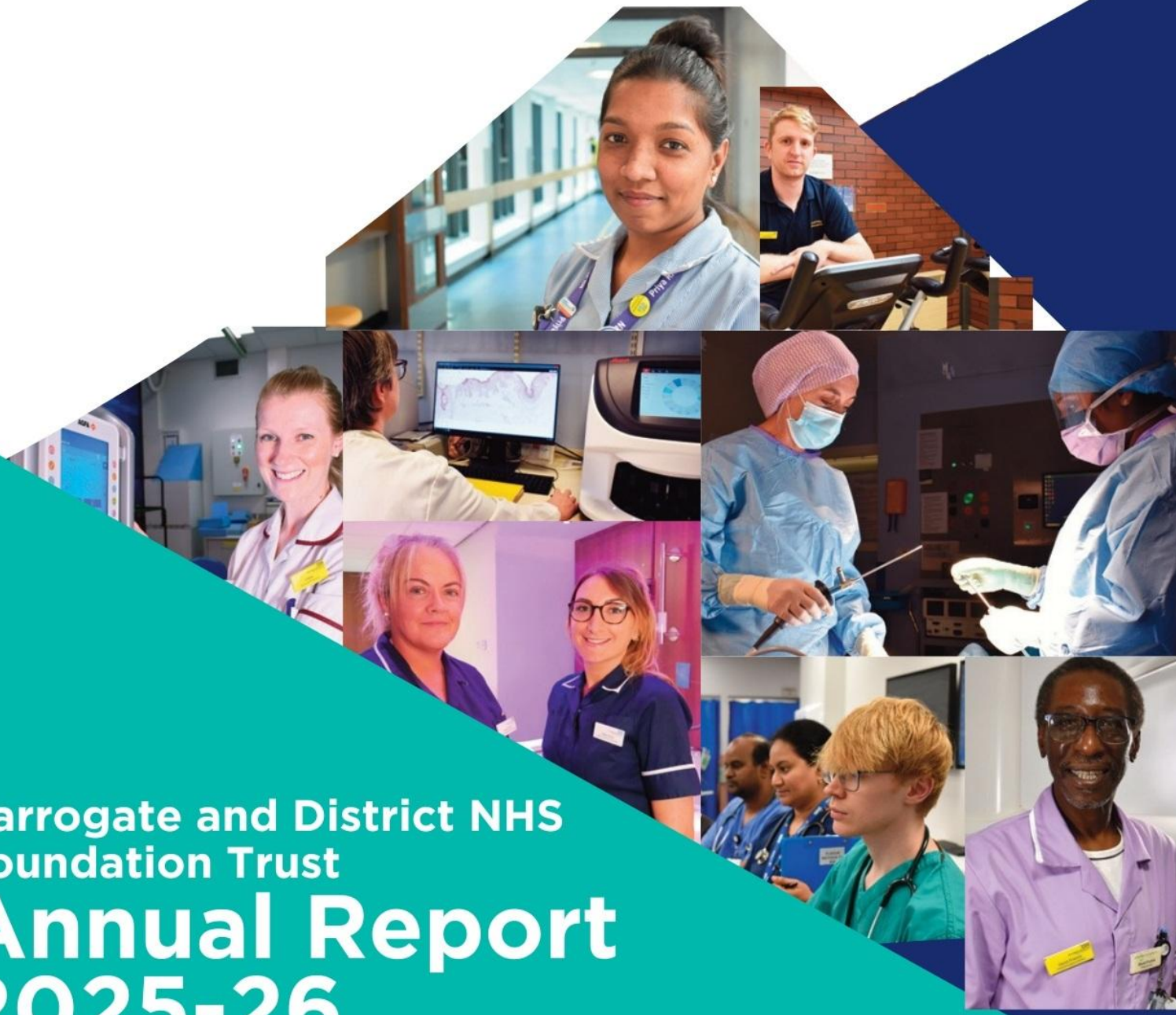
teamHDFT At our best

HIF HARROGATE INTEGRATED FACILITIES Taking Pride in our Services

NHS Harrogate and District NHS Foundation Trust



Harrogate and District NHS Foundation Trust

Annual Report 2025-26

THIS PAGE HAS BEEN LEFT BLANK INTENTIONALLY

HARROGATE AND DISTRICT NHS FOUNDATION TRUST

Annual Report and Accounts

1 April 2025 to 31 March 2026

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

Overview

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 2025-2026 financial year.

HDFT's Chair's Welcome and Statement

Thank you for taking the time to read this year's Annual Report. This report provides an important opportunity to reflect openly on the year we have experienced together — a year in which our staff have continued to deliver high-quality care despite significant financial pressures, including a reported deficit of £23.7 million.

Like many organisations across the NHS, we have had to work increasingly hard to provide services within the resources available to us, and this has not been without challenge.

Within this context, we recognise both our achievements and the areas where we must continue to improve, and we remain committed to being honest about the realities we face as a Trust while striving to deliver sustainable, high-quality services for our communities.

Your interest and engagement really matter, and I am grateful you are taking the time to learn more about our Trust.

Over the past year, our focus on continuous improvement has remained central to how we work. By maintaining a shared focus on learning, improvement and collaboration, we continue to strengthen the quality and safety of our services.

While there is always more to do, this approach is helping us to make progress in meaningful and sustainable ways. I would like to sincerely thank our colleagues for their commitment to this journey. Their expertise, insight and dedication are fundamental to everything we achieve, and we value not only what they do, but how they do it.

This has again been a demanding year for health and care services, with ongoing change and pressure across the system. Throughout this, our colleagues have continued to adapt with professionalism, compassion and resilience.

I am immensely proud of their continued commitment to providing high-quality care and of the kindness they show every day to patients, service users and one another.

Of particular note this year are the improvements shown in our latest NHS Staff Survey results. The NHS Staff Survey is one of the largest workforce surveys in the world, and in 2025 we heard from over 3,300 colleagues at Harrogate and District NHS Foundation Trust — 62% of our workforce and a 13% increase in participation compared with the previous year. This significant rise in response rate reflects growing engagement and a willingness among our staff to share their experiences and views.

Particularly encouraging are the continued increases in the proportion of colleagues who would recommend HDFT as a place to work, which has risen for the fourth successive year to 67.6%, and those who would be happy with the standard of care provided by the Trust should a friend or relative need treatment, which has increased for the third consecutive year to 74.5%. Both measures are well above the average for similar Trusts and provide a strong indication of the pride our colleagues feel in their work and the care we provide. We will continue to listen carefully to this feedback and use it to support our staff and further strengthen our culture.

I would like to sincerely thank our Governors for their ongoing dedication to our members and communities. As a Foundation Trust, their contribution is essential in ensuring that the voices of patients, service users and the public are heard and reflected in our decisions.

Partnership working remains at the heart of how we deliver care. We continue to work closely with NHS colleagues, local authorities, the voluntary and community sector and a wide range of partners. Integrated working is essential to meeting the needs of our population, and I am grateful for the shared commitment, collaboration and trust that underpin these relationships. As always, there is more to do in the year ahead, but we remain focussed and committed to being a effective and helpful partner and convener.

Finally, I would like to recognise the work of the HDFT Board. I would like to thank our Executive Directors, Non-Executive Directors and Associate Non-Executive Directors for their ongoing commitment, challenge and support. As a Board, we remain united by a clear purpose and a shared ambition to deliver the best possible care, while making responsible use of the resources available to us. We will always keep our focus on what matters most to patients, service users and their loved ones.

The year ahead will undoubtedly bring further change and challenge, but also new opportunities. We remain committed to building on our progress, learning from experience and continuing our journey of improvement. I look forward to sharing how we continue to develop and grow as a Trust over the coming year.

……...

Sarah Armstrong
Chair
Harrogate and District NHS Foundation Trust

A Message from Jonathan Coulter, HDFT Chief Executive

As I look back and reflect upon the year that was 2025-2026, I am struck by the contrast between the regular description of the NHS, which often references the many challenges and difficulties facing the service, and my experience talking to colleagues and seeing the great care that is delivered each and every day across Harrogate and District NHS Foundation Trust (HDFT).

This is not to underplay the challenges that we have, but at HDFT, we continue to deliver care and support to the wide population we serve across Yorkshire and the North of England, when people need it the most. It is good to see that the general population are gradually becoming more confident in the NHS, but it is clear that there is a long way to go to ensure that everyone can be happy in the knowledge that the NHS is there for all at times of need.

Our aim at HDFT is to provide high quality care, when it is needed, in a good environment and with excellent staff. And as a publicly funded NHS body, we need to do this within the resources that are entrusted in us by the taxpayer.

It is pleasing therefore to report that our waiting times are reducing for planned care, that we are achieving the national cancer standards, and our urgent care pathway delivered the aim of meeting the 78% 4 hour standard in March.

We also delivered really well against the Healthy Child Programme standards across eleven local authority areas, including significant improvement in our two new areas of Cumberland and Westmorland & Furness. As the NHS attempts to pivot towards a greater emphasis on prevention and public health outcomes, this is an important achievement to build on for the children and young people in our services.

As well as the nationally measured standards, we can also demonstrate improved safety and quality, upgraded facilities and the implementation of a new Electronic Patient Record, which will further improve services across the Trust.

One area which has been difficult for the Trust, has been to deliver all of our services within the resources that we have received, and we ended the year with a deficit of £23.7 million. We are a productive Trust when looking at many of the national indicators, but there is progress we need to make over the next year to ensure that the medium term position is one where we can deliver all of the services that the public should expect within the money that we earn.

The most important thing for me though is the engagement of our colleagues, because we know that having an engaged and happy workforce delivers better patient outcomes. It was really pleasing therefore to receive the very positive results of our national staff survey for 2025-2026, with a higher response rate and improved feedback from colleagues about their experience working within HDFT.

Whilst there is always more we can do together, I'd like to use this opportunity again to give my thanks to all 5,000 people who work together in the team that is HDFT to deliver the outcomes that we do.

We know across all colleagues and services, from Wakefield to Northumberland, from Scarborough to Cumberland, in Harrogate and Ripon hospitals, in our GP practice in Ripon, and in all of the communities that we serve, that what we do contributes to the most important thing that there is – improving health. And whilst we know that there are always challenges in delivering the level of care and support that we would want to provide every day, with the commitment of colleagues in HDFT, working alongside our partners across our wide

geographic area, I am positive and optimistic for the future of the NHS in general and HDFT in particular.

Thank you for your interest in HDFT, and please enjoy reading this annual report.

……...

Jonathan Coulter
Chief Executive
Harrogate and District NHS Foundation Trust

About Us

Harrogate and District NHS Foundation Trust (HDFT) is an **Integrated Accountable Care Organisation**, providing:

- Primary care, secondary care, community care, social care and public health services to the population of **Harrogate and District**; and
- **Children and Young People's Public Health Services** across the **North of England**.

The Trust was established under the *Health and Social Care (Community Health and Standards) Act 2003* and was authorised as an NHS Foundation Trust on **1 January 2005**.

HDFT is the principal provider of hospital services for the population of Harrogate and the surrounding district and also delivers services to **North and West Leeds**. The acute hospital serves a catchment population of approximately **316,000 people**.

In addition, the Trust provides community services across **North Yorkshire**, serving a population of around **621,000 people**, and delivers **Children's and Young People's Public Health Services** (0–19, or up to 25 where appropriate) across **North Yorkshire, County Durham, Darlington, Middlesbrough, Stockton-on-Tees, Sunderland, Gateshead, Northumberland, Wakefield, Westmorland and Furness**, and **Cumbria**.

Across these localities, the Trust's Children's Public Health Services support **around 700,000 children and young people**.

Our Acute Services

Harrogate District Hospital provides a comprehensive range of acute services, including:

- A 24-hour **Emergency Department**;
- Extensive **outpatient facilities**;
- An **Intensive Therapy Unit (ITU)** and **High Dependency Unit (HDU)**;
- A **Coronary Care Unit**;
- A **Medical Enhanced Care Unit (MECU)**; and
- Five main theatres, alongside a **Day Surgery Unit** with three additional theatres, and access to a theatre at **Wharfedale Hospital**.

The Hospital delivers emergency, urgent, outpatient, day case and inpatient care across a broad range of medical and surgical specialties.

Specialist facilities include the **Sir Robert Ogden Macmillan Centre (SROMC)** for cancer care, alongside purpose-built services for **Cardiology, Endoscopy, Pathology, Pharmacy, Imaging and Therapy Services**, as well as a **Child Development Centre, Stroke Ward and Women's Unit**.

The Trust also provides **Maternity Services**, including an Antenatal Unit, Central Delivery Suite, **Special Care Baby Unit (SCBU)**, Postnatal Ward and an **Early Pregnancy Assessment Unit**.

Our Community Services

HDFT delivers a wide range of community services across Harrogate and the wider North Yorkshire area. Services are delivered by community-based teams working closely with **primary care, acute providers, social care, mental health services and the voluntary sector**, supporting integrated and coordinated care closer to home.
Community services include:

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

Our Children's and Young People's Services

HDFT is the **largest provider of Children's and Young People's Public Health Services in England**, supporting **over 600,000 children, young people and their families** across a growing number of local authority areas.

Services are delivered by multi-disciplinary teams led by **Specialist Children's Public Health Nurses**, working as **Health Visitors** (0–5 years) and **School Nurses** (5+ years).

The service is underpinned by early intervention, prevention and strengths-based practice, ensuring the voices of children, young people and families are central to service design and delivery.

The Trust works closely with **local authorities, NHS partners and other organisations**, playing an active role in local governance and system working for children's services. Increasingly, services are delivered through **formal partnership agreements**, enabling long-term investment, stability and service development across local systems.

Our Subsidiary Company

In **2018**, HDFT established a wholly owned subsidiary, **Harrogate Healthcare Facilities Management Ltd**, trading as **Harrogate Integrated Facilities (HIF)**, to provide estates and facilities services.

While the majority of activity supports the Trust, HIF has continued to **expand its external portfolio**, providing services to organisations including the **Duchy Hospital** and a number of dental practices.

HDFT in Numbers

Our Strategy

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 in 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 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 (BAF) and our governance and management processes.


Harrogate and District NHS Foundation Trust
Trust Strategy
Setting the direction of our Trust to further improve on the high quality healthcare service we provide
Purpose
THE PATIENT AND CHILD FIRST
Improving the health and wellbeing of our patients, children and communities
True North Ambitions
BEST QUALITY, SAFEST CARE
TRUE NORTH METRICS
Moderate & Above Harm Events
Patient Experience
PERSON CENTRED, INTEGRATED CARE; STRONG PARTNERSHIPS
TRUE NORTH METRICS
Emergency Care 4 Hour Standard
18 Week Referral to Treatment
Cancer – 62 Day Treatment Standard
Admissions of People with Frailty
GREAT START IN LIFE
TRUE NORTH METRICS
Children at Risk of Vulnerability
Maternity Harm Events
Children's Patient Experience
AT OUR BEST: MAKING HDFT THE BEST PLACE TO WORK
TRUE NORTH METRICS
Staff Engagement
Staff Availability
Our KITE Behaviours
KINDNESS
INTEGRITY
TEAMWORK
EQUALITY
Enabling Ambitions
FINANCIAL SUSTAINABILITY
METRICS
Finance Actual vs Plan
Segmentation Oversight Framework (SOF) Rating
AN ENVIRONMENT THAT PROMOTES WELLBEING
METRICS
Capital Spend vs Plan
High Risk Backlog Maintenance
Natural Gas Usage
DIGITAL TRANSFORMATION
METRICS
Project Delivery
Electronic Patient Record (EPR) Programme Delivery
HEALTHCARE INNOVATION TO IMPROVE QUALITY
METRICS
Internal/External Innovations
Children and Young People Studies
Patient Recruitment
teamHDFT
At our best
HIF
HARROGATE INTEGRATED FACILITIES
Taking Pride in our Services
NHS
Harrogate and District
NHS Foundation Trust

