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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# 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.

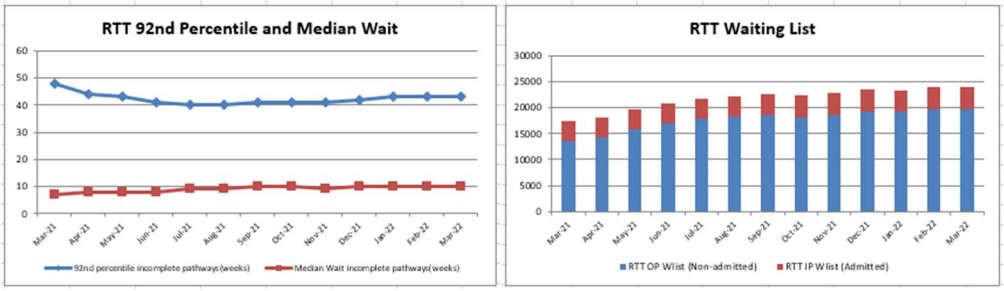
### 3.2.1 Operational Performance

#### 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.

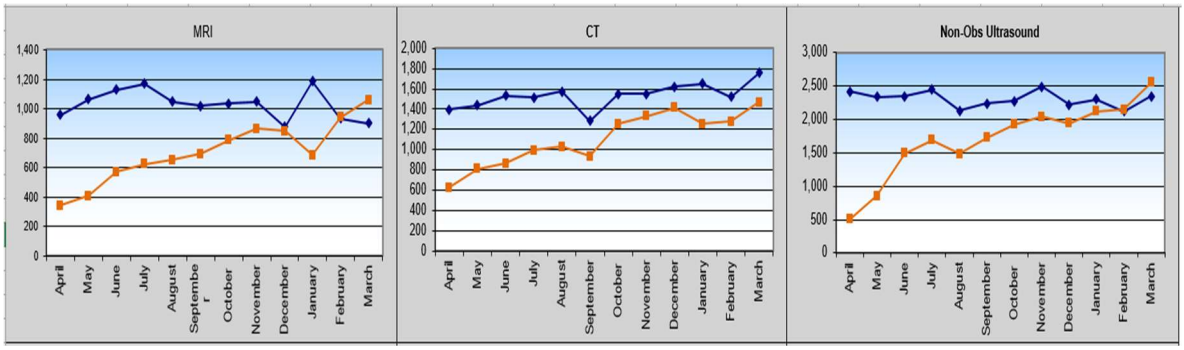
**Figure 1: RTT Waiting times**




#### 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

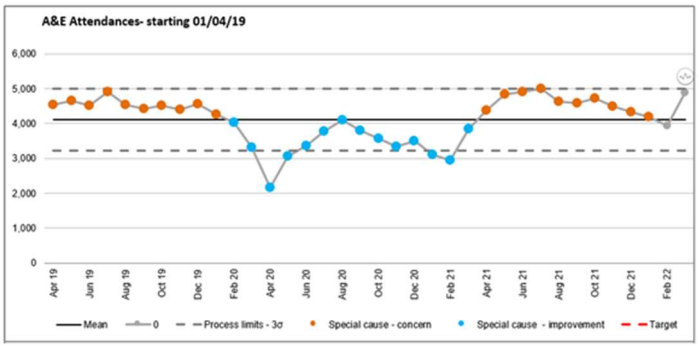
| 31 day first treatments | Apr-21 | May-21 | Jun-21 | Q1 | Jul-21 | Aug-21 | Sep-21 | Q2 | Oct-21 | Nov-21 | Dec-21 | Q3 | Jan-22 | Feb-22 | Mar-22 | Q4 | 2021/22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Treatments | 99 | 87 | 125 | 311 | 135 | 95 | 112 | 342 | 106 | 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

