior executive decision making forum and receives reports and recommendations from sub-groups and via the Chief Executive, reports to the Board of Directors.

The Senior Management Team is supported by the Clinical Directorates and a number of subgroups, with a collective responsibility to drive and co-ordinate the Trust's objectives.

Each Directorate Board oversees quality and governance within the Directorate to ensure appropriate representation on groups within the governance framework and reports to the Senior Management Team. The Executive Director Team regularly review the work of the Directorates at monthly resource meetings.

There is a weekly meeting of the Executive Directors where operational matters are discussed in detail and actions agreed.

Quality of Care Teams exist at ward, team and department level to champion, monitor and promote quality care and report to the Directorate quality and governance groups.

There are regular meetings with Commissioners and with NHS England/Improvement and Public Health Commissioners to review performance and quality.

The Trust conducted a self-assessment against the conditions set out in the NHS Provider Licence which was deemed to be fully compliant. In addition it has also carried out self-assessments against the updated NHS Foundation Trust Code of Governance, as part of the Annual Reporting Framework. This process has ensured that there is clarity relating to robust governance structures, responsibilities, reporting lines and accountabilities and the provision of timely and accurate performance information to the Board.

The Trust engages with patients, service users and stakeholders and has an effective structure for public stakeholder involvement, predominantly through the Council of Governors and its sub-committees. Consultations with commissioners on the wider aspects of risk are undertaken through the monthly contract management meetings.

The Trust has well-developed People Plan, which is reviewed by the People and Culture Committee and the Board of Directors.

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust publishes an up to date register of interest for Board, Clinical Directors and deputies who regularly attend the Board to provide advice at its of its Board meetings. A new system was developed in 2020/21 to capture all interests for decision making and non-decision making staff with the aim of registers of decision making staff made available for public review on the Trust's website. This system continued in its development during 2021-22. This system will enable the Trust to ensure new starters and colleagues changing roles are also included.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure compliance with all the Trust's obligations under

equality, diversity and human rights legislation are complied with.

The Trust has in place plans to undertake risk assessments and for a sustainable development management plan to be undertaken by an external specialist to take account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

4.10.5 Review of economy, efficiency and effectiveness of the use of resources

The capital programme and the prioritisation of revenue resources to form the annual Operating Plan are informed by the Trust Objectives, Quality Improvement priorities and identified risks.

The plans that developed were produced in consultation with the Council of Governors and approved by the Board of Directors.

Directorates meet regularly with Executive Directors to ensure delivery of objectives. There is a monthly report to the Board relating to performance and finance against plans and targets. The BAF serves as a monitoring document to ensure that appropriate action is being taken against the principal risks of failing to deliver the business plan.

There is monthly reporting to NHS Improvement relating to performance and finance against plans and targets, and reference costs are submitted annually. The Trust reviews information and feedback from regulators and external agencies e.g. Care Quality Commission, National Staff Survey, National Patient Surveys, to benchmark performance against other organisations and to improve economy, efficiency and effectiveness.

The Trust is a member of the West Yorkshire Associate of Acute Trusts (WYAAT), which in the year has continued to make good progress. The Committee in Common meeting is held four times per year with the governance and accountability of workstreams in place to support transformation across West Yorkshire and Harrogate, reporting and accountability to each sovereign Board. The Committee in Common's membership from each provider organisation includes Executive and Non-executive Directors, this is usually with attendance by the Chairman and Chief Executive.

4.10.6 Information governance

Information Governance breaches, which include breaches under Data Protection Act 2018/GDPR and Security of Network Information System Regulations 2018 (NIS) are managed in line with the Trust's incident management policy. Serious information governance breaches are also managed in line with the NHS Guide to the Notification of Data Security and Protection Incidents.

There have been no incidents at a level which required reporting to the Information Commissioner's Office (ICO) during 2021/22.

The Trust takes the threat of cyber-attacks very seriously and has robust measures and controls in place to improve cyber awareness and resilience of its IT infrastructure and manage the threat of Cyber-attack and other IT vulnerabilities and security threats.

4.10.7 Data Quality and governance

The Board is satisfied that steps are in place to assure that data quality and governance processes are in place with appropriate controls to ensure the accuracy of data. The Quality Committee has continued its work to gain assurance in relation to the CQC quality domains ensuring compliance with fundamental standards of care in acute and community services. During 2021/221 the Quality Committee received assurance to:

- **Identify Current Concerns**

1. Deep Dives- The Quality Committee hear from teams about current issues that are impacting upon the ability of the Trust to deliver quality care and to gain assurances that suitable actions / activity is underway to address these. Examples of this are:

a) Developments with the Emergency Department including discussions on clinical pathways and modelling and security;

b) Impact of the recruitment situation on quality of care;

c) Impact of cultural developments with Theatres.

This section also includes items that the Board of Directors require the Quality Committee to scrutinise on its behalf.

2. The Quality Committee reviews the Quality Report and Integrated Board Reports (quality section) in depth at each meeting and takes forward areas of concern, seeking further assurance where necessary by initiating deep dives. The Quality Report provides a good insight into quality issues. Where there are concerns individuals are requested to attend the committee to provide valuable insight and explanation.

Quality Accounts– In compliance with the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended), the Directors are required to prepare Quality Reports for each financial year. NHS Improvement (exercising powers conferred on Monitor) issues guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual. The Trust will publish the Quality Accounts in accordance with this.

Trust level Quality Report – are prepared and presented to all Quality Committee meetings where discussions are held on a range of topics such as Serious Incidents, Complaints, Claims, Infection Control.

Directorate Quality Governance Reports - are presented on a monthly basis to provide assurance that the quality priorities are embedded from the Board to the front line across the Trust.

External Reports – the system for recording receipt of external reports and a log for the lead individual responsible to action these remains robust. Where we consider that a plan requires support or focus specific leads are invited to provide an update on progress on action plans to provide assurance required.

4.10.8 Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the Executive Directors, Clinical Directors and Clinical Leads within Harrogate and District NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework.

The Covid-19 pandemic continued to impact the country during 2021-22 and HDFT was no exception. HDFT continued to ensure that a strong framework for governance arrangements was in place with the Board, Sub-Committees and Operational meetings continuing both face to face and virtually during the year as detailed in the report. I have drawn on performance information available to me. My review is also informed by the Head of Internal Audit Opinion and comments made by the external auditors in their reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Resource Committee, the Quality Committee and the People and Culture Committee and a plan to address shortcomings and ensure continuous improvement of the system is in place.

My review is also informed by other major sources of assurance such as:

- Internal Audit Reports
- External Audit Reports
- Clinical Audit Reports
- Patient Surveys
- Staff Survey
- Royal College accreditation(s)
- Health and Safety Executive Inspection Reports
- Care Quality Commission Intelligent Monitoring Standards
- Care Quality Commission – registration without conditions
- Equality and Diversity Reports
- General Medical Council Reports.

The Trust applies a robust process for maintaining and reviewing the effectiveness of the system of internal control. A number of key groups, Committees and groups make a significant contribution to this process, including:

Board of Directors – the statutory body of the Trust is responsible for strategic and operational management of the organisation and has overall accountability for the risk management frameworks, systems and activities, including the effectiveness of internal controls.

The Terms of Reference of all Board Committees and Groups are reviewed regularly to strengthen their roles in governance to the Board on risks and mitigations in place to the organisation's ability to achieve its key objectives.

Audit Committee – is a statutory Committee that provides an independent contribution to the Board's overall process for ensuring that an effective internal control system is maintained and provides a cornerstone of good governance.

Internal Audit – provides an independent and objective opinion to the Accounting Officer, the Board and the Audit Committee on the organisation's systems for risk management, control and governance support the achievement of the Trust's agreed priorities.

The Internal Audit team work to a risk based audit plan, which is agreed by the Audit Committee, and covering risk management, governance and internal control processes, both financial and non-financial across the Trust. The work includes identifying and evaluating controls and testing their effectiveness, in accordance with Public Sector Internal Audit Standards.

Following each audit a report is produced providing a conclusion and where a scope for improvement is found, recommendations are made and appropriate action plans are agreed with management. Reports are issued and followed up with responsible Executive Directors. The results of audits are reported to Audit Committee which has a key role to performance manage the action plans to address recommendations from all audits. Internal audits are also made available to the external auditors who may use them as part of their planning. In addition Internal Audit provides advice and assistance to senior management on control issues and other matters of concern. Internal Audit work also covers service delivery and performance, financial management and control, human resources, operational and other reviews.

Internal audit found a number of audit reports received Limited assurance in 2021/22 and

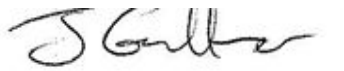
some included follow-up Limited assurance reports from 2020/21. Internal audit found that responses to these reports had been impacted by the pandemic and the Trust like other organisations across the NHS continues to face a number of challenging issues and wider organisational factors particularly with regards to the ongoing pandemic response and Covid-19 recovery. The Covid-19 pandemic led to changes to the NHS financial framework, the establishment of the control and command structures both regionally and within individual organisations and an ongoing focus on the emergency response. This has required NHS organisations to operate in a different way to previous 'business as usual' practice. Guidance was clear that financial constraints must not stand in the way of taking immediate and necessary action but that there was no relaxation in fiduciary duties.

Based on the work undertaken, including a review of the Board's risk and assurance arrangements, the Head of Internal Audit Opinion concluded in June 2022 that '*Significant assurance*' can be given and there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently.

Conclusion

The Annual Governance Statement requires me to consider whether there are any significant internal control issues facing the Trust. Risks and challenges regarding the Covid-19 pandemic are identified above and the Trust has an internal control environment in place to manage the Covid-19 pandemic in line with national guidance.

In summary, I am assured that Harrogate and District NHS Foundation Trust has an overall sound system of internal controls in place, which is designed to manage the key organisational objectives and minimise exposure to risk and that no significant internal control issues have been identified.