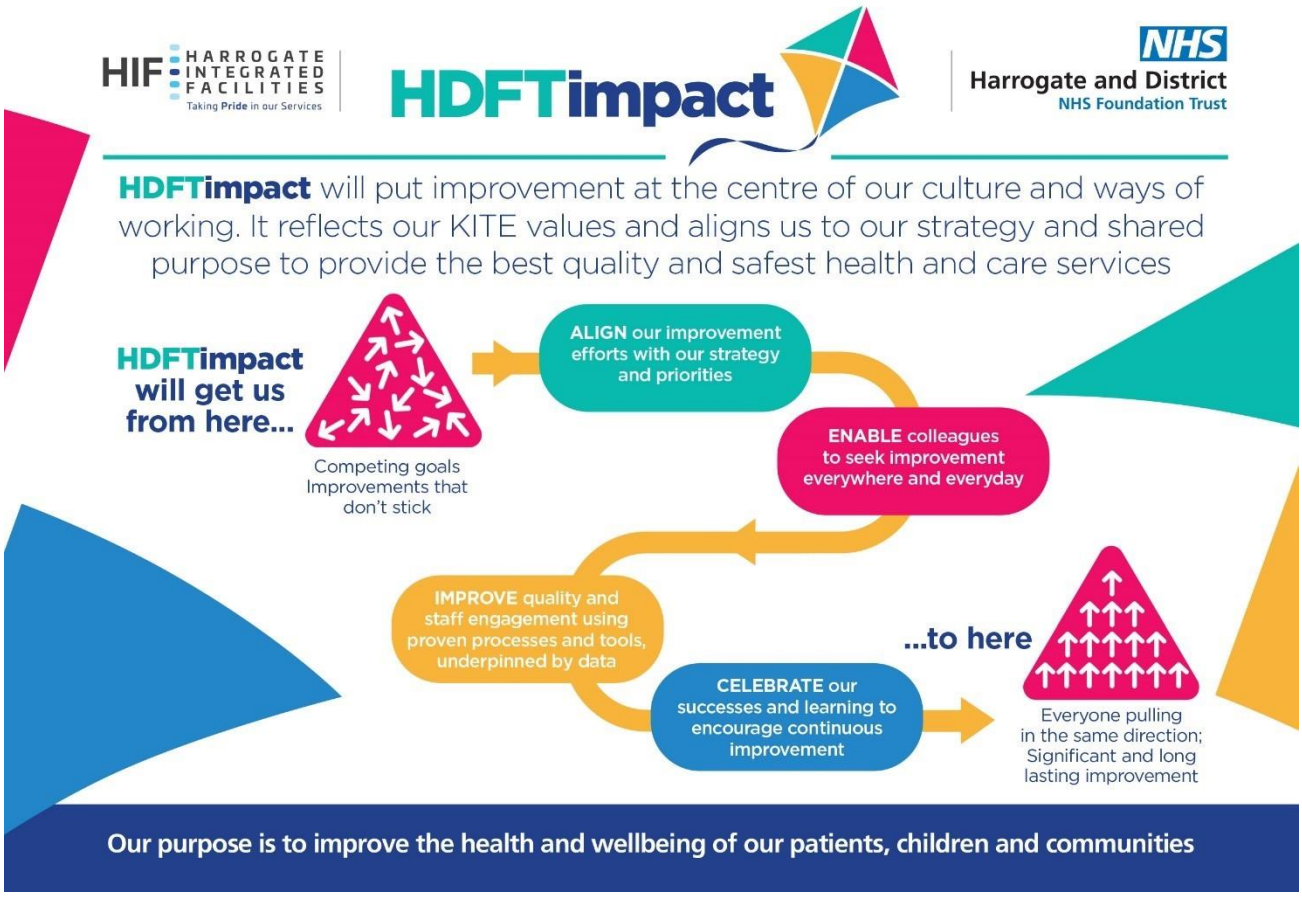
Our Values

Our values are a key component of what makes HDFT the organisation it is today and underpin our Strategy – it is not only important **what** we do, but also **how** we do it. Our values are:

HDFT Impact – delivering our Strategy

During 2023-2024 at HDFT we implemented a significant step change with our continuous improvement journey through the development of HDFT Impact. In 2024-2025 we saw significant positive progress towards our strategic goals driven by the implementation of our improvement operating model (IOM) which has continued throughout 2025-2026. Our HDFT Impact approach remains underpinned by our values and ensures meaningful consultation and connection from our frontline teams, through organisational layers, to our Board. It is this cohesion and alignment that gives us confidence that we can set and reach ambitious improvement objectives, using data to identify areas of priority and targeting our resources to optimise these opportunities.

HDFT Impact harnesses our 10 years of organisational experience using 'Lean' methodology to put continuous improvement at the centre of our culture and ways of working. It aligns improvement with our Strategy and embeds the systems, routines, tools, coaching and support needed for teams to make significant, sustainable improvements as part of their daily work. Our ambition is that HDFT Impact will mobilise all colleagues to improve quality in the areas that matter most, every day. We will celebrate and encourage improvement by everyone throughout the Trust.



Our vision for HDFT Impact is that all our colleagues can say:

- I understand our Strategy and how we are performing against our goals.
- I understand the contribution to the strategy that my team and I need to make using improvement techniques.
- I can deliver my work and improve how I do it as part of my day job.

In January 2026, 69% of colleagues responded positively that they understood their contribution to the Strategy in our most recent survey. This percentage is comparable to last year, however, as we have grown as an organisation, it represents a larger number of colleagues who are positively responding.

Through HDFT Impact we have also developed systems to deploy our Strategy more robustly throughout the organisation so that our priorities at every level are aligned to our True North Ambitions (the long-term outcomes we are seeking for our patients, children, communities and staff). Our True North Ambitions remain consistent from their launch in 2023-2024. The True North Metrics provide a measure of our progress against these ambitions. We are pleased to report encouraging performance against many of our ambitions over the last year which are summarised in the table below.

True North Ambition	True North Metric	Annual Performance
Best Quality, Safest Care	Moderate & Above Harm Events	21% overall year-on-year reduction in moderate harm safety events. Year 2's target was to have fewer than 88 events, this was achieved as 82 events were reported in 2025-2026.
	Patient Experience	96% positive responses to our Friends and Family Test (FFT) albeit with a significant reduction in the average number of responses.
Person Centred, Integrated Care	4hr Emergency Care Standard	In March 2026 performance was 79% (target 78%)
	52 Week Referral to Treatment	Target of zero patients waiting beyond 52 weeks achieved for several months this year, reported 8 patients delayed over 52 weeks in March.
	Cancer 62day Treatment Standard	85% March 2026 – at target following improving trajectory over the last 6 months.
	Admission of People with Frailty	Surpassed target to achieve benchmark performance in the upper quartile for median length of stay by March 2026.
Great Start in Life	Mandated Contacts	27% improvement (now 52/55) of areas achieving 90% of mandated contacts within the target timeframe
	Children's Patient Experience	An 95% increase in the number of surveys returned in month (40 April 2025 – 78 April 2026)
Best Place to Work	Staff Engagement	National Staff Survey Engagement score improvement from 7.00 in 2024 to 7.07 in 2025 an increase to 3.3% in our performance beyond benchmark.
	Staff Availability	Staff unavailability averaged 679 WTE in 2025-2026, 11% below the baseline value of 764 from 2023-2024.

Our Strategic Programmes are multi-year programmes which enable transformational change in the quality of care we provide to our patients, children and communities.

Strategic Programmes

Multi-year in nature our 2025-2026 Strategic Programmes have progressed well this year and will continue into the next fiscal cycle:

- **HDFT Impact.** HDFT Impact is our improvement management system. As such, it underpins everything we do as an organisation. During 2026-2027 we will deploy a new training model which will accelerate the pace at which we can implement HDFT Impact with frontline teams. We will test and deploy a new sustainability assessment process to evaluate the use of the improvement operating model. Our revised communication plan will help us share success and spread learning further and faster.
- **Electronic Patient Record.** By providing clinicians with instant access to patient information, our new electronic patient record provided by NerveCentre will enable a step change in the quality and safety of care in our acute services. We have already successfully launched the first phase in November 2025 and plan further significant functionality to 'go live' in April 2026. We have further modules to deploy later in 2026 as well as an ambitious optimisation plan. A parallel workstream focusing on benefits realisation will also continue through the next financial year.
- **Clinical Services Strategy.** Our Clinical Services Strategy describes how we will deliver transformational change to our services, ensuring they meet the future needs of our communities. This year we have been focusing on 3 workstream areas:
    - Clinical standards review: to ensure we can deliver best practice care across all of 38 our specialties.
    - Care Gateway Options: scoping and development of a model to ensure equitable, effective, and efficient access to our services.
    - Neighbourhood Health: exploring opportunities with external partners to improve pathways of care particularly where inequalities exist.

Breakthrough Objectives

Alongside long-term strategic programmes, each year we will identify a small number of "Breakthrough Objectives" which aim to focus the improvement efforts of every team in the Trust on the areas which will have the biggest impact on our True North Ambitions. Typically, the Breakthrough Objectives are supported by a small number of Corporate Projects: improvements that need project management and corporate support.

Based on analysis of our data for our True North Metrics, we identified four breakthrough objectives for 2025-2026:

- **Best Quality, Safest Care: Reducing moderate harm.** Our programme of work to reduce moderate harm from pressure ulcers, led to a 37% improvement. Consequently, re-analysis of our data illustrated focus on a specific type of harm was not appropriate in 2025-2026. Therefore, our target for Best Quality, Safest Care was to deliver a 20% reduction in moderate harm events overall.
- **Person Centred, Integrated Care: Time to medical bed.** One of the largest contributors to patients waiting over four hours in the Emergency Department when they needed admission was the availability of, and transfer processes to, an inpatient bed. We chose to keep this as a Breakthrough Objective this year due to its significant contribution to the four-hour Emergency Care Standard; the requirement that patients are discharged or admitted within 4-hours of arrival. However, we selected a new metric and target: to move 60% of patients within 60 minutes of the 'decision to admit' time. This revised metric proved challenging to achieve, in large part because of the data reliability. We were unable to deliver performance beyond 10% in 60-minutes. However, triangulation of the previous metric 'median time to an inpatient bed' indicated we had sustained the improvement delivered in 2024-2025 with some winter months showing significantly better comparative performance.
- **At Our Best – Making HDFT the best place to work: Increasing Involvement.** The level of staff engagement is recognised to correlate with quality of care and HDFT aspire to have best in class engagement scores. An important subset of the engagement metric in the NHS National Staff Survey is Involvement. This element was lower scoring than others for HDFT in the 2024 NSS with a baseline of 6.85 and

therefore set as a Breakthrough ambition in 2025-2026. After 6-months of focus, our 2025 score was 6.92 an increase of 1.0% and 2.2% better than our benchmark score. We hope the benefits of the full year effect of our work in this area will close much of the remaining 2.1% improvement to make HDFT best in class for Involvement.

- **Enabling Ambition - Financial Sustainability: Deliver waste reduction and productivity (WRAP) plans**
  Acknowledging our responsibility to make the best possible use of the public money we receive we decided to position our Breakthrough Objective around financial sustainability. As all areas of the Trust contribute to WRAP plans this was an effective area of focus with the opportunity to ensure we realised our target of £14.5m of savings. The NHS financial climate became increasingly challenging during the year but despite this turbulence we exceeded our target and delivered a total of £20.4m savings, and £13.4m of this was through cash releasing schemes.

Corporate Projects

In 2024-2025 we set out to use the HDFT management system to rationalise our corporate projects. We wanted to focus our effort and resources on projects that align clearly with our strategic ambitions and offer the greatest opportunity for transformational change in service delivery. Our strategic project filter is a collaborative process with the senior leadership group. This helps us to be confident that the projects selected have sufficient, leadership, project management, clinical, and operational capacity to be delivered successfully at pace. The projects outlined below represent a selection of those that were prioritised in 2025-2026. Some of these projects will continue as well as new ones being commissioned to support our strategic programmes and Breakthrough Objectives in 2026-2027.

- **Medical & Dental Rostering**
  A large project to implement e-rostering for our medical and dental workforce. This project continues as it has required an unanticipated level of change management due to the complexity of alignment of job plans with service need as well as integration with payroll functions. The revised target for implementation in Sept 2025 was achieved. Full deployment is anticipated to be complete in July 2026.

- **Patient Discharge**
  A large project requiring significant resources across multiple workstreams requiring collaboration between clinical, operational, and corporate teams. Having commenced late in 2024, this project has been a significant success. New ideas have been tested and implemented which have made a sustainable improvement to patient and staff experience as well as improving operational performance. Its success has been recognised at a national level by the Getting It Right First Time (GIRFT) team.

- **Electronic Patient Record (EPR) Benefits Realisation**
  A project aligned to EPR Implementation Strategic Programme. An EPR Benefits Lead has been introduced and co-produced a high-level benefits realisation and transformation plan. Alongside the project team, detailed current and future state mapping is in progress prior to configuration and testing. This project is due to complete following the EPR implementation early in 2026.

Section One
Performance Report

Section 1 – Performance Report

1.1 Strategic Risks

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

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. For oversight and assurance, the BAF is also considered at the monthly meetings of the Strategic Deployment Room (formerly Senior Management Team). Within the BAF, risks held on the Corporate Risk Register and linked to the relevant True North Ambition to ensure clear triangulation of operational and strategic risk profiles.

The Corporate Risk Register is managed by the Executive, through the monthly Executive Risk Management Group.

Between April 2025 and March 2026, the strategic and corporate risks identified on the Board Assurance Framework included:

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, to 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.

Corporate Risks Associated: There were no risks on the Corporate Risk Register in 2025-2026 that linked to this element of the Board Assurance Framework.

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, whilst ensuring that all our patients, also benefit from the services and approaches for the elderly and frail.

Corporate Risks Associated:

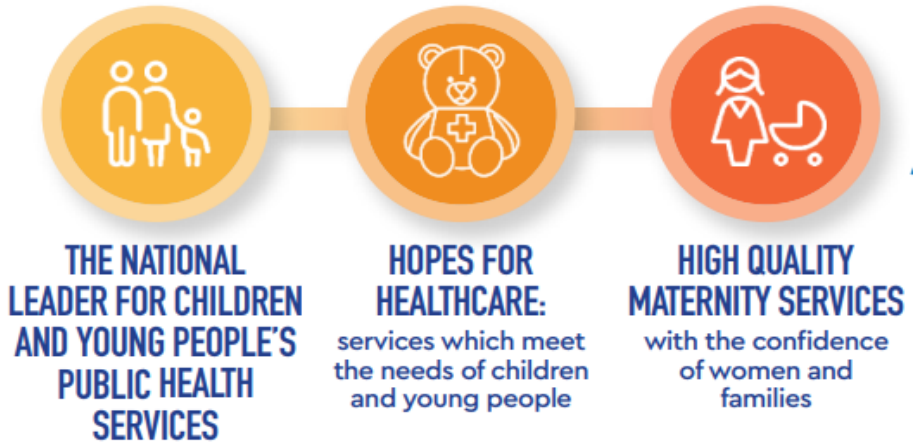
- Emergency Department (ED) 4 Hour Standard: Risk of increased morbidity / mortality for patients due to a failure to meet the 4-hour standard. This risk was escalated to the Corporate Risk Register prior to April 2025 and remained on the register for the duration of 2025-2026.
- Community Dental: Risk to patient safety due to correlation of long waiting times and increased risk of pain and infection, which may affect quality of life and treatment required. Secondary risk to Trust performance standards by failing to meet NHS annual planning target of no Referral To Treatment (RTT) waiters beyond 78 weeks currently, 65 weeks by end March 2024 and 52 weeks by end March 2025. This risk was escalated to the Corporate Risk Register prior to April 2025 and remained on the register for the duration of 2025-2026.
- Stroke: Provision at HDFT for Stroke: Risk to patient care and safety due to delayed treatment caused by: Lack of Hyper Acute Stroke Unit Capacity at Leeds Teaching Hospitals Trust and York and Scarborough Teaching Hospitals Foundation Trust and aspects of the regional stroke pathway not being followed. This risk was escalated to the Corporate Risk Register Prior to April 2025. The risk was removed and was removed when the risk grading reduced to below 12 for continued monitoring and oversight by the directorate in October 2025.
- Imaging for ED Patients: Risk to patient safety due to potential delays to diagnostic imaging. This risk was escalated onto the Corporate Risk Register prior to April 2025 and was removed for continued monitoring and oversight by the directorate in May 2025.
- Automated medicines supply services: Robot malfunctions increased frequency. This risk was escalated onto the Corporate Risk Register May 2025 and remained on the register for the duration of 2025-2026.
- Risk of harm to patients due to unreliability of aged equipment (CT): Risk of harm due to delays caused by breakdown and or radiation incidents due to repeated exposures. Staff harm due to manual handling of some aged equipment, staff morale due to operating in a difficult environment. This risk was escalated onto the Corporate Risk Register in November 2025 and was removed when the risk grading reduced to below 12 in March 2026.
- Histopathology space and safety concern: Risk to HDFT being able to deliver acute District General Hospital services due to the fragility of the cardiology service. This risk was escalated onto the Corporate Risk Register November 2025 and remained on the register for the duration of 2025-2026.
- Cardiology: Risk to providing DGH urgent and emergency care services due to lack of 24/7 cover: Risk to HDFT being able to deliver acute DGH services due to the fragility of the cardiology service. This risk was escalated onto the Corporate Risk

Register prior to April 2025 and remained on the register for the duration of 2025-2026.