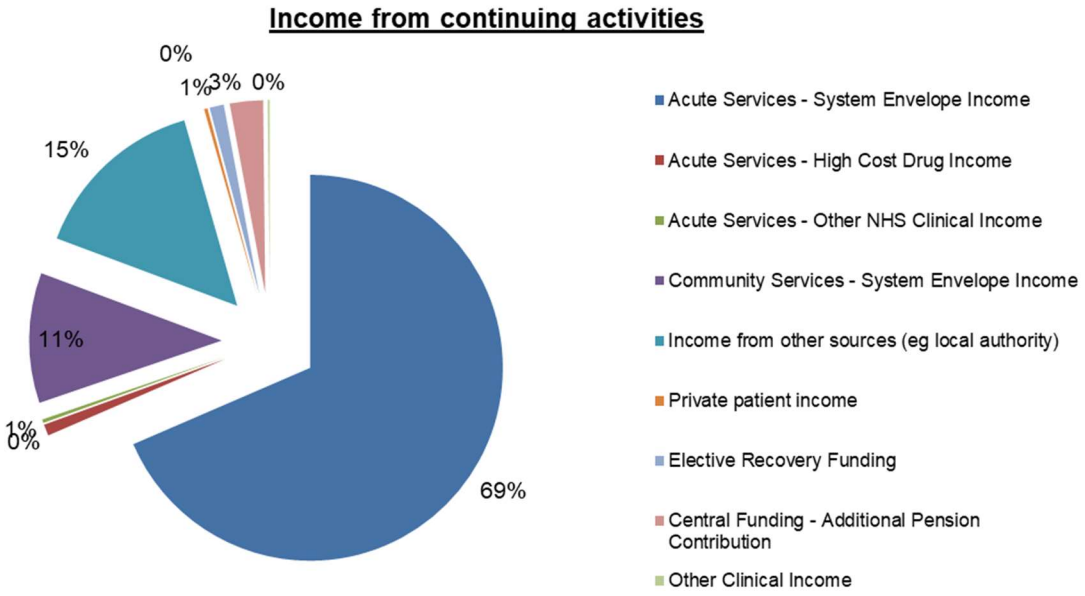
The Income and Expenditure position for the Trust for 2021/22 was a surplus of £9,612k. The table below provides a high level comparison of the Income and Expenditure account for the year.

| £'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.

#### 3.2.4.1. Income Generated from Continuing Activities

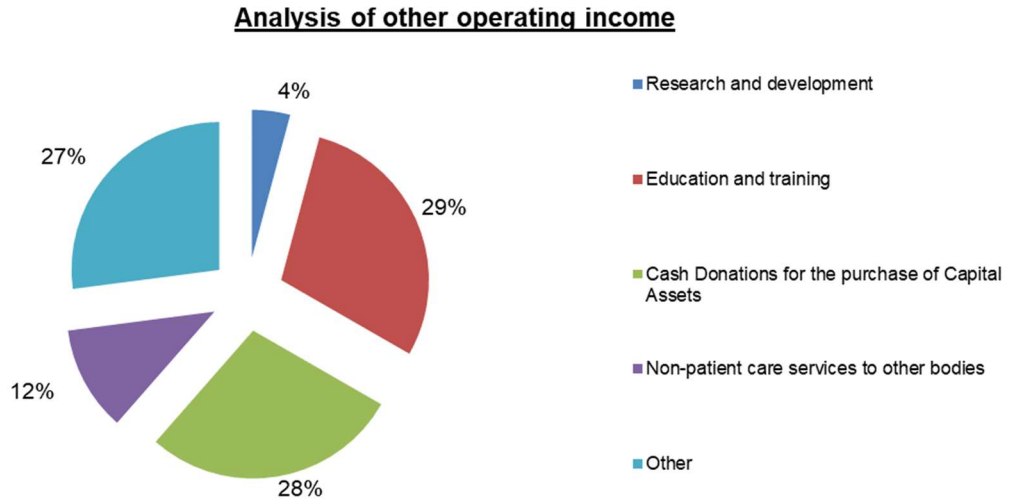
Total income from continuing activities for the year 2021/22 was £284,192k. This represented 87.6% of total income for the year. An analysis of this income is shown below:




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

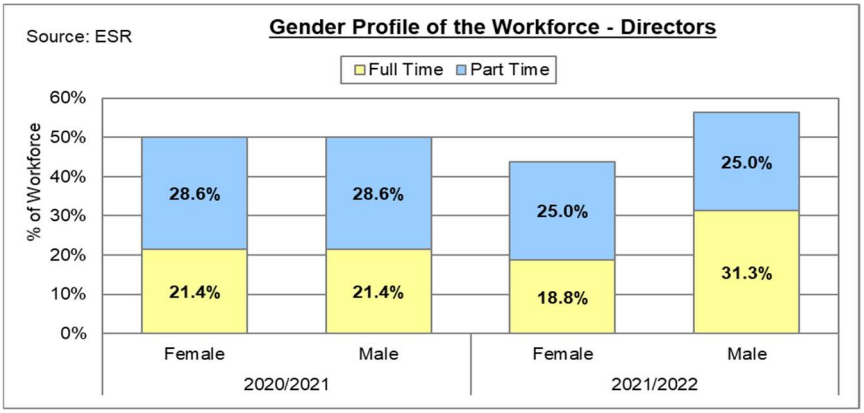
All of the data profiles of the Trust's staff in the charts below have been collated from the Trust's Electronic Staff Record (ESR) system and provides a comparison between 2020-21 and 2021-22. All figures are taken for the end of the financial year and include all staff employed by the Trust, with the 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.

