COUNCIL OF GOVERNORS' MEETING (held in PUBLIC)

Tuesday 21 November 2023 from 2.30pm – 4.00pm
To be held at the Pavilions of Harrogate (Nidd Room)
AGENDA

Agenda items listed in blue text are to be received for information / assurance with no discussion time allocated within the agenda.
Papers for these items may be found within the Supplementary paper pack

Item No.	Item	Lead	Action	Paper
1.0	**Welcome and Apologies for Absence**	Sarah Armstrong Chair	Note	Verbal
2.0	**Declarations of Interest**	Sarah Armstrong Chair	Note	Attached
3.0	**Minutes of meetings:**	Sarah Armstrong Chair	Approve	Attached
3.1	Council of Governors (6 June 2023)			
3.2	Annual Members Meeting 2022			
4.0	**Matters arising and Action Log**	Sarah Armstrong Chair	Note	Attached
5.0	**Chair's Update**	Sarah Armstrong Chair	Note	Verbal
6.0	**Chief Executive: Strategic and Operational Update**	Chief Executive	Note	Verbal
6.1	Corporate Risk Register		Note	Blue Box Item
6.2	Integrated Board Report		Note	Blue Box Item
7.0	**Annual Report & Accounts**	Sarah Armstrong	Approve	Attached
7.1	Annual Report	Chief Executive		
7.2	Annual Accounts	Director of Finance		
7.3	External Audit Opinion	Azets		
8.0	**CoG Sub-Committees: Terms of Reference**	Sue Grahamslaw	Approve	Attached
8.1	Remuneration, Nomination and Conduct Committee			
8.2	Governor Development and Membership Engagement Committee (GDMEC)			
9.0	**Formal Declaration: Deputy Lead Governor Election Outcome**	Sarah Armstrong Chair	Note	Verbal
10.0	**Questions from Governors**	Sarah Armstrong Chair	Note	Attached
11.0	**Any other relevant business**	Sarah Armstrong Chair	Note	Verbal
12.0	**Evaluation of meeting**	Sarah Armstrong Chair	Note	Verbal
13.0	**Date and Time of Next Meeting** Date & Venue: TBC; 4:00-5:30pm	Sarah Armstrong Chair	Note	Verbal

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Council of Governors – Register of Interests As at 14 November 2023				
Council Member	**Constituency**	**Relevant Dates From**	**To**	**Declaration Details**
Sarah Armstrong	Chair from 1 April 2022	April 2022	(current)	1. Company director for the flat management company of current residence 2. Chief Executive of the Ewing Foundation
Ian Barlow	Rest of Yorkshire	September 2023	(current)	1. Trustee – Forces Online charity
Nick Brown	Stakeholder: North Yorkshire Council	May 2023	(current)	1. North Yorkshire Councillor 2. Chair – Cundall with Leckby Parish Council 3. Trustee – Harrogate & District Improvement Trust 4. Board Member – Northern Aldborough Festival 5. Trustee – Harrogate International Partnership 6. Member – Skipton & Ripon Conservative Association 7. Vice-Chair – Newby & Wathvale Conservative Branch
Rachel Carter	Ripon & West District	July 2023	(current)	Nil
Donald Coverdale	Ripon & West District	September 2021	(current)	Nil
Martin Dennys	Harrogate & Surrounding Villages	January 2019	(current)	1. Directorships – not with any services to the NHS 2. Employee – NHS England
Tony Doveston	Harrogate & Surrounding Villages	January 2016	(current)	Nil
Mike Dunn	Wetherby and Harewood Wards and Alwoodley Adel and Wharfedale & Otley & Yeadon Wards	July 2022	(current)	Nil

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Council of Governors – Register of Interests As at 14 November 2023				
Council Member	**Constituency**	**Relevant Dates From**	**To**	**Declaration Details**
Kathy Gargan	Harrogate & Surrounding Villages	March 20221 July	(current)	1. Director – North of England Horticulture Society Ltd
Clare Illingworth	Stakeholder: HIF	January 2016	(current)	1. Employee – Harrogate Integrated Facilities Ltd
Jackie Lincoln	Knaresborough & East District	July 2022	(current)	1. Director, Jackie Lincoln Associates - Management Consultancy (07740067) 2. Clerk to Parish (non executive) Walkingham with Occaney
Binish Mehar	Staff: Medical Professionals	October 2023	(current)	TBC
Richard Owen-Hughes	Knaresborough & East District	January 2022	(current)	1. Marketing Director at Driver Hire Group Services Ltd
Kevin Parry	Harrogate and Surrounding Villages	July 2023	(current)	1. Director, Cogenic Ltd
Rick Sweeney	Harrogate & Surrounding Villages	July 2022	(current)	1. Trustee & Treasure of the White Rose Concert Band 2. Member/volunteer ranger at Longlands Common
Steve Treece	Wetherby and Harewood Wards and Alwoodley Adel and Wharfedale & Otley & Yeadon Wards	January 2017	(current)	1. Committee Member of Institute of Risk Management Health Special Interest Group
Stephen Williams	Staff: Nursing, Midwifery & AHPs	October 2023	(current)	TBC
Stuart Wilson	Staff: Non-Clinical	July 2022	(current)	Nil

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COUNCIL OF GOVERNORS' MEETING (HELD IN PUBLIC)
6th June 2023
The Crowne Plaza Hotel, Harrogate

Present:
Sarah Armstrong, Chair
Clare Illingworth, Lead Governor
Councillor Nick Brown, Stakeholder Governor (CB)
Donald Coverdale, Public Governor (DC)
Martin Dennys, Public Governor (MDe)
Tony Doveston, Public Governor (TD)
Mike Dunn, Public Governor (MDu)
Sue Eddleston, Public Governor (SE)
Jackie Lincoln, Public Governor (JL)
Kathy McClune, Staff Governor (KM) *via Teams (MC)*
Richard Owen-Hughes, Public Governor (ROH)
Karen Stansfield, Stakeholder Governor (KS)
Richard Sweeney, Public Governor (RSw)
Steve Treece, Public Governor (ST)
Stuart Wilson, Staff Governor (SW)

In attendance:
Jeremy Cross, Non-Executive Director (JCr)
Andy Papworth, Non-Executive Director (AP)
Richard Stiff, Non-Executive Director (RS)
Kama Melly, Non-Executive Director (KM)
Jonathan Coulter, Chief Executive
Jackie Andrews, Executive Medical Director
Matt Graham, Director of Strategy
Jordan McKie, Director of Finance
Russell Nightingale, Chief Operating Officer
Emma Nunez, Deputy CEO & Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs)
Angela Wilkinson, Director of Workforce & Organisational Development
Kate Southgate, Associate Director of Quality and Corporate Affairs
Andy Williams, Chief Digital Officer
Giles Latham, Communications Manager

Item No.	Item
COG/6/6/1	**Welcome and apologies for absence**
1.1	The Chair welcomed everyone to the meeting. The Chair welcomed Clare Illingworth, Lead Governor back to the Council as well as Sue Eddleston.
1.2	The Chief Digital Officer was welcomed to the Council to discuss the digital programme and the new Electronic Patient Record.
1.3	The Chair highlighted the use of "blue box" items and how they would be used as supplementary information at future meetings.
1.4	Apologies for absence were received from: Chiara Debiase, Non-Executive Director, Azlina Bulmer, Associate Non-Executive Director, Julia Weldon, Non-

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1.5	Executive Director, Ian Barlow, Public Governor, Laura Robson, Non-Executive Director, Wallace Sampson, Non-executive Director and Kathy Gargan, Public Governor (KG).
COG/6/6/2 **2.1**	**Declarations of Interest** No further declarations of interest were noted.
COG/6/6/3 **3.1**	**Minutes of the previous Council of Governors (Public) meeting held on 7th March 2023** **Resolved:** The minutes of the last meeting held on 7th March 2023 were agreed as an accurate record.
COG/6/6/4 **4.1**	**Matters Arising and Action Log** The following matters arising and actions were noted: • The Chief Operating Officer provided an updated on Glaucoma. It was noted that in 2020 3,000 Glaucoma Patients remained on the waiting list. This had reduced to a current position of 462. All patients sit within the amber and green pathway, and no patients were on the red pathway ie no high risk patients. The trajectory was 0 patients by June 2023 this has been moved to September 2023. The action would remain open until the backlog had been eradicated. • COG/3/7/10.21 – The Chief Operating Officer provided an update on the funding and provision of autism assessments. It was noted that it was currently on the Corporate Risk Register. Meetings had taken place between commissioners and the Trust. Updates on mitigation against the current risk were also provided. The action would remain open.
4.2	**Resolved:** Actions were agreed as above.
COG/6/6/5 **5.1**	**Overview by the Chair** The Chair noted that it had been a busy period since the last meeting of the Council.
5.2	The Chair highlighted: Attendance at the Healthcare Innovation Summit, National volunteers week with thanks expressed to the Council for their role in volunteering as a Governor to support HDFT and an update on the revised process for Chair and Non-executive Director appraisals was provided.
5.3	The Chair highlighted the Governor drop in session later in the week.
5.4	An NHS Providers event on the role of governors was noted. The Governor (TD) had attended and he provided an update on the event.
5.5	It was confirmed that the Governors Noticeboard were now displayed in the front entrance of the Harrogate Hospital site.
5.6	**Resolved:** The Chair's report was noted.
COG/6/6/6 **6.1**	**Non-Executive Director Briefing** The Non-executive Director (AP) expressed his thanks to all for their support as he became Vice Chair of the Trust.

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6.2	The Non-executive Director (AP) provided an update on maternity and his role as Non-executive Director Maternity Safety Champion. The four key aims of the role were highlighted. This included an independent oversight, resources available, visibility of maternity on the Trust Board agenda and finally to ensure the views of patients and staff are heard.
6.3	The recently published CQC Maternity Report was highlighted. The Non-executive Director highlighted the positive work that was noted in the report. There were areas that were noted as requiring further action and it was confirmed that a robust action plan had been submitted to the CQC. The CQC had accepted the action plan and this was now being monitored through the quality governance framework. Areas highlighted for national best practice were also noted.
6.4	The Governor (ROS) queried the impact on the confidence of women using the service as a result of the CQC report. The Non-executive Director (AP) and the Executive Director of Nursing, Midwifery and AHPs noted that a small number of women and families had made contact following the publication of the CQC report and discussions were held. The leadership team within Maternity Services met with the individuals and offers for visits to the Service were offered and taken up.
6.5	**Resolved:** The Non-Executive Directors update was noted.
COG/6/6/7	**Chief Executive, Strategic and Operational Update**
7.1	The Chief Executive took his report as read and confirmed that this report had also been presented to Public Board on the 31st May 2023.
7.2	The Governor (MDe) queried the learning from the Covid recovery programme. The Chief Operating Officer provided an update on innovation in place for post surgical procedure follow-ups. This included a post surgical personalised videos and letters as an alternative to in person follow up appointments. In a wider sense, learning was wide spread and clinically led and the changes that had been implemented since Covid would remain.
7.3	**Resolved:** The Chief Executives report was noted.
COG/6/6/7	**Elections**
7.1	The Chair took the report that was contained in the agenda as read. The Chair provided an overview of the work that had been undertaken to date which included ensuring the Council represented the full extent of the services provided by HDFT.
7.2	The Governor (MDu) queried if work was ongoing to ensure a reduced number of elections. It was confirmed that this was ongoing.
7.3	The Governor (MDe) queried how the services for young people were represented. The Chair confirmed that this was being achieved by changing the Rest of England constituency and the introduction of the 0-19 staff constituency.

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7.4	It was confirmed that the Youth Forum would also be re-launched to help ensure engagement of children and young people.
7.5	The Governor (SE) queried if as a member of RNCC she had been given the opportunity to comment on the proposals. The Chair would discuss this with the Governor outside of the meeting.
7.6	**Resolved:** (i) The 3 Public Governors impacted by the election timetable were approved to be extended for a further 2 weeks until the 14th July 2023, (ii) The 1 Staff Governor impacted by the election timetable was approved to be extended to the 1st October 2023.
COG/6/6//8 **8.1**	**Quality Accounts** The Executive Director of Nursing, Midwifery and AHPs provided an overview of the Quality Account for the Council. It was noted that the final submission was at the end of June 2023.
8.2	The Non-executive Director (AP) noted that he liked the style of the document this year. It was noted as an easier read than previous years.
8.3	It was noted that any comments can be provided to the Associate Director of Quality and Corporate Affairs.
8.4	**Resolved:** The Update was noted.
COG/6/6/9 **9.1**	**Electronic Patient Record (EPR) Update** The Chief Digital Officer and the Executive Medical Director introduced the update on digital and EPR. This was a complex digital transformation programme, that EPR was one of over 90 digital projects. This was a wide ranging change management project. 8 digital clinical leads had been appointed to ensure the clinical voice was represented. Future developments would include how the patient voice would be fed into the project.
9.2	The digital maturity of the organisation was not at an optimum level and as a result a new system to level up the Trust was being introduced. The Chief Digital Officer highlighted as part of the presentation the stages that would be undertaken from planning to implementation.
9.3	The EPR convergence principles were explained to the Council and the current system implications were highlighted.
9.4	The Council were briefed on the progress to date including key individuals in post and the governance system in place. The HDFT Business Case had been approved by Private Board and support had been received from the ICS. Regional and national approval would now be sought, this was anticipated in August 2023.
9.5	The Governor (TD) queried if digital skills were available externally. The Executive Medical Director noted that the last 12 months had been used to up skill internal teams. It was noted that external support would be required and this was included within the Business Case.

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9.6	The Governor (MDu) noted that the system needed to be intuitive as well as integrated with current systems and whether this product was available. It was noted that as part of the procurement process an adaptive system would be necessitated. A modular system supplier would enable this to a greater extent.
9.7	The Governor (MDu) also queried the software for use as a data platform. It was confirmed that this was being reviewed alongside the work of the Chief Operating Officers Team.
9.8	The Lead Governor queried if the input that colleagues within HDFT had at the commencement of the project had been taken into account. It was confirmed that these views had been utilised to build the core procurement requirements. The Lead Governor also queried how colleagues would be limited from procuring equipment and software that would not be compatible with the new EPR. It was confirmed that the digital governance structures should prevent this scenario from occurring.
9.9	The Governor (ST) queried the change management aspect of the project and how it was being addressed. It was confirmed that this work would require a framework and this was being undertaken with support from the KPMG / Catalysis Continuous Improvement project that the Council had been briefed on previously. The Executive Medical Director provided the Council with a short overview.
9.10	**Action:** To circulate the presentation from the Chief Digital Officer to member of the Council.
9.11	**Resolved:** The EPR and Digital Update was noted.
COG/6/6/10	**Annual Review: Code of Conduct**
10.1	The Chair noted the report as read and noted that all changes were highlighted in red text for ease of review for Council.
10.2	A discussion was held and further minor amendments to the Code were noted for consistency with the Constitution.
10.3	**Action:** To recirculate the amended Code of Conduct.
10.4	**Resolved:** The Code of Conduct was approved subject to minor amendments.
COG/6/6/11	**Questions from Governors**
11.1	The Chair thanked Governors for the questions submitted in advance of the meeting. The responses to each question were as follows:
11.2	Q1: Public Governor Steve Treece: Update on Freedom to Speak Up activity
11.2	

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11.3	The Executive Director of Nursing, Midwifery and AHPs confirmed that a new FTSU was in post, Joanna Cann. A review of the policy, processes and reporting arrangements had been undertaken. In addition, a network of Fairness Champions have been appointed to help support the FTSU process. An Associate FTSU has been appointed and a further vacancy remains. It was noted that 8 cases had been received in Quarter 4 for 2022-2023. This figure has remained relatively static over previous quarters. A review was ongoing in terms of noting themes and trends that had been raised via other routes. A network across the region had been established as a shared learning opportunity.
11.4	The Non-executive Director (AP) also confirmed that the FTSU attends the People and Culture Committee on a quarterly basis to discuss themes and trends.
11.5	<u>Q2: Public Governor Rick Sweeney: </u>Monitoring of diabetes for inpatients at HDFT
11.6	The Executive Medical Director had discussed the question with the Clinical Lead for Diabetes. It was confirmed that currently there were no guidelines on monitoring in hospital. In addition, due to the electronic system the Freestyle Libre could not be used and monitored.
11.7	<u>Q3: Public Governor Donald Coverdale: </u>Car Parking difficulties
11.8	The Director of Strategy and Transformation noted that the barriers at the Harrogate Hospital site were beyond their life expectancy and work was ongoing to address this. Whilst a longer term solution was in the process of being developed, a HIF colleague would be present within the car park to mitigate against these issues.
11.9	The Governors (TD) noted the new system for applying for car park passes was being developed and how colleagues will have to re-apply for car parking spaces. The Director of Strategy and Transformation confirmed that a points based system would be implemented.
11.10	<u>Q4 Public Governor Steve Treec: </u>smoking at the front entrance to the hospital
11.11	The Chief Executive noted that HDFT are committed to being a smoke free site and a separate smoking area would not be provided. Work was ongoing to increase cleaning in areas surrounding the wider site.
11.12	<u>Q5 Public Governor Steve Treece: </u>acute stroke services.
	The Executive Medical Director confirmed that this item was discussed regularly through the Quality Governance Framework including at Quality Committee and at Board via the Quality Committee Chair's Report. An update was provided on the networks that HDFT were part of for stroke services. A piece of work was ongoing to ensure that our pathways were fit for purpose. It was confirmed that the Hyper Acute Service at York was being utilised. The Non-executive Director (RS) confirmed as a member of the Quality Committee that this would remain under review via the Quality Committee.

COG/6/6/12 **12.1**	**Any Other Business** The Director of Strategy and Transformation provided an update on Ripon Hospital. A national review had been undertaken on diagnostic availability. An application had been made to ensure funding for reconfigure of the diagnostic services at Ripon. This would be completed by the end of the calendar year.
COG/6/6/13 **13.1**	**Evaluation of the Meeting** Any comments to be circulated to the Chair.
COG/6/6/14	**Date and Time of Next Meeting** The next meeting would take place on Tuesday, 5th September 2023 with venue and timings to be confirmed.

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

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

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

AMM/12/2022/1 Welcome and introductions

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

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

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

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

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

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

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

The minutes form the Council of Governors were noted.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AMM/12/2022/8.0 Questions and Answers

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

Question 1: John Topping

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

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Response: Matt Graham

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

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

Question 2: Lucy Pettit

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

Response: Jackie Andrews

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

Question 3: Doug Masterton

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

Response: Jonathan Coulter

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

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

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

Question 4: Alan Lunn

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

Response: Jonathan Coulter

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

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

Question 5: Harrogate Hospital Radio

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

Response: Jackie Andrews

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

Question 6: Alan Lunn

Harrogate and District
NHS Foundation Trust

What was the motivation to create HIF?