Jonathan Coulter
Acting Chief Executive Officer
Harrogate and District NHS Foundation Trust
5th October 2022

5. INDEPENDENT AUDITOR'S REPORT

Independent Auditor's Report to the Council of Governors of Harrogate and District NHS Foundation Trust

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of Harrogate and District NHS Foundation Trust (the 'Trust') and its subsidiary (the 'Group') for the year ended 31 March 2022, which comprise the Consolidated Statement of Comprehensive Income, the Statements of Financial Position, the Consolidated Statement of Changes in Equity, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted in the United Kingdom, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2021 to 2022.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Group and of the Trust as at 31 March 2022 and of the Group's and Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted in the United Kingdom, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), applicable law and Practice Note 10 'Audit of Financial Statements and Regularity of Public Sector Bodies in the United Kingdom'. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- The parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and
- The other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Annual Governance Statement

- Under the Code of Audit Practice, we are required to report to you if, in our opinion, the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The Accounting Officer is required to comply with the Department of Health and Social Care Group Accounting Manual and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Accounting Officer is responsible for assessing each year

whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

We obtain and update our understanding of the entity, its activities, its control environment, and likely future developments, including in relation to the legal and regulatory framework applicable and how the Trust is complying with that framework. Based on this understanding, we identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. This includes consideration of the risk of acts by the Trust that were contrary to applicable laws and regulations, including fraud.

In response to the risk of irregularities and non-compliance with laws and regulations, including fraud, we designed procedures which included:

- Enquiry of management and those charged with governance around actual and potential litigation and claims as well as actual, suspected and alleged fraud;
- Reviewing minutes of meetings of those charged with governance;
- Assessing the extent of compliance with the laws and regulations considered to have a direct material effect on the Trust's financial statements or the operations of the Trust through enquiry and inspection;
- Reviewing financial statement disclosures and testing to supporting documentation to assess compliance with applicable laws and regulations, the National Health Service Act 2006 and other related legislation;
- Performing audit work over the risk of management bias and override of controls, including testing of journal entries and other adjustments for appropriateness, evaluating the rationale of significant transactions outside the normal course of business and reviewing accounting estimates for indicators of potential bias; and
- Other audit procedures responsive to the risk of fraud, non-compliance with laws and regulation or irregularity as appropriate.

We also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

Because of the inherent limitations of an audit, there is a risk that we will not detect all irregularities, including those leading to a material misstatement in the financial statements or non-compliance with regulations. This risk increases the more that compliance with a law or regulation is removed from the events and transactions reflected in the financial statements, as we will be less likely to become aware of instances of non-compliance. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

Report on other legal and regulatory matters

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006, because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure that was unlawful, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022. We have nothing to report in this respect.

Responsibilities of the Accounting Officer

The Chief Executive as Accounting Officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Certificate of completion of the audit

We certify that we have completed the audit of the financial statements of Harrogate and District NHS Foundation Trust for the year ended 31 March 2022 in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the
National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Chris Brown

Digitally signed by Chris Brown
DN: cn=Chris Brown, c=GB, o=Azets, email=chris.brown@azets.co.uk
Reason: I am the author of this document
Date: 2022.10.11 18:43:29 +01'00'

Chris Brown, Key Audit Partner

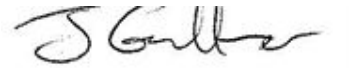
for and on behalf of Azets Audit Services, Local Auditor Edinburgh

11 October 2022

6. HARROGATE AND DISTRICT NHS FOUNDATION TRUST – ANNUAL ACCOUNTS 2021/22

Foreword to the accounts

These accounts, for the year ended 31 March 2022, have been prepared by Harrogate and District NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.



Jonathan Coulter
Acting Chief Executive Officer
Harrogate and District NHS Foundation Trust
5th October 2022

CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2022

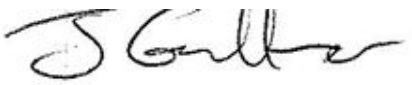
	Note	Group 2021/22 Total £000	Group 2020/21 Total £000
Operating income from continuing operations	3.1	**324,260**	297,379
Operating expenses of continuing operations	4.1	**(312,153)**	(293,907)
OPERATING SURPLUS		**12,107**	3,472
FINANCE COSTS			
Finance income	6.1	**64**	44
Finance expense - financial liabilities	7	**(202)**	(229)
Finance expense - unwinding of discount on provisions	16.2	**(2)**	(2)
Public Dividend Capital - dividends payable		**(2,366)**	(2,507)
NET FINANCE COSTS		**(2,506)**	(2,694)
Losses on disposal of assets	9.1	**(6)**	-
Movement in fair value of investments	10	**17**	346
SURPLUS FOR THE YEAR		**9,612**	1,124
Other comprehensive income			
Impairments charged to Revaluation Reserve	9.3	**-**	(3,401)
Revaluations	9.1	**6,570**	-
Other reserve movements - Subsidiary adjustment		**-**	(281)
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		**16,182**	(2,558)

The notes on pages 93 to 128 form part of these financial statements.

CONSOLIDATED STATEMENT OF FINANCIAL POSITION
as at 31 March 2022

	Note	Group 31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets	8	**4,149**	3,019
Property, plant and equipment	9.1 & 9.3	**130,262**	105,745
Other Investments	10	**1,830**	1,815
Trade and other receivables	13.1	**1,103**	716
Total non-current assets		**137,344**	111,295
Current assets			
Inventories	12.1	**1,931**	2,029
Trade and other receivables	13.1	**10,535**	8,499
Cash and cash equivalents	14	**42,854**	34,198
Total current assets		**55,320**	44,726
Current liabilities			
Trade and other payables	15	**(41,959)**	(23,526)
Borrowings	18	**(1,223)**	(2,178)
Provisions	16.1	**(100)**	(104)
Other liabilities	17	**(2,643)**	(1,430)
Total current liabilities		**(45,925)**	(27,238)
Total assets less current liabilities		**146,739**	128,783
Non-current liabilities			
Trade and other payables	15	**(187)**	(187)
Borrowings	18	**(9,054)**	(12,976)
Provisions	16.1	**(801)**	(198)
Total non-current liabilities		**(10,042)**	(13,361)
Total assets employed		**136,697**	115,422
Financed by taxpayers' equity:			
Public Dividend Capital		**103,938**	98,845
Revaluation reserve		**11,548**	4,978
Income and expenditure reserve		**18,676**	9,413
HDFT charitable fund reserves	25	**2,535**	2,186
Total taxpayers' equity (see page 8)		**136,697**	115,422

The notes on pages 93 to 128 form part of these financial statements.



Signed: …… Mr. Jonathan Coulter - Acting Chief Executive

Date: 5 October 2022

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2022

	HDFT charitable fund reserve	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Group Total
	£000	£000	£000	£000	£000
Balance as at 1 April 2021	2,186	98,845	4,978	9,413	115,422
Surplus for the financial year (Page 6)	637	-	-	8,975	9,612
Revaluations (Note 9.1)	-	-	6,570	-	6,570
Public Dividend Capital received	-	5,093	-	-	5,093
Other reserve movements - charitable funds consolidation adjustment	(288)	-	-	288	-
Balance at 31 March 2022	2,535	103,938	11,548	18,676	136,697

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2021

	HDFT charitable fund reserve	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Group Total
	£000	£000	£000	£000	£000
Balance as at 1 April 2020	1,648	82,862	8,379	9,108	101,997
Surplus for the financial year (Page 6)	768	-	-	356	1,124
Impairments (Note 9.3)	-	-	(3,401)	-	(3,401)
Public Dividend Capital received (*see below)	-	15,983	-	-	15,983
Other reserve movements - Subsidiary adjustment	-	-	-	(281)	(281)
Other reserve movements - charitable funds consolidation adjustment	(230)	-	-	230	-
Balance at 31 March 2021	2,186	98,845	4,978	9,413	115,422

*During 2020/21 the Trust received PDC from DHSC of £16m - £5m to extinguish the Revenue Support loan and £11m to support the Trust's Capital programme.

The notes on pages 93 to 128 form part of these financial statements.

CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2022

		Group	
		2021/22	2020/21
	Note	**£000**	£000
Cash flows from operating activities			
Operating surplus from continuing operations		**12,107**	3,472
		12,107	3,472
Non-cash income and expense			
Depreciation and amortisation	4.1	**7,509**	5,599
Impairments and reversals	9.1	**3,181**	705
Income recognised in respect of capital donations		**(12,717)**	(1,374)
Increase/(Decrease) in trade and other receivables		**(2,279)**	25,789
Decrease in inventories	12.1	**98**	411
Increase in trade and other payables		**12,329**	7,217
Increase/(Decrease) in other liabilities	17	**1,213**	(409)
Increase in provisions		**597**	97
HDFT Charitable Funds - net adjustments for working capital		**(10)**	(15)
NHS charitable funds: other movements in operating cash flows		**(148)**	-
Other movements in operating cash flows		**-**	(281)
NET CASH GENERATED FROM OPERATIONS		**21,880**	41,211
Cash flows from investing activities			
Interest received		**22**	2
Purchase of Intangible assets	8	**(1,292)**	(1,648)
Purchase of Property, Plant and Equipment		**(22,222)**	(15,183)
Receipt of cash donations to purchase capital assets		**12,717**	23
HDFT Charitable funds - net cash flows from investing activities		**44**	(9)
Net cash used in investing activities		**(10,731)**	(16,815)
Cash flows from financing activities			
Public dividend capital received (please see page 8)		**5,093**	15,983
Movement in loans from the DHSC	18	**(4,867)**	(7,019)
Interest paid		**(212)**	(237)
PDC dividend paid		**(2,507)**	(2,601)
Net cash generated/(used) in financing activities		**(2,493)**	6,126
Net increase in cash and cash equivalents	14	**8,656**	30,522
Cash and cash equivalents at 1 April 2021	14	**34,198**	3,676
Cash and cash equivalents at 31 March 2022	14	**42,854**	34,198

The notes on pages 93 to 128 form part of these financial statements.

FOUNDATION TRUST STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2022

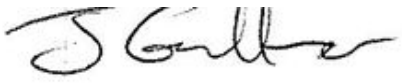
	Note	Foundation Trust 2021/22 Total £000	Foundation Trust 2020/21 Total £000
Operating income from continuing operations	3.1	**324,636**	297,580
Operating expenses of continuing operations	4.2	**(309,571)**	(293,947)
OPERATING SURPLUS		**15,065**	3,633
FINANCE COSTS			
Finance income	6.2	**36**	20
Finance expense - financial liabilities	7	**(202)**	(229)
Finance expense - unwinding of discount on provisions	16.2	**(2)**	(2)
Public Dividend Capital - dividends payable		**(2,366)**	(2,507)
NET FINANCE COSTS		**(2,534)**	(2,718)
Losses on disposal of assets	9.2	**(6)**	-
SURPLUS FOR THE YEAR		**12,525**	915
Other comprehensive income			
Impairments charged to Revaluation Reserve	9.4	**-**	(3,401)
Revaluations	9.2	**6,570**	-
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		**19,095**	(2,486)

The notes on pages 93 to 128 form part of these financial statements.