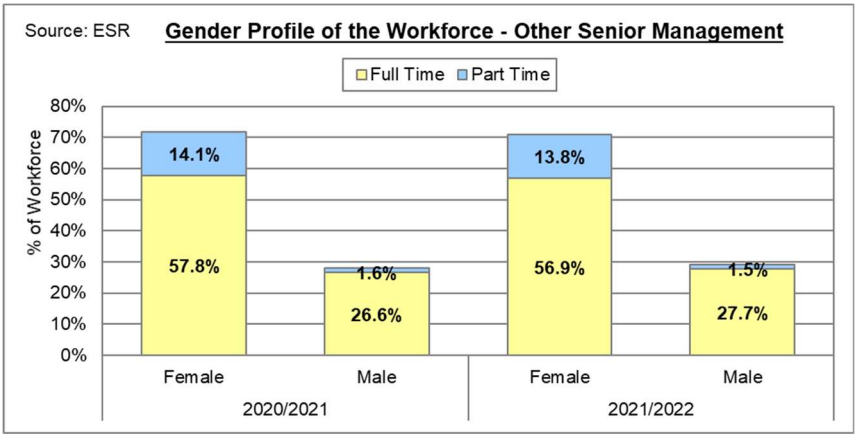
#### 4.3.2. Analysis of the Male and Female Directors, Other Senior Managers and Employees as at 31 March 2022




The table below gives a breakdown of the number of Directors, including Non-Executive Directors, by gender, as at 31 March 2022.

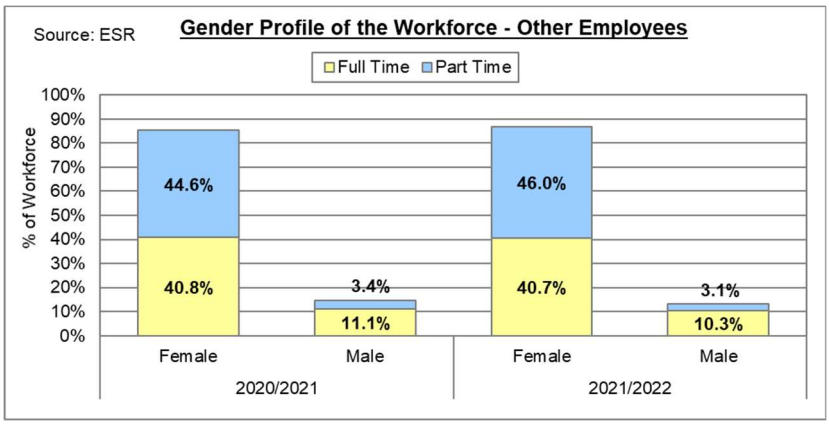
| Gender | Category | 2020/2021 | 2021/2022 |
|---|---|---|---|
| **DIRECTORS** | | **Headcount** | **Headcount** |
| Female | Full Time | 3 | 3 |
| | Part Time | 4 | 4 |
| Male | Full Time | 3 | 5 |
| | Part Time | 4 | 4 |
| **TOTAL** | | **14** | **16** |