Response: Mark Chamberlain

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

Comment: Jane Headley

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

Question 7: John Edwards

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

Response: Jonathan Coulter

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

AMM/12/2022/9 closing address

The Chair formally thanked everyone for attending the meeting.

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

Council of Governors (held in Public) Action Log for November 2023							
Minute Number	**Date of Meeting**	**Subject**	**Action Description**	**Responsible Officer**	**Due Date**	**Comments**	**Status -** completed is defined as confirmation received from ED responsible lead that the proposed action is completed as described in the comments column. Completed actions will not be closed until the Board has confirmed that action taken is satisfactory.
COG/12/2021/10	06 December 2021	Glaucoma	Glaucoma waiting times to be reviewed and noted	Chief Operating Officer	01 December 2023	Regular updates provided at each Council of Governors meeting since December 2021. Last update in March 2023 noted that . All patients sit within the amber and green pathway, and no patients were on the red pathway ie no high risk patients. The trajectory was 0 patients by June 2023 - updated to Setpember 2023. Action to remain open until backlog eradicated.	Ongoing
COG/12/5/9.5	05 December 2022	Integrated Board Report	Governors to be invited to a training session from the NHS England Statistical Team	Associate Director of Quality and Corporate Affairs	01 July 2023	Ongoing: To be arranged following revisions to the IBR	Ongoing
COG/3/7/10.18	07 March 2023	ICB	An overview of the ICB systems tl	Chief Executive	01 August 2023	Ongoing: To be held in the Summer Informal Governor Sessions	Ongoing
COG/3/7/10.21	07 March 2023	Autism Assessment	An update to be provided at the next Council of Governors meeting regarding	Chief Operating Officer	01 June 2023	Ongoing - Meetings had taken place between commissioners and the Trust - Council were updated on mitigation against the current risks. Action to remain open (from June 2023 minutes)	Ongoing
COG/6/5/9.10	06 June 2023	EPR Update	Circulate the presentation from the Chief Digital Officer to members of the Council	Chief Digital Officer	05 September 2023		Ongoing
COG/6/5/10.3	06 June 2023	Annual Review: Code of Conduct	To recirculate the amended Code of Conduct	Corporate Governance	05 September 2023	Final version Circulated 28 July 2023 and signed by Governors	Completed

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NHS Harrogate and District NHS Foundation Trust

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COUNCIL OF GOVERORS MEETING (PUBLIC)
21 NOVEMBER 2023

Title:	Annual Report & Accounts 2022-23
Responsible Director:	Chair, Chief Executive, Director of Finance
Author:	Chair, Chief Executive, Director of Finance

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

HIF HARROGATE INTEGRATED FACILITIES
Taking Pride in our Services

NHS
Harrogate and District
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Harrogate and District
NHS Foundation Trust

Annual Report and Accounts

1 April 2022 to 31 March 2023

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HARROGATE AND DISTRICT NHS FOUNDATION TRUST

Annual Report and Accounts

1 April 2022 to 31 March 2023

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

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Overview

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

Overview --

HDFT's Chair's Welcome and Statement

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

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

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

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

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

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

………………………………………………..
Sarah Armstrong
Chair
Harrogate and District NHS Foundation Trust

Overview ---

A Message from Jonathan Coulter, HDFT Chief Executive

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

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

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

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

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

J Coulter

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Jonathan Coulter
Chief Executive
Harrogate and District NHS Foundation Trust

Overview --

About Us

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

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

Our Acute Services

Harrogate District Hospital has:

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

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

Overview

Ripon Community Hospital has:

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

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

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

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

Additional outpatient outreach clinics are held at:

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

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

Overview

Our Community Services

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

Services include:

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

Our Children's and Young People's Services

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

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

Our Subsidiary Company

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

Overview

HDFT in Numbers

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

55,000 EMERGENCY DEPARTMENT ATTENDANCES

OVER **2,000** CANCER TREATMENTS

Overview

Our Strategy – 2022 and Beyond

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Overview

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

We exist to serve two groups:

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

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

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

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

Overview

Our strategic objectives for 2022-23 were:

Best Quality, Safest Care

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

Person Centred, Integrated Care; Strong Partnerships

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

Great Start in Life

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

At Our Best: making HDFT the best place to work

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

These objectives were supported by our enabling ambitions:

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

Overview --

Our Values

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

SECTION ONE

Performance Report

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Section 1 – Performance Report

1.1 Strategic Risks

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

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

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

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

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

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

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

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

Performance Report--

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

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

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

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

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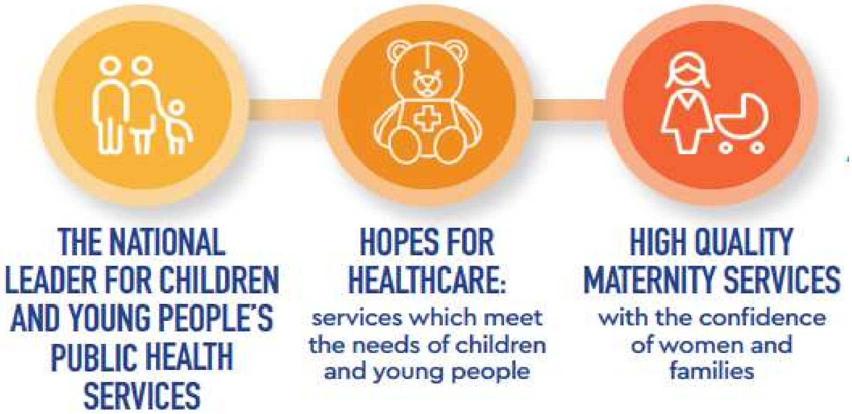
Performance Report---

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



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

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

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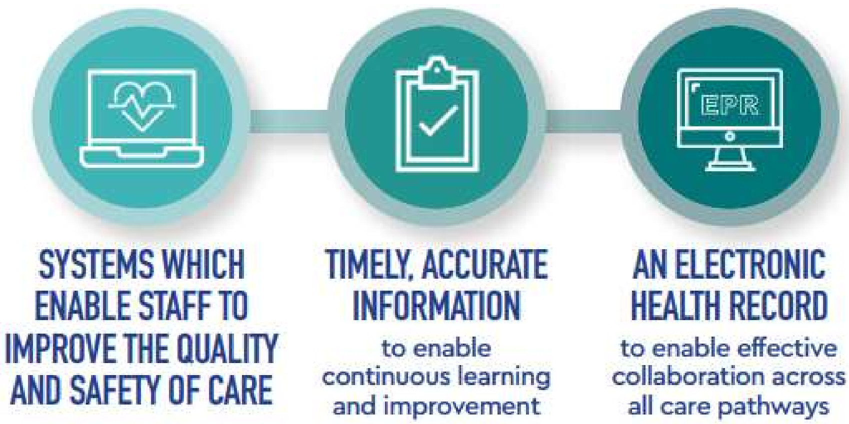
Performance Report---

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

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



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

Performance Report--

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

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

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

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

1.2 Going Concern Disclosure

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

1.3 Performance Summary

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

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

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

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

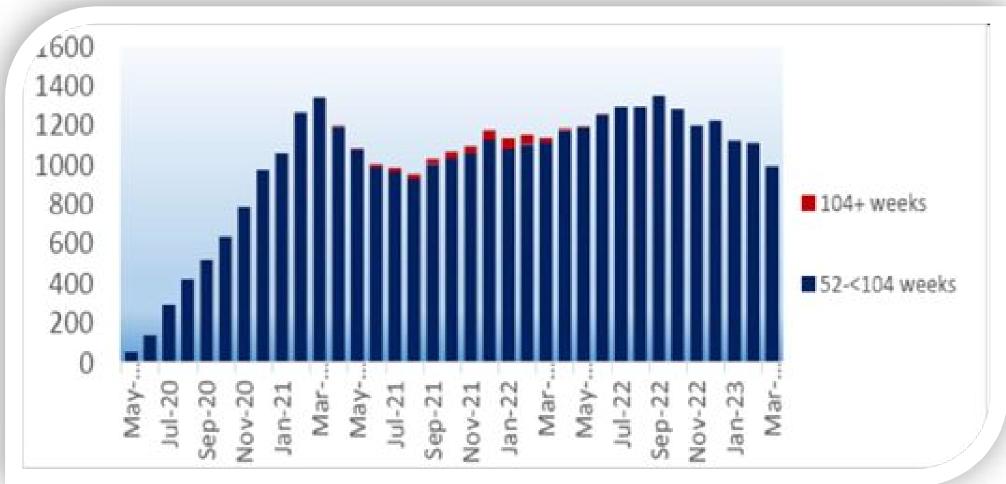
Our focus is maintaining patient safety. There has continued to be consistently good performance for timely ambulance handover in our Emergency Department.

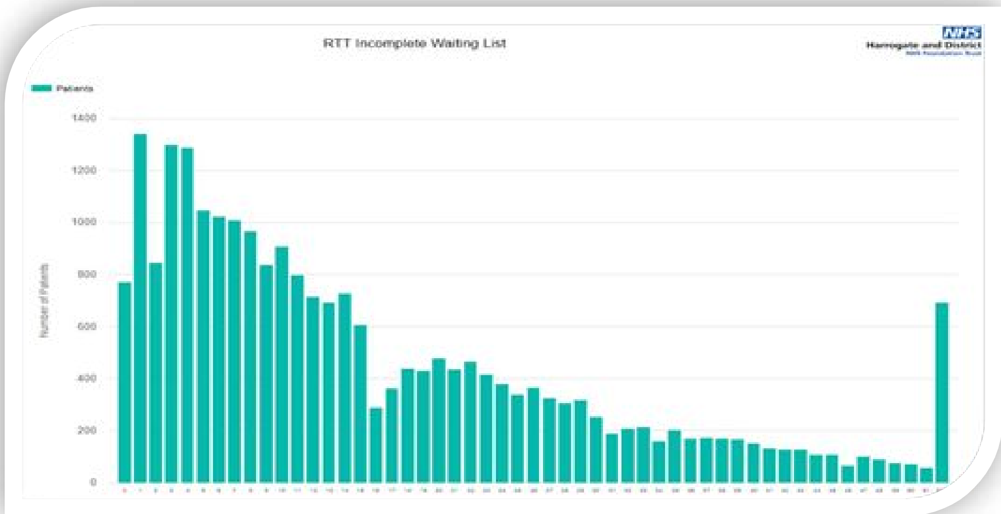
1.4 Operational Performance

Waiting Times

During 2022-23 the Trust continued to treat the most clinically urgent patients on the elective waiting list alongside patients waiting the longest time. Routine operations were impacted by the ongoing effects of COVID-19 on staff and patient availability as well as industrial action during the final quarter of the year. Routine primary care referrals remained at higher levels than 2019/20 (+5%), impacting on the total number of patients waiting, with the end of the year being at a slightly higher level (1500 patients) than the start of the year. Longer waiting times decreased throughout the year, the 92nd percentile reduced from 44 weeks in March 2022 to 42 weeks in March 2023. The number of patients waiting longer than 52 weeks decreased again by 15%, from 1176 in March 2022 to 997 in March 2023. Median waiting times remained at a consistent level throughout the year.

Long waiting patient progress and overall waiting list profile





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

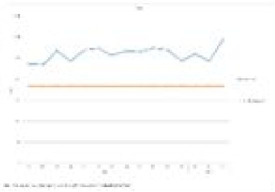
Diagnostic Tests

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

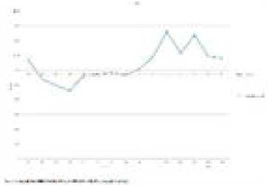
Performance Report---

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

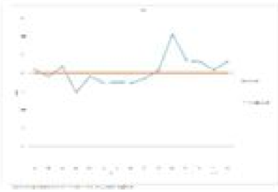
CT



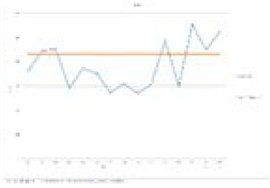
MRI



Ultrasound



Dexa



Cancer

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

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

Cancer 31 and 62 day standards

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

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

Emergency 4-hour standard and ambulance handover performance

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

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

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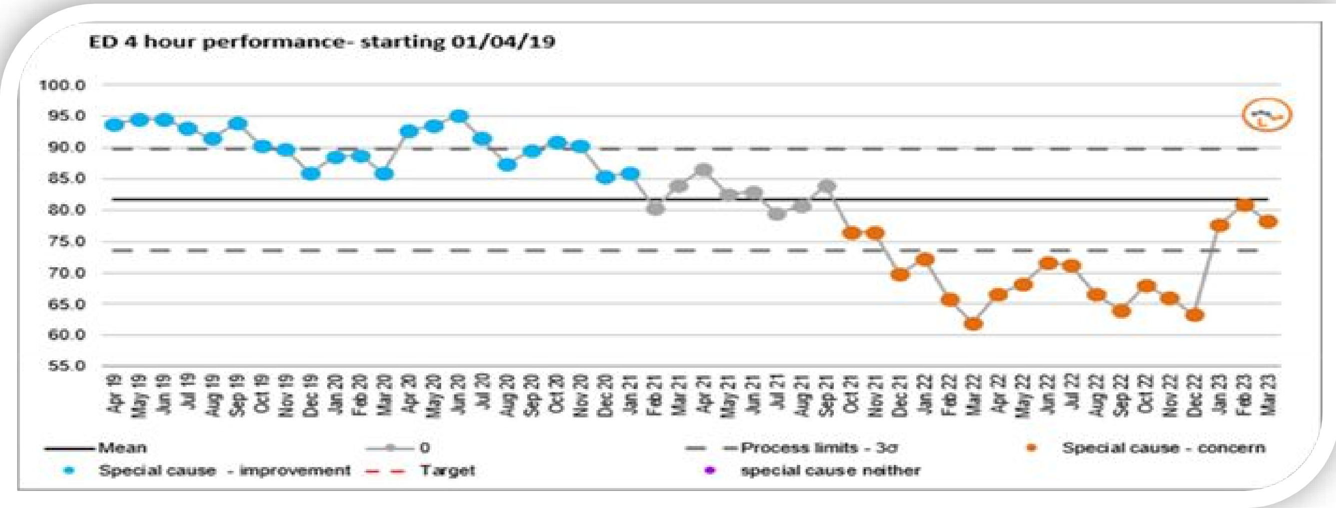
Performance Report



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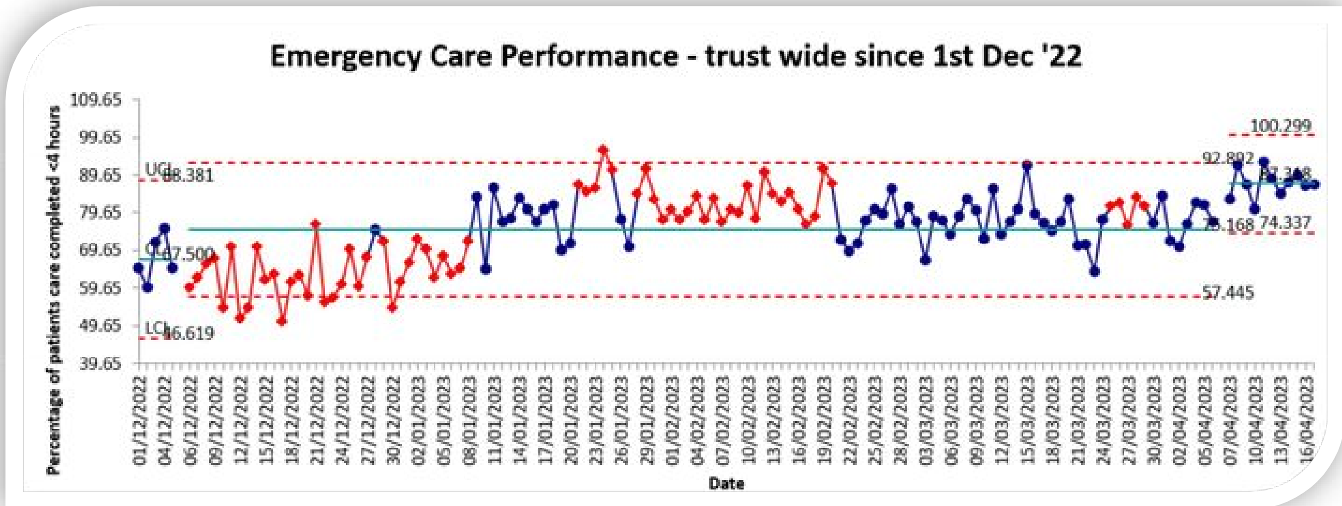

Ambulance handover has been another key focus nationally and internally, ensuring ambulance service colleagues are able to safely handover patients and be available to respond to the next community emergency. The Trust has maintained its position across the year as one of the top 10 providers. This means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

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

Infection Prevention and Control (IPC)

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

Performance Report--

Regulatory Ratings

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

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

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

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

Integrated Care Boards

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

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

Performance Report---

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

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

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

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Performance Report---

1.5 Operating and Financial Review of the Trust

Income and Expenditure Summary

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

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

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

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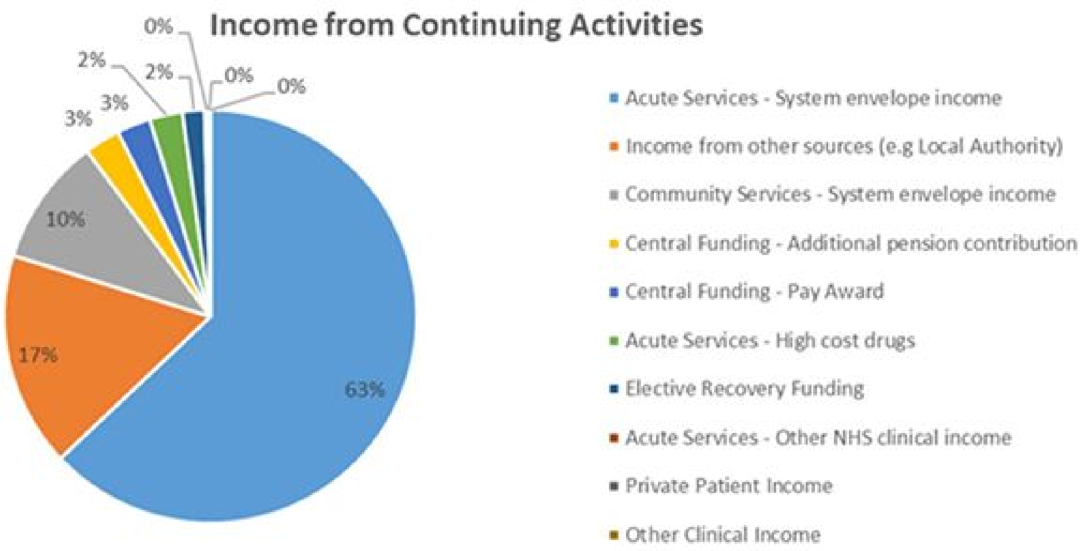
Income Generated from Continuing Activities