- Risk to Patient Safety & Experience due to non-compliance with National KPI's for waiting times and reporting in Imaging Services: Due to the delays in routine diagnostic imaging, there is an unknown risk of patients waiting up to 5.5 months for diagnostics which should be delivered within 6 weeks. This is causing delays in treatment, diagnosis and decision making for care plans for patients. It impacts on RTT performance, organisational reputation and patient experience. There is also a risk due to our non-compliance with National KPI's for waiting times and reporting. This risk was escalated onto the Corporate Risk Register in July 2025 and was removed when the risk grading reduced to below 12 in January 2026.

Great Start in Life:

The risk of the inability to deliver our ambition to lead the development of children and young people's public health services, sharing our expertise to benefit children nationally. As a district general hospital we often care for children and young people in our adult services and there is a risk that we will be unable to ensure that every service meets the needs of children and young people due to the inability to implement the 'Hopes for Healthcare' principles co-designed with our Youth Forum. There is a risk that we will therefore be unable to provide high quality, safe care and a great patient experience for mothers and their babies, and ensure they and their families have confidence in that care due to HDFT being the largest provider of public health services for children and young people in England supporting almost 600,000 children and young people to have a great start in life.



Corporate Risks Associated:

- Autism Assessment: Risk to quality of care by not meeting 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. This risk was escalated onto the Corporate Risk Register prior to April 2024 and remained on the register for the duration of 2025-26.

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.

Corporate Risks Associated: There were no risks on the corporate risk register in 2025-2026 that linked to this element of the Board Assurance Framework.

FINANCE

The risk of the inability to provide the best quality, safest care, whilst remaining a financially sustainable organisation.

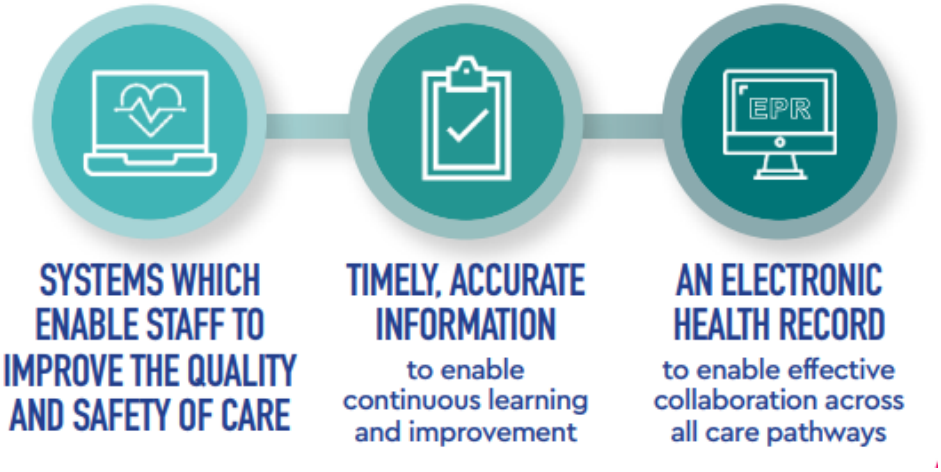
Corporate Risks Associated:

- 2024-2025 Delivery of Financial Plan: This risk was escalated onto the Corporate Risk Register for delivery of the 2024-25 Plan prior to April 2025. The risk closed in May 2025 with a new risk added for 2025-2026 plan. It remained on the register for the remainder of 2025-26.
- Recurrent delivery of efficiency programme (WRAP): The Trust has a £14.5m WRAP programme to deliver in 2025-2026. This risk was escalated onto the Corporate Risk Register June 2025 and remained on the register for the duration of 2025-2026.
- Group Cash Position: This risk was escalated onto the Corporate Risk Register in May 2025 and remained on the register for the duration of 2025-2026.
- CYPD - Financial Impact of the 2025-2026 Pay award in 0-19 Services: This risk was escalated onto the Corporate Risk Register in July 2025 and was de-escalated in November 2025 back to directorate register for continued oversight.

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 to 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.



Corporate Risks Associated: There were no risks on the corporate risk register in 2025-2026 that linked to this element of the Board Assurance Framework.

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.

Corporate Risks Associated: There were no risks on the corporate risk register in 2025-2026 that linked to this element of the Board Assurance Framework.

An Environment That Promotes Wellbeing:

The risk of the inability to continuously improve our estate and our equipment to promote wellbeing and enable us to deliver the best quality, safest care. Due to the inability to prioritise investments and design new facilities to promote wellbeing and best quality. As the largest employer in Harrogate and District, and covering a huge footprint across the North East and Yorkshire, we have an important leadership role in reducing our impact on the planet through our buildings, energy use, transport and food. Due to this there is a risk that we will be unable to build on our strong track record to continuously reduce our impact on the environment and achieve net zero carbon by 2040.

Corporate Risks Associated:

- Managing the risk of injury from fire: Organisational risk to compliance with legislative requirements, with risk of major injuries, fatality or permanent disability to employees, patients and others due to fire hazards. This risk was escalated onto the Corporate Risk Register prior to April 2025. The risk was removed when the risk grading reduced to below 12 in January 2026.
- HDH Goods Yard: Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and others due to unauthorised access to restricted areas of the hospital through the loading bay entrance. This risk was escalated onto the Corporate Risk Register prior to April 2025. The risk was removed when the risk grading reduced to below 12 in August 2025.
- Violence and Aggression against staff: risk to compliance with legislative requirements, with the potential risk of injuries, fatality or permanent disability to employees whilst carrying out their duties. This risk was escalated on to the Corporate Risk Register prior to April 2024 and remained on the register for the duration of 2025-2026.
- Containment Level 3 Laboratory: risk of failure of equipment. This risk was escalated to the Corporate Risk Register Prior to April 2025 and remained on the register for the duration of 2025-2026.
- Security: risk of harm to patients, service users and staff due to security incidents. This risk was escalated to the Corporate Risk Register Prior to April 2025 and remained on the register for the duration of 2025-2026.
- Risk to Theatre utilisation and scheduling due to aged condition of estates: This risk was escalated onto the Corporate Risk Register February 2026 and remained on the register for the rest of 2025-2026.

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

During 2025-2026, the Trust maintained a clear focus on improving access, quality and patient flow across urgent and emergency care, elective care and diagnostic pathways, while sustaining delivery against key national priorities.

The Trust prioritised the most clinically urgent patients and implemented targeted actions to reduce the longest waits. Improvement was supported by strengthened governance arrangements, enhanced operational oversight and continued application of the Trust's continuous improvement approach.

The Trust performed well against national oversight metrics and, in a number of areas, continued to deliver strongly when compared with peer organisations, including ambulance handover performance, cancer pathway standards and diagnostic turnaround times. This performance was delivered in the context of increasing demand and system-wide capacity constraints, and was underpinned by improved workforce stability, reduced reliance on temporary staffing and focused operational leadership at service and directorate level.

The Trust also achieved Surgical Hub accreditation, reflecting compliance with NHS England requirements and assurance processes for the delivery of high-quality, efficient elective care.

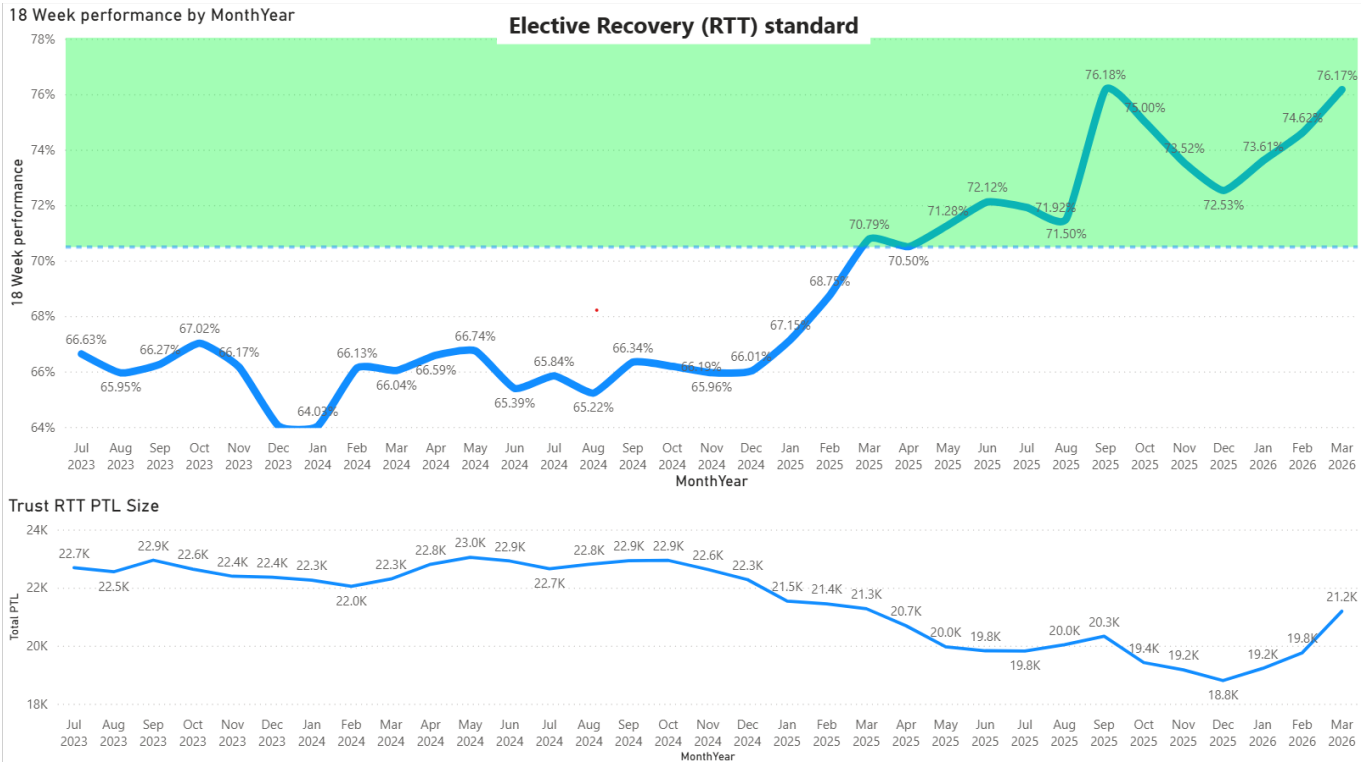
1.4 Operational Performance

Elective Care and Referral to Treatment (RTT)

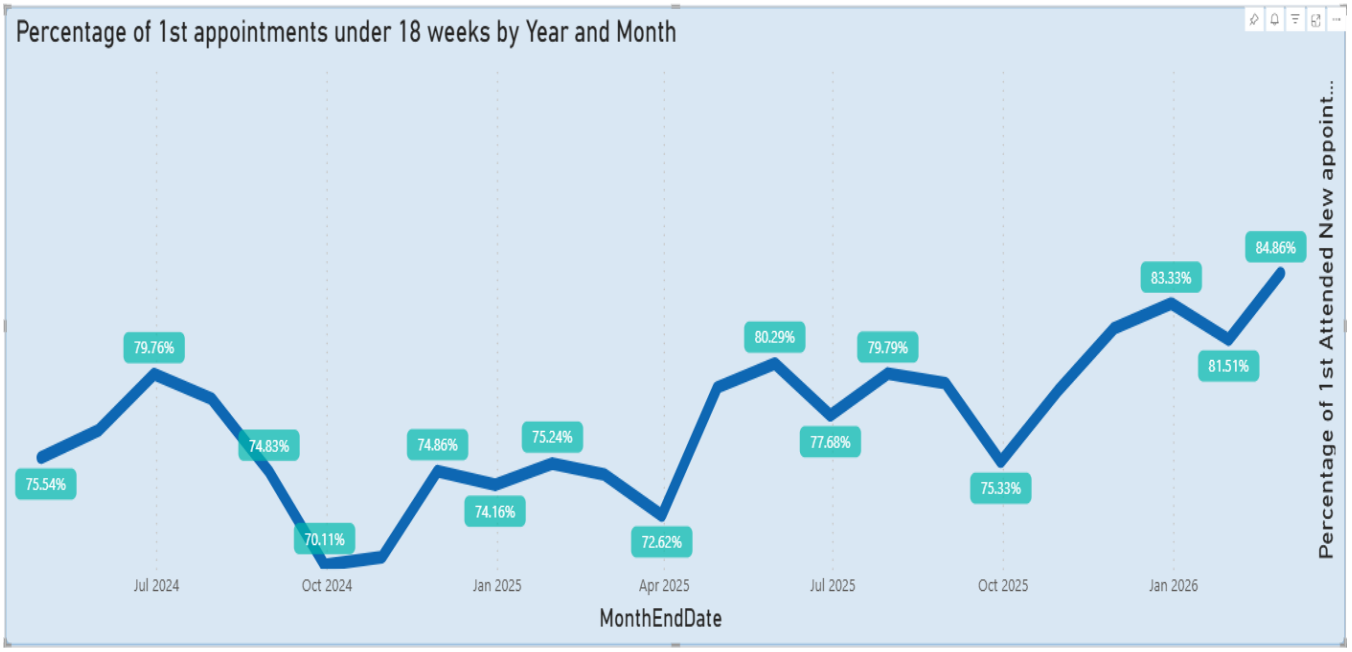
Throughout the year the Trust maintained its position of having **few patients waiting over 52 weeks, and achieved zero for several months**, maintaining compliance with national elective recovery ambitions. Median RTT waiting times remained stable and comparatively short and 18 week performance improved, reflecting effective waiting list validation, clinical prioritisation and focus on both outpatient and theatre utilisation.

The overall waiting list reduced modestly over the year despite continued demand pressures, supported by the Trust's continued use of digital validation processes, patient engagement via text messaging and the outpatient digital portal. These approaches have supported improved list accuracy and reduced the risk of avoidable harm associated with prolonged waits.

18 Week Performance and Total Waiting List



Across the year we saw an gradual improvement in percentage of first appointments in under 18 weeks, another measure of reducing waiting times and a nationally identified benchmark (72% by March 2026)

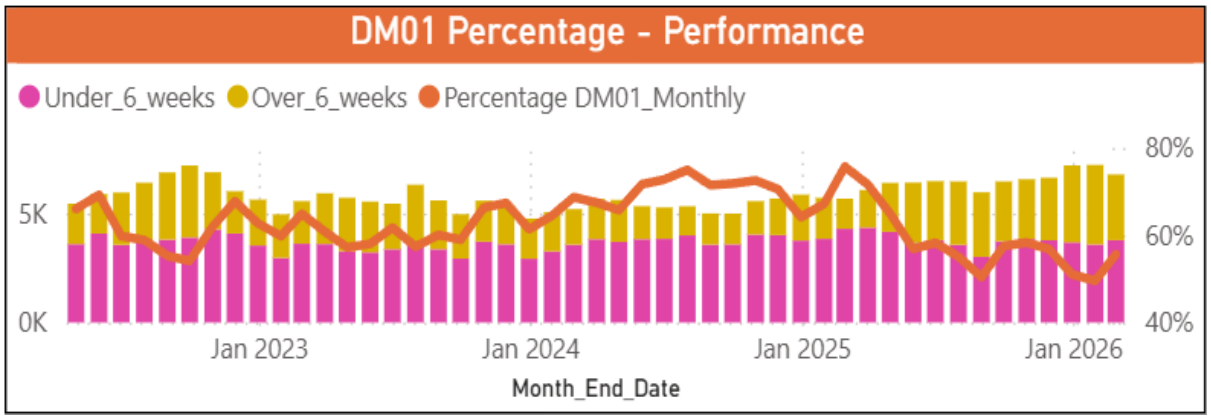


Diagnostics

Diagnostic services continued to play a critical role in supporting both planned and emergency pathways. Performance against the six week diagnostic standard deteriorated during the year, with an increasing proportion of patients waiting for tests driven by difficulties primarily in the CT and MRI capacity.

While this demand for the high volume modalities such as CT and MRI remained a material operational challenge, targeted actions to improve utilisation, extend capacity and optimise scheduling have contributed to measurable improvement in the last month of the year, and

with a new modern scanner recently installed and further capacity to come on stream in the form of a Community Diagnostic Centre for Harrogate, the capacity gap will diminish and see performance and waiting times improve further.



Diagnostic performance across other modalities with lower volumes of activity such as Dexa, Echocardiography, Endoscopy has been much higher, around 85% across the year.

Diagnostic performance continues to be monitored closely (DM01 standard – percentage scanned below 6 weeks) through established governance arrangements.