*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** |

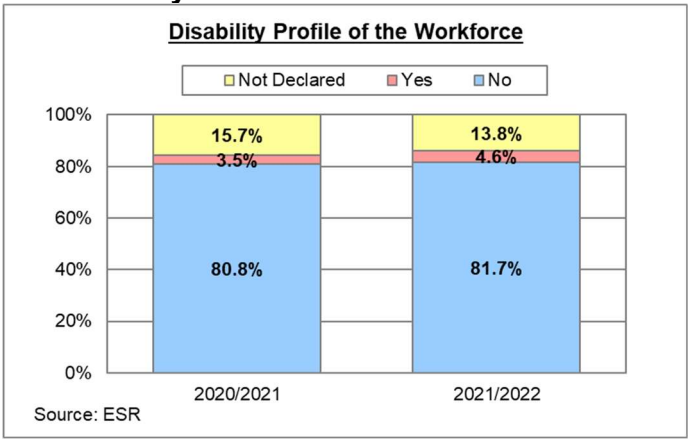
### 4.3.3 Sickness absence data

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



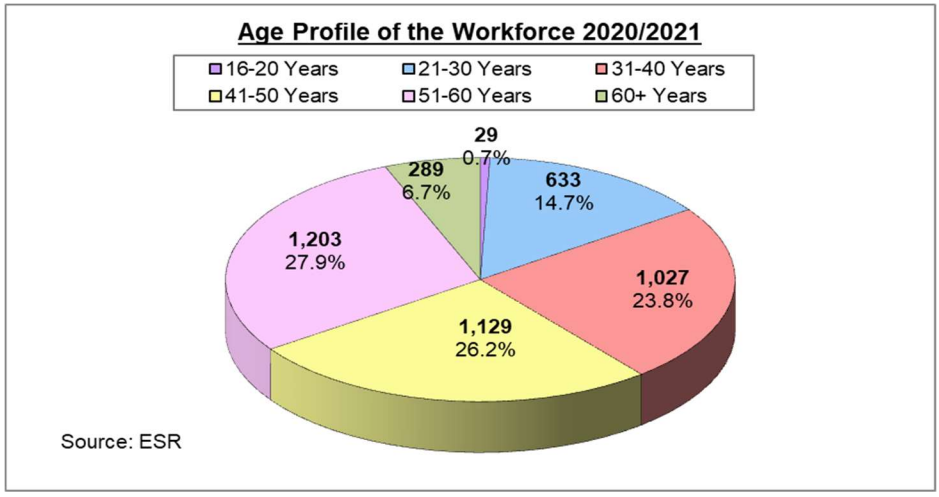

The table below gives a breakdown of the number of employees registered as having a disability as at 31 March 2022.

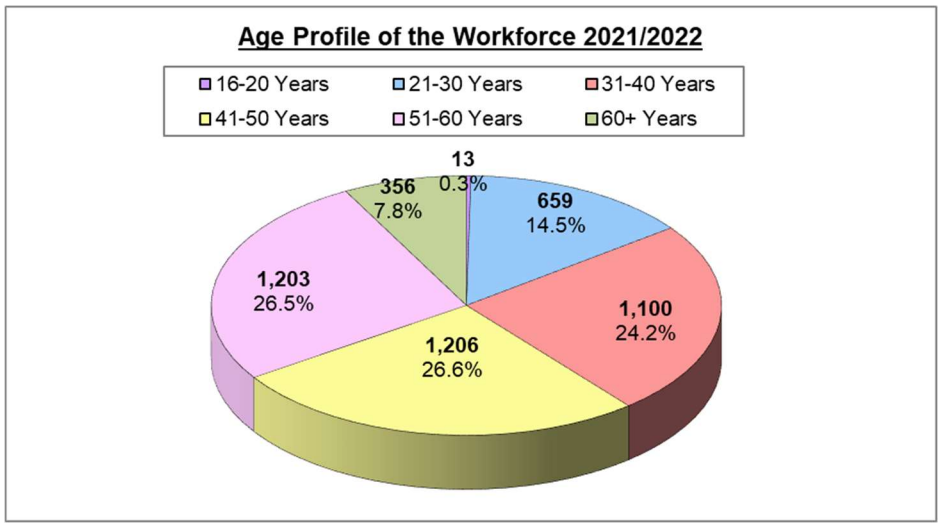
| Disabled | 2020/2021 | 2021/2022 |
|---|---|---|
| | Headcount | Headcount |
| No | 3,483 | 3,706 |
| Yes | 152 | 207 |
| Not Declared | 675 | 624 |
| **TOTAL** | **4,310** | **4,537** |

### 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.

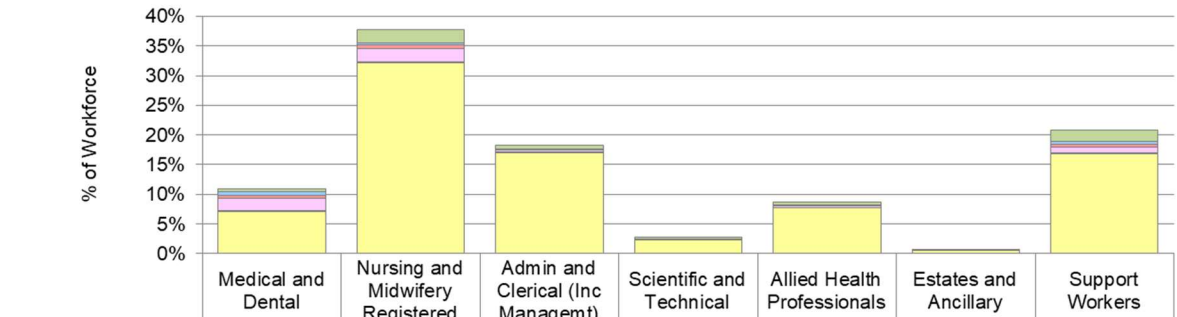
| | 2020/2021 | | 2021/2022 | |
|---|---|---|---|---|
| Age Band | Headcount | % of Workforce | Headcount | % of Workforce |
| 16-20 Years | 29 | 0.7% | 13 | 0.3% |
| 21-30 Years | 633 | 14.7% | 659 | 14.5% |
| 31-40 Years | 1,027 | 23.8% | 1,100 | 24.2% |
| 41-50 Years | 1,129 | 26.2% | 1,206 | 26.6% |
| 51-60 Years | 1,203 | 27.9% | 1,203 | 26.5% |
| 60+ Years | 289 | 6.7% | 356 | 7.8% |
| **TOTAL** | **4,310** | | **4,537** | |