FOUNDATION TRUST STATEMENT OF FINANCIAL POSITION
as at 31 March 2022

		Foundation Trust	
		31 March 2022	31 March 2021
	Note	**£000**	£000
Non-current assets			
Intangible assets	8	**4,149**	3,019
Property, plant and equipment	9.2 & 9.4	**111,956**	100,321
Investment in Subsidiary	11	**1,000**	1,000
Loan to Subsidiary	11	**20,191**	3,581
Trade and other receivables	13.1	**1,103**	716
Total non-current assets		**138,399**	108,637
Current assets			
Inventories	12.1	**1,816**	1,913
Loan to Subsidiary	11	**1,643**	200
Trade and other receivables	13.1	**8,533**	8,323
Cash and cash equivalents	14	**38,846**	33,424
Total current assets		**50,838**	43,860
Current liabilities			
Trade and other payables	15	**(37,248)**	(21,631)
Borrowings	18	**(1,223)**	(2,178)
Provisions	16.1	**(100)**	(104)
Other liabilities	17	**(2,643)**	(1,430)
Total current liabilities		**(41,214)**	(25,343)
Total assets less current liabilities		**148,023**	127,154
Non-current liabilities			
Trade and other payables	15	**(187)**	(187)
Borrowings	18	**(9,054)**	(12,976)
Provisions	16.1	**(801)**	(198)
Total non-current liabilities		**(10,042)**	(13,361)
Total assets employed		**137,981**	113,793
Financed by taxpayers' equity:			
Public Dividend Capital		**103,938**	98,845
Revaluation reserve		**11,548**	4,978
Income and expenditure reserve		**22,495**	9,970
Total taxpayers' equity (see page 12)		**137,981**	113,793

The notes on pages 93 to 128 form part of these financial statements.



Signed: …… Mr. Jonathan Coulter - Acting Chief Executive

Date: 5 October 2022

FOUNDATION TRUST STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2022

	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Foundation Trust Total
	£000	£000	£000	£000
Balance as at 1 April 2021	**98,845**	**4,978**	**9,970**	**113,793**
Surplus for the financial year (see page 10)	**-**	**-**	**12,525**	**12,525**
Revaluations (Note 9.2)	**-**	**6,570**	**-**	**6,570**
Public Dividend Capital received	**5,093**	**-**	**-**	**5,093**
Balance at 31 March 2022	**103,938**	**11,548**	**22,495**	**137,981**

FOUNDATION TRUST STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2021

	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Foundation Trust Total
	£000	£000	£000	£000
Balance as at 1 April 2020	82,862	8,379	9,055	100,296
Surplus for the financial year (see page 10)	-	-	915	915
Revaluations (Note 9.4)	-	(3,401)	-	(3,401)
Public Dividend Capital received (*see below)	15,983	-	-	15,983
Balance at 31 March 2021	98,845	4,978	9,970	113,793

*During 2020/21 the Trust received PDC from DHSC of £16m - £5m to extinguish the Revenue Support loan and £11m to support the Trust's Capital programme.

The notes on pages 93 to 128 form part of these financial statements.

FOUNDATION TRUST STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2022

	Note	Foundation Trust 2021/22 £000	2020/21 £000
Cash flows from operating activities			
Operating surplus from continuing operations		**15,065**	3,633
		15,065	3,633
Non-cash income and expense			
Depreciation and amortisation	4.2	**7,149**	5,384
Impairments and (reversals)	9.2	**(147)**	82
Income recognised in respect of capital donations		**-**	(1,374)
(Increase)/Decrease in trade and other receivables		**(456)**	25,746
Decrease in inventories	12.1	**97**	412
Increase in trade and other payables		**11,912**	7,085
Increase /(Decrease) in other liabilities	17	**1,213**	(409)
Increase in provisions		**597**	97
NET CASH GENERATED FROM OPERATIONS		**35,430**	40,656
Cash flows from investing activities			
Interest received		**36**	24
Purchase of Intangible assets	8	**(1,292)**	(1,648)
Purchase of Property, Plant and Equipment		**(8,206)**	(11,494)
Net cash used in investing activities		**(9,462)**	(13,118)
Cash flows from financing activities			
Public dividend capital received (please see page 12)		**5,093**	15,983
Movement in loans from the DHSC		**(4,867)**	(7,019)
Movement in loans to subsidiary		**(18,053)**	(3,181)
Interest paid		**(212)**	(237)
PDC dividend paid		**(2,507)**	(2,601)
Net cash generated/(used) in financing activities		**(20,546)**	2,945
Net increase/(decrease) in cash and cash equivalents	14	**5,422**	30,483
Cash and cash equivalents at 1 April 2021	14	**33,424**	2,941
Cash and cash equivalents at 31 March 2022	14	**38,846**	33,424

The notes on pages 93 to 128 form part of these financial statements.

1 GROUP ACCOUNTING POLICIES AND OTHER INFORMATION

NHS Improvement (NHSI), in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC GAM 2021/22, issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC GAM permits a choice of accounting policy. The accounting policy that is judged to be most appropriate to the particular circumstances of the NHS foundation trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the Trust's services in the public sector is normally sufficient evidence of going concern.

After making enquiries, the directors have a reasonable expectation that the services provided by Harrogate and District NHS NHS Foundation Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and certain financial assets and financial liabilities.

1.3 Consolidation

The NHS foundation trust is the corporate trustee to the Harrogate and District NHS Foundation Trust Charitable Fund (registered charity number 1050008). The NHS foundation trust has assessed its relationship with the charitable fund and determined it to be a subsidiary because the NHS foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable funds statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the NHS foundation trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

The NHS foundation trust launched Harrogate Healthcare Facilities Management Ltd (HHFM) a wholly owned subsidiary with effect from the 1 March 2018 (registered company number 11048040). The income, expenses, assets, liabilities, equity and reserves of HHFM are consolidated in full into the appropriate financial statement lines.

1.4 Operating segments

Income and expenditure are analysed in the Operating Segments note (2.1) and are reported in line with management information used within the NHS foundation trust.

1.5 Revenue

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

- The NHS foundation trust does not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less.
- The NHS foundation trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in the Standard, where the right to consideration corresponds directly with value of the performance completed to date.
- HM Treasury's Financial Reporting Manual (FReM) has mandated the exercise of the practical expedient offered in the Standard that requires the NHS foundation trust to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of revenue for the NHS foundation trust is contracts with commissioners in respect of healthcare services. Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. At the year end, the NHS foundation trust accrues income relating to performance obligations satisfied in that year. Where a patient care spell is incomplete at the year end, revenue relating to the partially complete spell is accrued in the same manner as other revenue.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred. The method adopted to assess progress towards the complete satisfaction of a performance obligation is determined by reviewing key milestones/deliverables determined at inception.

The NHS foundation trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The NHS foundation trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements or measuring expected credit losses over the lifetime of the asset.

Income from the sale of non-current assets is recognised only when all material conditions of sales have been met, and is measured as the sums due under the sale contract.

1.6 Expenditure on employee benefits

Short term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs - NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust (consistent with all participating members of the scheme) to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the Scheme, except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the NHS foundation trust commits itself to the retirement, regardless of the method of payment.

1.6 Expenditure on employee benefits (continued)

Pension costs - National Employment Savings Trust (NEST) Pension Scheme

The Pensions Act 2008 requirements created a duty for the NHS foundation trust to provide a pension scheme for employees who are ineligible to join the NHS Pension Scheme. The NHS foundation trust selected NEST as it's partner to meet this duty. The scheme operated by NEST on the NHS foundation trust's behalf is a defined contribution scheme and employers contributions are charged to operating expenses as and when they become due.

Pension costs - HHFM defined contribution scheme (The People's Pension)

A defined contribution plan is a post employment benefit plan under which the Company pays fixed contributions into a separate entity and will have no legal or constructive obligation to pay further amounts. Obligations for contributions to defined contribution pension plans are recognised as an expense in the profit and loss account in the periods during which services are rendered by employees.

A number of the HHFM employees remain within the NHS Pension Scheme, however HHFM also operates a defined contribution pension scheme, The assets of the scheme are held separately from those of the Group in an independently administered fund. The amount charged to the profit and loss account represents the contributions payable to the scheme in respect of the accounting period.

1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of the consideration payable. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.8 Value Added Tax

Most of the activities of the NHS foundation trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable the amounts are stated net of VAT.

1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the NHS foundation trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- individually has a cost of at least £5,000; or
- collectively has a cost of at least £5,000 and individually has a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Capitalised set up costs and grouped assets are reviewed annually and if fully depreciated are removed from the Fixed Asset Register and the Accounts. Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

1.9 Property, plant and equipment (continued)

Valuation

Land and buildings used for the NHS foundation trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the statement of financial position date. Fair values are determined as follows:

Land and specialised buildings – depreciated replacement cost
Non specialised buildings – existing use value

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. All valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS). The NHS foundation trust had a desktop valuation of its land buildings carried out as at 31 March 2021 based on an alternative site in-line with HM Treasury's approach. The NHS foundation trust's management having taken advice from professionally qualified valuers, determined that a full valuation should be carried out as at 31 March 2022 ensuring that land and buildings are held at fair value. The full valuation will also be based on an alternative site in-line with HM Treasury's approach, this revised valuation has been incorporated in the financial statements.

An item of property, plant and equipment which is surplus with no plan to bring back into use is valued at fair value under IFRS 13.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Costs include professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by International Accounting Standard (IAS) 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as a proxy for fair value.

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income. Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of "Other Comprehensive Income".

In accordance with the DHSC GAM, impairments that arise from a clear consumption of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment. Other impairments are treated as revaluation losses. Reversals of other impairments are treated as revaluation gains.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.9 Property, plant and equipment (continued)

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Plant and equipment assets are depreciated on a straight line basis over the following asset life ranges:

	Years
Plant and machinery	5-16
Transport equipment	11
Information technology	5-11
Furniture and fittings	5-11
Buildings and Dwellings (Assessed by a RICS qualified valuer when a valuation takes place)	1-90

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;

- the sale must be highly probable i.e.

  - management is committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale. Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Years
Software licences	2-5
Development expenditure	2-5
Websites	2-5
Other	2-5

1.11 Leases - The Trust as Lessee

Finance Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating Leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight line basis over the term of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.11.1 Leases - The Trust as Lessor

Operating Leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.12 Inventories

Pharmacy inventories are valued at weighted average historical cost. Other inventories are valued at the lower of cost and net realisable value using the first in, first out method.