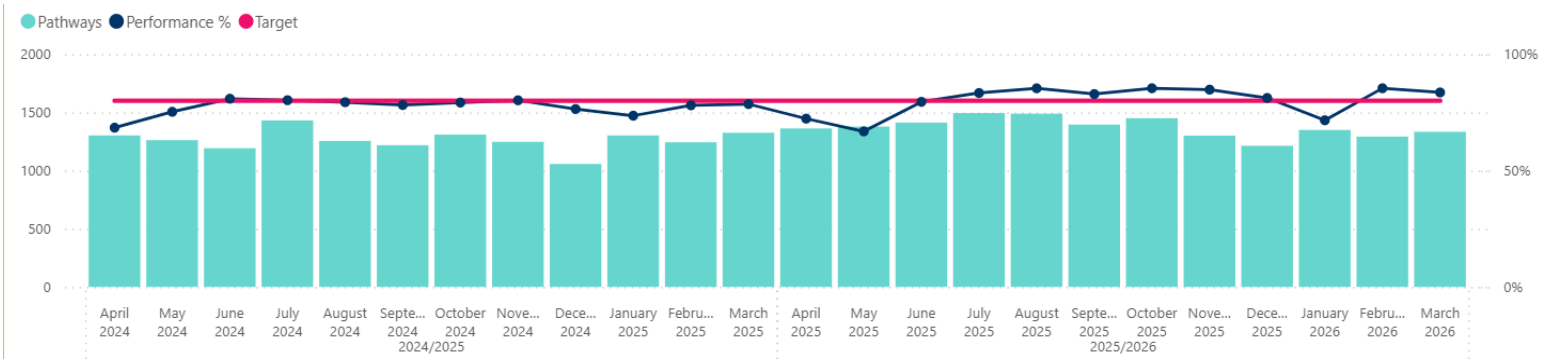
Cancer Services

Cancer services-maintained delivery throughout the year delivering the national standards in March 2026.

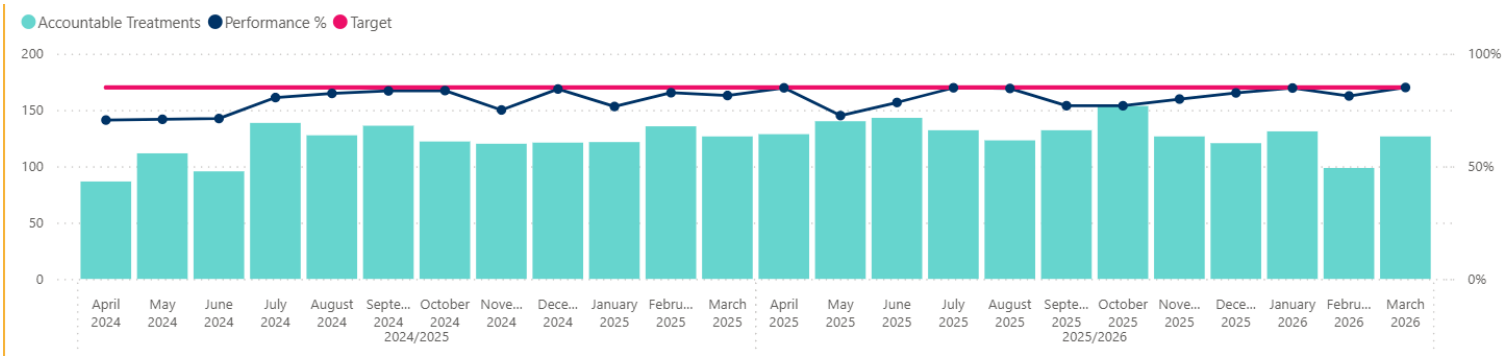
Demand through the two week wait pathway increased from average of 257 to 303 per week across all pathways

Performance against the **Faster Diagnosis Standard (28 days)** - ensuring diagnosis is rapid, both to identify and rule out cancer and the **62 day treatment standard** – time to first definitive treatment where cancer has been identified improved and was sustained through the year. This has been supported by the Cancer Board, focused operational leadership and with a continued emphasis on patient experience and timeliness.

Faster Diagnosis Standard



62-day Treatment Standard



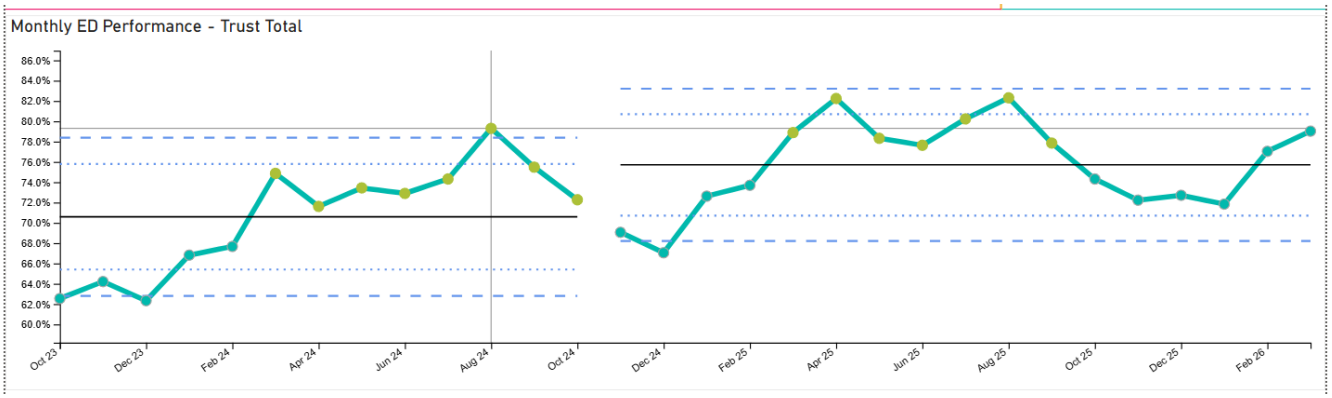
Urgent and Emergency Care

Performance against the four hour emergency care standard showed improvement through early part of the year, took a dip during winter seasonal pressures and recovered well to close the year.

Overall performance across the full year was 77.1% compared to 73.4% last year and the year finished with a March position at 79%.

In addition, Ripon Minor Injuries was successfully upgraded to an Urgent Treatment Centre (UTC) extending the conditions that it can manage with a resultant increase in daily attendances from around 30 to 70 per day.

Ambulance handover performance remained a consistent strength, with average handover times maintained well below national thresholds.



ED Whole Trust Perfromance (SQL)	MIU + ED Attends	Sum of Over_4_hours	Sum of Non_Admitted_Breaches	Sum of Admitted_Breaches	Sum of Twelve_Hour_arrival_breach_only	Sum of Twelve_Hour_dta_and_arrival_breach	Year	Month	Day
71.62%	5429	1540	725	815	93	73	2024	April	30
73.44%	6231	1655	865	790	106	56	2024	May	31
72.89%	6128	1661	874	787	113	34	2024	June	30
74.32%	6183	1588	816	772	96	47	2024	July	31
79.31%	5934	1228	636	592	31	7	2024	August	31
75.48%	6117	1500	832	668	23	3	2024	September	30
72.27%	5990	1661	837	824	120	50	2024	October	31
69.06%	5980	1849	987	862	154	100	2024	November	30
67.05%	6061	1997	1068	929	214	108	2024	December	31
72.63%	5659	1549	704	845	153	90	2025	January	31
73.70%	5258	1382	718	664	74	13	2025	February	28
78.88%	6189	1306	665	641	64	23	2025	March	31
82.24%	5947	1055	522	533	19	2	2025	April	30
78.32%	6417	1391	745	646	44	16	2025	May	31
77.64%	6582	1472	799	673	12	5	2025	June	30
80.23%	6667	1318	723	595	8	0	2025	July	31
82.31%	6196	1096	585	511	12	0	2025	August	31
77.86%	6313	1398	807	591	10	0	2025	September	30
74.32%	6428	1649	960	689	27	6	2025	October	31
72.23%	6760	1877	1101	776	61	7	2025	November	30
72.71%	6659	1817	1014	803	64	23	2025	December	31
71.84%	6496	1827	974	853	151	51	2026	January	31
77.04%	5915	1357	740	617	39	26	2026	February	28
79.03%	6919	1445	792	653	20	10	2026	March	31

1.5 Operating and Financial Review of the Trust

Income and Expenditure Summary

The adjusted financial performance position for the Trust for 2025-2026 was a £23.7m deficit. The table below provides a high level comparison of the Income and Expenditure account for the year

£000's	2025-2026	2024-2025
Operating Income	417,451	401,381
Employee Expenses	-323,397	-292,877
Operating Expenses excluding Employee Expenses	-121,660	-106,508
Finance Costs	-3,212	-2,670
Surplus/(Deficit) for the year	**-30,818**	**-674**
Adjustments - Impairments/Donations	7,062	692
Adjusted Financial Performance	**-23,756**	**18**

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

The Trust followed the forecast change protocol in December following the adverse trajectory to plan. The key drivers for this change included:

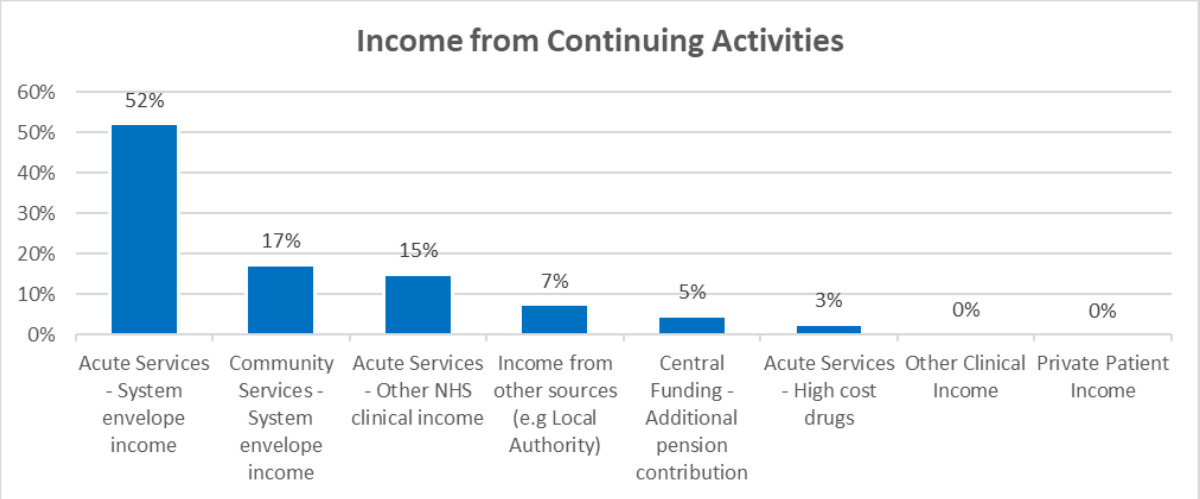
- Delivery of the Activity Plan £5.9m
- Delivery of Run-rate reducing efficiencies £3m
- Elective sprint shortfall £2.3m
- Drugs and devices £2.1m
- Ward overspend £2m (enhanced care, super-numerary time, sickness)
- Loss of deficit support in Q4 £1.4m

Other items included winter pressures, band2-band3 care support workers re-banding, inflation and Public Dividend Capital (PDC) charges.

The Trust are committed to returning back to a break even position by the end of 2027-2028.

Income Generated from Continuing Activities

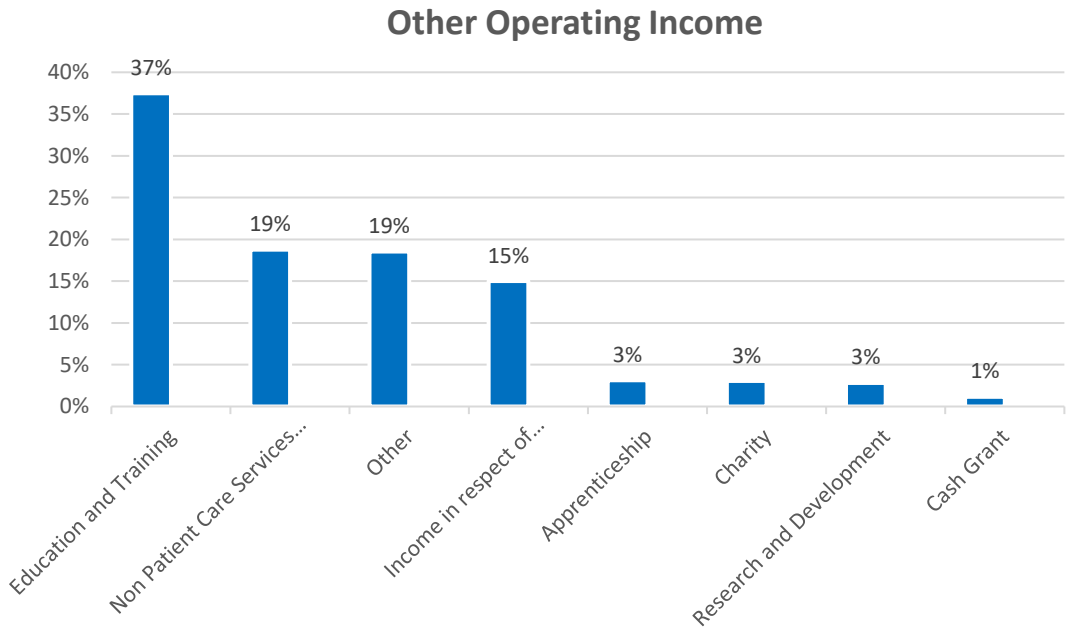
Total income from continuing activities for the year 2025-2026 was £384,817k. This represented 9% of total income for the year. An analysis of this income is shown below:



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.

Other Operating Income

Total income from other operating income for the year 2025-2026 was £32,634k including Charity. This represented 8% of total income for the year. An analysis of this income is shown below:



Cash

The Trust has a cash balance of £6,360k 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 delivered a deficit position, however bank and agency spend continued to reduce in comparison to the previous year.

Financial Outlook 2026-2027

The Trust has developed an operational plan for 2026-2027 that delivers operational asks for the NHS. This triangulates with workforce and activity plans and results in a £15.3m deficit plan. In order to achieve the financial plan, £32m efficiency delivery is required.

The Trust has a 7.3% Waste Reduction and Productivity Programme (WRAP) which has been developed utilising benchmarking information available, along with ensuring the Trust returns back to a breakeven position by 2027-2028, £32m of efficiencies are expected to be delivered in 2026-2027.

Key pressures that will need to be negotiated throughout the year include the delivery of a recurrent cash releasing efficiency programme, impact of inflation and operational support to the wider system as well as the various demands on ensuring the workforce is in place to continue delivering elective recovery and provide safe effective care.

Capital Investment Activity

During 2025-2026 the Trust undertook another significant capital programme, £50.6m in totality. There were several large schemes which additional resource was received for, including:- Electronic Patient Record (EPR), £8m, TIF2 (Targeted Investment Fund - Support Elective Recovery), £6.8m, Constitutional Standards, £5m and RAAC £9.8m.

Scheme	2025-2026 £000's
CDEL	
RAAC/TIF2 – Block C	9,919
Other	3,207
Total CDEL	**13,126**
Grant	390
CDEL plus Grants	**13,516**
PDC	
EPR	8,045
Constitutional Standards	5,000
RAAC/TIF2 – Block C	6,804
RAAC eradication	3,000
Other Schemes	13,807
Total PDC	**36,656**
Total Capital (CDEL and PDC)	**50,172**

Land Interests

During the financial year ending 31 March 2026, the Trust's land and buildings were re-valued (desktop valuation) 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 £110,943k which has been incorporated into the accounts.

Investments

Harrogate Healthcare Facilities Management, which trades as Harrogate Integrated Facilities (HIF), is the wholly owned subsidiary of the Trust. The Trust is also a member of a joint venture arrangement for Pathology Services. In March 2025, HDFT purchased North House Surgery following discussions with the ICB, this is the first GP practice the Trust owns.

Cash support was required in 2025-2026, £14.4m was approved.

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 (WYAAT).

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

The Equality and Quality Impact Assessment (EQIA) process relating to the efficiency programme continues to play a key role in ensuring quality, safety and access are not compromised by efficiencies.

The Trust Waste Reduction and Productivity target is £32m for 2026-2027, 7.3% of the Trust Operating Expenditure. The Trust has based the target on utilising benchmarking information available which has highlighted key areas to focus on along with trying to address the underlying deficit position to enable the Trust to return to a breakeven position by 2027-2028.

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.