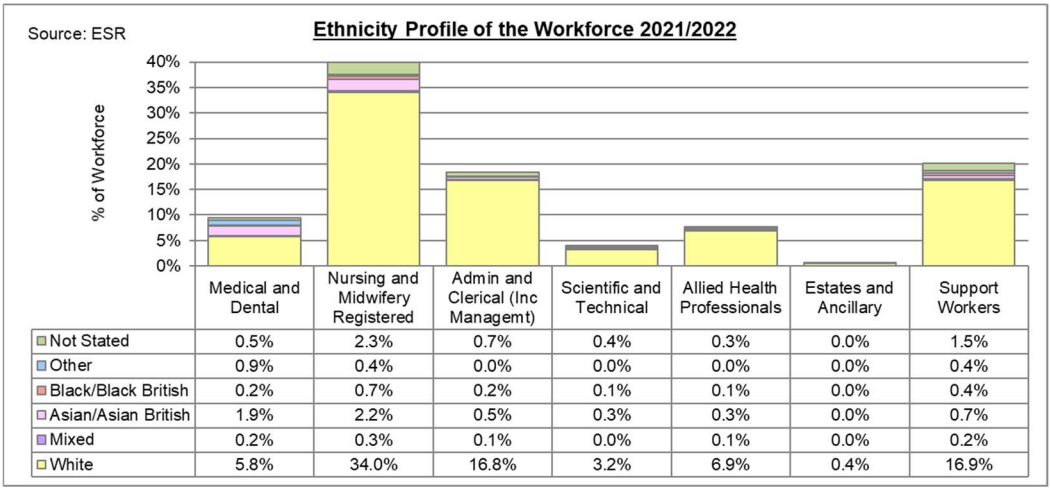




### 4.3.6 Analysis of the Ethnicity Profile of the Workforce as at 31 March 2022

Source: ESR




| | 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.<br><br>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.<br><br>Ensuring that systems for financial reporting are subject to review to ensure completeness and accuracy of information and compliance with relevant legislation and requirements.<br><br>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.<br><br>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.<br><br>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.<br><br>Review the annual report and plan for the following year. |
| • External Audit | Ensuring that the organisation benefits from an effective external audit service.<br><br>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.<br><br>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 | | | | ✓ |

### 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

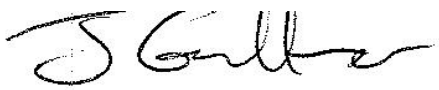
| | Note | Group 2021/22 Total £000 | Group 2020/21 Total £000 |
|---|---|---|---|
| **Operating income from continuing operations** | 3.1 | **324,260** | 297,379 |
| **Operating expenses of continuing operations** | 4.1 | **(312,153)** | (293,907) |
| **OPERATING SURPLUS** | | **12,107** | 3,472 |
| **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

| | | Group | |
|---|---|---|---|
| | | **31 March 2022** | 31 March 2021 |
| | **Note** | **£000** | £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

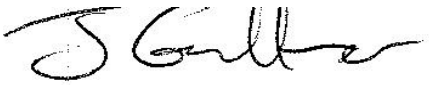
| | Note | Foundation Trust 2021/22 Total £000 | Foundation Trust 2020/21 Total £000 |
|---|---|---|---|
| **Operating income from continuing operations** | 3.1 | **324,636** | 297,580 |
| **Operating expenses of continuing operations** | 4.2 | **(309,571)** | (293,947) |
| **OPERATING SURPLUS** | | **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.

**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 | | Foundation Trust | |
|---|---|---|---|---|
| | **2021/22 £000** | 2020/21 £000 | **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**

| | Group | | Foundation Trust | |
|---|---|---|---|---|
| **Current** | **2021/22 £000** | 2020/21 £000 | **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 £000** | 2020/21 Total number of cases | 2020/21 Total value of cases £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.