1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.14 Provisions

The NHS foundation trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted at a discount rate of 2.9% in real terms.

1.15 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to operating expenses. Although NHS Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the NHS foundation trust is disclosed in note 16.

1.16 Non-clinical risk pooling

The NHS foundation trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS foundation trust pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in the financial statements, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.18 Foreign currencies

Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange profits and losses are taken to the Statement of Comprehensive Income. At the Statement of Financial Position date, monetary items denominated in foreign currencies are retranslated at the rates prevailing.

1.19 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. Details of third party assets are given in note 21 to the accounts.

1.20 Public Dividend Capital (PDC) and PDC dividend

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of International Accounting Standard (IAS) 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets, cash held with the Government Banking Service (GBS), excluding cash balances held in GBS accounts that relate to a short term working capital facility and any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average net assets as set out in the "pre-audit" version of the annual accounts. The dividend so calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.21 Corporation Tax

The NHS foundation trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this but the trust is potentially within the scope of corporation tax in respect of activities where income is received from a non public sector source.

The NHS foundation trust has determined that it has no corporation tax liability, as all activities are either ancillary to healthcare or below the de minimus level of profit at which tax is payable. However Harrogate Healthcare Facilities Management Ltd is a wholly owned subsidiary of NHS foundation trust and is subject to corporation tax on its profits.

1.22 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the Statement of Comprehensive Income on an accruals basis, including losses which would have been made good through insurance cover had NHS foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which is prepared on a cash basis.

1.23 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the NHS foundation trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described in note 1.8 above.

Purchase or sales are recognised and derecognised, as applicable, using the trade date.

All other financial assets and financial liabilities are recognised when the NHS foundation trust becomes party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the NHS foundation trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as loans and receivables.

Financial liabilities are classified as other financial liabilities.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The NHS foundation trust's loans and receivables comprise: cash and cash equivalents, NHS receivables and other receivables.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income. Loans from the Department of Health are not held for trading and are measured at historic cost with any unpaid interest accrued separately.

1.23 Financial instruments and financial liabilities (continued)

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from discounted cash flow analysis.

Impairment of financial assets

At the Statement of Financial Position date, the NHS foundation trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the assets carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly or through the use of a bad debt provision. Bad debt provisions are used when there is some uncertainty that the debt will be paid. Bad debts are written off directly only when there is certainty that the debt will not be paid.

1.24 Critical accounting estimates and judgements

The preparation of financial statements under IFRS requires the trust to make estimates and assumptions that affect the application of policies and reported amounts. Estimates and judgements are continually evaluated and are based on historical experience and other factors that are considered to be relevant.

Revisions to accounting estimates are recognised in the period that the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Although the NHS foundation trust makes estimates within these financial statements such as incomplete patient spells, accrued income, annual leave accrual and provisions e.g. early retirements, the amounts involved would not cause a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

In relation to estimations for uncoded NHS income at the financial yearend, the NHS foundation trust runs a forecast for income relating to March based on the average income received by specialty and point of delivery, all uncoded activity is then priced using an average. This methodology is used throughout the year and has proven to be robust with only very minor variances showing once the activity is coded and then costed.

1.24 Critical accounting estimates and judgements (continued)

In addition, a revaluation of the NHS foundation trust's land and buildings was undertaken at a prospective date of 31 March 2022, the valuation excludes the cost of VAT. Since the NHS foundation trust created a subsidiary company "Harrogate Healthcare Facilities Management Ltd". The subsidiary company became responsible for the provision of a Managed Healthcare Facility to the NHS foundation trust, a consequence of this was that VAT became recoverable under an MEA alternative site valuation (see 1.9). The NHS foundation trust relies on the professional services of the Valuation Office for the accuracy of such valuations.

1.25 Non current investments

Investments are stated at market value as at the statement of financial position date. The statement of comprehensive income includes the net gains and losses arising on revaluation and disposals throughout the year.

1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

1.27 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases* , *IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

Estimated impact on 1 April 2022 statement of financial position	£000
Additional right of use assets recognised for existing operating leases	9,150
Additional lease obligations recognised for existing operating leases	(9,150)
Changes to other statement of financial position line items	-
Net impact on net assets on 1 April 2022	**-**

Estimated in-year impact in 2022/23	£000
Additional depreciation on right of use assets	(1,600)
Additional finance costs on lease liabilities	(200)
Lease rentals no longer charged to operating expenditure	1,700
Other impact on income / expenditure	(180)
Estimated impact on surplus / deficit in 2022/23	**(280)**

2 Operating segments

2.1 Group operating segments

The NHS foundation trust's management has reviewed IFRS 8 (Operating Segments) and has determined that the consolidated financial statements consist of two segments "Healthcare" and "Charity".

	Group		Group	
	Healthcare 2021/22 £000	**Charity 2021/22 £000**	Healthcare 2020/21 £000	Charity 2020/21 £000
Operating Surplus/(Deficit)	**11,817**	**290**	3,326	146
Net Finance (Costs)/Income	**(2,548)**	**42**	(2,740)	46
Movement in fair value of investments/Loss on disposal of assets/Corporation tax expenses	**(6)**	**17**	-	346
SURPLUS/(DEFICIT) FOR THE YEAR	**9,263**	**349**	586	538
Non-current assets	**135,514**	**1,830**	109,480	1,815
Current assets	**54,585**	**735**	44,318	408
Current liabilities	**(45,895)**	**(30)**	(27,201)	(37)
Non-current liabilities	**(10,042)**	**-**	(13,361)	-
TOTAL ASSETS EMPLOYED	**134,162**	**2,535**	113,236	2,186
Financed by taxpayers' equity:				
Public Dividend Capital	**103,938**	**-**	98,845	-
Revaluation reserve	**11,548**	**-**	4,978	-
Income and expenditure reserve	**18,676**	**-**	9,413	-
HDFT Charitable fund reserves	**-**	**2,535**	-	2,186
TOTAL TAXPAYERS' EQUITY	**134,162**	**2,535**	113,236	2,186

3 Operating Income from continuing operations

3.1 Analysis of operating income

	Foundation Trust & Group	
	2021/22	2020/21
	£000	£000
Income from activities by nature:		
Acute services		
Block contract / system envelope income	**194,736**	140,022
High cost drugs income from commissioners	**2,692**	568
Other NHS clinical income	**857**	738
Community services		
Block contract / system envelope income	**31,010**	28,854
Income from other sources (e.g. local authorities)	**42,286**	41,207
All trusts		
Private patient income	**815**	652
Elective recovery fund	**3,385**	-
Additional pension contribution central funding (see below*)	**7,934**	7,533
Other clinical income	**477**	33,427
Total income from activities	**284,192**	253,001

	Foundation Trust & Group	
	2021/22	2020/21
	£000	£000
Income from activities by source:		
NHS Foundation Trusts	**441**	280
NHS Trusts	**37**	18
NHS England	**33,646**	33,349
Clinical commissioning groups	**206,499**	177,020
Local Authorities	**42,286**	41,002
Department of Health and Social Care	**-**	7
NHS Other	**45**	14
Non NHS: Private Patients	**815**	652
Non-NHS: Overseas patients (chargeable to patient)	**48**	75
NHS injury scheme (see below**)	**275**	495
Non NHS: Other	**100**	89
Total income from activities	**284,192**	253,001

	Group	
	2021/22	2020/21
	£000	£000
Group other operating income:		
Research and development	**1,008**	1,039
Education and training	**11,566**	11,234
Education and training - notional income from apprenticeship fund	**284**	197
Non-patient care services to other bodies	**1,855**	1,608
Reimbursement and top up funding	**1,676**	20,448
Donated equipment from DHSC for COVID response (non-cash)	**-**	1,351
Cash donations for the purchase of capital assets - received from other bodies	**12,717**	23
Contributions to expenditure - consumables (inventory) donated from DHSC	**643**	4,112
Rental revenue from operating leases (see note 3.4)	**162**	162
Staff recharges (secondments)	**4,145**	3,586
HDFT Charitable Funds: Incoming Resources excluding investment income	**879**	921
Other	**5,133**	(303)
Group total other operating income	**40,068**	44,378
Group total operating income	**324,260**	297,379

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

** NHS injury scheme income is subject to a provision for doubtful debts of 22.43% (2021: 22.43%) to reflect expected rates of collection.

3.1 Analysis of operating income (continued)

	Foundation Trust	
	2021/22	2020/21
	£000	£000
Total income from activities	**284,192**	253,001
Foundation Trust other operating income:		
Research and development	**1,008**	1,039
Education and training	**11,566**	11,234
Education and training - notional income from apprenticeship fund	**284**	197
Received from NHS charities: Receipt of grants/donations for capital acquisitions	**148**	125
Non-patient care services to other bodies	**2,647**	2,321
Reimbursement and top up funding	**1,676**	20,448
Donated equipment from DHSC for COVID response (non-cash)	**-**	1,351
Cash donations for the purchase of capital assets - received from other bodies	**12,717**	23
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies	**643**	4,112
Rental revenue from operating leases (see note 3.5)	**1,265**	1,272
Staff recharges (secondments)	**4,283**	3,602
Other	**4,207**	(1,145)
Foundation Trust total other operating income	**40,444**	44,579
Foundation Trust total operating income	**324,636**	297,580

3.2 Overseas visitors (relating to patients charged directly by the foundation trust)

Income recognised in year relating to overseas visitors was £48k (2021 £75k), payments received in year (relating to invoices raised in current and previous years) was £21k (2021 £45k) and amounts written off in year (relating to invoices raised in current and previous years) was £5k (2021 £32k).

3.3 Analysis of income from activities by Commissioner Requested Services (CRS) and Non-Commissioner Requested Services (Non-CRS).