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

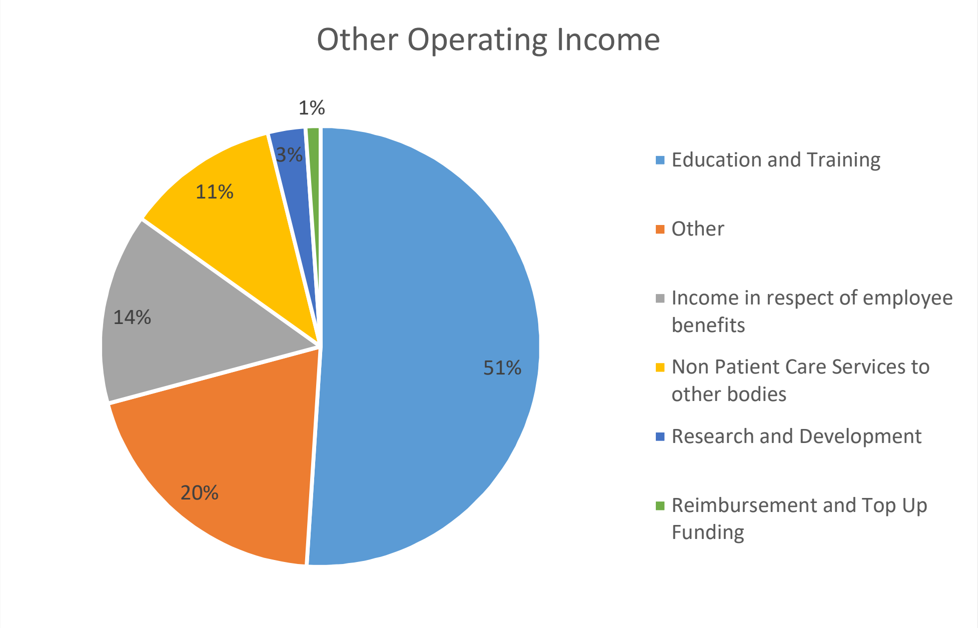


The Trust has met the requirements of section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), in that the income from the provision of goods and services for the purposes of the health service in England (principal) has exceeded income from the provision of goods and services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

Performance Report---

Other Operating Income

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



Cash

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

Use of Resource Metric

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

Financial Outlook 2023-24

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

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

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

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

Performance Report---

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

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

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

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

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

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

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

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

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

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

Performance Report---

Oversees Operation

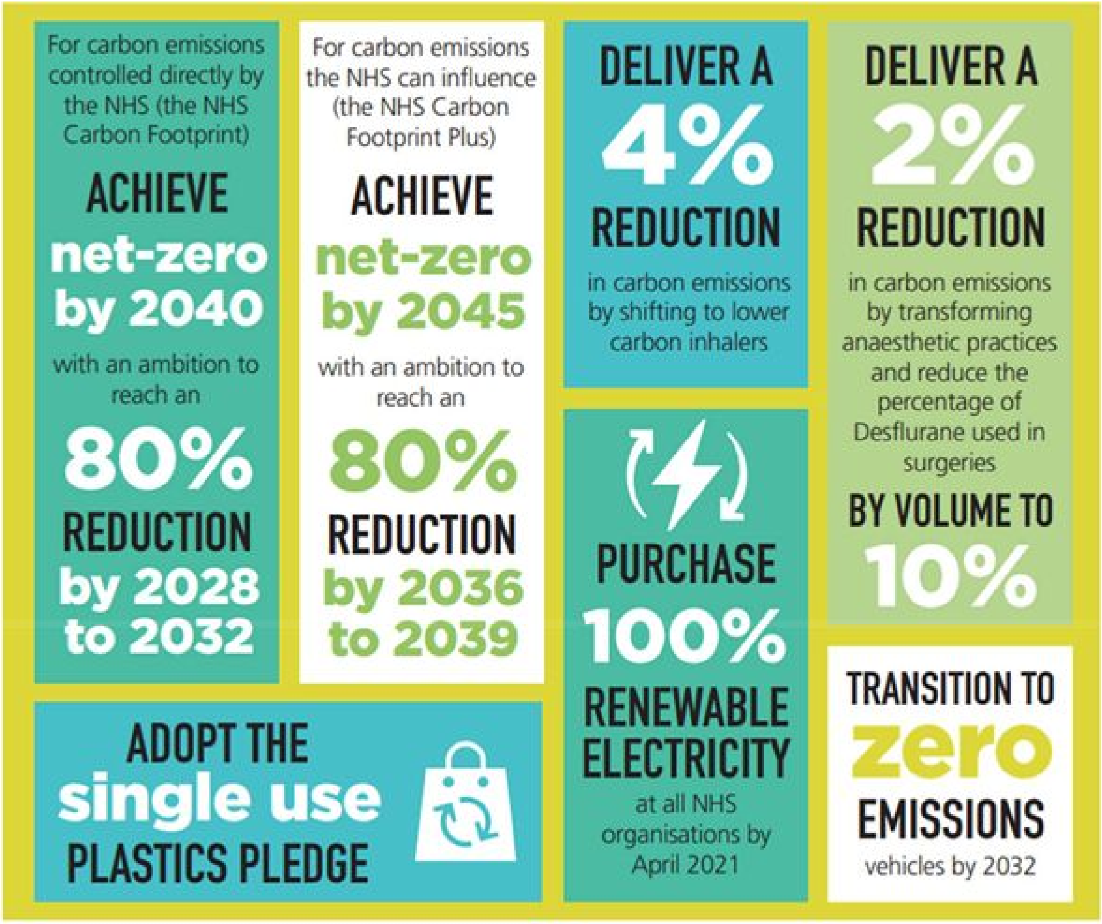
The Trust has no overseas operations.

1.6 Environmental Matters

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

Performance Report---

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



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

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

Performance Report---

1.7 Quality

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

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

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

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

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

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

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

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

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

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

The Trust operates seven staff networks:

LGBT+

Disability and Long-Term Conditions

Neurodiversity

Menopause

BAME and Allies

Men's network

Armed Forces

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

Performance Report---

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

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

Workforce Race Equality Standard (WRES)

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

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

Workforce Disability Equality Standard (WDES)

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

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

Equality Delivery Standard 2022 (EDS22)

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

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

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

Gender Pay-Gap report

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

Performance Report---

Ethnicity Pay-Gap report

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

Rainbow Badge Accreditation

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

Freedom to Speak Up Guardian

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

Belonging Sub-Group

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

Health Inequalities

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

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

Performance Report---

Approval by the Directors of the Performance Report

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

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

SECTION TWO

Accountabilty

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Accountability --

Section 2 - Accountability Report

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

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

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

2.1 Members of the Trust Board

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

Non-executive Directors

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

Associate Non-executive Directors

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

Executive Directors

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

2.2 Company Directorships held by Directors or Governors

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

Accountability

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

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

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

2.3 Accounting Policies

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

2.4 Charitable and Political Donations

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

2.5 Better Payment Code of Practice

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

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

Accountability

2.6 NHS Improvement Well Led Framework

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

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

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

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

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

2.9 NHS Oversight Framework

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

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

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

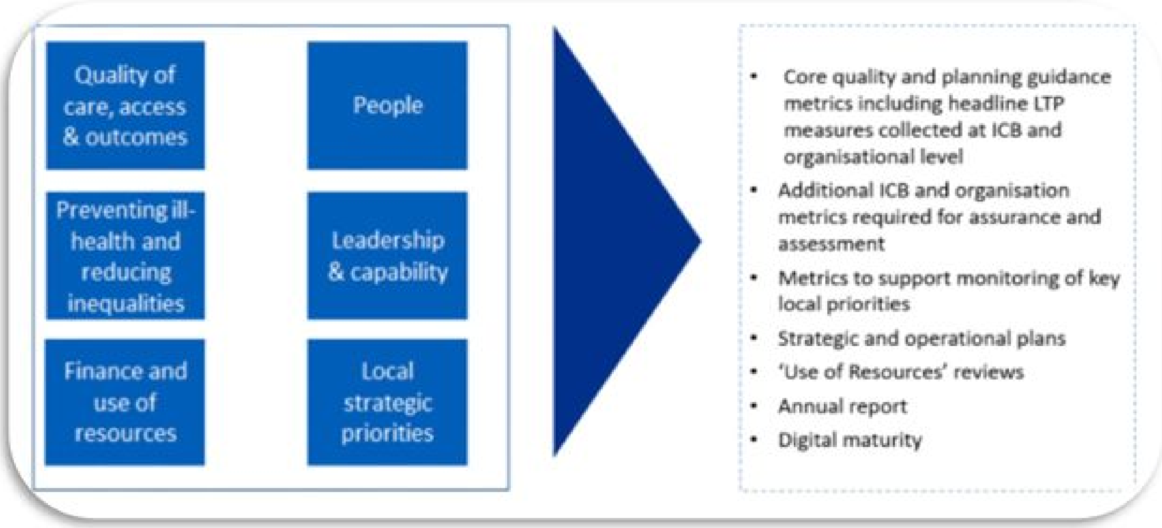
a. working with and through ICBs, wherever possible, to tackle problems.
b. a greater emphasis on system performance and quality of care outcomes, alongside the contributions of individual healthcare providers and commissioners to system goals.
c. matching accountability for results with improvement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

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

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

Accountability ---

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



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

SECTION THREE

Patients, Service Users and Stakeholders

7

Section 3 – Patients, Service Users and Stakeholders

3. Patient Care Activities

3.1 Complaints Handling

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

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

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

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

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

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

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

Patients, Service Users and Stakeholders--

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

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

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

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

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

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

3.2 Patient and Public Involvement

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

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

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

Patients, Service Users and Stakeholders

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

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

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

3.3 Stakeholder Relations

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

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

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

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

  As an acute and community services provider, the Trust is a member of the HNY Collaborative of Acute Providers (CAP) and the HNY Community Collaborative. The HNY CAP also includes Yorkshire and Scarborough Teaching Hospitals NHS Foundation Trust (YSTHFT), Hull University Teaching Hospitals NHS Trust and North Lincolnshire and Goole NHS Foundation Trust. HNY CAP leads on elective care, diagnostics, cancer and urgent and emergency care for HNY ICS. The Trust is playing an active role in developing the mission, priorities and governance of the CAP.

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

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

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

- **West Yorkshire Health and Care Partnership**

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

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

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

Patients, Service Users and Stakeholders---

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

  This ICS includes:

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

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

7

SECTION FOUR

Annual Statement on Remuneration

7

Remuneration

4. Annual Statement on Remuneration – Remuneration Report

4.1 Annual Statement on Remuneration

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

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

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

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

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

4.2 Remuneration Committee

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

Attendance at Remuneration Committee Meetings 2022-23

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

Remuneration---

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

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

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

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

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

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

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

4.3 Remuneration Policy

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

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

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

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

Remuneration--

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

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

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

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

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

Remuneration

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

Remuneration

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

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

Remuneration

4.5 Fair Pay Declaration

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

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

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

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

4.6 Payments to Past Senior Managers, if relevant

As detailed in section 4.4.

4.7 Payments for Loss of Office, if relevant

There have been no payments made for loss of office.

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

SECTION FIVE

People

People

5. Staff Report

5.1 Overview

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

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

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

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

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5.2 Analysis of Staff Numbers as at 31 March 2023

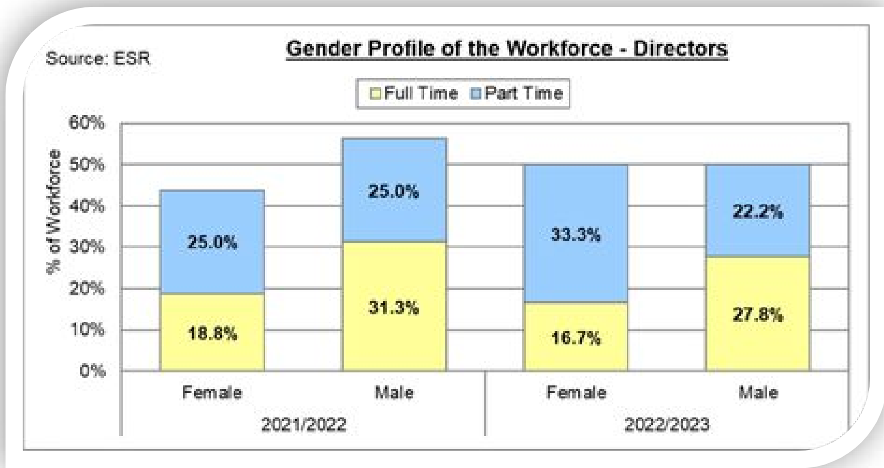
Staff Group	2021/2022		2022/2023	
	Headcount	WTE	Headcount	WTE
Administrative and Clerical	834	718.78	901	783.71
of which Senior Management	*80*	*77.47*	*91*	*89.17*
Allied Health Professionals	348	286.61	405	340.80
Estates and Ancillary	22	15.86	11	6.58
Medical and Dental	426	362.80	448	380.76
Nursing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

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

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

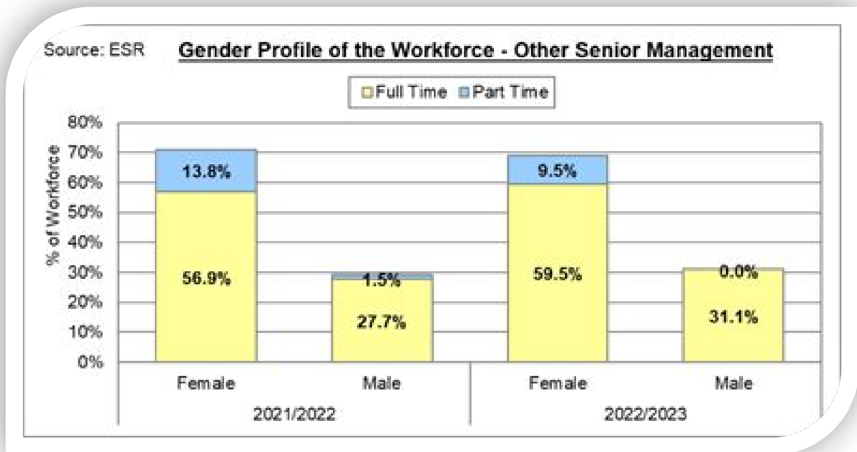
The graph and table below give a breakdown of the number of Directors, including Non-executive Directors, by gender, as at 31 March 2023.

People



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

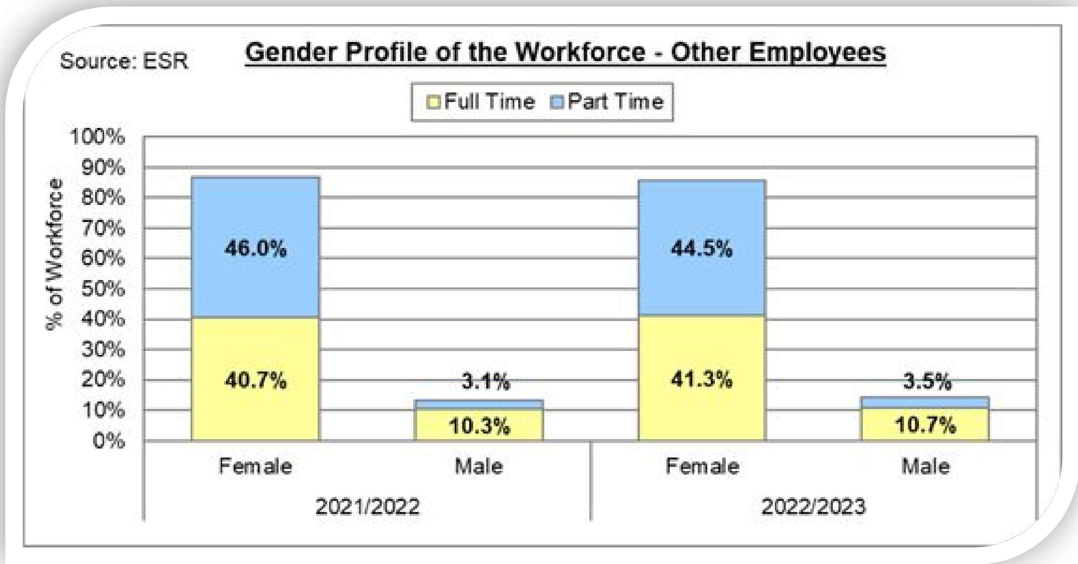
The graph and table below give a breakdown of the number of other senior management, by gender, as at 31 March 2023.