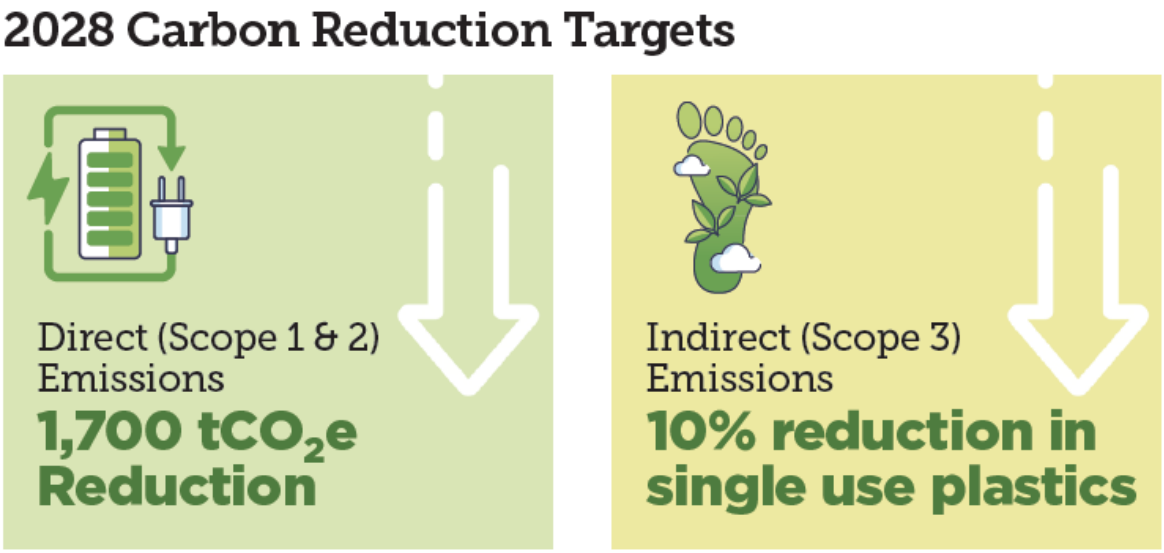
Overseas Operation

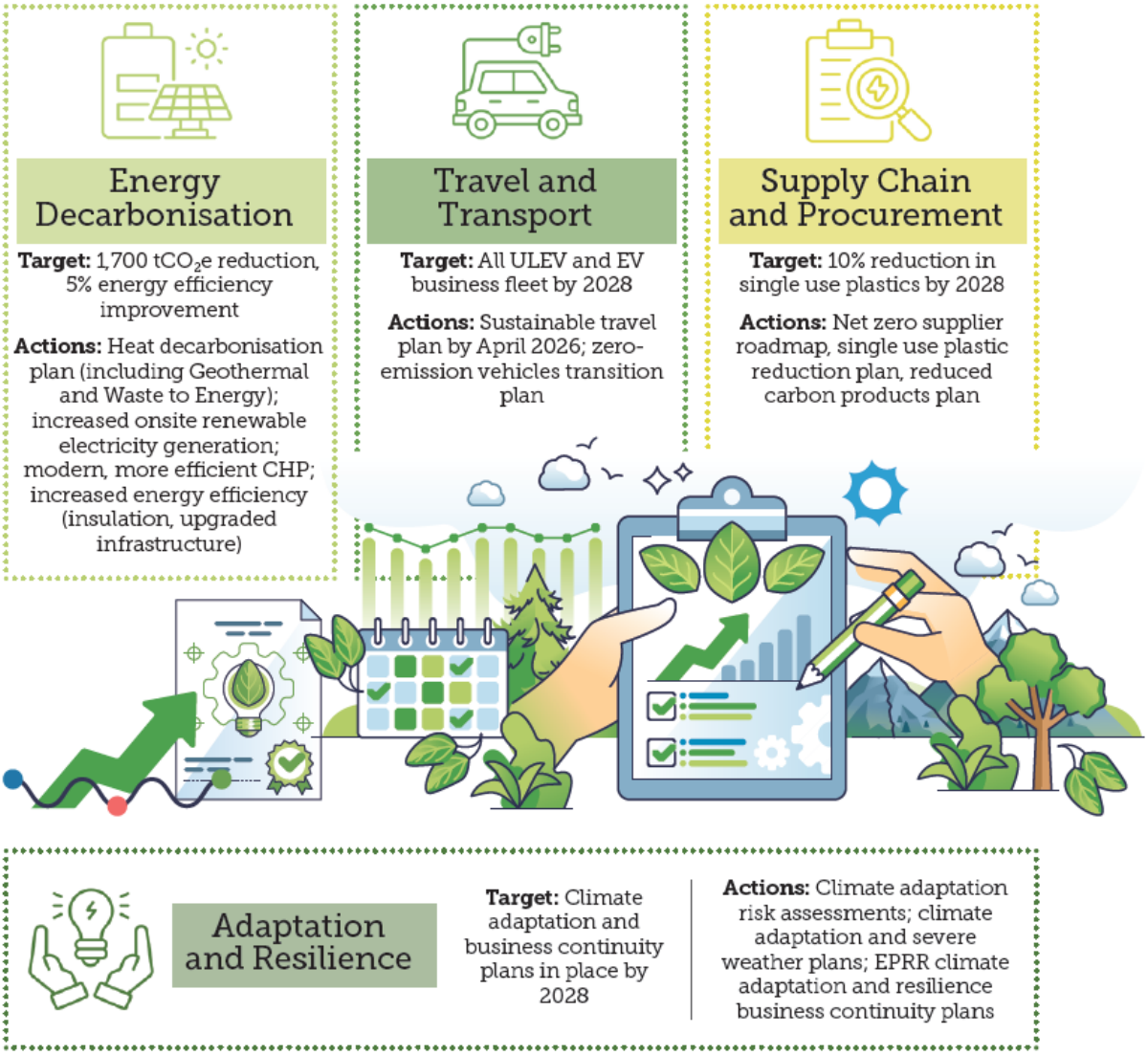
The Trust has no overseas operations.

1.6 Environmental Matters

In 2025-2026, HDFT continued to build on its strong foundations for environmental sustainability through the development of a new Green Plan for 2025-2028. This Plan sets out the Trust's continuing approach to reducing environmental impact, supporting national NHS net zero ambitions, and embedding sustainability into everyday decision-making across clinical and non-clinical services. The new Green Plan focuses on accelerating delivery of the highest-impact areas, including energy decarbonisation, sustainable travel and transport, supply chain sustainability, and climate resilience.

The Trust remains fully committed to the NHS ambition to become the world's first net zero health service, with national targets of achieving net zero for direct emissions (Scope 1 and 2) by 2040 and indirect emissions (Scope 3) by 2045. Against its 1990 baseline, the Trust has already reduced its direct emissions by over 50%, demonstrating sustained progress and effective delivery. Over the 2025-2028 Green Plan period the Trust has set itself targets to reduce its direct emissions by 65% from the 1990 baseline (a further 1700 tCO2e) and to reduce use of single use plastics in all supplies by 10%.





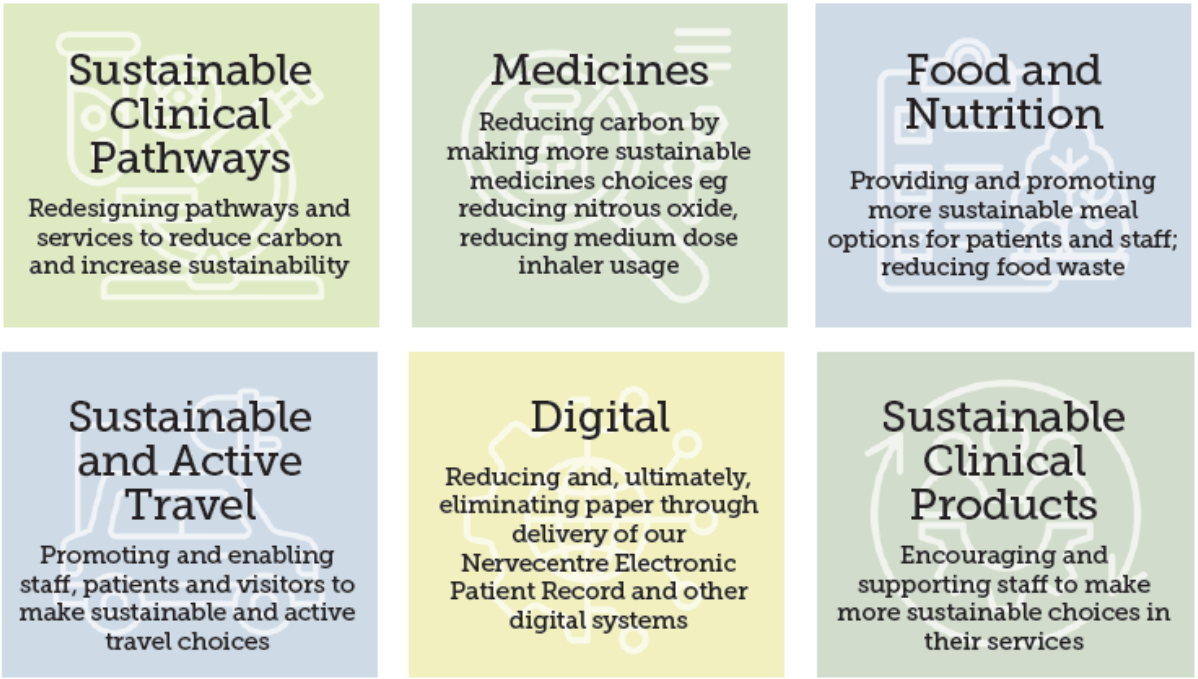
Significant progress has been made through continued investment in low-carbon infrastructure, improvements in energy efficiency, the transition to more sustainable clinical practices, and the expansion of digital solutions that reduce travel and resource use. During 2025-2026 the Trust completed a £14m Public Sector Decarbonisation Scheme upgrade to Harrogate District Hospital (HDH) including heat pumps, solar PV, windows and roof insulation. Clinical improvements included the complete removal of desflurane, saving an estimated 800 tCO2e annually, and the transition from piped Nitrous Oxide to cylinders, an overall reduction of 82% in anaesthetic gas emissions.

Following publication of the new Green Plan in July 2025, the Green Plan Delivery Group identified key workstreams for the next phase. These include:

- **Waste to Energy**. Implement a waste to energy system that will reduce waste sent to landfill or for incineration while also providing energy back to HDH.
- **Travel Plan**. Update the Trust's travel plan to reduce travel related emissions through active and environmentally sustainable transport, and use of digital technology to reduce the need for travel at all.
- **£4m Public Sector Decarbonisation Scheme**. A further £4m investment in renewable energy and efficiency for HDH over 2025-2027.
- **Reuseable Sharps Bins**. Implementing reuseable sharps bins at HDH to improve safety, save money and reduce carbon emissions.

- **Geothermal**. Develop a long-term project to investigate the feasibility and delivery of a geothermal heat system for HDH and, potentially, the surrounding area.
- **Sub-Metering Programme**. Following successful NHS sustainability funding, the Trust will begin an electrical sub-metering project in April. This programme will provide granular energy consumption data, identify inefficiencies, support targeted interventions, and is projected to deliver a 5% reduction in electricity use across site.
- **Carbon Accounting Project** This year the Trust will begin implementing internal carbon-accounting software to improve data accuracy and empower evidence-based decision making. This will enable Trust-level annual carbon footprints, benchmarking, and targeted carbon reduction planning, especially within Scope 3 emissions.

Alongside our High Impact Areas we are building a network of Green Champions to create energy and commitment for service level and individual actions to reduce environmental impact and increase sustainability. For instance:



Environmental sustainability is governed with the same rigour as safety, quality and operational performance. Oversight is provided by the Trust Board, supported by the Executive Lead for Net Zero and the Green Plan Delivery Group. Progress is monitored through established governance and reporting arrangements, including regular Board assurance and annual public reporting.

Through the Green Plan 2025-2028, the Trust continues to strengthen accountability, data quality and delivery, ensuring that sustainability supports high-quality patient care, operational resilience and long-term value for the communities we serve.

1.7 Task Force on Climate Related Financial Disclosures (TCFD)

NHS England's NHS Foundation Trust annual reporting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports.

TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025-2026 financial year. Local NHS

bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The phased approach incorporates the disclosure requirements of the governance pillar for 2025-2026. These disclosures are provided below.

1. Governance
Board oversight of climate-related issues

The Trust maintains robust governance arrangements to oversee climate-related risks and opportunities. Delivery of the Trust's Green Plan and wider sustainability programme is overseen through the Environment Board, chaired by the Director of Finance. The Environment Board receives regular updates on progress against sustainability objectives and provides scrutiny and challenge.

Key matters arising from the Environment Board are escalated to the Trust Board where required, ensuring that climate-related considerations are incorporated into strategic decision-making. In addition, an annual sustainability report is presented to both the Trust Board and the Board of the Trust's subsidiary company, Harrogate Integrated Facilities (HIF), providing assurance on progress and future priorities.

Management's role in assessing and managing climate-related issues

Executive and senior management are responsible for the day-to-day operational delivery of the Trust's sustainability objectives. Climate-related issues are considered through routine management processes, supported by the Environment Board which provides additional oversight, coordination and assurance.

2. Strategy
The Trust is committed to supporting the NHS Net Zero ambition through the delivery of its Green Plan, which sets out the organisation's approach to reducing emissions and improving environmental sustainability.

Climate change presents both risks and opportunities for the Trust, including impacts on service delivery, estates, and population health. The Trust recognises the importance of embedding sustainability within its broader strategic and operational planning, ensuring that environmental considerations are integrated into decision-making where appropriate.

The Green Plan outlines key priority areas, including estate decarbonisation, sustainable travel, and resource efficiency, and provides a pathway for contributing to national targets.

3. Risk Management
The Trust assesses and manages climate-related risks in line with its Risk Management Policy, as described throughout this Annual Report.
Climate-related risks are considered at both a strategic and operational level, including:
High-level review through the Executive Risk Management Group
More detailed consideration through the Environment Board

At the time of reporting, there are no climate-related risks recorded on the Corporate Risk Register. However, the Trust continues to monitor emerging risks associated with climate change and will incorporate these into formal risk management processes as appropriate.

4. Metrics and Targets
The Trust is committed to contributing to the delivery of the national NHS Green Plan and Net Zero targets through implementation of its own Green Plan.

Progress against sustainability objectives is monitored through the governance structures outlined above, with performance reported regularly to the Environment Board and annually to the Trust Board. The Trust continues to develop its approach to measuring, monitoring and reporting environmental performance, aligned to national guidance.
The Green Plan sets out the Trust's key metrics, actions and targets for reducing its environmental impact, and progress against these will be tracked and reported on an ongoing basis.

1.8 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 2025-2026 quality priorities and their achievements are detailed within the Quality Accounts. The document also details the quality priorities for 2026-2027.

Following extensive review and consultation, the Trust set an ambitious continuous improvement programme as detailed in the overview section of this report. In relation to our Quality Priorities, an improvement programme was set as follows:

An Overview of True North Metric – Moderate and Above Harm

Our Target for 2025-2026
As part of HDFT Impact, moderate and above safety events are analysed each year for themes and trends to determine the greatest impact on safety.

The long term aim for this programme of work is to eliminate moderate and above harm entirely over the course of 10 – 15 years.

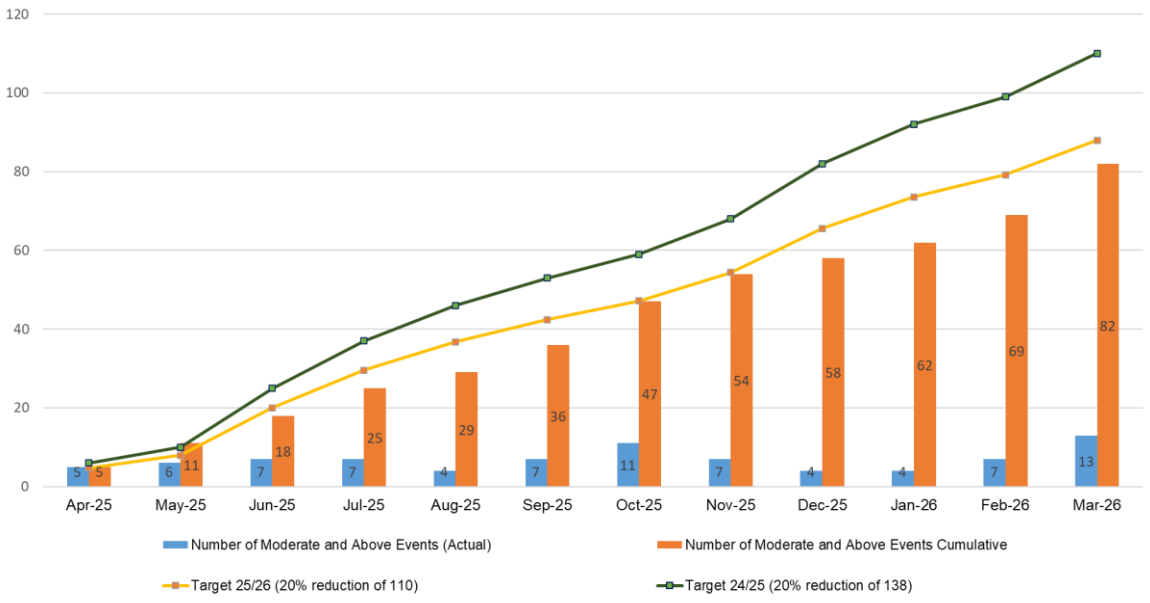
The Trust set a stretch target for Year 1 to reduce the number of events by 20%. This was a target of 110 events or less in 2024-2025 and this was met. In 2025-2026, the Trust set a further 20% reduction target for Year 2. This meant no more than 88 moderate and above events in the year. This was achieved.