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Foundation Trust & Group	
	2021/22	2020/21
	£000	£000
Commissioner Requested Services	**162,041**	143,597
Non-Commissioner Requested Services	**122,151**	109,404
Total	**284,192**	253,001

3.4 Additional information on revenue from contracts with customers recognised in the period.

	Foundation Trust & Group	
	2021/22	2020/21
	£000	£000
Revenue recognised in the reporting period that was included in contract liabilities at the previous period end	**-**	-
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	**-**	-

3.5 Operating lease income and future annual lease receipts

	Group	
	2021/22	2020/21
	£000	£000
Operating lease income	**162**	162
	162	162
Future minimum lease receipts due on buildings expiring		
- not later than one year;	**162**	158
- later than one year and not later than five years;	**650**	455
- later than five years.	**194**	256
	1,006	869

3.6 Operating lease income and future annual lease receipts

	Foundation Trust	
	2021/22	2020/21
	£000	£000
Operating lease income	**1,265**	1,272
	1,265	1,272
Future minimum lease receipts due on buildings expiring		
- not later than one year;	**1,265**	1,272
- later than one year and not later than five years;	**5,126**	4,931
- later than five years.	**18,098**	19,279
	24,489	25,482

4. Operating Expenses from continuing operations

4.1 Group operating expenses comprise:

	Group	
	2021/22	2020/21
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	**115**	3,309
Purchase of healthcare from non-NHS and non-DHSC bodies	**105**	1,070
Staff and executive directors costs	**213,770**	202,820
Non-executive directors	**196**	193
Drug costs (see note 12.2)	**18,289**	16,405
Supplies and services - clinical	**24,867**	20,923
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	**643**	4,112
Supplies and services - general	**8,901**	2,741
Establishment	**2,092**	2,209
Research and development	**11**	(4)
Transport (including Patients' travel)	**1,238**	987
Premises - business rates payable to local authorities	**1,101**	1,101
Premises - other	**9,883**	9,249
Increase in provision for irrecoverable debts	**916**	1,627
Rentals under operating leases	**4,056**	4,200
Depreciation on property, plant and equipment (see note 9.1)	**6,728**	5,145
Amortisation on intangible assets (see note 8)	**781**	454
Impairments/(Reversals) of property, plant and equipment	**3,181**	705
Audit services- statutory audit	**184**	144
NHS Resolution contribution - Clinical Negligence	**7,210**	5,915
Legal fees	**562**	220
Consultancy costs	**799**	856
Internal audit costs	**193**	192
Education and training	**2,285**	6,215
Education and training - notional expenditure funded from apprenticeship fund	**284**	197
Redundancy	**6**	-
Early retirements	**7**	148
Hospitality	**73**	5
Insurance	**369**	447
Losses, ex gratia and special payments (see note 20) - Non Pay	**39**	332
Losses, ex gratia and special payments (see note 20) - Pay	**488**	-
Other	**2,480**	1,445
HDFT Charitable funds: Other resources expended	**301**	545
Group total operating expenses	**312,153**	293,907

4. Operating Expenses from continuing operations (Continued)

4.2 Foundation Trust operating expenses comprise:

	Foundation Trust	
	2021/22	2020/21
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	**115**	3,308
Purchase of healthcare from non-NHS and non-DHSC bodies	**105**	1,070
Staff and executive directors costs	**205,004**	193,869
Non-executive directors	**164**	163
Drug costs (see note 12.2)	**18,289**	16,405
Supplies and services - clinical	**22,786**	19,227
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	**643**	4,112
Supplies and services - general	**25,365**	19,027
Establishment	**1,811**	2,157
Research and development	**11**	(4)
Transport (including Patients' travel)	**1,193**	959
Premises - business rates payable to local authorities	**1,101**	1,101
Premises - other	**6,559**	5,768
Increase in provision for irrecoverable debts	**916**	1,627
Rentals under operating leases	**4,004**	4,167
Depreciation on property, plant and equipment (see note 9.2)	**6,395**	4,900
Amortisation on intangible assets (see note 8)	**754**	484
Impairments/(Reversals) of property, plant and equipment	**(147)**	82
Audit services- statutory audit	**150**	122
NHS Resolution contribution - Clinical Negligence	**7,210**	5,915
Legal fees	**562**	218
Consultancy costs	**756**	787
Internal audit costs	**173**	161
Education and training	**2,234**	6,181
Education and training - notional expenditure funded from apprenticeship fund	**284**	197
Redundancy	**6**	-
Early retirements	**7**	148
Hospitality	**73**	5
Insurance	**305**	356
Losses, ex gratia and special payments (see note 20) - Non Pay	**39**	332
Losses, ex gratia and special payments (see note 20) - Pay	**488**	-
Other	**2,216**	1,103
Foundation Trust total operating expenses	**309,571**	293,947

4.3 Operating lease expenditure and future annual lease payments

2020/21 restated (see below *)	Group	
	2021/22	2020/21
	£000	£000
Minimum lease payments (see below **)	**4,056**	4,200
	4,056	4,200
Future minimum lease payments due expiring;		
Within 1 year (see below **)	**1,063**	1,007
Between 1 and 5 years	**1,388**	921
Later than five years	**491**	399
	2,942	2,327

4.4 Operating lease expenditure and future annual lease payments

2020/21 restated (see below *)	Foundation Trust	
	2021/22	2020/21
	£000	£000
Minimum lease payments (see below **)	**4,004**	4,167
	4,004	4,167
Future minimum lease payments due expiring;		
Within 1 year (see below **)	**1,011**	974
Between 1 and 5 years	**1,388**	921
Later than five years	**491**	399
	2,890	2,294

*The future minimum lease payments figures for 2020/21 have been restated from £5,088k to £2,327k and £5,088k to £2,294k, for the Group (note 4.3) and Foundation Trust (note 4.4) respectively, to correctly reflect the lease obligations as at 31 March 2021.
**The difference between the payments due within one year as at 31 March 2021 and the minimum lease payments made at 31 March 2022 (notes 4.3 and 4.4 above) is due to properties occupied which do not have a formal lease agreement in place which are not disclosed in future minimum lease payments due.

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4.5 Limitation on external auditor's liability

	Foundation Trust & Group	
	2021/22	2020/21
	£000	£000
Limitation on external auditor's liability	**1,000**	1,000
	1,000	1,000

5. Employee costs and numbers

5.1 Employee costs

		Group			Group	
	Total	**Permanently**		Total	Permanently	
	2021/22	**Employed**	**Other**	2020/21	Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**167,262**	**164,613**	**2,649**	159,806	157,263	2,543
Social Security costs (Employers NI costs)	**14,480**	**14,480**	**-**	13,457	13,457	-
Apprenticeship levy	**759**	**759**	**-**	713	713	-
Employer contributions to NHS Pensions Agency	**18,567**	**18,567**	**-**	17,642	17,642	-
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	**7,934**	**7,934**	**-**	7,533	7,533	-
Pension cost - other	**240**	**240**	**-**	193	193	-
Termination benefits	**6**	**6**	**-**	62	62	-
Agency/contract staff	**6,302**	**-**	**6,302**	4,238	-	4,238
Total employee expenses	**215,550**	**206,599**	**8,951**	203,644	196,863	6,781
Less costs capitalised as part of assets	**(1,286)**	**(1,286)**	**-**	(824)	(824)	-
Total employee costs excluding capitalised costs	**214,264**	**205,313**	**8,951**	202,820	196,039	6,781

5. Employee costs and numbers (continued)

5.2 Employee costs

	Foundation Trust			Foundation Trust		
	Total 2021/22 £000	**Permanently Employed £000**	**Other £000**	Total 2020/21 £000	Permanently Employed £000	Other £000
Salaries and wages	**159,820**	**157,162**	**2,658**	152,565	150,022	2,543
Social Security costs (Employers NI costs)	**13,877**	**13,877**	**-**	12,900	12,900	-
Apprenticeship levy	**722**	**722**	**-**	677	677	-
Employer contributions to NHS Pensions Agency	**18,117**	**18,117**	**-**	17,154	17,154	-
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	**7,934**	**7,934**	**-**	7,533	7,533	-
Pension cost - other	**102**	**102**	**-**	89	89	-
Termination benefits	**6**	**6**	**-**	62	62	-
Agency/contract staff	**5,922**	**-**	**5,922**	3,536	-	3,536
Total employee expenses	**206,500**	**197,920**	**8,580**	194,516	188,437	6,079
Less costs capitalised as part of assets	**(1,002)**	**(1,002)**	**-**	(647)	(647)	-
Total employee costs excluding capitalised costs	**205,498**	**196,918**	**8,580**	193,869	187,790	6,079

5.3 Average number of employees (WTE basis)

	Group			Group		
	Total 2021/22 Number	**Permanently Employed Number**	**Other Number**	Total 2020/21 Number	Permanently Employed Number	Other Number
Medical and dental	**413**	**386**	**27**	393	369	24
Ambulance staff	**1**	**1**	**-**	2	2	-
Administration and estates	**726**	**706**	**20**	708	682	26
Healthcare assistants and other support staff	**412**	**412**	**-**	399	399	-
Nursing, midwifery and health visiting staff	**1,842**	**1,806**	**36**	1,796	1,773	23
Nursing, midwifery and health visiting learners	**43**	**43**	**-**	44	44	-
Scientific, therapeutic and technical staff	**515**	**515**	**-**	497	497	-
Healthcare science staff	**106**	**97**	**9**	102	95	7
Other	**8**	**8**	**-**	6	6	-
Total	**4,066**	**3,974**	**92**	3,947	3,867	80
Less capitalised employees	**(28)**	**(28)**	**-**	(20)	(20)	-
Total excluding capitalised WTE	**4,038**	**3,946**	**92**	3,927	3,847	80

5.4 Average number of employees (WTE basis)

	Foundation Trust			Foundation Trust		
	Total 2021/22 Number	**Permanently Employed Number**	**Other Number**	Total 2020/21 Number	Permanently Employed Number	Other Number
Medical and dental	**413**	**386**	**27**	393	369	24
Ambulance staff	**1**	**1**	**-**	2	2	-
Administration and estates	**667**	**656**	**11**	632	628	4
Healthcare assistants and other support staff	**198**	**198**	**-**	185	185	-
Nursing, midwifery and health visiting staff	**1,842**	**1,806**	**36**	1,795	1,772	23
Nursing, midwifery and health visiting learners	**43**	**43**	**-**	44	44	-
Scientific, therapeutic and technical staff	**515**	**515**	**-**	497	497	-
Healthcare science staff	**106**	**97**	**9**	102	95	7
Other	**5**	**5**	**-**	6	6	-
Total	**3,790**	**3,707**	**83**	3,656	3,598	58
Less capitalised employees	**(21)**	**(21)**		(15)	(15)	-
Total excluding capitalised WTE	**3,769**	**3,686**	**83**	3,641	3,583	58

WTE = Whole time equivalents

5.5 Pensions costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

5.6 Retirements due to ill-health

During the year ended 31 March 2022 there were 4 (2021: 6) early retirements from the NHS foundation trust agreed on the grounds of ill-health. The estimated additional pension liability of the ill-health retirement is £142,000 (2021: £173,000). The cost of ill-health retirements are borne by the NHS Business Services Authority Pensions Division.