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

People

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



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

5.4 Sickness Absence Data

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

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

People

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

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

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

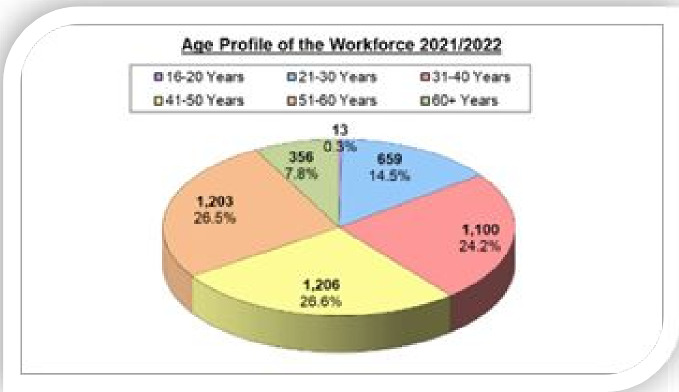
7

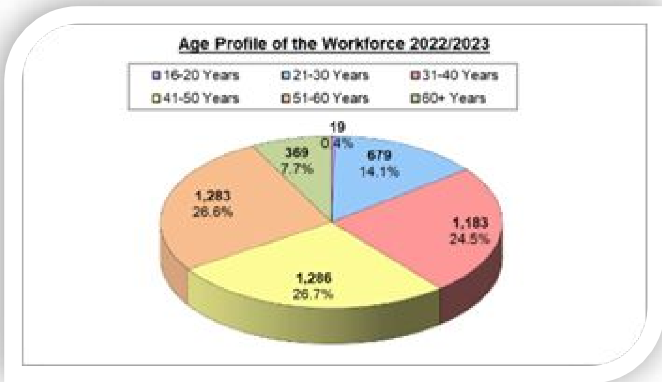
5.6 Analysis of the Age Profile of the Workforce as at 31 March 2023

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

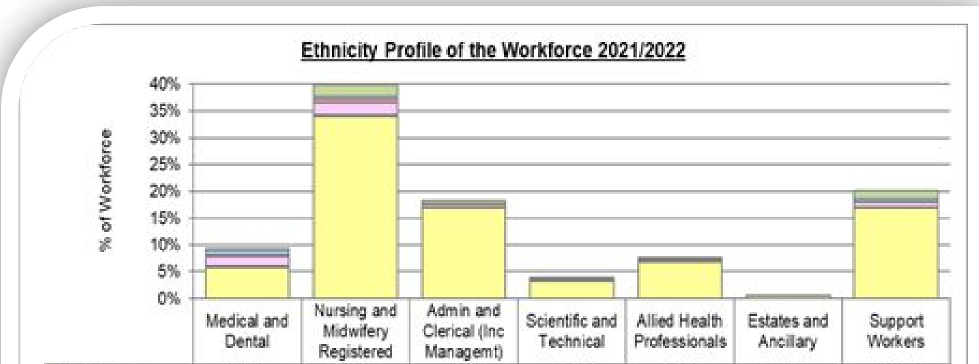
	2021/2022		2022/2023	
Age Band	**Headcount**	**% of Workforce**	**Headcount**	**% of Workforce**
16-20 Years	13	0.3%	19	0.4%
21-30 Years	659	14.5%	679	14.1%
31-40 Years	1,100	24.2%	1,183	24.5%
41-50 Years	1,206	26.6%	1,286	26.7%
51-60 Years	1,203	26.5%	1,283	26.6%
60+ Years	356	7.8%	369	7.7%
TOTAL	**4,537**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

People

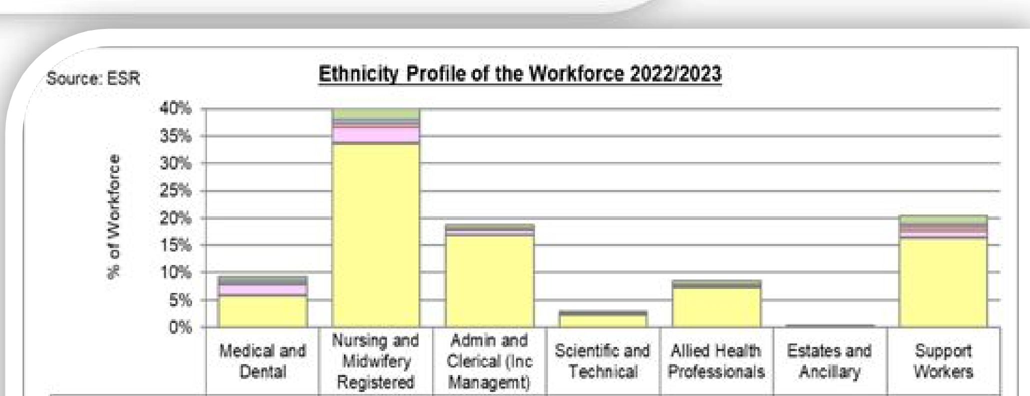




5.7 Analysis of the Ethnicity Profile of the Workforce as at 31 March 2023



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



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

People

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

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

5.8 Starters and Leavers 2022-23

	Headcount	FTE
Starters	660	574.76
Leavers	628	497.25

Exclusions applied

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

5.9 Trade Union Facility Time Disclosures

The Trade Union (Facility Time Publication Requirements) Regulations 2017

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

Relevant union officials

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

People

Percentage of time spent on facility time

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

Percentage of pay bill spent on facility time

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

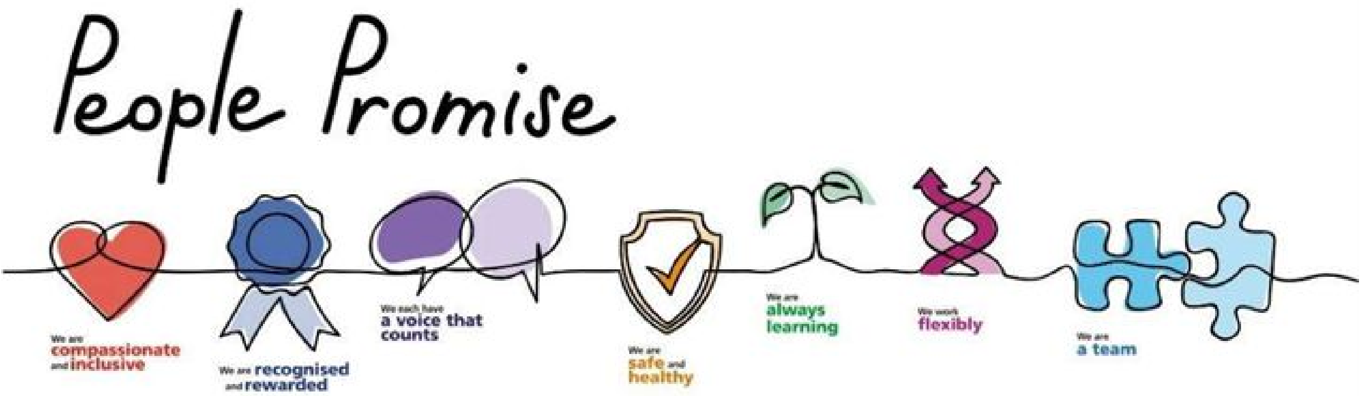
Paid trade union activities

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

5.10 National Staff Survey

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

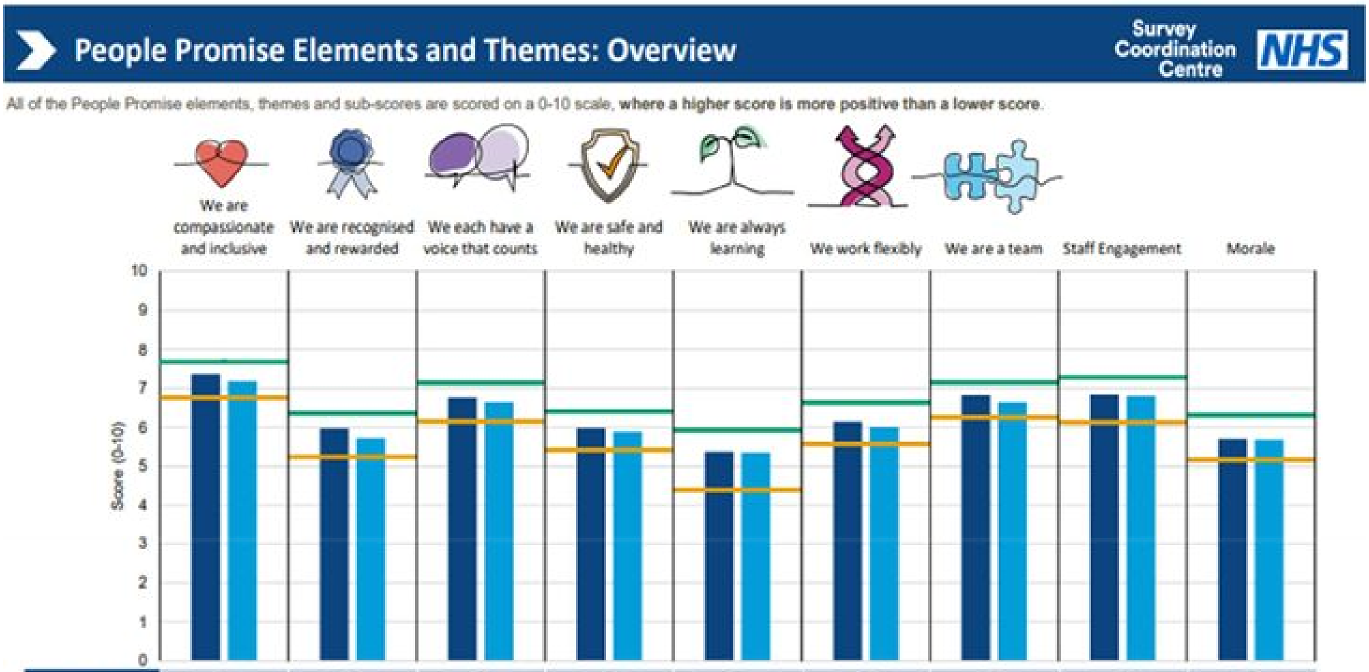
The NHS staff survey is conducted annually. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those. The response rate to the 2022-23 survey among HDFT staff was 43% compared to 39% the previous year.



People

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

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



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.4	6.0	6.8	6.0	5.4	6.2	6.8	6.8	5.7
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	1913	1910	1898	1908	1846	1906	1908	1914	1915

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

Areas to Celebrate

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

Areas to Focus On

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

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

5.11 Off-Payroll Arrangements

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

5.12 Consultancy Expenditure

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

5.13 Exit Packages

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

SECTION SIX

NHS Foundation Code of Governance

Code of Governance

6. NHS Foundation Trust Code of Governance

6.1 Overview

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

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

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

6.2 Audit Committee

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

Work Performance

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

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

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

The Committee was supported by:

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

Code of Governance

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

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

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

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

Governance, Risk Management and Internal Control

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

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

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

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

Clinical Assurance

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

Internal Audit and Counter Fraud Service

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

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

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

External Audit

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

6.3 The Board of Directors and Council of Governors

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

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

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

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

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

6.4 Balance, Completeness and Appropriateness of the Board of Directors

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

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

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

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

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6.5 Executive Directors

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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6.6 Non-executive Directors and Associate Non-executive Directors

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Wallace is the Chair of the new Innovation Committee.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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6.7 Performance Evaluation of the Board of Directors

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

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

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

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

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

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

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

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6.9 Council of Governors Overview

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

6.10 Council of Governors Attendance 2022-23

Council of Governors Attendance 2022-23

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

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

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

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

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

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

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

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

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

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

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

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6.12 Statement of Accounting Officer's Responsibilities

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

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

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

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

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

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

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

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

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

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SECTION SEVEN

Annual Governance Statement

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7. Annual Governance Statement

Annual Governance Statement 2022-23

Scope of responsibility

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

The purpose of the system of internal control

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

Capacity to handle risk

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The risk and control framework

The key objectives regarding risk and control are to achieve:

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

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

<u>Determine priorities</u>
The Board of Directors determines corporate objectives annually and these establish the priorities for Executive Directors and clinical services.

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

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

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

Risk Reporting

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

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

Risk Review

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

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

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

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

Care Quality Commission (CQC) Registration

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

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

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

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

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

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

Risks and challenges

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Annual Governance Statement---

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

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

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

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

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

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

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

Information governance

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

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

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

Annual Governance Statement---

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

SECTION EIGHT

Independent Auditors Report

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8. Independent Auditors Statement

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

Report on the audit of the financial statements

Opinion on the financial statements

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

In our opinion, the financial statements:

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

Basis for opinion

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

Conclusions relating to going concern

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

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

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

Other information

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

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

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

We have nothing to report in this regard.

Independent Auditors Statement ---

Opinion on other matters required by the Code of Audit Practice

In our opinion:

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

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

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

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

Responsibilities of the Accounting Officer

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

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

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

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

Independent Auditors Statement ---

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

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

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

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

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

Report on other legal and regulatory matters

Reports in the public interest or to the regulator

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

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

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

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

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

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

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

Independent Auditors Statement

Responsibilities of the Accounting Officer

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

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

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

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

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

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

Delay in certification of completion of the audit

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

Use of our report

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

Chris Brown, Key Audit Partner

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

8 September 2023

Independent Auditors Statement ---

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

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

Opinion on the financial statements

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

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

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

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

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

We have nothing to report in this respect.

Responsibilities of the Accounting Officer

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

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

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

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

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

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

Independent Auditors Statement

Certificate of completion of the audit

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

Use of our report

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

Chris Brown

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

Chris Brown, Key Audit Partner

for and on behalf of Azets Audit Services, Local Auditor

Edinburgh
29 September 2023

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SECTION NINE

Annual Accounts 2022-2023

7

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

Foreword to the Accounts

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

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

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

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

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

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

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

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

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

CONSOLIDATED STATEMENT OF FINANCIAL POSITION
as at 31 March 2023

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

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

Signed: ………………………………………………… Mr. Jonathan Coulter - Chief Executive

Date: 8 September 2023

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

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

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

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

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

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

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

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

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

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

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

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FOUNDATION TRUST STATEMENT OF FINANCIAL POSITION
as at 31 March 2023

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

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

Signed: ………………………………………………… Mr. Jonathan Coulter - Chief Executive

Date: 8 September 2023

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

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

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

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

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

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

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

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

1 GROUP ACCOUNTING POLICIES AND OTHER INFORMATION

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

1.1 Going concern

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

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

1.2 Accounting convention

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

1.3 Consolidation

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

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

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

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

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

1.4 Operating segments

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

1.5 Revenue

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

1.5 Revenue (continued)

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

- The NHS foundation trust is not required to disclose information regarding performance obligations that are part of a contract that has an original expected duration of one year or less.

- The NHS foundation trust is not required to disclose information where revenue is recognised in line with the practical expedient offered in the Standard, where the right to consideration corresponds directly with value of the performance completed to date.

- The FReM has mandated the exercise of the practical expedient offered in the Standard that requires [the entity] to reflect the aggregate effect of all contracts modified before the date of initial application.

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

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

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

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

1.6 Expenditure on employee benefits

Short term employee benefits

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

Pension costs - NHS Pension Scheme

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

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

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

1.6 Expenditure on employee benefits (continued)

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

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

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

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

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

1.7 Expenditure on other goods and services

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

1.8 Value Added Tax

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

1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if;

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

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

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1.9 Property, plant and equipment (continued)

Valuation

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

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

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

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

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

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

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

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

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

Subsequent expenditure

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

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

1.10 Intangible Assets

Recognition

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

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

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

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

Measurement

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

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

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

1.11 Depreciation, amortisation and impairments

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

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

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

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

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1.11 Depreciation, amortisation and impairments (cont)

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

Useful lives of property, plant and equipment

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

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

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

Amortisation

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

Useful lives of intangible assets

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

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

1.12 Donated assets

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

1.13 Government grant funded assets

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

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1.14 Leases

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

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

The Trust as a lessee

Recognition and initial measurement

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

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

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

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

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

Subsequent measurement

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

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

The Trust as a lessor

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

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

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1.14 Leases (cont)

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

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

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

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

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

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

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

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

1.15 Inventories

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

1.16 Cash and cash equivalents

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

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

1.17 Provisions

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

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

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

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

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

1.18 Clinical negligence costs

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

1.19 Non-clinical risk pooling

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

1.20 Contingent liabilities and contingent assets

A contingent liability is:

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

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

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

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

1.21 Losses and special payments

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

1.21 Losses and special payments (cont)

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

1.22 Gifts

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

1.23 Third party assets

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

1.24 Financial instruments and financial liabilities

Recognition

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

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

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

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

De-recognition

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

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

Classification and measurement

Financial assets are categorised as loans and receivables.

Financial liabilities are classified as other financial liabilities.

Loans and receivables

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

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

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

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

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1.24 Financial instruments and financial liabilities (cont)

Other financial liabilities

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

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

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

Determination of fair value

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

Impairment of financial assets

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

1.25 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital is a type of public sector equity finance, which represents the Department of Health and Social Care’s investment in the trust. HM Treasury has determined that, being issued under statutory authority rather than under

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the trust. Relevant net assets are calculated as the value of all assets less all liabilities, except for:

- donated and grant funded assets
- charitable funds
- average daily cash balances held with the Government Banking Service (GBS) and National Loans Fund (NLF) deposits (excluding cash balances held in GBS accounts that relate to a short-term working capital facility)
- approved expenditure on COVID-19 capital assets
- assets under construction for nationally directed schemes
- any PDC dividend balance receivable or payable.

The average relevant net assets are calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health and Social Care, the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts. The PDC dividend calculation is based upon the trust’s group accounts (i.e. including subsidiaries), but excluding consolidated charitable funds.

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1.26 Corporation Tax

The NHS foundation trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this but the trust is potentially within the scope of corporation tax in respect of activities where income is received from a non public sector source.

The NHS foundation trust has determined that it has no corporation tax liability, as all activities are either ancillary to healthcare or below the de minimus level of profit at which tax is payable. However Harrogate Healthcare Facilities Management Ltd is a wholly owned subsidiary of NHS foundation trust and is subject to corporation tax on its profits.

1.27 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2022/23.

1.28 IFRS Standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2022-23. These Standards are still subject to HM Treasury FReM adoption.

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 is yet to be adopted by the FReM, therefore early adoption is not permitted.

1.29 Critical estimates and judgements in applying accounting policies

The preparation of financial statements under IFRS requires the foundation trust to make estimates and assumptions that affect the application of policies and reported amounts. Estimates and judgements are continually evaluated and are based on historical experience and other factors that are considered to be relevant.

Revisions to accounting estimates are recognised in the period that the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Although the NHS foundation trust makes estimates within these financial statements such as incomplete patient spells, accrued income, annual leave accrual and provisions e.g. early retirements, the amounts involved would not cause a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

In relation to estimations for uncoded NHS income at the financial yearend, the NHS foundation trust runs a forecast for income relating to March based on the average income received by specialty and point of delivery, all uncoded activity is then priced using an average. This methodology is used throughout the year and has proven to be robust with only very minor variances showing once the activity is coded and then costed. Added to this, there is less variation in this position due to the changes as a result of the funding approach adopted nationally in response to the Covid-19 pandemic.

In addition, a revaluation of the NHS foundation trust's land and buildings was undertaken at a prospective date of 31 March 2022, the valuation excludes the cost of VAT. Since the NHS foundation trust created a subsidiary company "Harrogate Healthcare Facilities Management Ltd". The subsidiary company became responsible for the provision of a Managed Healthcare Facility to the NHS foundation trust, a consequence of this was that VAT became recoverable under an MEA alternative site valuation. The NHS foundation trust relies on the professional services of the Valuation Office for the accuracy of such valuations.

Finally, the NHS foundation trust has made utilised estimates provided by NHS England in relation to the pay award for agenda for change staff, and the settlement of the ongoing pay dispute. These payments have been made in 2022/23 and the figures are accurate for this staff group. It is assumed that any other agreement with other staff groups will be supported with income.

1.30 Climate Change Levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

2 Operating segments

2.1 Group operating segments

The NHS foundation trust's management has reviewed IFRS 8 (Operating Segments) and has determined that the consolidated financial statements consist of two segments "Healthcare" and "Charity".