Our Countermeasures
To achieve this goal the following countermeasures or workstreams were commissioned:

- Falls Improvement Plan
- Safeguarding Improvement Plan
- Quality Governance Framework
- PSIRF Plan
- Thematic Review – Diagnosis, Treatment and Procedures
- Thematic Review – Never Events

Further details of the countermeasures are contained in the Quality Accounts.

Our Progress
The Trust has seen a significant improvement in 2025-2026 with the target of 20% reduction in moderate and above harm events achieved.



An Overview of True North Metric Positive Patient Experience

Our Target for 2025-2026
The long term aim for this programme of work is to devise a real time engagement tool.

The Trust's focus in 2025-2026 was to ensure strong scores within the Friends and Family Test (FFT).

Our Countermeasures
To achieve this goal the following countermeasures or workstreams were commissioned:

- Real Time Engagement Tool – Breakthrough Objective
- HDFT Reader Group
- Complaints and Concerns
- Accessible Information Standards
- Engagement and Surveys

Further details of the countermeasures are contained in the Quality Accounts.

Our Progress
The Trust maintained a consistency of over 96% both inpatient and outpatient rating their care as good or very good during the year.

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

Workforce Race Equality Standard (WRES)

The WRES report captures workforce information from nine indicators regarding colleagues who have disclosed their ethnicity. The report considers their career trajectory and areas in their working practice where they may face barriers. The Trust is committed to the action plan and its progress is monitored in governance and leadership during the reporting period.

Workforce Disability Equality Standard (WDES)

The WDES report captures workforce information from ten indicators regarding colleagues who have disclosed their disability or long term condition. The report considers their career trajectory and areas in their working practice where they may face barriers. The Trust is committed to the action plan and its progress is monitored in governance and leadership during the reporting period.

Equality Delivery Standard 2022 (EDS22)

The EDS22 stakeholder meeting took place in February 2026 where the Trust maintained its overall ranking of 'Achieving' (since 2024). The Trust produced comprehensive evidence to demonstrate its commitment to the three domains.

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

As part of the Trusts' commitment to the Equality Agenda, each Executive Director has an equality, diversity and inclusion objective that helps to drive forward the agenda and deliver the Trust Equality Delivery System 22 Workforce, Race and Disability Equality Schemes and local equality programmes.

Gender Pay-Gap report

The Trust continues to publish its Gender Pay Gap Report annually as part of its commitment to transparency and equality. The report highlights differences in pay between men and women across the organisation. While some disparities remain, more significantly across the Medical and Dental workforce, the Trust is actively reviewing the data and taking steps to address the underlying causes. We remain committed to being an equal pay employer and are encouraged by the progress and improvements seen year on year.

Ethnicity Pay-Gap report

The Trust has continued to publish its Ethnicity Pay Gap Report in recent years as a matter of best practice and transparency. The report highlights disparities in pay between staff who have disclosed their ethnicity and those who identify as White. Notably, among medical staff receiving Clinical Excellence Awards, White colleagues were more likely than their Black and Minority Ethnic (BME) peers to receive an award or to achieve a comparable monetary value. The Trust remains committed to reviewing these findings and taking meaningful action in response. We are dedicated to being an equal pay employer, and we are encouraged to see year-on-year improvements as part of this ongoing work.

Freedom to Speak Up Guardian

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

Belonging Sub-Group

The Belonging Sub-Group meets six times a year and has evolved to encompass all aspects of Organisational Development, Equality, Diversity and Inclusion, allowing for a more holistic approach to shaping and supporting organisational culture. Discussions are facilitated to encourage broad engagement, with the steering group developing recommendations that are subsequently presented to the People and Culture Programme Board and the People and Culture Committee.

Staff Policies

The Trust is committed to the development of positive policies and practices to promote equal opportunities in recruitment and selection, education and training, career development and for staff who have become disabled during their career. The Trust believes that it is essential to eliminate discrimination and to promote good relations and equality of opportunity in order to

utilise to the full, the skills and talents of the entire workforce, which is evidenced in policies which continue to be followed, this list is not exhaustive, but examples include:

- National Recruitment Policy
- Training Policy
- Induction Policy
- Flexible Working Policy
- Remote and Agile Working Policy

Modern Slavery Act 2015

The Modern Slavery Act 2015 established a duty for commercial organisations to prepare an annual slavery and human trafficking statement. This is a statement of the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains or in any part of its own business.

HDFT is committed to ensuring that there is no modern slavery or human trafficking in any part of our business, including our supply chains. The aim of this statement is to demonstrate that the Trust follows best practice and that all reasonable steps are taken to prevent slavery and human trafficking.

Policies relating to Modern Slavery

All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking with the procurement department taking responsibility for overall compliance. The Trust has internal policies and procedures in place that assess supplier risk in relation to the potential for modern slavery or human trafficking. The Trust's internal Safeguarding Adults Policy and Procedures supports our staff to identify and report concerns about slavery and human trafficking. Our Speaking Up policy and procedures also provide supportive guidance for our employees to raise concerns about poor working practices.

Our People

We confirm the identities of all new employees and their right to work in the United Kingdom and pay all our employees above the National Living Wage.

Our Supply Chain

Our procurement senior team are all Chartered Institute of Purchasing and Supply (CIPs) qualified and abide by the CIPs code of professional conduct. The procurement team follows the Crown Commercial Service standard and includes a mandatory exclusion question regarding the Modern Slavery Act 2015. When procuring goods and services, we additionally apply NHS Terms and Conditions (for nonclinical procurement) and the NHS Standard Contract (for clinical procurement). Both require suppliers to comply with relevant legislation.

Our Performance

We know the effectiveness of the steps that we are taking to ensure that slavery and/or human trafficking is not taking place within our business or supply chain if: No reports are received from our staff, the public, or law enforcement agencies to indicate that modern slavery practices have been identified. Risks associated with this Act are managed in accordance with the Trust's Risk Management Policy.

Health Inequalities

Differential waiting times are analysed and reported to Board on a bimonthly basis specifically examining gender, ethnicity, deprivation and learning disability status. The Trust notes fluctuations above and below, with no significant differences in waiting times influenced by relatively low total numbers in these categories of the population we serve. The Trust has routinely integrated health inequality data into our internal performance data to allow continued focus on reducing health inequalities.

The Trust is a partner in the Harrogate and Rural Districts partnership, working collaboratively with local community anchor organisations, primary care networks, the council and the integrated care board to identify and support those experiencing health inequalities. A programme of work is underway to support those in receipt of attendance allowance and with complex needs, who will have multidisciplinary meetings to ensure their needs are met.

The Trust completed the annual Equality Delivery System Assessment (EDS22) to review three clinical services. This year we reviewed Children in Care services in Tees Valley, Specialist Children's Services and Respiratory Nursing Services in the hospital and community setting. The assessment is based on a panel of Trust and Partnership leaders who reviews our services against the national framework to assess how our services are delivered with those who may experience health inequalities due to protected characteristics or are part of a defined vulnerable population. Our services demonstrated a high level of awareness and responsiveness in addressing their needs.

We continue to build on improving all of our services in line with the 10 Year Health Plan for England: Fit for the Future and Neighbourhood Health Guidelines 2025-2026.

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
DATE 25th June 2026

Section Two
Accountability Report

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 colleagues 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 are considered independent and offer external expertise and perspective. The Board of Directors is the body legally responsible for the day-to-day management of the Trust and is accountable for the operational delivery of services, targets and performance, as well as the definition and implementation of our strategy. It has a duty to ensure the provision of safe and effective services for our patients, both in the community and in our hospital environments.

The Chair of the Trust is responsible for ensuring that the Trust Board focuses on the strategic development of the Trust and that robust governance and accountability arrangements are in place. The Chair of the Trust chairs both the Board of Directors (Trust Board) as well as the Council of Governors ensuring there is effective communication between the two bodies and that, the views of the Governors are taken into account by the Board, as appropriate.

2.1 Members of the Trust Board

During the year 2025-2026, the Board was comprised of eight non-Executive Directors (including the Chair of the Trust), seven Executive Directors (including the Chief Executive) and one Associate Non-executive Director. The Associate Non-executive Directors are not voting members of the Board.

Trust Non-executive Directors during 2025-2026		
Name	**Title**	**Period**
Sarah Armstrong	Chair	April 2022 – present (NED from October 2018)
Denise Chong	Interim Non-executive Director	March 2025 – March 2026
Jeremy Cross	Non-executive Director	January 2020 - present
Chiara De Biase	Non-executive Director	November 2022 - present
Andrew Papworth	Non-executive Director and Vice Chair	March 2020 – present
Laura Robson	Non-executive Director and Senior Independent Director	September 2017 – present
Wallace Sampson OBE	Non-executive Director	March 2020 - present
Julia Weldon	Non-executive Director	November 2022 - present
Colin Melville	Non-executive Director	September 2025 - present
Azlina Bulmer	Associate Non-executive Director	November 2022 – August 2025

Trust Executive Directors during 2025-2026		
Name	**Title**	**Period**
Jonathan Coulter	Chief Executive Officer	March 2022 - present
Jacqueline Andrews	Executive Medical Director	June 2020 - present
Matthew Graham	Director of Strategy & Transformation	September 2021 - present
Jordan McKie	Director of Finance	August 2022 - present
Russell Nightingale	Chief Operating Officer (and Deputy Chief Executive)	April 2021 – present (April 2025 – present)
Breeda Columb	Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs) and Deputy Chief Executive	June 2025 - present
Alison Smith	Interim Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs)	April 2025 – June 2025
Angela Wilkinson	Director of People and Culture	October 2019 - present

Taking into account the wide experience of the whole Board, the Board believes that its membership is balanced, complete and appropriate and that no individual or group of individuals dominate the Board. There is a clear division of responsibilities between the Chair of the Trust and Chief Executive which ensures a balance of power and authority.

2.2 Company Directorships held by Directors or Governors

The Trust is required to hold and maintain a register setting out details of any company directorships and/or significant interests held by Board members, which may conflict with their responsibilities as Trust Directors. This register is received at each Board meeting and at Committee meetings. It requires all Executive and Non-executive Directors to make known any interests in relation to the agenda and any changes to their declared interests.

Additionally, the Register of Interests for all members of the Council of Governors is also held within the Trust. The Council of Governors' register is received at each Council of Governors meeting.

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

During the year, the Trust's appointments of Matthew Graham (Director of Strategy & Transformation) and Jeremy Cross (Non-executive Director) continued as Stakeholder Non-executive Directors of the wholly-owned subsidiary, 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 Solutions LLP (IPS) and Integrated Laboratory Solutions LLP (ILS).

Both Registers of Interests are continually updated as required and are available through public papers, pages on the Trust's website (https://www.hdft.nhs.uk/) or by contacting:

The Company Secretary
Corporate Affairs Office
Harrogate & District NHS Foundation Trust
Trust Headquarters
Harrogate District Hospital
Lancaster Park Road
Harrogate HG2 7SX
hdft.nhsfoundationTrust@nhs.net

2.3 Accounting Policies

The Trust prepares its financial statements under direction from NHS England (NHSE), in accordance with the Government Financial Reporting Manual 2026-2027, 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 2025-2026 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. This has become more challenging in quarter 4 as cash was being monitored on a weekly basis. The information below provides an update on the Trust's compliance to this:

Year to 31 March 2025				Year to 31 March 2026		
NHS	Non NHS	Total	Numbers	NHS	Non NHS	Total
2,208	42,198	44,406	No of Invoices Paid to Date	1,773	43,415	45,188
1,655	37,248	38,903	No of Invoices Paid in 30 Days	570	9,057	9,627
75.0%	88.3%	87.6%	% of Invoices Paid in 30 Days	32.1%	20.9%	21.3%

Year to 31 March 2025				Year to 31 March 2026		
NHS	Non NHS	Total	Values	NHS	Non NHS	Total
23,406	106,544	129,950	£x value of Invoices Paid to Date	13,871	130,743	144,614
16,154	100,234	116,388	£k value of Invoices Paid in 30 Days	3,415	75,576	78,991
69.0%	94.1%	89.6%	% of Invoices Paid in 30 Days	24.6%	57.8%	54.6%

2.6 NHS England 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 2025-2026.

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 Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than the Trust's income from the provision of goods and services for any other purposes. The Trust confirms that it has met this requirement during 2025-2026.

2.9 NHS Oversight Framework

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

a) Objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)

b) Additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity. An NHS foundation Trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

HDFT were placed in Segment 3 during 2025-2026. This segmentation information is the Trust's position as at 31st March 2026.

HDFT can confirm that the rationale for movement into Segment 3 is based on finance only. All other areas detail in the components above were in line with Segment 2 requirements.

Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS England website.

Jonathan Coulter
Chief Executive Officer
Harrogate and District NHS Foundation Trust
DATE 25th June 2026

Section Three
Patients, Service Users and Stakeholders Report

Section 3 – Patients, Service Users and Stakeholders

3.1 Complaints Handling

The Trust's aim is to 'get it right first time, every time'. We recognise 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, and complaints and concerns are discussed weekly as part of all directorate Quality huddles.

The Trust has a Complaints Policy, supplemented by an Unreasonable Behaviour procedure which has been developed to support staff and services when handling habitual or challenging complainants.

The Patient Experience Team offer Lead Investigator and Complaint Training to staff across the whole organisation, both online and in person.

The Team also offer patients and complainants the opportunity to give feedback once their complaint has concluded. This includes asking about how accessible the process was, whether they feel their complaint had been resolved in a timely way and whether their final response was open, honest and provided clear answers and explanations to their concerns.

Action plans are considered by the Directorates for each complaint 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 Making Experience's Count Forum and the Quality Governance Management Group on a regular basis and in turn to the Board of Directors. Any actions that are identified following a complaint are added to the relevant Datix record and progress is monitored by the action owners, Quality Assurance Leads and Patient Experience Team.

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.

In line with the NHS Complaint Standard Framework, Early Resolution Complaints (ERCs) are embedded at HDFT, as a further option to investigate and respond to concerns that require a written response, but do not necessarily require a full formal investigation. Services have 10 days to respond in writing, and ERCs can be shared with the Parliamentary Health Service Ombudsman should the patient/complainant remain unhappy and want to request an independent review.

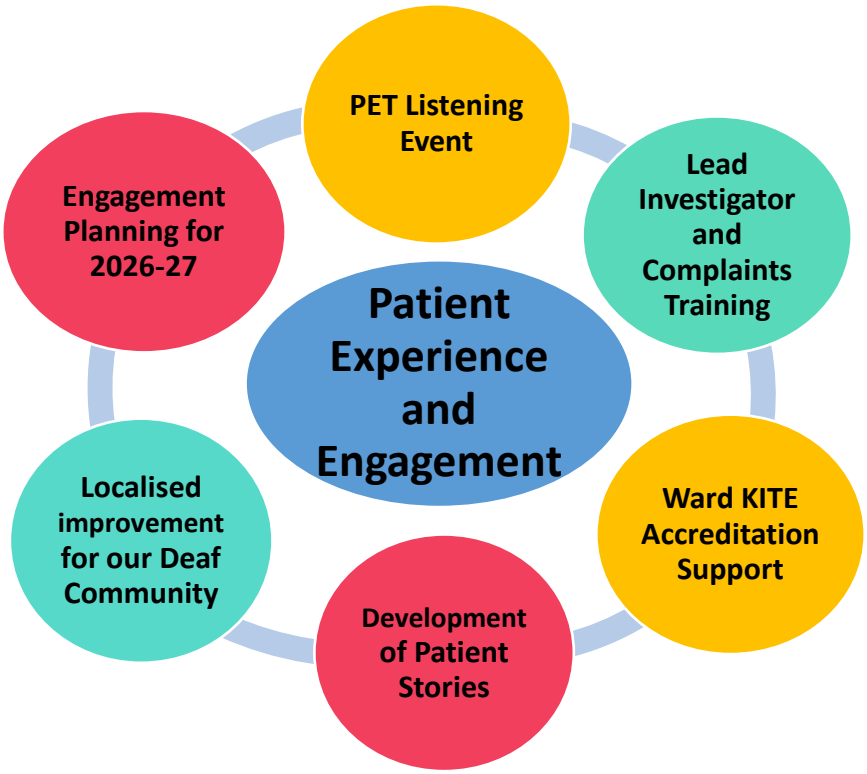
Where there are serious patient safety implications, close links are maintained with the Patient Safety work streams within the wider Quality Team, to ensure swift, appropriate action is taken in relation to any ongoing patient care or incident investigation and to promote partnership working between teams.

3.2 Patient and Public Involvement

Patient and public involvement remains a vital part of our Trust's vision. As part of our quality governance structures, the Making Experiences Count (MEC) Forum oversees and supports much of 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.

An Engagement Strategy is in development and will be finalised once the NHS 10 Year Delivery Plan is published.