5.7 Staff exit costs

NHS Improvement requires NHS foundation trusts to disclose summary information regarding redundancy and other departures in staff costs agreed in the financial year.

	Foundation Trust & Group		Foundation Trust & Group	
Exit cost band	**2021/22 Number of compulsory redundancies**	**2021/22 Number of other departures agreed**	2020/21 Number of compulsory redundancies	2020/21 Number of other departures agreed
<£10,000	**1**	**-**	-	-
£10,001 - £25,000	**-**	**-**	-	-
£25,001 - £50,000	**-**	**-**	-	-
£50,001 - £100,000	**-**	**-**	-	1
£100,001 - £150,000	**-**	**-**	-	-
£150,001 - £200,000	**-**	**-**	-	-
>£200,000	**-**	**-**	-	-
Total number of exits by type	**-**	**-**	-	-
Total resource cost	**£6,000**	-	-	£62,000

5.8 Analysis of termination benefits

	Foundation Trust & Group		Foundation Trust & Group	
	2021/22 Number	**2021/22 £000**	2020/21 Number	2020/21 £000
Compulsory redundancies	**1**	**6**	-	-
Contractual payments in lieu of notice	**-**	**-**	1	62
	1	**6**	1	62

6. Finance revenue

6.1 Group finance revenue received during the year is as follows:

Finance revenue received during the year is as follows:	Group	
	2021/22	2020/21
	£000	£000
Interest income:		
Interest on bank accounts	**22**	(2)
HDFT Charitable funds: investment income	**42**	46
	64	44

6.2 Foundation Trust finance revenue received during the year is as follows:

Finance revenue received during the year is as follows:	Foundation Trust	
	2021/22	2020/21
	£000	£000
Interest income:		
Interest on bank accounts	**22**	(2)
Interest on working capital loan to HHFM	**14**	22
	36	20

7. Finance expenses

Finance expenses incurred during the year are as follows:	Foundation Trust & Group	
	2021/22	2020/21
	£000	£000
Interest expense:		
Capital Loans from the Department of Health (formerly ITFF see note 18)	**202**	229
	202	229

8. Current year intangible fixed assets

	Foundation Trust & Group				
	Software Licences	**Development Expenditure**	**Websites**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
Gross cost at 1 April 2021	1,287	2,918	187	306	**4,698**
Additions - purchased	54	786	-	452	**1,292**
Reclassifications	18	16	-	585	**619**
Disposals	(5)	-	-	-	**(5)**
Gross cost at 31 March 2022	**1,354**	**3,720**	**187**	**1,343**	**6,604**
Amortisation at 1 April 2021	868	672	24	115	**1,679**
Provided during the year	113	447	27	194	**781**
Disposals	(5)	-	-	-	**(5)**
Amortisation at 31 March 2022	**976**	**1,119**	**51**	**309**	**2,455**
Net book value					
- Purchased at 31 March 2022	378	2,601	136	1,034	**4,149**
- Total at 31 March 2022	**378**	**2,601**	**136**	**1,034**	**4,149**

8.1 Prior year intangible fixed assets

	Foundation Trust & Group				
	Software Licences	**Development Expenditure**	**Websites**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
Gross cost at 1 April 2020	873	-	-	-	873
Additions - purchased	238	1,189	139	82	1,648
Reclassifications*	176	1,729	48	224	2,177
Gross cost at 31 March 2021	**1,287**	**2,918**	**187**	**306**	**4,698**
Amortisation at 1 April 2020	643	-	-	-	643
Provided during the year	119	293	7	35	454
Reclassifications	106	379	17	80	582
Amortisation at 31 March 2021	**868**	**672**	**24**	**115**	**1,679**
Net book value					
- Purchased at 31 March 2021	419	2,246	163	191	3,019
- Total at 31 March 2021	**419**	**2,246**	**163**	**191**	**3,019**

*Reclassifications total of £2,177,000 (gross) and £582,000 (depreciation) represents a movement between Tanglible and Intantagible assets - see note 9.3.

9. Property, plant and equipment

9.1 Current year property, plant and equipment comprises of the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Group Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2021	3,500	75,875	871	3,783	29,425	184	13,729	718	**128,085**
Additions - purchased	-	5,844	-	19,665	1,669	-	1,115	40	**28,333**
Additions - donations of physical assets	-	11	-	-	137	-	-	-	**148**
Impairments charged to operating expenses	-	(3,328)	-	-	-	-	-	-	**(3,328)**
Transfer to revaluation reserve	-	4,085	(23)	-	-	-	-	-	**4,062**
Reclassifications*	-	284	290	(3,257)	633	(6)	1,435	2	**(619)**
Disposals	-	(1)	-	-	(1,266)	-	-	(15)	**(1,282)**
Cost or valuation At 31 March 2022	**3,500**	**82,770**	**1,138**	**20,191**	**30,598**	**178**	**16,279**	**745**	**155,399**
Depreciation at 1 April 2021	-	-	-	-	14,467	112	7,417	344	**22,340**
Provided during the year (see note 4.1)	-	2,593	66	-	2,589	14	1,404	62	**6,728**
Reversal of impairments charged to operating expenses	-	(147)	-	-	-	-	-	-	**(147)**
Transfer to revaluation reserve	-	(2,442)	(66)	-	-	-	-	-	**(2,508)**
Reclassifications	-	(3)	-	-	5	(2)	-	-	**-**
Disposals	-	(1)	-	-	(1,260)	-	-	(15)	**(1,276)**
Depreciation at 31 March 2022	**-**	**-**	**-**	**-**	**15,801**	**124**	**8,821**	**391**	**25,137**
Net book value									
- Purchased at 31 March 2022	3,500	74,914	1,138	11,225	12,899	54	7,441	337	**111,508**
- Donated at 31 March 2022	-	7,856	-	8,966	779	-	17	17	**17,635**
- Donated (DHSC) at 31 March 2022	-	-	-	-	1,119	-	-	-	**1,119**
Net book value at 31 March 2022	**3,500**	**82,770**	**1,138**	**20,191**	**14,797**	**54**	**7,458**	**354**	**130,262**

*Reclassifications total of £619,000 represents a movement between Tanglible and Intantagible assets - see note 8.

At 31 March 2021, of the Net Book Value £3,500,000 related to land valued at open market value and £75,875,000 related to buildings valued at open market value and £871,000 related to dwellings valued at open market value. The land and buildings (including dwellings) of the trust were revalued by the Valuation Office Agency which is a government agency of Her Majesty's Revenue and Customs (RICS qualified) as at 31 March 2022. This valuation, in line with the NHS foundation trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in an increase in value of £3,389,000.00.

9. Property, plant and equipment

9.2 Current year property, plant and equipment comprises of the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Foundation Trust Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2021	3,500	72,938	451	3,020	27,104	25	13,728	658	**121,424**
Additions - purchased	-	176	-	9,106	1,510	-	1,105	41	**11,938**
Reversals charged to operating expenses	-	147	-	-	-	-	-	-	**147**
Reclassifications	-	(168)	239	(2,687)	560	-	1,435	2	**(619)**
Transfer to revaluation reserve	-	4,110	(36)	-	-	-	-	-	**4,074**
Disposals	-	(1)	-	-	(1,266)	-	-	(15)	**(1,282)**
Cost or valuation At 31 March 2022	**3,500**	**77,202**	**654**	**9,439**	**27,908**	**25**	**16,268**	**686**	**135,682**
Depreciation at 1 April 2021	-	-	-	-	13,346	-	7,418	339	**21,103**
Provided during the year (see note 4.2)	-	2,458	39	-	2,435	4	1,403	56	**6,395**
Transfer to revaluation reserve	-	(2,457)	(39)	-	-	-	-	-	**(2,496)**
Disposals	-	(1)	-	-	(1,260)	-	-	(15)	**(1,276)**
Depreciation at 31 March 2022	**-**	**-**	**-**	**-**	**14,521**	**4**	**8,821**	**380**	**23,726**
Net book value									
- Purchased at 31 March 2022	3,500	73,080	654	9,439	11,489	21	7,447	289	**105,919**
- Donated at 31 March 2022	-	4,122	-	-	779	-	-	17	**4,918**
- Donated (DHSC) at 31 March 2022	-	-	-	-	1,119	-	-	-	**1,119**
Net book value at 31 March 2022	**3,500**	**77,202**	**654**	**9,439**	**13,387**	**21**	**7,447**	**306**	**111,956**

At 31 March 2021, of the Net Book Value £3,500,000 related to land valued at open market value and £72,938,000 related to buildings valued at open market value and £451,000 related to dwellings valued at open market value. The land and buildings (including dwellings) of the trust were revalued by the Valuation Office Agency which is a government agency of Her Majesty's Revenue and Customs (RICS qualified) as at 31 March 2022. This valuation, in line with the NHS foundation trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in a increase in value of £6,717,000.00.

9. Property, plant and equipment (continued)

9.3 Prior year property, plant and equipment comprises of the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Group Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2020	3,225	78,320	1,700	1,915	21,997	159	13,141	730	121,187
Additions - purchased	-	3,060	-	3,535	6,240	25	1,945	57	14,862
Additions - equipment donated from DHSC	-	-	-	-	1,351	-	-	-	1,351
Impairments charged to operating expenses	-	(705)	-	-	-	-	-	-	(705)
Reclassifications	275	663	(275)	(1,667)	113	-	(1,302)	16	(2,177)
Transfer to revaluation reserve	-	(5,459)	(554)	-	-	-	-	-	(6,013)
Disposals	-	(4)	-	-	(276)	-	(55)	(85)	(420)
Cost or valuation At 31 March 2021	**3,500**	**75,875**	**871**	**3,783**	**29,425**	**184**	**13,729**	**718**	**128,085**
Depreciation at 1 April 2020	-	-	-	-	13,269	102	7,067	371	20,809
Provided during the year (see note 4.1)	-	2,527	89	-	1,474	10	987	58	5,145
Reclassifications	-	-	-	-	-	-	(582)	-	(582)
Transfer to revaluation reserve	-	(2,523)	(89)	-	-	-	-	-	(2,612)
Disposals	-	(4)	-	-	(276)	-	(55)	(85)	(420)
Depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**14,467**	**112**	**7,417**	**344**	**22,340**
Net book value									
- Purchased at 31 March 2021	3,500	71,661	871	3,783	12,804	72	6,288	356	99,335
- Donated at 31 March 2021	-	4,214	-	-	803	-	24	18	5,059
- Donated (DHSC) at 31 March 2021	-	-	-	-	1,351	-	-	-	1,351
Net book value at 31 March 2021	**3,500**	**75,875**	**871**	**3,783**	**14,958**	**72**	**6,312**	**374**	**105,745**

At 31 March 2020, of the Net Book Value £3,225,000 related to land valued at open market value and £78,320,000 related to buildings valued at open market value and £1,700,000 related to dwellings valued at open market value. The land and buildings (including dwellings) of the trust were revalued by the Valuation Office Agency which is a government agency of Her Majesty's Revenue and Customs (RICS qualified) as at 31 March 2021. This desktop valuation, in line with the NHS foundation trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in a decrease in value of £4,106,000.00.