	Group		Group	
	Healthcare 2022/23 £000	**Charity 2022/23 £000**	Healthcare 2021/22 £000	Charity 2021/22 £000
Operating Surplus/(Deficit)	**3,486**	**(220)**	11,817	290
Net Finance (Costs)/Income	**(2,521)**	**53**	(2,548)	42
Movement in fair value of investments/Loss on disposal of assets/Corporation tax expenses	**(21)**	**(124)**	(6)	17
SURPLUS/(DEFICIT) FOR THE YEAR	**944**	**(291)**	9,263	349
Non-current assets	**162,365**	**1,685**	135,514	1,830
Current assets	**61,136**	**593**	54,585	735
Current liabilities	**(55,959)**	**(34)**	(45,895)	(30)
Non-current liabilities	**(15,936)**	**-**	(10,042)	-
TOTAL ASSETS EMPLOYED	**151,606**	**2,244**	134,162	2,535
Financed by taxpayers' equity:				
Public Dividend Capital	**116,818**	**-**	103,938	-
Revaluation reserve	**15,166**	**-**	11,548	-
Income and expenditure reserve	**19,622**	**-**	18,676	-
HDFT Charitable fund reserves	**-**	**2,244**	-	2,535
TOTAL TAXPAYERS' EQUITY	**151,606**	**2,244**	134,162	2,535

3 Operating Income from continuing operations

3.1 Analysis of operating income

	Foundation Trust & Group	
	2022/23	2021/22
	£000	£000
Income from activities by nature:		
Acute services		
Block contract / system envelope income	**198,262**	194,736
High cost drugs income from commissioners	**8,148**	2,692
Other NHS clinical income	**787**	857
Community services		
Block contract / system envelope income	**31,570**	31,010
Income from other sources (e.g. local authorities)	**53,011**	42,286
All trusts		
Private patient income	**521**	815
Elective recovery fund	**5,431**	3,385
Agenda for change pay offer central funding	**8,325**	-
Additional pension contribution central funding (see below*)	**8,818**	7,934
Other clinical income	**33**	477
Total income from activities	**314,906**	284,192

	Foundation Trust & Group	
	2022/23	2021/22
	£000	£000
Income from activities by source:		
NHS Foundation Trusts	**335**	441
NHS Trusts	**-**	37
NHS England	**41,918**	33,646
Clinical commissioning groups	**48,630**	206,499
Integrated care boards	**166,016**	-
Local Authorities	**53,010**	42,286
Department of Health and Social Care	**20**	-
NHS Other	**4,028**	45
Non NHS: Private Patients	**463**	815
Non-NHS: Overseas patients (chargeable to patient)	**59**	48
NHS injury scheme (see below**)	**335**	275
Non NHS: Other	**92**	100
Total income from activities	**314,906**	284,192

	Group	
	2022/23	2021/22
	£000	£000
Group other operating income:		
Research and development	**1,030**	1,008
Education and training	**19,028**	11,566
Education and training - notional income from apprenticeship fund	**880**	284
Non-patient care services to other bodies	**4,201**	1,855
Reimbursement and top up funding	**414**	1,676
Donated equipment from DHSC for COVID response (non-cash)	**461**	-
Cash donations for the purchase of capital assets - received from other bodies	**572**	12,717
Contributions to expenditure - consumables (inventory) donated from DHSC	**455**	643
Rental revenue from operating leases (see note 3.4)	**-**	162
Staff recharges (secondments)	**5,278**	4,145
HDFT Charitable Funds: Incoming Resources excluding investment income	**604**	879
Other	**4,441**	5,133
Group total other operating income	**37,364**	40,068
Group total operating income	**352,270**	324,260

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

** NHS injury scheme income is subject to a provision for doubtful debts of 22.43% (2021: 22.43%) to reflect expected rates of collection.

3.1 Analysis of operating income (continued)

	Foundation Trust 2022/23 £000	Foundation Trust 2021/22 £000
Total income from activities	**314,906**	284,192
Foundation Trust other operating income:		
Research and development	**1,030**	1,008
Education and training	**19,028**	11,566
Education and training - notional income from apprenticeship fund	**880**	284
Received from NHS charities: Receipt of grants/donations for capital acquisitions	**-**	148
Non-patient care services to other bodies	**4,988**	2,647
Reimbursement and top up funding	**298**	1,676
Cash donations for the purchase of capital assets - received from other bodies	**571**	12,717
Donated equipment from DHSC/UKHSA for COVID response (non-cash)	**461**	
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies	**455**	643
Rental revenue from operating leases (see note 3.6)	**-**	1,265
Staff recharges (secondments)	**5,378**	4,283
Other	**4,171**	4,207
Foundation Trust total other operating income	**37,260**	40,444
Foundation Trust total operating income	**352,166**	324,636

3.2 Overseas visitors (relating to patients charged directly by the foundation trust)

Income recognised in year relating to overseas visitors was £59k (2022 £48k), payments received in year (relating to invoices raised in current and previous years) was £26k (2022 £21k) and amounts written off in year (relating to invoices raised in current and previous years) was £0k (2022 £5k).

3.3 Analysis of income from activities by Commissioner Requested Services (CRS) and Non-Commissioner Requested Services (Non-CRS).

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Foundation Trust & Group 2022/23 £000	Foundation Trust & Group 2021/22 £000
Commissioner Requested Services	**179,577**	162,041
Non-Commissioner Requested Services	**135,329**	122,151
Total	**314,906**	284,192

3.4 Additional information on revenue from contracts with customers recognised in the period.

	Foundation Trust & Group 2022/23 £000	Foundation Trust & Group 2021/22 £000
Revenue recognised in the reporting period that was included in contract liabilities at the previous period end	**-**	-
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	**-**	-

3.5 Operating lease income and future annual lease receipts - Group

This note discloses income generated in operating lease agreements where No trust selected is the lessor.
The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis. This includes a different maturity analysis of future minimum lease receipts under IAS 17 compared to IFRS 16.

	Group	
	2022/23	2021/22
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	**-**	162
Variable lease receipts / contingent rents	**-**	-
Other	**-**	-
	-	162
Future minimum lease receipts due on buildings expiring		
- not later than one year;	**-**	162
- later than one year and not later than five years;	**-**	650
- later than five years.	**-**	194
	-	1,006

3.6 Operating lease income and future annual lease receipts - Foundation Trust

	Foundation Trust	
	2022/23	2021/22
Lease receipts recognised as income in year:	**£000**	£000
Minimum lease receipts	**-**	-
Variable lease receipts / contingent rents	**-**	1,265
Other	**-**	-
	-	1,265
Future minimum lease receipts due on buildings expiring		
- not later than one year;	**-**	1,265
- later than one year and not later than five years;	**-**	5,126
- later than five years.	**-**	18,098
	-	24,489

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4. Operating Expenses from continuing operations

4.1 Group operating expenses comprise:	**Group**	
	2022/23	2021/22
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	**110**	115
Purchase of healthcare from non-NHS and non-DHSC bodies	**229**	105
Staff and executive directors costs	**252,229**	213,770
Non-executive directors	**212**	196
Drug costs (see note 13.2)	**20,168**	18,289
Supplies and services - clinical	**25,731**	24,867
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	**455**	643
Supplies and services - general	**2,318**	8,901
Establishment	**2,552**	2,092
Research and development	**12**	11
Transport (including Patients' travel)	**1,866**	1,238
Premises - business rates payable to local authorities	**371**	1,101
Premises - other	**12,029**	9,883
Increase in provision for irrecoverable debts	**(1,707)**	916
Operating leases expenditure (comparative only)	**-**	4,056
Depreciation on property, plant and equipment	**9,299**	6,728
Amortisation on intangible assets (see note 8)	**1,275**	781
Impairments/(Reversals) of property, plant and equipment	**(238)**	3,181
Audit services- statutory audit	**174**	184
NHS Resolution contribution - Clinical Negligence	**6,529**	7,210
Legal fees	**58**	562
Consultancy costs	**1,018**	799
Internal audit costs	**201**	193
Education and training	**9,414**	2,285
Education and training - notional expenditure funded from apprenticeship fund	**880**	284
Redundancy	**134**	6
Early retirements	**10**	7
Hospitality	**4**	73
Insurance	**30**	369
Losses, ex gratia and special payments (see note 20) - Non Pay	**22**	39
Losses, ex gratia and special payments (see note 20) - Pay	**-**	488
Other	**2,627**	2,480
HDFT Charitable funds: Other resources expended	**992**	301
Group total operating expenses	**349,004**	312,153

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4. Operating Expenses from continuing operations (Continued)

4.2 Foundation Trust operating expenses comprise:	**Foundation Trust**	
	2022/23	2021/22
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	**109**	115
Purchase of healthcare from non-NHS and non-DHSC bodies	**229**	105
Staff and executive directors costs	**242,329**	205,004
Non-executive directors	**185**	164
Drug costs (see note 13.2)	**20,168**	18,289
Supplies and services - clinical	**23,163**	22,786
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	**455**	643
Supplies and services - general	**22,683**	25,365
Establishment	**2,227**	1,811
Research and development	**12**	11
Transport (including Patients' travel)	**1,749**	1,193
Premises - business rates payable to local authorities	**371**	1,101
Premises - other	**8,999**	6,559
Increase/(Decrease) in provision for irrecoverable debts	**(1,707)**	916
Operating leases expenditure (comparative only)	**(1,321)**	4,004
Depreciation on property, plant and equipment	**8,758**	6,395
Amortisation on intangible assets (see note 8)	**1,275**	754
Impairments/(Reversals) of property, plant and equipment	**(238)**	(147)
Audit services- statutory audit	**141**	150
NHS Resolution contribution - Clinical Negligence	**6,529**	7,210
Legal fees	**(233)**	562
Consultancy costs	**1,004**	756
Internal audit costs	**182**	173
Education and training	**9,374**	2,234
Education and training - notional expenditure funded from apprenticeship fund	**880**	284
Redundancy	**134**	6
Early retirements	**10**	7
Hospitality	**73**	73
Insurance	**289**	305
Losses, ex gratia and special payments (see note 20) - Non Pay	**22**	39
Losses, ex gratia and special payments (see note 20) - Pay	**-**	488
Other	**2,196**	2,216
Foundation Trust total operating expenses	**350,047**	309,571

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4.3 Limitation on external auditor's liability

	Foundation Trust & Group 2022/23 £000	2021/22 £000
Limitation on external auditor's liability	**1,000**	1,000
	1,000	1,000

5. Employee costs and numbers

5.1 Employee costs

	Total 2022/23 £000	**Group Permanently Employed £000**	**Other £000**	Total 2021/22 £000	Group Permanently Employed £000	Other £000
Salaries and wages	**195,389**	**193,056**	**2,333**	167,262	164,613	2,649
Social Security costs (Employers NI costs)	**17,223**	**17,223**	**-**	14,480	14,480	-
Apprenticeship levy	**846**	**846**	**-**	759	759	-
Pension cost - employer contributions to NHS pension scheme	**20,448**	**20,448**	**-**	18,567	18,567	-
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	**8,818**	**8,818**	**-**	7,934	7,934	-
Pension cost - other	**309**	**309**	**-**	240	240	-
Termination benefits	**144**	**144**	**-**	6	6	-
External bank	**46**	**-**	**46**	-	-	-
Agency/contract staff	**10,911**	**-**	**10,911**	12,604	6,302	6,302
Total employee expenses	**254,134**	**240,845**	**13,290**	221,852	212,901	8,951
Less costs capitalised as part of assets	**(1,761)**	**(1,761)**	**-**	(1,286)	(1,286)	-
Total employee costs excluding capitalised costs	**252,373**	**239,084**	**13,290**	220,566	211,615	8,951

5. Employee costs and numbers (continued)

5.2 Employee costs

	Foundation Trust			Foundation Trust		
	Total 2022/23 £000	**Permanently Employed £000**	**Other £000**	Total 2021/22 £000	Permanently Employed £000	Other £000
Salaries and wages	**187,409**	**184,955**	**2,454**	159,820	157,162	2,658
Social Security costs (Employers NI costs)	**16,511**	**16,511**	**-**	13,877	13,877	-
Apprenticeship levy	**805**	**805**	**-**	722	722	-
Employer contributions to NHS Pensions Agency	**20,072**	**20,072**	**-**	18,117	18,117	-
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	**8,818**	**8,818**	**-**	7,934	7,934	-
Pension cost - other	**125**	**125**	**-**	102	102	-
Termination benefits	**144**	**144**	**-**	13	13	-
Agency/contract staff	**10,220**	**-**	**10,220**	5,922	-	5,922
Total employee expenses	**244,104**	**231,430**	**12,674**	206,507	197,927	8,580
Less costs capitalised as part of assets	**(1,631)**	**(1,631)**	**-**	(1,002)	(1,002)	-
Total employee costs excluding capitalised costs	**242,473**	**229,799**	**12,674**	205,505	196,925	8,580

5.3 Average number of employees (WTE basis)

	Group			Group		
	Total 2022/23 Number	**Permanently Employed Number**	**Other Number**	Total 2021/22 Number	Permanently Employed Number	Other Number
Medical and dental	**407**	**378**	**30**	413	386	27
Ambulance staff	**1**	**1**	**-**	1	1	-
Administration and estates	**773**	**751**	**22**	726	706	20
Healthcare assistants and other support staff	**412**	**412**	**-**	412	412	-
Nursing, midwifery and health visiting staff	**2,024**	**1,965**	**59**	1,842	1,806	36
Nursing, midwifery and health visiting learners	**47**	**47**	**-**	43	43	-
Scientific, therapeutic and technical staff	**533**	**533**	**-**	515	515	-
Healthcare science staff	**102**	**101**	**1**	106	97	9
Social care staff	**-**	**-**	**-**	-	-	-
Other	**12**	**12**	**-**	8	8	-
Total	**4,311**	**4,199**	**113**	4,066	3,974	92
Less capitalised employees	**(44)**	**(44)**	**-**	(28)	(28)	-
Total excluding capitalised WTE	**4,267**	**4,155**	**113**	4,038	3,946	92

5.4 Average number of employees (WTE basis)

	Foundation Trust			Foundation Trust		
	Total 2022/23 Number	**Permanently Employed Number**	**Other Number**	Total 2021/22 Number	Permanently Employed Number	Other Number
Medical and dental	**408**	**378**	**30**	413	386	27
Ambulance staff	**1**	**1**	**-**	1	1	-
Administration and estates	**702**	**698**	**4**	667	656	11
Healthcare assistants and other support staff	**200**	**200**	**-**	198	198	-
Nursing, midwifery and health visiting staff	**2,024**	**1,965**	**59**	1,842	1,806	36
Nursing, midwifery and health visiting learners	**47**	**47**	**-**	43	43	-
Scientific, therapeutic and technical staff	**533**	**533**	**-**	515	515	-
Healthcare science staff	**102**	**101**	**1**	106	97	9
Other	**8**	**8**	**-**	5	5	-
Total	**4,024**	**3,930**	**94**	3,790	3,707	83
Less capitalised employees	**(44)**	**(44)**	**-**	(21)	(21)	
Total excluding capitalised WTE	**3,980**	**3,886**	**94**	3,769	3,686	83

WTE = Whole time equivalents

5.5 Pensions costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as at 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

5.6 Retirements due to ill-health

During the year ended 31 March 2023 there were 2 (2022: 4) early retirements from the NHS foundation trust agreed on the grounds of ill-health. The estimated additional pension liability of the ill-health retirement is £68,000 (2022: £142,000). The cost of ill-health retirements are borne by the NHS Business Services Authority Pensions Division.

5.7 Staff exit costs

NHS Improvement requires NHS foundation trusts to disclose summary information regarding redundancy and other departures in staff costs agreed in the financial year.

	Foundation Trust & Group		Foundation Trust & Group	
Exit cost band	**2022/23 Number of compulsory redundancies**	**2022/23 Number of other departures agreed**	2021/22 Number of compulsory redundancies	2021/22 Number of other departures agreed
<£10,000	**-**	**-**	1	-
£10,001 - £25,000	**-**	**-**	-	-
£25,001 - £50,000	**-**	**-**	-	-
£50,001 - £100,000	**-**	**-**	-	-
£100,001 - £150,000	**1**	**-**	-	-
£150,001 - £200,000	**-**	**-**	-	-
>£200,000	**-**	**-**	-	-
Total number of exits by type	**1**	**-**	1	-
Total resource cost	**£134,000**	-	£6,000	-

5.8 Analysis of termination benefits

	Foundation Trust & Group		Foundation Trust & Group	
	2022/23 Number	**2022/23 £000**	2021/22 Number	2021/22 £000
Compulsory redundancies	**1**	**134**	1	6
Contractual payments in lieu of notice	**-**	**-**	-	-
	1	**134**	1	6

6. Finance revenue

6.1 Group finance revenue received during the year is as follows:

Finance revenue received during the year is as follows:	**Group**	
	2022/23	2021/22
	£000	£000
Interest income:		
Interest on bank accounts	**798**	22
HDFT Charitable funds: investment income	**53**	42
	851	64

6.2 Foundation Trust finance revenue received during the year is as follows:

Finance revenue received during the year is as follows:	**Foundation Trust**	
	2022/23	2021/22
	£000	£000
Interest income:		
Interest on bank accounts	**794**	22
Interest on loans to HHFM	**1,171**	14
	1,965	36

7. Finance expenses

Finance expenses incurred during the year are as follows:	**Foundation Trust & Group**	
	2022/23	2021/22
	£000	£000
Interest expense:		
Capital Loans from the Department of Health (formerly ITFF see note 18)	**162**	202
Interest on lease obligations	**203**	-
	365	**202**

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8. Current year intangible fixed assets

	Foundation Trust & Group					
	Software Licences	Development Expenditure	Websites	Assets Under Construction	Other	Total
	£000	£000	£000	£000	£000	£000
Gross cost at 1 April 2022	1,354	3,720	187	-	1,343	**6,604**
Additions - purchased	43	926	-	2,294	622	**3,885**
Reclassifications	657	502	-	(1,390)	231	**-**
Disposals	-	-	-	-	-	**-**
Gross cost at 31 March 2023	**2,054**	**5,148**	**187**	**904**	**2,196**	**10,489**
Amortisation at 1 April 2022	976	1,119	51	-	309	**2,455**
Provided during the year	263	666	26	-	320	**1,275**
Disposals	-	-	-	-	-	**-**
Amortisation at 31 March 2023	**1,239**	**1,785**	**77**	**-**	**629**	**3,730**
Net book value						
- Purchased at 31 March 2023	815	3,363	110	904	1,567	**6,759**
- Total at 31 March 2023	**815**	**3,363**	**110**	**904**	**1,567**	**6,759**