Key Projects in 2025-2026 included:



If you would like to know more about our patient engagement activities please review the information contained in our Quality Accounts.

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 appreciate our success is inherently linked to our ability to work effectively in collaboration and partnership. We intend our Trust Strategy to complement and support the delivery of the strategies of our local and system partners as well as align with national priorities.

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

Humber and North Yorkshire Integrated Care System (HNY ICS)

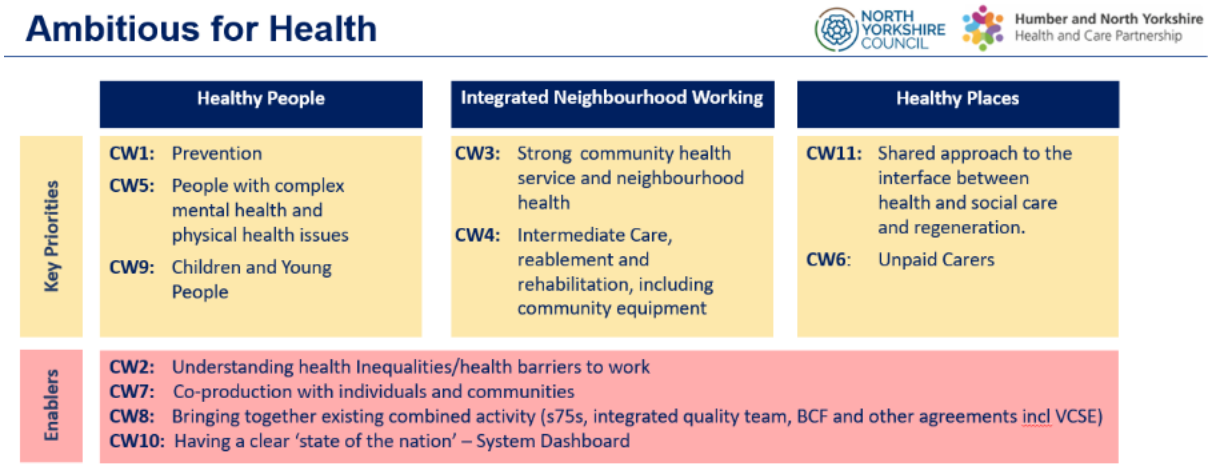
Due to the location of our acute and adult community services in North Yorkshire, HDFT is formally a member of the Humber and North Yorkshire (HNY) ICS, led by the HNY Integrated Care Board (ICB), although most of our acute patient pathways are into Leeds and West Yorkshire. A large proportion of the funding for our NHS services, including capital funding, flows through the HNY ICB.

As an acute provider, the Trust is a member of the HNY Collaborative of Acute Providers (CAP). The HNY CAP also includes Yorkshire and Scarborough Teaching Hospitals NHS Foundation Trust (YSTHFT), Hull University Teaching Hospitals NHS Trust (HUTH) and North Lincolnshire and Goole NHS Foundation Trust (NLAG), with the latter two now part of a group structure. Each Trust has been reviewing its services to identify any services that are currently unsustainable, and how closer collaboration with partners could improve or mitigate these risks. This builds on existing significant collaborations with YSTHFT on:

- Our joint Electronic Patient Record programme (EPR);
- Urgent and emergency care through a formal change to the ambulance catchment boundary so that more ambulances, from closer to York, bring patients to the HDFT emergency department;
- A joint stroke pathway with hyper acute stroke care for Harrogate patients provided by YSTHFT and Leeds Teaching Hospitals Trust (LTHT), and
- Various services such as ear nose and throat, audiology and nephrology, where YSTHFT provides services to HDFT, and others such as podiatry where HDFT provides the service to YSTHFT.

While there are opportunities to share good practice and ideas, the distance between Harrogate and the HUTH/NLAG means there are very limited patient flows and direct clinical links between us.

HNY ICS is made up of six places based on local authority areas, including North Yorkshire. In 2025, health and care partners in North Yorkshire, including HDFT, established a Section 75 agreement aligning approximately £590m of NHS and local authority funding. This aligned budget supports delivery of the Ambitious for Health programme (figure blow) and provides a shared platform for transforming community and neighbourhood-based health and care services, overseen by the North Yorkshire Health Collaborative Joint Committee.



HDFT has taken a lead on bringing the North Yorkshire system together to deliver Ambitious for Health, establishing and chairing the North Yorkshire Directors Group which provides the engine room for the programme. With the other four providers of community

health services in North Yorkshire, HDFT has led the community health services project bringing community services teams from across North Yorkshire together to learn and improve. Through a community of practice, the teams are collaborating to improve self care support for patients, efficiency and effectiveness through better digital systems.

The Harrogate and Rural District Local Care Partnership (HARD LCP) brings together partners across health, care and beyond to improve the health and wellbeing of the Harrogate and District population. During 2025-2026 HARD LCP has strengthened relationships between partners, particularly focusing on building links with the voluntary, community and social enterprise sector to address health inequalities. HDFT has hosted events for the seven "Community Anchor" organisations in HARD to build links between our clinicians and VCSE services. The Community Anchors are local Voluntary Community and Social Enterprise organisations which provide a coordination and sign posting service to local charities and community organisations. Through the Community Anchors, clinicians can support patients to access VCSE services such as befriending, community transport and access to benefits.

The HARD LCP Health Inequalities project, facilitated by HDFT, brought together clinicians and teams from HDFT, primary care, North Yorkshire Council, the voluntary sector and others to find ways to address the, often hidden, inequalities in the District. Splitting into two groups for Harrogate town and the more rural areas, we identified two priorities: delivering a multi-disciplinary, open access health and care clinic for people who do not engage with services; enabling VCSE organisations to join primary care multi-disciplinary team meetings so that patients can access voluntary sector services as well as statutory services. The first clinic was delivery in February 2026 and the LCP is now planning the next steps for 2026-2027.

As the acute and community provider for Harrogate and District, HDFT has important roles as a health care provider and as an anchor institution for our community. We have built strong links with local schools and education providers through volunteering and work experience. Our partnership with Harrogate College has supported training for our international nurses, the delivery of the Healthcare T Level and the fourth year of our supported internship programme for young people with learning disabilities and autism.

West Yorkshire Health and Care Partnership

Being located only 15 miles to the north, Harrogate has always had strong links with Leeds. As such, HDFT has close links to LTHT. Until 2020, 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 model of collaboration between organisations is built on trust, long-standing relationships and mutual benefits, without changes to structure or organisational form such as mergers or group models. The WYAAT Trusts collaborate on a wide range of programmes and issues including diagnostic imaging, pathology, elective care, non-surgical oncology and procurement. In 2025-2026 we collaborated with our WYAAT partners on:

- Optimisation of a single laboratory information management system to connect pathology services in all six WYAAT Trusts.

- A networked clinical model for non-surgical oncology to provide resilience and improved quality.
- A new, centralised aseptics production facility to manufacture aseptic pharmaceutical products at scale for all WYAAT Trusts to improve safety, release nursing time and reduce costs.
- Shared theatres with LTHT at Wharfedale Hospital, to reduce waiting times for elective procedures and improve patient experience.
- The Yorkshire Imaging Collaborative (YIC) implemented transformational Artificial Intelligence (AI) imaging and decision support tools that could help diagnose patients with life-threatening diseases more quickly.

WYAAT completed a comprehensive service review in April 2025. The purpose was to consider how its corporate functions and clinical services can be delivered differently to improve productivity, support their sustainability and meet patient need. The review recommended the following priority areas for further collaboration through WYAAT:

- WY Pathology Network
- WY Imaging Network
- WY Aseptics Manufacturing Hub
- Elective Delivery
- Corporate Services Productivity
- Clinical Sustainability for neurology, haematology, renal services and stroke.

HDFT has a significant number of patients from North Leeds and Wetherby and 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.

North East and North Cumbria Integrated Care System

HDFT provides children's public health services to 7 local authorities in the North East: County Durham, Darlington, Middlesbrough, Stockton-On-Tees, Sunderland, Gateshead and Northumberland as well as a Section 75 partnership arrangement with the local authority for Stockton-On-Tees and with Gateshead local authority. We have worked hard to improve our strategic relationships with our local authority partners, through the Directors of Public Health and membership of Health and Wellbeing Boards and Healthy Children's Boards A key focus in 2025-2026 was raising the profile of our children's public health services nationally. We became corporate members of both the Institute of Health Visiting and the Queen's Institute of Community Nursing which has given us access to national forums, conferences and training for our staff. We hosted successful visits to our services for Professor Jamie Waterall, Deputy Chief Nurse for Public Health Nursing for England, and Professor Peter Kelly, OBE, Office for Health Inequalities and Disparities (OHID) Regional Director and NHS Director of Public Health for the North East and Yorkshire Both visits allowed our staff and teams to present the incredible work they do for their children and families and have created opportunities to share nationally our approach to children's public health services and the quality and innovation that we deliver.

We continue to explore opportunities for long-term partnerships in all our contract areas and to expand our services where we can add value and improve care for children and families.

In April 2025 we added two new children's public health services to our Trust taking on responsibility for Cumberland and Westmoreland and Furness. During the year we have seen sustained improvements in the delivery of the Healthy Child Programme contacts,

increasing the percentage of children seen within the expected timescales from very low levels to over 90% in most cases.

During 2025-2026 we also successfully bid to deliver the South Tyneside children's public health service. Staff engagement and service mobilisation was completed by the end of March 2026 and the service started with HDFT on 1 April 2026.

Jonathan Coulter
Chief Executive Officer
Harrogate and District NHS Foundation Trust
DATE 25th June 2026

Section Four
Annual Statement on Remuneration

4. Annual Statement on Remuneration – Remuneration Report

4.1 Annual Statement on Remuneration

The Trust recognises that the remuneration policy is important 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, the Associate Director of Quality and Corporate Affairs and the 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 2025-2026 the Committee met two times as per the table below:

Attendance at Remuneration Committee Meetings 2025-2026

Board Member	Number of business meetings attended	3rd September 2025	11th March 2026
Sarah Armstrong*	2/2	✓	✓
Jeremy Cross	1/2	✓	-
Chiara De Biase	1/2	-	✓
Andrew Papworth	2/2	✓	✓
Laura Robson	2/2	✓	✓
Wallace Sampson OBE	2/2	✓	✓
Julia Weldon	1/2	-	✓
Colin Melville	2/2	✓	✓
Denise Chong	2/2	✓	✓

* 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 are 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 are 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.

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 follows the VSM Framework Guidance for Director roles.

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

4.4 Annual Report on Remuneration (Senior Managers including Pension Disclosure) – Subject to audit

Remuneration Framework

During the reporting year, the Trust complied with the applicable NHS Remuneration Framework in respect of senior managers remuneration. No national approval was required for remuneration proposals during the year.

Single Total Figure of Remuneration – 2025-2026 (Subject to Audit):

Name and Title	Salary (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
	£'000s	£'000s	£'000s
Mr. J Coulter - Chief Executive	210-215	82.5-85	290-295
Dr. J Andrews - Medical Director	210-215	90-92.5	300-305
Mrs. A Smith - Director of Nursing, Midwifery and AHP's (1)	25-30	-	25-30
Mrs.B Columb - Director of Nursing, Midwifery and AHP's (2)	105-110	157.5-160	265-270
Mr. R Nightingale - Chief Operating Officer (3)	145-150	97.5-100	240-245
Ms. A Wilkinson - Director of People and Culture	125-130	50-52.5	175-180
Mr. M Graham - Director of Strategy	130-135	25-27.5	155-160
Mr. J McKie - Director of Finance (4)	140-145	-	140-145
Ms. S Armstrong - Chair	45-50	-	45-50
Ms. L Robson - Non-Executive Director	15-20	-	15-20
Mr. J Cross - Non-Executive Director	15-20	-	15-20
Mr. W Sampson - Non-Executive Director	10-15	-	10-15
Miss. C De Biase - Non-Executive Director / Audit Committee Chair	15-20	-	15-20
Mrs. J Weldon - Non-Executive Director	10-15	-	10-15
Mr. A Papworth - Non-Executive Director	15-20	-	15-20
Mrs. D Chong - Non-Executive Director	10-15	-	10-15
Mr. C Melville - Non-Executive Director	5-10	-	5-10

Remuneration----------

(1) Mrs A. Smith left the organisation 30/06/25 and chose not to be covered by the pension arrangements during the reporting year.
(2) Mrs B Columb commenced her role 23/06/2025.
(3) Mr. R. Nightingale commenced as Deputy Chief-Executive on 1st April 2025.
(4) Mr. J, McKie chose not to be covered by the pension arrangements during the reporting year.
(5) Prof. C. Melville commenced in role 25/09/25.
NB: No payments were made for expense payments, performance pay and bonuses or Long term performance pay during 2025/26.

Single Total Figure of Remuneration 2024-2025 – Subject to Audit:

Name and Title	Salary (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. J Coulter - Chief Executive	200-205	200-205	45-47.5	250-255
Dr. J Andrews - Medical Director	205-210	205-210	47.5-50	250-255
Mrs. E Nunez - Director of Nursing, Midwifery and AHPs, Deputy Chief Executive (1)	145-150	145-150	240-242.5	385-390
Mrs. A Smith -Director of Nursing, Midwifery and AHP's (2)	0-5	0-5	Nil	0-5
Mr. R Nightingale - Chief Operating Officer	125-130	125-130	30-32.5	155-160
Ms. A Wilkinson - Director of Workforce and Organisational Development	120-125	120-125	Nil	120-125
Mr. M Graham - Director of Strategy	130-135	130-135	25-27.5	155-160
Mr. J McKie - Director of Finance (4)	140-145	140-145	0	140-145
Ms. S Armstrong - Chair	45-50	45-50	0	45-50
Ms. L Robson - Non-Executive Director	15-20	15-20	0	15-20
Mr. J Cross - Non-Executive Director	15-20	15-20	0	15-20
Mr. W Sampson - Non-Executive Director	10-15	10-15	0	10-15
Miss. C De Biase - Non-Executive Director / Audit Committee Chair	15-20	15-20	0	15-20
Mrs. J Weldon - Non-Executive Director	10-15	10-15	0	10-15
Mr. A Papworth - Non-Executive Director	15-20	15-20	0	15-20
Mrs. D Chong - Non-Executive Director (3)	-	-	0	-

(1) Mrs E. Nunez left the Trust on 31st March 2025.
(2) Mrs A. Smith commenced as Interim Director of Nursing, Midwifery and AHPs 24th March 2025..
(3) Mr. J. McKie has opted out of the pension scheme.
(4) Mrs D. Chong commenced as Non-Executive Director 24th March 2025..

Total Pension Entitlement 2025-2026 – Subject to Audit:

Name and title	Real increase in pension at pension age (bands of £2,500) £.000s	Real increase in pension lump sum at pension age (bands of £2,500) £'000s	Total accrued pension at pension age at 31 March 2026 (bands of £5,000) £'000s	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000) £'000s	Cash Equivalent Transfer Value at 1 April 2025 £'000s	Real increase in Cash Equivalent Transfer Value £'000s	Cash Equivalent Transfer at 31 March 2026 £'000s	Employer's contribution to stakeholder pension £'000s
Mr Jonathan Coulter - Chief Executive	5-7.5	2.5-5	90-95	225-230	2,011	103	2,175	£Nil
Dr Jacqueline Andrews - Medical Director	5-7.5	5-7.5	70-75	170-175	1,489	100	1,639	£Nil
Ms Angela Wilkinson - Director of People and Culture	2.5-5	£Nil	60-65	£Nil	1,085	59	1,179	£Nil
Mr Russell Nightingale - Chief Operating Officer & Deputy Chief Executive	5-7.5	£Nil	40-45	£Nil	479	65	571	£Nil
Mr Matthew Graham - Director of Strategy	0-2.5	£Nil	35-40	£Nil	565	25	615	£Nil
Mrs Breeda Columb - Director of Nursing, Midwifery and AHPs	7.5-10	15-17.5	55-60	145-150	1,139	177	1,404	£Nil

4.5 Fair Pay Declaration – subject to audit

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 2025-2026 was £210-215k (2024-25 was £205-210k).

The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Pension Entitlement 2025-2026, 2024-2025 & 2023-2024– Subject to Audit:

2025-2026	25th Percentile	Median	75th Percentile
Total Remuneration (£)	31,159	42,226	54,596
Salary Component of total remunerations (£)	31,159	42,226	54,596
Pay Ratio information	6.86	5.06	3.91
2024-2025	**25th Percentile**	**Median**	**75th Percentile**
Total Remuneration (£)	29,114	39,405	49,909
Salary Component of total remunerations (£)	29,114	39,405	49,909
Pay Ratio information	7.13	5.27	3.92
2023-2024	**25th Percentile**	**Median**	**75th Percentile**
Total Remuneration (£)	28,407	37,350	50,056
Salary Component of total remunerations (£)	28,407	37,350	50,056
Pay Ratio information	6.91	5.26	4.16

The median salary at Harrogate and District NHS Foundation Trust increased by 7%.