9. Property, plant and equipment

9.4 Prior year property, plant and equipment comprises of the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Foundation Trust Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2020	3,225	77,611	1,715	1,179	20,071	-	13,139	693	**117,633**
Additions - purchased	-	294	-	2,958	5,846	25	1,902	45	**11,070**
Additions - equipment donated from DHSC	-	-	-	-	1,351	-	-	-	**1,351**
Impairments charged to operating expenses	-	(82)	-	-	-	-	-	-	**(82)**
Reclassifications	275	86	(275)	(1,117)	108	-	(1,259)	5	**(2,177)**
Transfer to revaluation reserve	-	(4,971)	(989)	-	-	-	-	-	**(5,960)**
Disposals	-	-	-	-	(272)	-	(54)	(85)	**(411)**
Cost or valuation At 31 March 2021	**3,500**	**72,938**	**451**	**3,020**	**27,104**	**25**	**13,728**	**658**	**121,424**
Depreciation at 1 April 2020	-	-	-	-	12,318	-	7,067	370	**19,755**
Provided during the year (see note 4.2)	-	2,471	88	-	1,300	-	987	54	**4,900**
Reclassifications	-	-	-	-	-	-	(582)	-	**(582)**
Transfer to revaluation reserve	-	(2,471)	(88)	-	-	-	-	-	**(2,559)**
Disposals	-	-	-	-	(272)	-	(54)	(85)	**(411)**
Depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**13,346**	**-**	**7,418**	**339**	**21,103**
Net book value									
- Purchased at 31 March 2021	3,500	68,724	451	3,020	11,604	25	6,286	301	**93,911**
- Donated at 31 March 2021	-	4,214	-	-	803	-	24	18	**5,059**
- Donated (DHSC) at 31 March 2021	-	-	-	-	1,351	-	-	-	**1,351**
Net book value at 31 March 2021	**3,500**	**72,938**	**451**	**3,020**	**13,758**	**25**	**6,310**	**319**	**100,321**

At 31 March 2020, of the Net Book Value £3,225,000 related to land valued at open market value and £77,611,000 related to buildings valued at open market value and £1,715,000 related to dwellings valued at open market value. The land and buildings (including dwellings) of the trust were revalued by the Valuation Office Agency which is a government agency of Her Majesty's Revenue and Customs (RICS qualified) as at 31 March 2021. This desktop valuation, in line with the NHS foundation trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in a decrease in value of £3,483,000.00.

10. Investments

	Group	
	2021/22	2020/21
	£000	£000
Carrying value at 1 April 2021	**1,815**	1,414
Acquisitions in year - other	**408**	522
Movement in fair value of investments	**17**	346
Disposals	**(410)**	(467)
Carrying value at 31 March 2022	**1,830**	1,815

Investments held are wholly attributable to the Harrogate and District NHS Foundation Trust Charitable Fund (registered charity number 1050008), for further information please see the charity's Annual Report and Accounts.

11. Subsidiary Undertaking - Harrogate Healthcare Facilities Management Ltd.

	Foundation Trust	
	2021/22	2020/21
	£000	£000
Non-current assets		
Shares in Subsidiary	**1,000**	1,000
Loans to Subsidiary	**20,191**	3,581
	21,191	4,581
Current assets		
Loans to Subsidiary	**1,643**	200
	22,834	4,781

The shares in the subsidiary company Harrogate Healthcare Facilities Management Ltd comprises a 100% holding of the share capital. Details of the NHS foundation trust loans to it's Subsidiary as at 31 March 2022 are in the table below.

			Non-current	Current
Loan Name - Principal Borrowed	Term	Interest Rate	£000	£000
Working Capital Loan - £1m	5 Years	4.00%	-	200
Capital Loan - £7.5m	10 Years	3.60%	6,562	938
Capital Loan - £14.1m	15 Years	3.75%	13,629	505
			20,191	1,643

There have been no defaults or breaches by the subsidiary in relation to the above loans from the NHS foundation trust.

The principal activity of Harrogate Healthcare Facilities Management Ltd is to provide estate management and facilities services.

12. Inventories

12.1 Analysis of inventories

	Group		Foundation Trust	
	2021/22	2020/21	**2021/22**	2020/21
	£000	£000	**£000**	£000
Drugs	**603**	771	**603**	771
Consumables	**1,328**	1,258	**1,213**	1,142
Total	**1,931**	2,029	**1,816**	1,913

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2021/22 the Trust received £643k of items purchased by DHSC (2020/21: £4,112k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses - please see notes 4.1 and 4.2.

12.2 Inventories recognised in expenses

	Foundation Trust & Group	
	2021/22	2020/21
	£000	£000
Drug Inventories recognised as an expense in the year	**18,289**	16,405
Total	**18,289**	16,405

13. Trade and other receivables

13.1 Trade and other receivables are made up of:

	Group	
	2021/22	2020/21
Current	**£000**	£000
Contract receivables (IFRS 15): invoiced	**4,563**	4,593
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	**1,279**	772
PDC Dividend receivable (Department of Health)	**394**	253
Deposits and advances	**33**	14
Provision for the impairment of contract receivables (see note 13.2)	**(1,371)**	(450)
Prepayments	**3,386**	2,379
VAT receivables	**1,775**	328
Other receivables	**476**	610
Total	**10,535**	8,499

	Foundation Trust	
	2021/22	2020/21
Current	**£000**	£000
Contract receivables (IFRS 15): invoiced	**4,543**	4,511
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	**1,279**	772
PDC Dividend receivable (Department of Health)	**394**	253
Deposits and advances	**31**	9
Provision for the impairment of contract receivables (see note 13.2)	**(1,371)**	(450)
Prepayments	**2,496**	2,056
VAT receivables	**705**	610
Other receivables	**456**	562
Total	**8,533**	8,323

	Foundation Trust & Group	
	2021/22	2020/21
	£000	£000
Non-Current		
Other receivables	**204**	220
VAT receivables	**303**	545
Provision for the impairment of receivables (see note 13.2)	**(44)**	(49)
Clinician pension tax provision reimbursement funding from NHSE	**640**	-
Total	**1,103**	716
Of which receivable from NHS and DHSC group bodies:	**3,919**	5,695
Current	**640**	-
Non-Current		

The majority of the NHS foundation trust's trade is with Commissioners for NHS patient care services which are funded by the Government to buy NHS patient care services therefore no credit scoring for them is considered necessary.

13. Trade and other receivables (continued)

13.2 Allowances for credit losses (doubtful debts)	Foundation Trust & Group 2021/22 £000	2020/21 £000
Allowance for credit losses at 1 April 2021	**499**	542
New allowances arising	**916**	1,627
Utilisation of allowances (where receivable is written off)	**-**	(1,670)
Balance at 31 March 2022	**1,415**	499

NHS Injury Benefit Scheme income is subject to a provision for impairment of 22.43% (2021: 22.43%) to reflect expected rates of collection. Other debts are assessed by management considering age of debt and the probability of collection.

14. Cash and cash equivalents

	Group 2021/22 £000	2020/21 £000	Foundation Trust 2021/22 £000	2020/21 £000
Balance at 1 April 2021	**34,198**	3,676	**33,424**	2,941
Net change in year	**8,656**	30,522	**5,422**	30,483
Balance at 31 March 2022	**42,854**	34,198	**38,846**	33,424
Made up of:				
Cash with Government Banking Service	**39,508**	33,760	**38,811**	2,919
Cash at commercial banks and in hand	**3,328**	423	**35**	22
Other current investments	**18**	15	**-**	-
Cash and cash equivalents	**42,854**	34,198	**38,846**	2,941

15. Trade and other payables

Current	Group 2021/22 £000	2020/21 £000	Foundation Trust 2021/22 £000	2020/21 £000
Receipts in advance	**48**	28	**48**	28
Trade payables	**5,006**	3,243	**4,138**	2,616
Other trade payables - capital	**7,296**	1,185	**4,482**	777
Social Security costs	**2,070**	1,985	**2,003**	1,902
Other tax payable	**2,268**	1,690	**2,175**	1,631
Other payables	**3,944**	3,137	**3,912**	2,481
Accruals	**21,327**	12,258	**20,490**	12,196
Total	**41,959**	23,526	**37,248**	21,631

Non-Current	Foundation Trust & Group 2021/22 £000	2020/21 £000
Accruals	**187**	187
Total	**187**	187

16. Provisions

16.1 Provisions current and non current

	Foundation Trust & Group Current		Foundation Trust & Group Non current	
	2021/22	2020/21	**2021/22**	2020/21
	£000	£000	**£000**	£000
Pensions relating to the early retirement of staff pre 1995	**33**	37	**135**	161
Legal claims	**50**	53	**-**	-
Pensions - Injury benefits	**17**	14	**26**	37
2019/20 Clinicians' pension reimbursement	**-**	-	**640**	-
	100	104	**801**	198

16.2 Provisions by category

	Pensions relating to the early retirement of staff pre 1995	Legal claims	Pensions - Injury benefits	2019/20 Clinicians' pension reimbursement	**Foundation Trust & Group Total 2021/22**
	£000	£000	£000	£000	**£000**
At 1 April 2021	198	53	51	-	**302**
Arising during the year	1	47	1	640	**689**
Utilised during the year	(32)	(28)	(10)	-	**(70)**
No longer required	-	(22)	-	-	**(22)**
Unwinding of discount	1	-	1	-	**2**
At 31 March 2022	**168**	**50**	**43**	**640**	**901**

16.3 Expected timing of cashflows by category:

	Pensions relating to the early retirement of staff pre 1995	Legal claims	Pensions - Injury benefits	2019/20 Clinicians' pension reimbursement	**Foundation Trust & Group Total 2021/22**
	£000	£000	£000	£000	**£000**
Within one year	33	50	17	-	**100**
Between one and five years	132	-	26	-	**158**
After five years	3	-	-	640	**643**
	168	**50**	**43**	**640**	**901**

Pensions relating to the early retirement of staff pre 1995
Provisions for capitalised pension benefits are based on tables provided by the Office for National Statistics, reflecting years to normal retirement age and the additional pension costs associated with early retirement.