8.1 Prior year intangible fixed assets

	Foundation Trust & Group					
	Software Licences	Development Expenditure	Websites	Assets Under Construction	Other	Total
	£000	£000	£000	£000	£000	£000
Gross cost at 1 April 2021	1,287	2,918	187	-	306	**4,698**
Additions - purchased	54	786	-	-	452	**1,292**
Reclassifications	18	16	-	-	585	**619**
Disposals	(5)	-	-	-	-	**(5)**
Gross cost at 31 March 2022	**1,354**	**3,720**	**187**	**-**	**1,343**	**6,604**
Amortisation at 1 April 2021	868	672	24	-	115	1,679
Provided during the year	113	447	27	-	194	781
Disposals	(5)	-	-	-	-	(5)
Amortisation at 31 March 2022	**976**	**1,119**	**51**	**-**	**309**	**2,455**
Net book value						
- Purchased at 31 March 2022	378	2,601	136	-	1,034	4,149
- Total at 31 March 2022	**378**	**2,601**	**136**	**-**	**1,034**	**4,149**

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9. Property, plant and equipment

9.1 Current year property, plant and equipment (group) comprises of the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Group Total
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Cost or valuation at 1 April 2022	3,500	82,770	1,138	20,191	30,598	178	16,279	745	**155,399**
Additions - purchased	-	1,259	-	15,299	203	-	1,103	66	**17,930**
Additions - donations of physical assets	-	197	-	375	-	-	-	-	**572**
Additions - equipment donated from DHSC	-	-	-	-	461	-	-	-	**461**
Impairments charged to operating expenses	-	-	-	-	-	-	-	-	**-**
Transfer to revaluation reserve	-	1,089	79	-	-	-	-	-	**1,168**
Reclassifications	-	9,417	-	(16,375)	3,912	-	2,972	74	**-**
Disposals	-	-	-	-	(138)	(8)	-	-	**(146)**
Cost or valuation At 31 March 2023	**3,500**	**94,732**	**1,217**	**19,490**	**35,036**	**170**	**20,354**	**885**	**175,384**
Depreciation at 1 April 2022	-	-	-	-	15,801	124	8,821	391	**25,137**
Provided during the year (see note 4.1)	-	2,630	58	-	2,977	11	1,836	66	**7,578**
Reversal of impairments charged to operating expenses	-	(238)	-	-	-	-	-	-	**(238)**
Transfer to revaluation reserve	-	(2,392)	(58)	-	-	-	-	-	**(2,450)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Disposals	-	-	-	-	(117)	(8)	-	-	**(125)**
Depreciation at 31 March 2023	**-**	**-**	**-**	**-**	**18,661**	**127**	**10,657**	**457**	**29,902**
Net book value									
- Purchased at 31 March 2023	3,500	81,781	1,217	17,116	13,581	43	9,684	413	**127,335**
- Donated at 31 March 2023	-	12,951	-	2,374	1,939	-	13	15	**17,292**
- Donated (DHSC) at 31 March 2023	-	-	-	-	855	-	-	-	**855**
Net book value at 31 March 2023	**3,500**	**94,732**	**1,217**	**19,490**	**16,375**	**43**	**9,697**	**428**	**145,482**

At 31 March 2023, of the Net Book Value £3,500,000 related to land valued at open market value and £94,732,000 related to buildings valued at open market value and £1,217,000 related to dwellings valued at open market value. The land and buildings (including dwellings) of the trust were revalued by the Valuation Office Agency which is a government agency of Her Majesty's Revenue and Customs (RICS qualified) as at 31 March 2023. This valuation, in line with the NHS foundation trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in an increase in value of £3,856,000.00.

9. Property, plant and equipment

9.2 Current year property, plant and equipment (Trust) comprises of the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Foundation Trust Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2022	3,500	77,202	654	9,439	27,908	25	16,268	686	**135,682**
Additions - purchased	-	1	-	10,719	79	-	1,115	36	**11,950**
Additions - donations of physical assets	-	197	-	375	-	-	-	-	**572**
Additions - equipment donated from DHSC	-	-	-	-	461	-	-	-	**461**
Reversals charged to operating expenses	-	238	-	-	-	-	-	-	**238**
Reclassifications	-	239	-	(6,794)	3,761	-	2,763	31	**-**
Transfer to revaluation reserve	-	7,265	28	-	-	-	-	-	**7,293**
Disposals	-		-	-	(138)		-		**(138)**
Cost or valuation At 31 March 2023	**3,500**	**85,142**	**682**	**13,739**	**32,071**	**25**	**20,146**	**753**	**156,058**
Depreciation at 1 April 2022	-	-	-	-	14,521	4	8,821	380	**23,726**
Provided during the year (see note 4.2)	-	2,383	29	-	2,764	4	1,817	58	**7,055**
Transfer to revaluation reserve	-	(2,383)	(29)	-	-	-	-	-	**(2,412)**
Disposals	-		-	-	(117)	-	-	-	**(117)**
Depreciation at 31 March 2023	**-**	**-**	**-**	**-**	**17,168**	**8**	**10,638**	**438**	**28,252**
Net book value									
- Purchased at 31 March 2023	3,500	80,278	682	13,739	12,964	17	9,508	300	**120,988**
- Donated at 31 March 2023	-	4,864	-	-	1,084	-	-	15	**5,963**
- Donated (DHSC) at 31 March 2023	-	-	-	-	855	-	-	-	**855**
Net book value at 31 March 2023	**3,500**	**85,142**	**682**	**13,739**	**14,903**	**17**	**9,508**	**315**	**127,806**

At 31 March 2023, of the Net Book Value £3,500,000 related to land valued at open market value and £85,115,000 related to buildings valued at open market value and £682,000 related to dwellings valued at open market value. The land and buildings (including dwellings) of the trust were revalued by the Valuation Office Agency which is a government agency of Her Majesty's Revenue and Customs (RICS qualified) as at 31 March 2023. This valuation, in line with the NHS foundation trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in a increase in value of £9,943,000.00.

9. Property, plant and equipment (continued)

9.3 Prior year property, plant and equipment (group) comprises of the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Group Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2021	3,500	75,875	871	3,783	29,425	184	13,729	718	128,085
Additions - purchased	-	5,844	-	19,665	1,669	-	1,115	40	28,333
Additions - donations of physical assets	-	11	-	-	137	-	- 0	-	148
Impairments charged to operating expenses	-	(3,328)	-	-	-	-	-	-	(3,328)
Transfer to revaluation reserve	-	4,085	(23)	-	-	-	-	-	4,062
Reclassifications*	-	284	290	(3,257)	633	(6)	1,435	2	(619)
Disposals	-	(1)	-	-	(1,266)	-	-	(15)	(1,282)
Cost or valuation At 31 March 2022	**3,500**	**82,770**	**1,138**	**20,191**	**30,598**	**178**	**16,279**	**745**	**155,399**
Depreciation at 1 April 2021	-	-	-	-	14,467	112	7,417	344	22,340
Provided during the year (see note 4.1)	-	2,593	66	-	2,589	14	1,404	62	6,728
Reversal of impairments charged to operating expe	-	(147)	-	-	-	-	-	-	(147)
Transfer to revaluation reserve	-	(2,442)	(66)	-	-	-	-	-	(2,508)
Reclassifications	-	(3)	-	-	5	(2)	-	-	-
Disposals	-	(1)	-	-	(1,260)	-	-	(15)	(1,276)
Depreciation at 31 March 2022	**-**	**-**	**-**	**-**	**15,801**	**124**	**8,821**	**391**	**25,137**
Net book value									
- Purchased at 31 March 2022	3,500	74,914	1,138	11,225	12,899	54	7,441	337	111,508
- Donated at 31 March 2022	-	7,856	-	8,966	779	-	17	17	17,635
- Donated (DHSC) at 31 March 2022	-	-	-	-	1,119	-	-	-	1,119
Net book value at 31 March 2022	**3,500**	**82,770**	**1,138**	**20,191**	**14,797**	**54**	**7,458**	**354**	**130,262**

At 31 March 2022, of the Net Book Value £3,500,000 related to land valued at open market value and £82,770,000 related to buildings valued at open market value and £1,138,000 related to dwellings valued at open market value. The land and buildings (including dwellings) of the trust were revalued by the Valuation Office Agency which is a government agency of Her Majesty's Revenue and Customs (RICS qualified) as at 31 March 2022. This desktop valuation, in line with the NHS foundation trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in a decrease in value of £3,389,000.

9. Property, plant and equipment

9.4 Prior year property, plant and equipment comprises (Trust) of the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Foundation Trust Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2021	3,500	72,938	451	3,020	27,104	25	13,728	658	**121,424**
Additions - purchased	-	176	-	9,106	1,510	-	1,105	41	**11,938**
Reversals charged to operating expenses	-	147	-	-	-	-	-	-	**147**
Reclassifications	-	(168)	239	(2,687)	560	-	1,435	2	**(619)**
Transfer to revaluation reserve	-	4,110	(36)	-	-	-	-	-	**4,074**
Disposals	-	(1)	-	-	(1,266)	-	-	(15)	**(1,282)**
Cost or valuation At 31 March 2022	**3,500**	**77,202**	**654**	**9,439**	**27,908**	**25**	**16,268**	**686**	**135,682**
Depreciation at 1 April 2021	-	-	-	-	13,346	-	7,418	339	**21,103**
Provided during the year (see note 4.2)	-	2,458	39	-	2,435	4	1,403	56	**6,395**
Transfer to revaluation reserve	-	(2,457)	(39)	-	-	-	-	-	**(2,496)**
Disposals	-	(1)	-	-	(1,260)	-	-	(15)	**(1,276)**
Depreciation at 31 March 2022	**-**	**-**	**-**	**-**	**14,521**	**4**	**8,821**	**380**	**23,726**
Net book value									
- Purchased at 31 March 2022	3,500	73,080	654	9,439	11,489	21	7,447	289	**105,919**
- Donated at 31 March 2022	-	4,122	-	-	779	-	-	17	**4,918**
- Donated (DHSC) at 31 March 2022	-	-	-	-	1,119	-	-	-	**1,119**
Net book value at 31 March 2022	**3,500**	**77,202**	**654**	**9,439**	**13,387**	**21**	**7,447**	**306**	**111,956**

At 31 March 2022, of the Net Book Value £3,500,000 related to land valued at open market value and £77,202,000 related to buildings valued at open market value and £654,000 related to dwellings valued at open market value. The land and buildings (including dwellings) of the trust were revalued by the Valuation Office Agency which is a government agency of Her Majesty's Revenue and Customs (RICS qualified) as at 31 March 2022. This valuation, in line with the NHS foundation trust's accounting policies and using the best practice Modern Equivalent Asset valuation methodology, resulted in a increase in value of £6,717,000.00.

10. Leases - Harrogate and District NHS Foundation Trust as a lessee

10.1 This note details information about leases for which the Trust is a lessee.
The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis.

Group	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	leased from DHSC group bodies £000
IFRS 16 implementation - reclassification of existing leased assets from PPE or intangible assets	-	-	-	-	-
IFRS 16 implementation - adjustments for existing operating leases / subleases	9,100	96	17	9,213	6,615
Transfers by absorption	-	-	-	-	-
Additions	1,770	-	223	1,992	41
Remeasurements of the lease liability	-	-	-	-	-
Movements in provisions for restoration / removal costs	-	-	-	-	-
Impairments	-	-	-	-	-
Reversal of impairments	-	-	-	-	-
Revaluations	-	-	-	-	-
Reclassifications	-	-	-	-	-
Disposals / derecognition	(193)	-	-	(193)	(193)
Valuation/gross cost at 31 March 2023	**10,677**	**96**	**240**	**11,013**	**6,462**
Accumulated depreciation at 1 April 2022 - brought forward	-	-	-	-	-
IFRS 16 implementation - reclassification of existing leased assets from PPE or intangible assets	-	-	-	-	-
IFRS 16 implementation - adjustments for existing subleases	-	-	-	-	-
Transfers by absorption	-	-	-	-	-
Provided during the year	1,574	41	106	1,721	619
Impairments	-	-	-	-	-
Reversal of impairments	-	-	-	-	-
Revaluations	-	-	-	-	-
Reclassifications	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-
Accumulated depreciation at 31 March 2023	**1,574**	**41**	**106**	**1,721**	**619**
Net book value at 31 March 2023	**9,102**	**56**	**133**	**9,291**	**5,843**

Net book value of right of use assets leased from other NHS providers	1,516
Net book value of right of use assets leased from other DHSC group bodies	4,328
	5,843

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Note 10.2 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 19.

	Foundation Trust & Group 2022/23 £000
Carrying value at 31 March 2022	-
IFRS 16 implementation - adjustments for existing operating leases	9,213
Lease additions	1,993
Interest charge arising in year	203
Early terminations	(193)
Financing cash flows - principal	(1,744)
Financing cash flows - interest	(203)
Carrying value at 31 March 2023	**9,269**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 10.3 Maturity analysis of future lease payments at 31 March 2023

	Foundation Trust & Group	
	Total 2022/23 £000	Of which leased from DHSC group bodies: 2022/23 £000
Undiscounted future lease payments payable in:		
- not later than one year;	1,869	671
- later than one year and not later than five years;	5,762	3,652
- later than five years.	1,639	1,521
Net lease liabilities at 31 March 2023	**9,270**	**5,844**
Net lease liabilities at 31 March 2023		
Of which:		
Current	1,869	671
Non-Current	7,401	5,173
	9,270	**5,844**
Of which:		
Leased from other NHS providers		1,516
Leased from other DHSC group bodies		4,328

Note 10.4 Commitments in respect of operating leases at 31 March 2022 (IAS 17 basis)

This note discloses costs incurred in 2021/22 and commitments as at 31 March 2022 for leases the trust previously determined to be operating leases under IAS 17.

	Foundation Trust & Group 2021/22 £000
Lease payments recognised as an expense in year:	
Minimum lease payments	4,056
Contingent rents	-
Less sublease payments received	-
Total	**4,056**

	2021/22 £000
Future minimum lease payments due:	
- not later than one year;	1,063
- later than one year and not later than five years;	1,388
- later than five years.	491
Total	**2,942**

Note 10.5 Initial application of IFRS 16 on 1 April 2022

IFRS 16 as adapted and interpreted for the public sector by HM Treasury has been applied to leases in these financial statements with an initial application date of 1 April 2022.

The standard has been applied using a modified retrospective approach without the restatement of comparatives. Practical expedients applied by the Trust on initial application are detailed in the leases accounting policy in note 15.

Lease liabilities created for existing operating leases on 1 April 2022 were discounted using the weighted average incremental borrowing rate determined by HM Treasury as 0.95%.

Reconciliation of operating lease commitments as at 31 March 2022 to lease liabilities under IFRS 16 as at 1 April 2022

	Foundation Trust & Group 1 April 2022 £000
Operating lease commitments under IAS 17 at 31 March 2022	2,942
IAS 17 operating lease commitment discounted at incremental borrowing rate	**2,942**
Adjustments:	
Public sector leases without full documentation previously excluded from operating lease commitments	2,927
Adjustments for contracts reassessed for being or containing a lease on transition to IFRS 16.	3,344
Total lease liabilities under IFRS 16 as at 1 April 2022	**9,213**

11. Investments

	Group 2022/23 £000	Group 2021/22 £000
Carrying value at 1 April 2022	**1,830**	1,815
Acquisitions in year - other	**156**	408
Movement in fair value of investments	**(124)**	17
Disposals	**(177)**	(410)
Carrying value at 31 March 2023	**1,685**	1,830

Investments held are wholly attributable to the Harrogate and District NHS Foundation Trust Charitable Fund (registered charity number 1050008), for further information please see the charity's Annual Report and Accounts.

12. Subsidiary Undertaking - Harrogate Healthcare Facilities Management Ltd.

	Foundation Trust 2022/23 £000	Foundation Trust 2021/22 £000
Non-current assets		
Shares in Subsidiary	**1,000**	1,000
Loans to Subsidiary	**23,155**	20,191
	24,155	21,191
Current assets		
Loans to Subsidiary	**2,649**	1,643
	26,804	22,834

The shares in the subsidiary company Harrogate Healthcare Facilities Management Ltd comprises a 100% holding of the share capital. Details of the NHS foundation trust loans to it's Subsidiary as at 31 March 2023 are in the table below.

Loan Name - Principal Borrowed	Term	Interest Rate	Non-current £000	Current £000
Working Capital Loan - £1m - REPAID	5 Years	4.00%	-	-
Capital Loan - £7.5m	10 Years	3.60%	5,625	938
Capital Loan - £14.1m	15 Years	3.75%	12,619	1,009
Capital Loan - £5.6m	10 Years	7.50%	4,911	702
			23,155	**2,649**

There have been no defaults or breaches by the subsidiary in relation to the above loans from the NHS foundation trust.

The principal activity of Harrogate Healthcare Facilities Management Ltd is to provide estate management and facilities services.

13. Inventories

13.1 Analysis of inventories

	Group 2022/23 £000	Group 2021/22 £000	Foundation Trust 2022/23 £000	Foundation Trust 2021/22 £000
Drugs	**1,040**	603	**1,040**	603
Consumables	**1,403**	1,328	**1,257**	1,213
Total	**2,443**	1,931	**2,297**	1,816

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2022/23 the Trust received £455k of items purchased by DHSC (2021/22: £643k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses - please see notes 4.1 and 4.2.

13.2 Inventories recognised in expenses

	Foundation Trust & Group	
	2022/23	2021/22
	£000	£000
Drug Inventories recognised as an expense in the year	**20,168**	18,289
Total	**20,168**	18,289

14. Trade and other receivables

14.1 Trade and other receivables are made up of:

	Group	
	2022/23	2021/22
Current	**£000**	£000
Contract receivables (IFRS 15): invoiced	**5,934**	4,563
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	**10,437**	1,279
PDC Dividend receivable (Department of Health)	**40**	394
Deposits and advances	**(12)**	33
Provision for the impairment of contract receivables (see note 14.2)	**(518)**	(1,371)
Prepayments	**4,038**	3,386
Interest receivable (excludes finance lease interest)	**90**	-
VAT receivables	**2,964**	1,775
Other receivables	**634**	476
Total	**23,607**	10,535

	Foundation Trust	
	2022/23	2021/22
Current	**£000**	£000
Contract receivables (IFRS 15): invoiced	**6,012**	4,543
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	**10,498**	1,279
PDC Dividend receivable (Department of Health)	**40**	394
Deposits and advances	**(14)**	31
Provision for the impairment of contract receivables (see note 14.2)	**(518)**	(1,371)
Prepayments	**3,003**	2,496
Interest receivable (excludes finance lease interest)	**90**	**-**
VAT receivables	**2,828**	705
Other receivables	**633**	456
Total	**22,572**	8,533

	Foundation Trust & Group	
	2022/23	2021/22
Non-Current	**£000**	£000
Other receivables	**350**	204
VAT receivables	**-**	303
Provision for the impairment of receivables (see note 14.2)	**(57)**	(44)
Clinician pension tax provision reimbursement funding from NHSE	**539**	640
Total	**832**	1,103

Of which receivable from NHS and DHSC group bodies:	**15,294**	3,919
Current	**539**	640
Non-Current		

The majority of the NHS foundation trust's trade is with Commissioners for NHS patient care services which are funded by the Government to buy NHS patient care services therefore no credit scoring for them is considered necessary.

14. Trade and other receivables (continued)

14.2 Allowances for credit losses (doubtful debts)	Foundation Trust & Group 2022/23 £000	2021/22 £000
Allowance for credit losses at 1 April 2022	**1,415**	499
New allowances arising	**-**	916
Reversals of allowances (where receivable is collected in-year)	**(1,707)**	-
Utilisation of allowances (where receivable is written off)	**867**	-
Balance at 31 March 2023	**575**	1,415

NHS Injury Benefit Scheme income is subject to a provision for impairment of 22.43% (2022: 22.43%) to reflect expected rates of collection. Other debts are assessed by management considering age of debt and the probability of collection.

15. Cash and cash equivalents

	Group		Foundation Trust	
	2022/23 £000	2021/22 £000	**2022/23 £000**	2021/22 £000
Balance at 1 April 2022	**42,854**	34,198	**38,846**	33,424
Net change in year	**(7,175)**	8,656	**(6,565)**	5,422
Balance at 31 March 2023	**35,679**	42,854	**32,281**	38,846
Made up of:				
Cash with Government Banking Service	**32,742**	39,508	**32,274**	38,811
Cash at commercial banks and in hand	**2,872**	3,328	**7**	35
Other current investments	**65**	18	**-**	-
Cash and cash equivalents	**35,679**	42,854	**32,281**	38,846

16. Trade and other payables

	Group		Foundation Trust	
Current	**2022/23 £000**	2021/22 £000	**2022/23 £000**	2021/22 £000
Receipts in advance	**47**	48	**47**	48
Trade payables	**6,015**	5,006	**6,197**	4,138
Other trade payables - capital	**8,655**	7,296	**5,725**	4,482
Social Security costs	**3,360**	2,070	**3,269**	2,003
Other tax payable	**2,148**	2,268	**2,059**	2,175
Pension contributions payable	**2,912**	2,660	**2,845**	2,605
Other payables	**511**	1,284	**615**	1,307
Accruals	**26,313**	21,327	**24,497**	20,490
Total	**49,960**	41,959	**45,254**	37,248

Non-Current	Foundation Trust & Group 2022/23 £000	2021/22 £000
Accruals	**-**	187
Total	**-**	187

17. Provisions

17.1 Provisions current and non current

	Foundation Trust & Group Current		Foundation Trust & Group Non current	
	2022/23	2021/22	**2022/23**	2021/22
	£000	£000	**£000**	£000
Pensions relating to the early retirement of staff pre 1995	**33**	33	**105**	135
Legal claims	**54**	50	**(0)**	-
Pensions - Injury benefits	**17**	17	**18**	26
2019/20 Clinicians' pension reimbursement	**-**	-	**539**	640
	104	100	**662**	801

17.2 Provisions by category

	Pensions relating to the early retirement of staff pre 1995	Legal claims	Pensions - Injury benefits	2019/20 Clinicians' pension reimbursement	**Foundation Trust & Group Total 2022/23**
	£000	£000	£000	£000	**£000**
At 1 April 2022	168	50	43	640	**901**
Change in discount rate	-	-	-	(475)	**(475)**
Arising during the year	1	35	1	363	**400**
Utilised during the year	(33)	(8)	(10)	-	**(50)**
No longer required	-	(24)	-	-	**(24)**
Unwinding of discount	2	-	1	11	**13**
At 31 March 2023	**138**	**54**	**35**	**539**	**766**

17.3 Expected timing of cashflows by category:

	Pensions relating to the early retirement of staff pre 1995	Legal claims	Pensions - Injury benefits	2019/20 Clinicians' pension reimbursement	**Foundation Trust & Group Total 2022/23**
	£000	£000	£000	£000	**£000**
Within one year	33	54	17	-	**104**
Between one and five years	102	-	18	-	**120**
After five years	3	-	-	539	**542**
	138	**54**	**35**	**539**	**766**

Pensions relating to the early retirement of staff pre 1995

Provisions for capitalised pension benefits are based on tables provided by the Office for National Statistics, reflecting years to normal retirement age and the additional pension costs associated with early retirement.

Legal claims

Legal claims consist of amounts due as a result of third party and employee liability claims. These values are based on information provided by NHS Resolution (formerly the NHS Litigation Authority).

Pensions - Injury benefits

Permanent Injury Benefits are payable to eligible individuals, and are calculated in the same way as capitalised pension benefits.

2019/20 Clinicians' pension

These consist of the pensions tax costs of clinicians working additional sessions, which the UK Government committed to pay. These values are based on information provided by NHS England.

£129,126,819 is included in the provisions of NHS Resolution (formerly the NHS Litigation Authority) at 31 March 2023 in respect of clinical negligence liabilities of the NHS foundation trust (31 March 2022 - £151,496,000). Please see note 1.15.

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18. Other liabilities

	Foundation Trust & Group	
	2022/23	2021/22
Current	**£000**	£000
Deferred income	**2,840**	2,643
Total	**2,840**	2,643

19. Borrowings

	Group	
	2022/23	2021/22
Current	**£000**	£000
Capital loans from DHSC (formerly ITFF)*	**1,220**	1,223
Lease liabilities	**1,869**	-
Total	**3,089**	1,223
Non-Current		
Capital loans from DHSC (formerly ITFF)*	**7,873**	9,054
Lease liabilities	**7,401**	-
Total	**15,274**	9,054

	Foundation Trust	
	2022/23	2021/22
Current	**£000**	£000
Capital loans from DHSC (formerly ITFF)*	**1,220**	1,223
Lease liabilities	**1,620**	-
Total	**2,840**	1,223
Non-Current		
Capital loans from DHSC (formerly ITFF)*	**7,873**	9,054
Lease liabilities	**7,535**	-
Total	**15,408**	9,054

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19. Borrowings (Continued)

*During 2012/13, the Trust signed a 10 year loan agreement for £3.4m from the Independent Trust Financing Facility (ITFF) to fund the provision of additional theatre capacity, the loan was drawn down in full during the financial year. During 2013/14, the Trust signed an additional 10 year loan for £1.5m from the ITFF to fund the replacement of an MRI Scanner. The loan was drawn down in full during the financial year. During 2014/15 the NHS foundation trust did not undertake any additional borrowing. During 2015/16 the Trust signed a 25 year loan agreement from the Department of Health for £7.5m to fund a Carbon Efficiency capital scheme and a 10 year loan agreement from the Department of Health for £1.5m to fund the purchase of a Mobile MRI Scanner, both of these loans were drawn down in full during the financial year. The NHS foundation trust did not undertake any additional borrowing during 2016/17. During 2017/18, the Trust signed two loan agreements (both with 10 year terms). Replacement of automatic endoscope reprocessors for £3.8m and a modular build endoscopy suite for £6.9m.

During the 2021/22 financial year the NHS foundation trust repaid in full three of the outstanding loans (please see below).
Additional theatre capacity loan £375k
Replacement MRI loan £166k
Replacement of Automated Endoscope Reprocessors scheme loan £2,401k

The interest rates on the NHS foundation trust's loans are:-
Additional theatre capacity loan originally £3.4m is fixed at 0.93% per annum (10 year term).
Replacement MRI loan originally £1.5m is fixed at 1.75% per annum (10 year term).
Carbon efficiency capital scheme loan originally £7.5m is fixed at 2.5% per annum (25 year term).
Mobile MRI Scanner loan originally £1.5m is fixed at 0.90% per annum (10 year term).

Replacement of Automated Endoscope Reprocessors scheme loan originally £3.8m is fixed at 0.76% per annum (10 year term).
Modular Build Endoscopy Suite loan originally £6.9m is fixed at 0.56% per annum (10 year term).
Working capital loan originally £4.9m is fixed at 1.5% per annum (3 year term - see **above).

Interest accrued is paid every six months see finance expense note 7.

There have been no defaults or breaches in relation to the DHSC (formerly ITFF) loans.

20. Losses and special payments

	Foundation Trust & Group			
	2022/23 Total number of cases	**2022/23 Total value of cases**	2021/22 Total number of cases	2021/22 Total value of cases
		£000		£000
Losses:				
Bad debts private patients	**-**	**-**	4	1
Bad debts overseas visitors	**-**	**-**	5	5
Bad debts other	**188**	**2**	243	3
Total losses	**188**	**2**	252	9
Special payments:				
Ex gratia payment loss of personal effects	**27**	**13**	18	14
Compensation under court order or legally binding arbitration award	**-**	**-**	-	**-**
Ex gratia payment personal injury with advice	**1**	**7**	4	16
Ex gratia payment other employment payments	**-**	**-**	-	-
Overtime corrective payments	**-**	**-**	1	488
Ex gratia payment other	**-**	**-**	3	-
Total special payments	**28**	**20**	26	518
Total losses and special payments	**216**	**22**	278	527

21. Third Party Assets

The NHS foundation trust held £0 cash at bank and in hand at 31 March 2023 which related to monies held by the NHS foundation trust on behalf of patients (31 March 2022: £0).

22. Contractual Capital Commitments

Commitments under capital expenditure contracts at 31 March 2023 were £4,041,000 (31 March 2022: £1,025,000).

23. Related Party Transactions

23.1 Transactions with key management personnel

IAS 24 requires disclosure of transactions with key management personnel during the year. Key management personnel is defined in IAS 24 as "those persons having authority and responsibility for planning, directing and controlling the activities of the entity, directly or indirectly, including any director (whether executive or otherwise) of that entity". The Trust has deemed that its key management personnel are the board members (voting and non-voting directors and non-executive directors) of the NHS foundation trust.

However the DHSC GAM states the requirement in IAS 24 to disclose the compensation paid to management, expenses allowances and similar items paid in the ordinary course of an entity's operations will be satisfied with the disclosures in the Remuneration Report. There were no transactions with board members or parties related to them other than those from the ordinary course the NHS foundation trust's operations.

23.2 Transactions with other related parties

The Department of Health and Social Care is the parent department of Harrogate and District NHS Foundation Trust, paragraph 25 of IAS 24 allows entities which are related parties because they are under the same government control to reduce the volume of detailed disclosures.

The DHSC GAM interprets this as requiring the disclosure of the main entities within the public sector with which the NHS foundation trust has had dealings, but no information needs to be given about these transactions. These entities are listed below:-

County Durham Unitary Authority
Darlington Borough Council
Gateshead Council
Health Education England
HM Revenue & Customs
Leeds Teaching Hospitals NHS Trust
Middlesbrough Council
NHS Humber and North Yorkshire ICB
NHS West Yorkshire ICB
NHS Bradford District and Craven CCG
NHS England
NHS Leeds CCG
NHS North Yorkshire CCG
NHS Pension Scheme
NHS Property Services
NHS Resolution (formerly NHS Litigation Authority)
NHS Vale of York CCG
North Yorkshire County Council
Northumberland Unitary Authority
Stockton-on-Tees Borough Council
Sunderland City Metropolitan Borough Council
Wakefield Council
York Teaching Hospital NHS Foundation Trust

24. Financial instruments.

Disclosure is required under International Accounting Standards of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The Harrogate and District NHS Foundation Trust actively seeks to minimise its financial risks. In line with this policy, the Trust neither buys nor sells financial instruments. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Interest Rate Risk

All of the Trust's financial liabilities carry nil or fixed rates of interest. In addition, the only element of the Trust's assets that are subject to a variable rate are short term cash investments. The Trust is not, therefore, exposed to significant interest-rate risk.

Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

Credit Risk

The Trust operates primarily within the NHS market and receives the majority of its income from other NHS organisations. There is therefore little risk that one party will fail to discharge its obligation with the other. Disputes can arise, however, around how the amounts owed are calculated, particularly due to the complex nature of the Payment by Results regime. For this reason the Trust makes a provision for irrecoverable amounts based on historic patterns and the best information available at the time the accounts are prepared. The Trust does not hold any collateral as security.

Liquidity Risk

The Trust's net operating costs are incurred under three year agency purchase contracts with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust receives such contract income in accordance with Payment by Results (PBR), which is intended to match the income received in year to the activity delivered in that year by reference to the National Tariff procedure cost. The Trust received cash each month based on an annually agreed level of contract activity and there are quarterly payments made to adjust for the actual income due under PBR. This means that in periods of significant variance against contracts there can be a significant cash-flow impact. The Trust has adequate liquidity to deal with these variances.

The Trust finances it's capital expenditure from internally generated funds or funds made available from Government, in the form of additional Public Dividend Capital, under an agreed limit. In addition, the Trust has borrowed from the Department of Health Financing Facility and may also borrow commercially in order to finance capital schemes. Financing is drawn down to match the capital spend profile of the scheme concerned and the Trust is not, therefore exposed to significant liquidity risks in this area.

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24. Financial instruments (continued).

	Group		Foundation Trust	
	2022/23	2021/22	**2022/23**	2021/22
	£000	£000	**£000**	£000
Financial assets at amortised cost				
Loans and receivables (including cash and cash equivalents)	**52,495**	47,410	**48,656**	44,097
Investments	**-**	-	**1,000**	1,000
Consolidated NHS Charitable fund financial assets	**2,278**	2,565	**-**	-
	54,773	49,975	**49,656**	45,097
Financial liabilities at amortised cost				
Loans and payables	**59,823**	41,473	**55,282**	36,820
Consolidated NHS Charitable fund financial liabiilities	**34**	30	**-**	-
	59,857	41,503	**55,282**	36,820

Management consider that the carrying amounts of financial assets and financial liabilities recorded at amortised cost in the financial statements approximate to their fair value.

Maturity of Financial Liabilities
The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group	
	31 March 2023	**31 March 2022**
	£000	**£000**
In one year or less	45,232	32,573
In more than one year but not more than five years	11,524	5,107
In more than five years	4,167	5,204
Total	**60,923**	**42,884**

25. Charitable funds reserve.

Unrestricted income funds comprise those funds which the Trustee is free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include designated funds, where the donor has made known their non binding wishes or where the Corporate Trustee, at its discretion, has created a fund for a specific purpose.

Restricted funds are funds which are to be used in accordance with specific restrictions imposed by the donor.

The charity has one permanent endowment fund. The income of the Elsie Sykes Endowment Fund can be used for medical equipment or medical research (excluding transplant or vivisection work).

	Group	
	2022/23	2021/22
	£000	£000
Unrestricted income funds	**504**	745
Restricted funds	**74**	37
Endowment fund	**1,666**	1,753
	2,244	2,535

27. Ultimate parent.

As an entity operating in the National Health Service in England, the ultimate parent holding is considered as the Department of Health and Social Care.

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Terms of Reference

Remuneration, Nomination and Conduct Committee

Document Details:	Terms of Reference for the Quality Committee
Version:	4
Approved By:	Remuneration, Nomination and Conduct Committee
Date Approved:	17 October 2023
Ratified By:	Council of Governors
Date Ratified:	21 November 2023
Job Title – Author:	Assistant Company Secretary
Job Title – Responsible Director:	Chair of the Trust (Non-executive Director)
Date Issued:	22 November 2023
Review Date:	October 2024
Frequency of Review:	At least annual
Amendment Summary: 1. Transferred to new Terms of Reference Template to include standard wording.	

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8.1

1. Name of the Committee

Council of Governors' Remuneration, Nomination and Conduct Committee (RNCC)

2. Accountability

The Committee is directly accountable to the Council of Governors.

3. Role of the Committee

3.1. Purpose of the Committee

The Committee is established for the purposes of:
- Setting the remuneration of the Chair and other Non-Executive Directors.
- Carrying out the duties of Governors with respect to the appointment, re-appointment, and removal of the Chair and other Non-Executive Directors.
- Receiving reports from the Chair on issues of Governor conduct, eligibility and removal.

All procedural matters in respect of conduct of meetings shall follow the Constitution and Standing Orders of the Council of Governors, as far as possible.

3.2. Guiding Principles

In carrying out their duties, members of the committee and any attendees must ensure that they act in accordance with the values of the Trust which are:
- Kindness
- Integrity
- Teamwork
- Equality

3.3. Responsibilities of the Committee

3.3.1 Remuneration Matters

3.3.1.1 To recommend to the Council of Governors remuneration packages for the Non-Executive Directors and Chair of the Trust in line with current market intelligence.

3.3.1.2 To judge where to position the Trust relative to other NHS Foundation Trusts and comparable organisations in relation to remuneration levels.

3.3.1.3 To be sensitive to pay and employment conditions elsewhere in the Trust when determining any salary increase.

3.3.2 Nominations Matters

3.3.2.1 To recommend to the Council of Governors potential candidates for appointment as Chair and/or Non-Executive Director.

8.1

3.3.2.2 To determine a formal, rigorous and transparent procedure for the selection of candidates for the office as Chair or Non-Executive Director of the Trust, having regard to the views of the Board of Directors.

3.3.2.3 To regularly review the job description and person specification of the role of the Chair, Senior Independent Director and Non-Executive Directors, to ensure capabilities and competencies required by the roles remain appropriate and in line with development of the Trust. In this review the Committee will evaluate the balance of skills, diversity, knowledge and experience on the Board.

3.3.2.4 To establish an appointments panel for the purposes of managing the process for the appointment of a Chair and/or Non-Executive Director. The Panel shall be comprised of a majority of Governors, the majority of which shall be Public Governors.

3.3.2.5 To have the freedom and support to appoint independent consultants to provide advice on the appointment of the Trust Chair and Non-Executive Directors. In addition, the Committee may use open advertising and/or the services of external advisors to facilitate the search.

3.3.2.6 To identify candidates who meet the *'Fit and Proper Persons Test'* as set out in the Provider Licence. In doing so, the Committee shall be at liberty to seek advice and assistance from persons other than members of the Committee or the Council of Governors.

3.3.2.7 On a regular systematic basis, to ensure a system is in place to monitor the performance of the Chair and other Non-Executive Directors, and report the outcome of these reviews to the Council of Governors on an annual basis.

3.3.2.8 To ensure there is a formal and transparent procedure for the appraisal of the Trust Chair and Non-Executive Directors' performance.

3.3.2.9 To give consideration to succession planning for Non-Executive Directors, taking into account the future challenges, risks and opportunities facing the Trust, and the skills and expertise required to meet them.

3.3.3 Governor Conduct Matters

3.3.3.1 To promote high standards of conduct by Governors and assist Governors to observe the Code of Conduct.

3.3.3.2 To review the Governor Code of Conduct and Procedure for Management of Governor Conduct Concerns annually and make relevant recommendations to the Council of Governors for approval.