Legal claims
Legal claims consist of amounts due as a result of third party and employee liability claims. These values are based on information provided by NHS Resolution (formerly the NHS Litigation Authority).

Pensions - Injury benefits
Permanent Injury Benefits are payable to eligible individuals, and are calculated in the same way as capitalised pension benefits.

2019/20 Clinicians' pension
These consist of the pensions tax costs of clinicians working additional sessions, which the UK Government committed to pay. These values are based on information provided by NHS England.

£151,496,000 is included in the provisions of NHS Resolution (formerly the NHS Litigation Authority) at 31 March 2022 in respect of clinical negligence liabilities of the NHS foundation trust (31 March 2021 - £103,716,000). Please see note 1.15.

17. Other liabilities

	Foundation Trust & Group	
	2021/22	2020/21
Current	**£000**	£000
Deferred income	**2,643**	1,430
Total	**2,643**	1,430

18. Borrowings

	Foundation Trust & Group	
	2021/22	2020/21
Current	**£000**	£000
Capital loans from DHSC (formerly ITFF)*	**1,223**	2,178
Total	**1,223**	2,178
Non-Current		
Capital loans from DHSC (formerly ITFF)*	**9,054**	12,976
Total	**9,054**	12,976

*During 2012/13, the Trust signed a 10 year loan agreement for £3.4m from the Independent Trust Financing Facility (ITFF) to fund the provision of additional theatre capacity, the loan was drawn down in full during the financial year. During 2013/14, the Trust signed an additional 10 year loan for £1.5m from the ITFF to fund the replacement of an MRI Scanner. The loan was drawn down in full during the financial year. During 2014/15 the NHS foundation trust did not undertake any additional borrowing. During 2015/16 the Trust signed a 25 year loan agreement from the Department of Health for £7.5m to fund a Carbon Efficiency capital scheme and a 10 year loan agreement from the Department of Health for £1.5m to fund the purchase of a Mobile MRI Scanner, both of these loans were drawn down in full during the financial year. The NHS foundation trust did not undertake any additional borrowing during 2016/17. During 2017/18, the Trust signed two loan agreements (both with 10 year terms). Replacement of automatic endoscope reprocessors for £3.8m and a modular build endoscopy suite for £6.9m.
During the 2021/22 financial year the NHS foundation trust repaid in full three of the outstanding loans (please see below).

Additional theatre capacity loan £375k
Replacement MRI loan £166k
Replacement of Automated Endoscope Reprocessors scheme loan £2,401k

The interest rates on the NHS foundation trust's loans are:-

Additional theatre capacity loan originally £3.4m is fixed at 0.93% per annum (10 year term).
Replacement MRI loan originally £1.5m is fixed at 1.75% per annum (10 year term).
Carbon efficiency capital scheme loan originally £7.5m is fixed at 2.5% per annum (25 year term).
Mobile MRI Scanner loan originally £1.5m is fixed at 0.90% per annum (10 year term).
Replacement of Automated Endoscope Reprocessors scheme loan originally £3.8m is fixed at 0.76% per annum (10 year term).
Modular Build Endoscopy Suite loan originally £6.9m is fixed at 0.56% per annum (10 year term).
Working capital loan originally £4.9m is fixed at 1.5% per annum (3 year term - see **above).

Interest accrued is paid every six months see finance expense note 7.

There have been no defaults or breaches in relation to the DHSC (formerly ITFF) loans.

19. Finance lease obligations

The NHS foundation trust does not have any finance leases obligations either as a lessee or lessor.

20. Losses and special payments

	Foundation Trust & Group			
	2021/22 Total number of cases	**2021/22 Total value of cases**	2020/21 Total number of cases	2020/21 Total value of cases
		£000		£000
Losses:				
Bad debts private patients	**4**	**1**	51	10
Bad debts overseas visitors	**5**	**5**	12	32
Bad debts other	**243**	**3**	460	264
Total losses	**252**	**9**	523	306
Special payments:				
Ex gratia payment loss of personal effects	**18**	**14**	10	6
Compensation under court order or legally binding arbitration award	**-**	**-**	1	**2**
Ex gratia payment personal injury with advice	**4**	**16**	5	18
Ex gratia payment other employment payments	**-**	**-**	1	-
Overtime corrective payments	**1**	**488**	-	-
Ex gratia payment other	**3**	**-**	2	-
Total special payments	**26**	**518**	19	26
Total losses and special payments	**278**	**527**	542	332

21. Third Party Assets

The NHS foundation trust held £0 cash at bank and in hand at 31 March 2022 which related to monies held by the NHS foundation trust on behalf of patients (31 March 2021: £60).

22. Contractual Capital Commitments

Commitments under capital expenditure contracts at 31 March 2022 were £1,025,000 (31 March 2021: £1,069,000).

23. Related Party Transactions

23.1 Transactions with key management personnel

IAS 24 requires disclosure of transactions with key management personnel during the year. Key management personnel is defined in IAS 24 as "those persons having authority and responsibility for planning, directing and controlling the activities of the entity, directly or indirectly, including any director (whether executive or otherwise) of that entity". The Trust has deemed that its key management personnel are the board members (voting and non-voting directors and non-executive directors) of the NHS foundation trust.

However the DHSC GAM states the requirement in IAS 24 to disclose the compensation paid to management, expenses allowances and similar items paid in the ordinary course of an entity's operations will be satisfied with the disclosures in the Remuneration Report. There were no transactions with board members or parties related to them other than those from the ordinary course the NHS foundation trust's operations.

23.2 Transactions with other related parties

The Department of Health and Social Care is the parent department of Harrogate and District NHS Foundation Trust, paragraph 25 of IAS 24 allows entities which are related parties because they are under the same government control to reduce the volume of detailed disclosures.

The DHSC GAM interprets this as requiring the disclosure of the main entities within the public sector with which the NHS foundation trust has had dealings, but no information needs to be given about these transactions. These entities are listed below:-

County Durham Unitary Authority
Darlington Borough Council
Gateshead Council
Health Education England
HM Revenue & Customs
Leeds Teaching Hospitals NHS Trust
Middlesbrough Council
NHS Bradford District and Craven CCG
NHS England
NHS Leeds CCG
NHS North Yorkshire CCG
NHS Pension Scheme
NHS Property Services
NHS Resolution (formerly NHS Litigation Authority)
NHS Vale of York CCG
North Yorkshire County Council
Northumberland Unitary Authority
Stockton-on-Tees Borough Council
Sunderland City Metropolitan Borough Council
York Teaching Hospital NHS Foundation Trust

24. Financial instruments.

Disclosure is required under International Accounting Standards of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The Harrogate and District NHS Foundation Trust actively seeks to minimise its financial risks. In line with this policy, the Trust neither buys nor sells financial instruments. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Interest Rate Risk

All of the Trust's financial liabilities carry nil or fixed rates of interest. In addition, the only element of the Trust's assets that are subject to a variable rate are short term cash investments. The Trust is not, therefore, exposed to significant interest-rate risk.

Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

Credit Risk

The Trust operates primarily within the NHS market and receives the majority of its income from other NHS organisations. There is therefore little risk that one party will fail to discharge its obligation with the other. Disputes can arise, however, around how the amounts owed are calculated, particularly due to the complex nature of the Payment by Results regime. For this reason the Trust makes a provision for irrecoverable amounts based on historic patterns and the best information available at the time the accounts are prepared. The Trust does not hold any collateral as security.

Liquidity Risk

The Trust's net operating costs are incurred under three year agency purchase contracts with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust receives such contract income in accordance with Payment by Results (PBR), which is intended to match the income received in year to the activity delivered in that year by reference to the National Tariff procedure cost. The Trust received cash each month based on an annually agreed level of contract activity and there are quarterly payments made to adjust for the actual income due under PBR. This means that in periods of significant variance against contracts there can be a significant cash-flow impact. The Trust has adequate liquidity to deal with these variances.

The Trust finances it's capital expenditure from internally generated funds or funds made available from Government, in the form of additional Public Dividend Capital, under an agreed limit. In addition, the Trust has borrowed from the Department of Health Financing Facility and may also borrow commercially in order to finance capital schemes. Financing is drawn down to match the capital spend profile of the scheme concerned and the Trust is not, therefore exposed to significant liquidity risks in this area.

24. Financial instruments (continued).

	Group		Foundation Trust	
	2021/22	2020/21	**2021/22**	2020/21
	£000	£000	**£000**	£000
Financial assets at amortised cost				
Loans and receivables (including cash and cash equivalents)	**47,410**	39,486	**44,097**	38,990
Investments	**-**	-	**1,000**	1,000
Consolidated NHS Charitable fund financial assets	**2,565**	2,223	**-**	-
	49,975	41,709	**45,097**	39,990
Financial liabilities at amortised cost				
Loans and payables	**41,473**	32,471	**36,820**	30,743
Consolidated NHS Charitable fund financial liabiilities	**30**	37	**-**	-
	41,503	32,508	**36,820**	30,743

Management consider that the carrying amounts of financial assets and financial liabilities recorded at amortised cost in the financial statements approximate to their fair value.

25. Charitable funds reserve.

Unrestricted income funds comprise those funds which the Trustee is free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include designated funds, where the donor has made known their non binding wishes or where the Corporate Trustee, at its discretion, has created a fund for a specific purpose**.**

Restricted funds are funds which are to be used in accordance with specific restrictions imposed by the donor.

The charity has one permanent endowment fund. The income of the Elsie Sykes Endowment Fund can be used for medical equipment or medical research (excluding transplant or vivisection work).

	Group	
	2021/22	2020/21
	£000	£000
Unrestricted income funds	**745**	398
Restricted funds	**37**	49
Endowment fund	**1,753**	1,739
	2,535	2,186

26. Ultimate parent.

As an entity operating in the National Health Service in England, the ultimate parent holding is considered as the Department of Health and Social Care.