3.3.3.3 To receive and consider reports from the Trust Chair on issues of Governor conduct, eligibility and removal.

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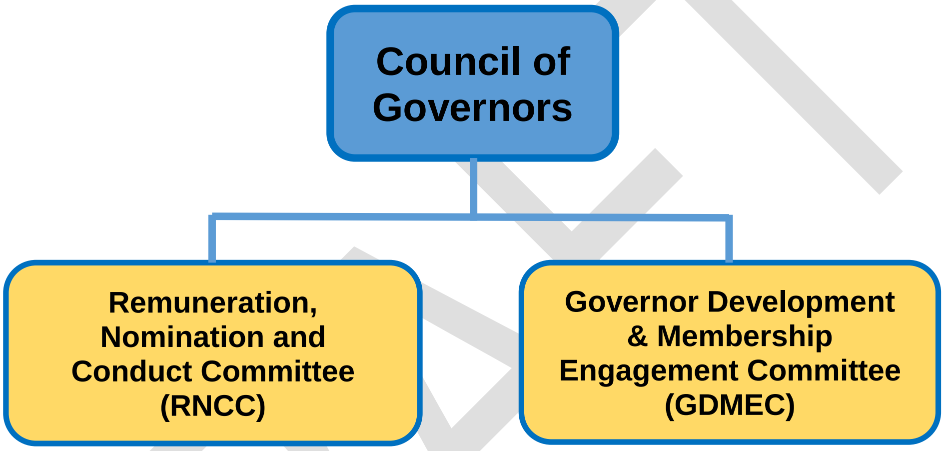
3.3.3.4 To provide recommendations (in accordance with the Governor Code of Conduct) to the Council of Governors on issues of:

- Governor conduct, eligibility and removal.
- Process for dealing with any reports of breaches of the Code of Conduct or Trust Constitution.

3.3.3.5 To receive reports on Governor attendance and provide relevant recommendations to the Council of Governors.

3.3.3.6 The Committee is authorised to investigate any activity within its terms of reference.

4. Relationships with other groups and committees



The Committee shall report to the Council of Governors following every meeting and, where appropriate, present recommendations for approval to the Council of Governors.

5. Composition of the Committee

5.1. Members: Full Rights

Membership of the Committee shall be appointed by the Council of Governors.

Title	Role in the group / committee
Trust Chair	Committee Chair (subject to any conflict of interest)
Lead Governor	Deputises as Committee Chair in the even to a conflict of interest for the Trust Chair
Governor, public elected	
Governor, public elected	
Governor	
Governor	
Governor	

Where there is a conflict of interest meaning the Trust Chair is unable to participate in the work of the Committee, the Lead Governor will chair the meeting, or part of the meeting, as required.

Governors shall be appointed to the Committee until their term of office as a Governor ends, or they choose to resign from the Committee, which shall be confirmed in writing to the Chair of the Committee.

There may be occasions where the post of Trust Chair post has been filled on an interim basis. Where this arrangement is in place, the interim post holder will be considered a member of this group for the period they hold the interim position.

5.2. In attendance: in an advisory capacity

Job Title
The Chief Executive
The Senior Independent Non-Executive Director and/or Vice Chair (subject to any conflicts of interest).
The Director of People & Culture
Associate Director of Quality and Corporate Affairs / Company Secretary

In addition to anyone listed above as a member or attendee, at the discretion of the Chair, the Committee may also request individuals to attend on an ad hoc basis to provide advice and support for specific items from its work plan when these are discussed at the meetings.

6. Quoracy

Number: The minimum number of members for a meeting to be quorate is three, comprising the Chair (or Vice Chair/Senior Independent Director in the Chair's absence) and three Governors. Attendees do not count towards quoracy.

Deputies: Owing to the membership of the committee, deputies are not able to be nominated to attend in a member's place. However, attendees may nominate a deputy to attend in their absence.

Non-quorate meeting: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting and documented in the minutes.

7. Meetings of the Committee

Frequency: Meetings will be scheduled on a quarterly basis. If there is no business to discuss, the meetings may not go ahead. However, there will be a minimum of one meeting a year. Meetings may also be convened on an ad-hoc basis.

Urgent Meetings: Any member of the Committee may request an urgent meeting. The Chair of the Committee will normally agree to call an urgent meeting to discuss the specific matter, unless the opportunity exists to discuss the matter in a more expedient manner.

Committee Support: The Director of People & Culture will provide information and advice to the Committee to ensure compliance with best practice in remuneration and recruitment issues. The Committee is authorised to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The costs of such advice must first be agreed with the Trust.

Administrative Support: The Committee Secretariat will be provided by the Corporate Directorate, including to arrange meetings, prepare agendas, circulate papers and draft minutes, maintain a register of attendance. All information provided will be agreed with the Chair of the meeting prior to circulation as described below. Papers will be made available a minimum of five days prior to scheduled meetings. An action log will be maintained, and a log of items reviewed throughout each 12 month period.

Minutes: Draft minutes will be approved by the Chair of the meeting and then shared with the members of the Committee. The draft minutes will be reviewed and the final record agreed at the next quorate meeting.

Chair Reports: The Chair of the Committee will provide an update of key issues arising from the meeting, including decisions taken, to the next Board of Directors meeting held in public.

Voting: It is at the discretion of the Chair of the meeting to call a vote during a meeting. When voting, decisions at meetings shall be determined by a majority of the votes of the Committee Members present and voting. In the case of any equality of votes, the person presiding shall have a second or casting vote.

8. Authority

Establishment: The Committee is a sub-committee of the Council of Governors and has been formally established by the Council.

Powers: The Committee's powers are to make recommendations to the Council of Governors.

Cessation: The Committee is a standing sub-committee of the Council of Governors in that its responsibilities and purpose are not time limited. However, the Committee has a responsibility to review its effectiveness annually.

9. Duties of the Chair

The Chair of the Committee shall be responsible for:

- Agreeing the agenda in partnership with the Corporate Team;
- Directing the meeting, ensuring it operates in accordance with the Trust's values whilst ensuring all attendees have an opportunity to contribute to the discussion;
- Ensuring the agenda is balanced and discussion is productive;

- Giving direction to the secretariat and checking the draft minutes; and
- Ensuring sufficient information is presented to the Council of Governors in respect of the work of the Committee

10. Review of Committee Effectiveness and Terms of Reference

It will be the responsibility of the Chair of the Committee to ensure that it carries out an assessment of committee effectiveness annually, and ensure the outcome is reported to the Council of Governors along with any remedial action to address any weaknesses identified. The Chair of the Committee will also be responsible for ensuring that the actions to address any areas of weakness are completed.

The Terms of Reference shall be reviewed by the Committee at least annually and be presented to the Council of Governors for ratification.

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Terms of Reference

Governor Development & Membership Engagement Committee

Document Details:	Terms of Reference for the Governor Development & Membership Engagement Committee
Version:	3
Approved By:	Governor Development & Membership Engagement Committee
Date Approved:	15 November 2023
Ratified By:	Council of Governors
Date Ratified:	21 November 2023
Job Title – Author:	Assistant Company Secretary
Job Title – Responsible Director:	Company Secretary
Date Issued:	
Review Date:	July 2024
Frequency of Review:	At least annual

Amendment Summary:

1. Transferred to new Terms of Reference Template to include standard wording.
2. Amended "Purpose" and "Responsibilities" sections

8.2

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1. Name of the Committee

Governor Development & Membership Engagement Committee

2. Accountability

The Governor Development & Membership Engagement Committee is a Sub-Committee of the Council of Governors.

3. Role of the Committee

3.1. Purpose of the Committee

The overall aims of the Committee will be to:

- Strive to build and maintain membership that is actively engaged, well-informed and representative of the communities served by the Trust.
- Ensure the Governors drawn from the membership are equipped with the skills to enable them to both engage with their constituencies and also perform the statutory duties of a governor as set out in the Health and Social Care Acts of 2006 and 2012 and in NHS England's Foundation Trust Code of Governance.
- To develop and fulfil an agreed membership engagement strategy, approved by the Council of Governors.

3.2. Guiding Principles

In carrying out their duties, members of the Committee and any attendees must ensure that they act in accordance with the values of the Trust which are:

- Kindness
- Integrity
- Teamwork
- Equality

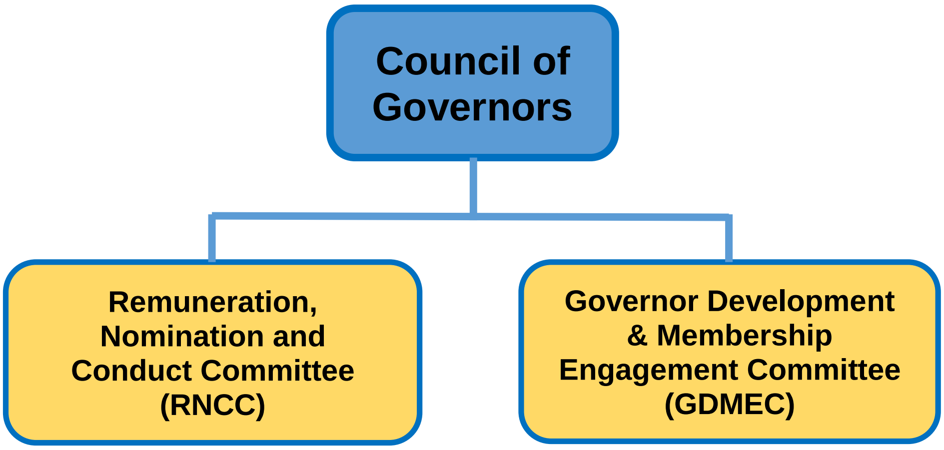
3.3. Responsibilities of the Committee

The key responsibilities of the Committee are to:

- Identify development needs of Governors and associated appropriate development opportunities
- Review the Governor induction programme, suggesting improvements where appropriate
- Produce, maintain and deliver a Membership Development Strategy to be agreed with the Trust, including:
  - Membership recruitment, ensuring membership is representative of the local communities served by the Trust
  - Identifying ways Governors can engage further within their constituencies
  - Support membership activities such as “Medicine for Members” sessions
  - Membership database updates
  - Ongoing implementation/action plan

- Participate in the development and content of an online / electronic members' publication
- Promote the Governor election process
- Contribute to and participate in arrangements for the Trust's Annual Members' Meeting

4. Relationships with other groups and committees



5. Composition of the Committee

5.1. Members: Full Rights

Title	Role in the group / committee
Lead Governor	Committee Chair
Deputy Lead Governor	Elected by Public Governors
Public Governor	Elected by Public Governors
Public Governor	Elected by Public Governors
Public Governor	Elected by Public Governors
Public Governor	Elected by Public Governors
Staff Governor	Agreed / nominated by Staff Governors
Stakeholder Governor	Agreed / nominated by Stakeholder Governors
Trust Chair	Chair of Governors

5.2. Attendees

Title	Role in the group / committee
Company Secretary	Corporate Team Member
Assistant Company Secretary	Corporate Team Member
Communications Manager	Corporate Team Member

There may be occasions where a Corporate Team Member position has been filled on an interim basis. Where this arrangement is in place, the interim post holder will be considered a member of this group for the period they hold the interim position.

Where a Committee member is unable to attend, they may delegate to a governor in the same class (Public, Staff or Stakeholder). In such cases it should be made clear at the meeting who is undertaking the deputising role.

In addition to anyone listed above as a member, at the discretion of the Chair of the Committee, the Committee may also request individuals to attend on an ad hoc and advisory only basis to provide advice and support for specific items from its work plan when these are discussed at the meetings.

When a Governor member of the Committee comes to the end of their term of office, their membership of the Committee will cease. They will be able to seek reappointment if re-elected as a Governor.

6. Quoracy

Number: The minimum number of members for a meeting to be quorate is five, comprising at least three Governors including the Lead Governor and/or the Trust Chair. If the Chair of the Committee is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by the Deputy Lead Governor.

Deputies: Where appropriate, members may nominate deputies to represent them at a meeting. Deputies do not count towards the calculation of whether the meeting is quorate except if the deputy is representing the member under formal "acting up" arrangements. In this case the deputy will be deemed a full member of the Committee. It may also be appropriate for attendees to nominate a deputy to attend in their absence.

Non-quorate meeting: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting and documented in the minutes.

7. Meetings of the Committee

Frequency: Meetings will be held quarterly with the meeting dates agreed in advance. There will be additional meetings if required by the Committee and the Council of Governors would be informed of additional meetings.

Attendance: Elected or nominated Members will be required to attend a minimum of 50% of the meetings in a financial year. If they are unable to meet the attendance requirement without good reason approved by the Council of Governors, their position within the Committee will be open to the Council of Governors to agree a replacement member within the same class.

Administrative Support: The Committee Secretariat will be provided by the Corporate Directorate, including arranging meetings including a register of attendance, preparing agendas, circulating papers and draft minutes, to be agreed with the Chair of the meeting prior to circulation. Papers will be made available approximately five working days prior to scheduled meetings. An action log will be maintained, and a log of items reviewed throughout each 12 month period.

8.2

Minutes: Draft minutes will be approved by the Chair of the meeting with the aim of being shared with the members of the Committee within 10 working days and then reviewed at the next Council of Governors' meeting. The draft minutes will be reviewed and the final record agreed at the next quorate meeting.

Chair Reports: The Chair of the Committee will provide an update of key issues arising from the meeting, including decisions taken, to the next Council of Governors' meeting held in public.

8. Authority

Establishment: The Committee is a sub-committee of the Council of Governors.

Powers: The Committee has powers as delegated by the Council of Governors. The Committee makes recommendations and reports to the Council of Governors.

Cessation: The Committee is a working group with its effectiveness and content reviewed by the Council of Governors. It will continue to meet in accordance with these Terms of Reference until the Council of Governors determines otherwise.

9. Duties of the Chair

The Chair of the Committee shall be responsible for:

- Agreeing the agenda in partnership with the Corporate Team;
- Directing the meeting, ensuring it operates in accordance with the Trust's values whilst ensuring all attendees have an opportunity to contribute to the discussion;
- Ensuring the agenda is balanced and discussion is productive;
- Giving direction to the secretariat and checking the draft minutes; and
- Ensuring sufficient information is presented to the Council of Governors in respect of the work of the Committee.

10. Review of Committee Effectiveness, Terms of Reference and Annual Report

It will be the responsibility of the Chair of the Committee to ensure that it carries out an assessment of committee effectiveness annually, and ensure the outcome is reported to the Council of Governors along with any remedial action to address any weaknesses identified. The Chair of the Committee will also be responsible for ensuring that the actions to address any areas of weakness are completed.

The Terms of Reference shall be reviewed by the Committee at least annually and be presented to the Council of Governors for ratification.

The Committee will present an annual report to the Council of Governors outlining its work against its duties set out in these Terms of Reference. The Committee will make recommendations to the Council of Governors on any area within its remit where action or improvement is required.

Questions Submitted for Council of Governors' Meeting: 21 November 2023		
Governor	**Constituency**	**Question**
Donald Coverdale	Ripon And West	Many months ago we were told that Governors' questions were to be collated and, together with the answers, made readily accessible to all Governors. This has not been done. Why not?
Donald Coverdale	Ripon And West	Over the last year a considerable number of Governors' questions have been left unanswered. When can we expect the answers?
Donald Coverdale	Ripon And West	Governors' Questions are not properly recorded in the Minutes of the meetings. I have been asking for this to be done for at least a year. Can it now be done? It is all very well recording the answers but without the questions (transcribed in full) it is not easy to see that matters are being addressed properly.
Donald Coverdale	Ripon And West	Minutes of the Council of Governors meetings are still being produced late. Why can they not be produced (and distributed) within, say, one week of the meeting?
Rachel Carter	Ripon And West	I would be interested to hear about the impact on HDFT of the Right Care, Right Person new national partnership agreement. In particular how/where is the discussion taking place about appropriate action where the threshold for police involvement is not met? How is HDFT engaged in these discussions? What discussion has there been at HDFT Board or committees and how sighted are the NEDs on the issue?
Tony Doveston	Harrogate and Surrounding Villages	The Stray Ferret recently stated that HDFT was about to spend £1.2m on a major management consultant study. Could Governors be assured by NEDs that they are in full support of this initiative and have received the necessary level of assurances from the management team that this is money well spent and will produce genuine benefits and efficiencies for the Trust.
Steve Treece	Wetherby and Harewood etc	Update on FTSU arrangements. I have asked a question about these but happy for this to be removed we are going to have a substantive agenda item. It is of course very relevant in light of recent events.
Steve Treece	Wetherby and Harewood etc	Update on the Domiciliary Care service - how it is operating, number of "customers", impacts on delayed discharge etc.
Steve Treece	Wetherby and Harewood etc	Update on the new complaints processes, including whether this has improved performance.
Steve Treece	Wetherby and Harewood etc	Are NEDs confident that the Trust provides adequate support and facilities for disabled patients and how do they get assurance on this issue?
Steve Treece	Wetherby and Harewood etc	Are NEDs confident about the effectiveness of the Trust's Freedom to Speak Up arrangements and how do they get assurance on these?
Kathy Gargan	Harrogate and Surrounding Villages	Please may we have a briefing on the business development strategy for Our Childrens' and Young Peoples Public Health Services - in light of the loss of 4 contracts we bid for in 2023 to competitors.

Questions Submitted for Council of Governors' Meeting: 21 November 2023		
Governor	**Constituency**	**Question**
Kathy Gargan	Harrogate and Surrounding Villages	Please may we have a briefing on the Green Plan - 2022- 25 and progress against it - I had not heard of this until I read the annual report. *(Sue G sent link from website after receipt of question, but Kathy would still like to know progress against the plan)*
Kathy Gargan	Harrogate and Surrounding Villages	Please may we have an update on progress on all things food related in light of the Limited Assurance IA report and coming bottom of all NHS trusts on food matters earlier this year.
Rachel Carter	Ripon And West	• Management of RAAC was helpfully addressed at the public Board meeting in September, following recent media interest, and it is great to know that RAAC-specific risks both at Harrogate District Hospital and other buildings that our teams work out of are being monitored and appropriate actions taken. • Following on from this, it would be helpful to understand how more general estate condition is monitored and managed, and how NEDs receive assurance on this. For example when was a 6-facet survey (or the current equivalent) last carried out or refreshed, what proportion of the estate is category C (or the current equivalent) or below and what NED oversight is there of this position? • More generally how are estate responsibilities split between HDFT and HIF? Where is this documented and how is/was it scrutinised by HDFT Board and what NED oversight is there? If any estate responsibilities are delegated to HIF, what is the reporting mechanism to HDFT and what NED oversight is there? Specifically what are the processes to ensure no gaps in responsibility or accountability, that escalation processes are timely and effective, and that there is clear reporting route to HDFT Board & appropriate NED oversight? • - Do estate issues feature on the Trust Board Assurance Framework? What are the highlights (other than RAAC) and what is the NED oversight?