In 2025-2026, 22 employees received remuneration in excess of the highest-paid director / member (53 in 2024-2025). Remuneration ranged from £21k to £312k (£7k to £438k in 2024-2025). 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, Subject to audit

In 2025-2026 or 2024-2025, there have been no payments made to past senior managers.

4.7 Payments for Loss of Office, Subject to audit

In 2025-2026 or 2024-2025, there have been no payments made for loss of office.

Jonathan Coulter
Chief Executive Officer
Harrogate and District NHS Foundation Trust
DATE 25th June 2026

Section Five
People Report

5. Staff Report

5.1 Overview

To support the Trust's purpose of putting Patients and Children First our ambition is to make HDFT The Best Place to Work. Our People Plan outlines the key priority areas and focus required to achieve this ambition. These are:

People Plan Pillar	
Looking After Our People	Physical and emotional support to help colleagues be "At Our Best," including health and wellbeing support through Occupational Health and Wellbeing Services, Health and Safety measures to ensure a safe working environment, and dedicated support for mental health.
Belonging in the NHS	Developing teams through strong leadership, where everyone feels valued and recognised, diversity is celebrated, and colleagues feel included and proud to work here.
New Ways of Working	Ensuring we have the right people with the right skills in the right roles by effectively planning and designing our workforce, recruiting talented colleagues, and developing medical, allied health, and advanced practice roles.
Growing for the Future	Ensuring our colleagues can reach their full potential through clear career development pathways, effective talent management, and by being an excellent place to learn and grow for both our current workforce and the future NHS workforce.

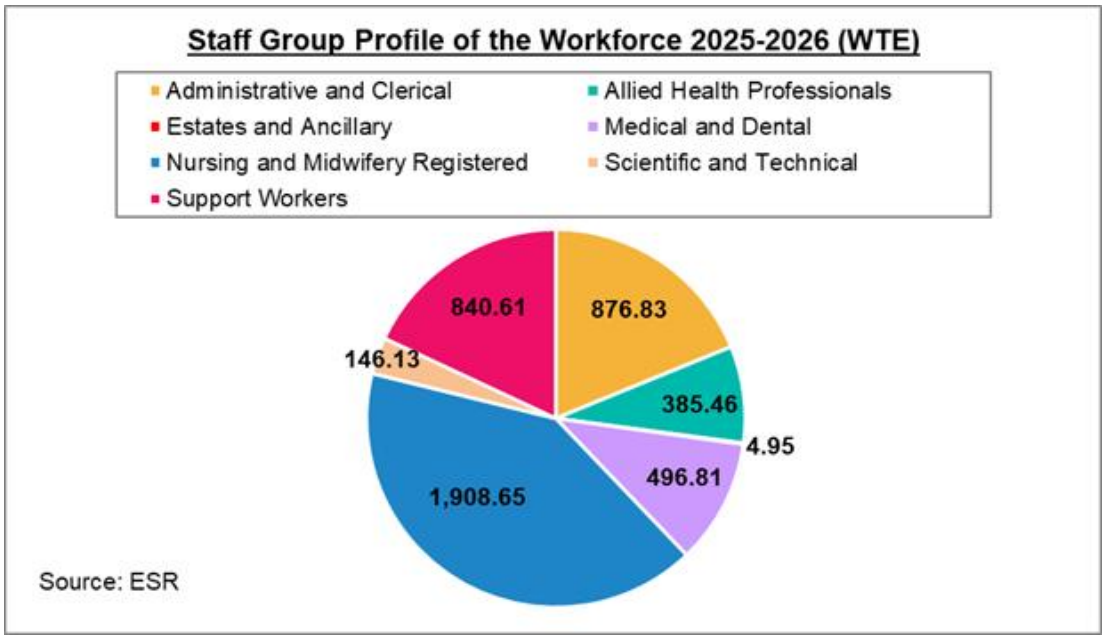
5.2 Analysis of Staff Numbers as at 31 March 2026, Subject to audit

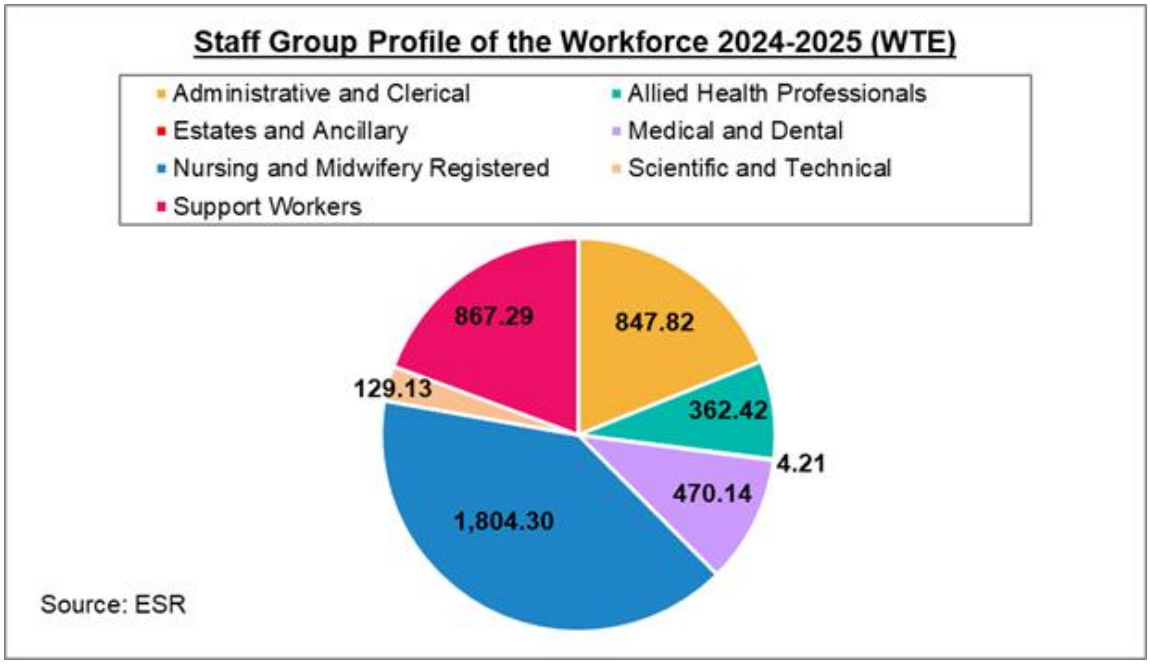
Analysis of Staff Numbers – subject to audit

Group Position	Total 2025/26	Permanently Employed	Other	Total 2024/25	Permanently Employed	Other
	Average number (WTE)	Average number (WTE)	Average number (WTE)	Average number (WTE)	Average number (WTE)	Average number (WTE)
Medical and dental	488	479	9	471	459	12
Ambulance staff	6	6	0	6	6	0
Administration and estates	905	898	7	876	864	12
Healthcare assistants and other support staff	605	605	0	455	455	0
Nursing, midwifery and health visiting staff	2,155	2,152	3	2,208	2,194	14
Nursing, midwifery and health visiting learners	55	55	0	59	59	0
Scientific, therapeutic and technical staff	624	623	1	579	577	2
Healthcare science staff	119	119	0	108	108	0
Social care staff	0	0	0	0	0	0
Other	0	0	0	0	0	0
Total	**4,957**	**4,937**	**20**	**4,762**	**4,722**	**40**
Of which are employed by HIF	323	312	11	309	305	4

Analysis of Staff Costs, subject to audit

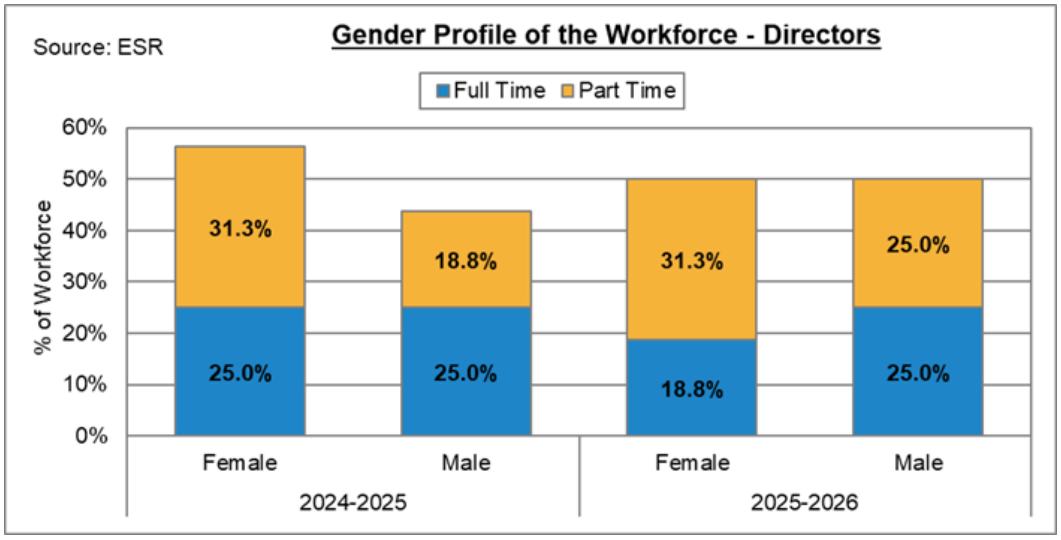
	Group Total 2025-2026	Permanently Employed	Other	Group Total 2024-2025	Permanently Employed	Other
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	245,606	241,695	3,911	226,521	223,774	2,747
Annual Leave Accrual	0	0	0	297	297	0
Social Security costs (Employers NI costs)	28,792	28,792	0	20,481	20,481	0
Apprenticeship levy	1,139	1,139	0	1,037	1,037	0
Pension cost - employer contributions to NHS pension scheme	29,224	29,224	0	26,081	26,081	0
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	18,472	18,472	0	16,626	16,626	0
Pension cost - other	124	124	0	106	0	106
Termination benefits	0	0	0	0	0	0
External bank	4	0	4	0	0	0
Agency/contract staff	2,041	0	2,041	3,902	0	3,902
Total employee expenses	**325,402**	**319,446**	**5,956**	**295,051**	**286,122**	**6,755**





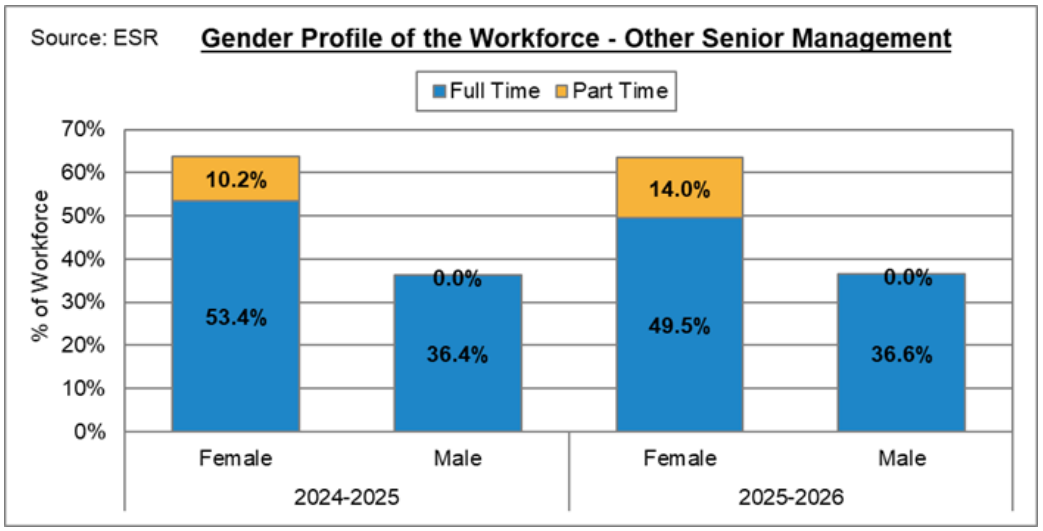
5.3 Analysis of Male and Female Directors, Other Senior Managers and Employees as at 31 March 2026

The graph and table below gives a breakdown of the number of Directors, including Non-Executive Directors, by gender, as at 31 March 2026.



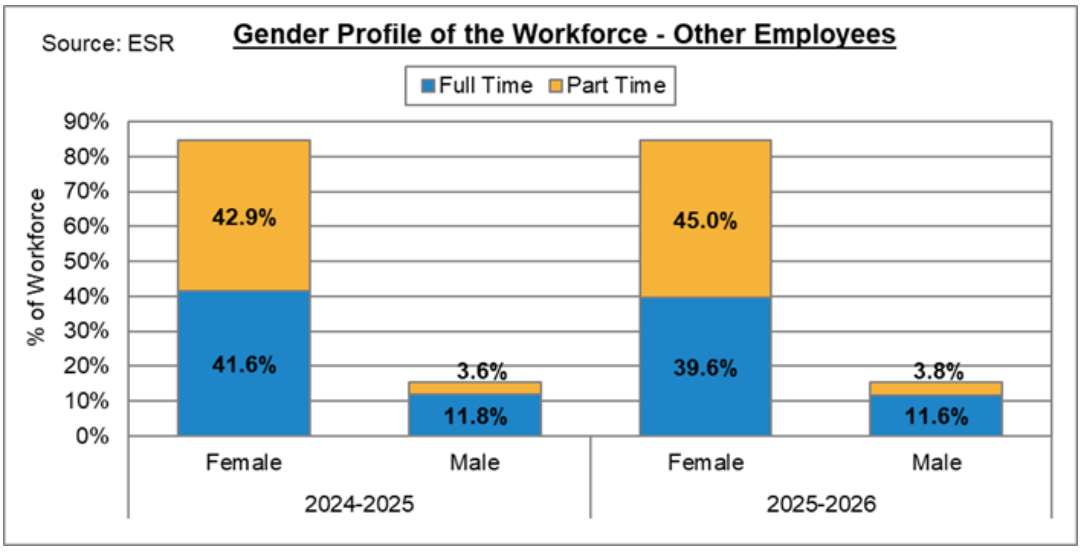
Gender	Category	2024-2025	2025-2026
DIRECTORS		**Headcount**	**Headcount**
Female	Full Time	4	3
	Part Time	5	5
Male	Full Time	4	4
	Part Time	3	4
TOTAL		**16**	**16**

The graph and table below gives a breakdown of the number of other senior management, by gender, as at 31 March 2026.



Gender	Category	2024-2025	2025-2026
OTHER SNR MANAGEMENT		Headcount	Headcount
Female	Full Time	47	46
	Part Time	9	13
Male	Full Time	32	34
	Part Time	0	0
TOTAL		**88**	**93**

The graph and table below gives a breakdown of the number of other employees, by gender, as at 31 March 2026.



Gender	Category	2024-2025	2025-2026
OTHER EMPLOYEES		Headcount	Headcount
Female	Full Time	2,145	2,129
	Part Time	2,212	2,417
Male	Full Time	610	624
	Part Time	184	203
TOTAL		**5,151**	**5,373**

5.4 Sickness Absence Data as at 31 March 2026

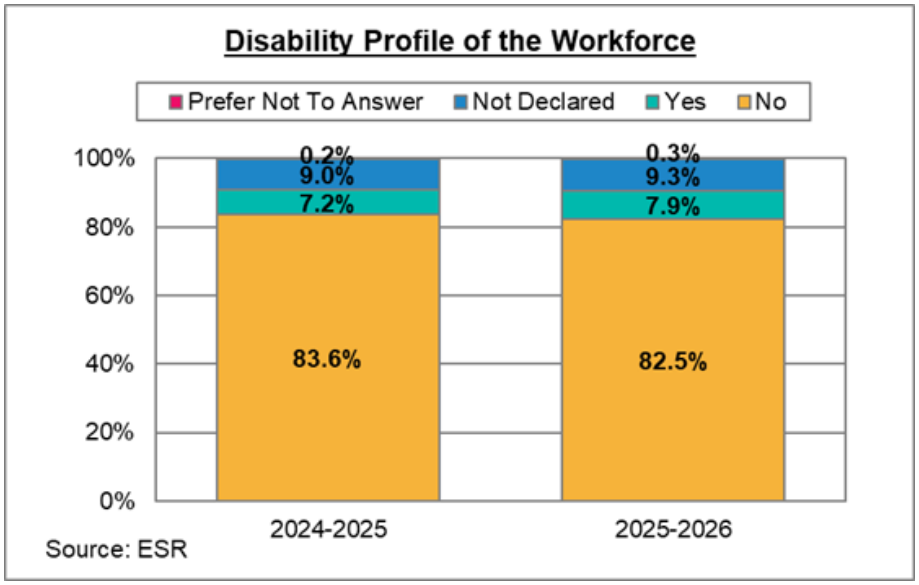
Directorate	Sickness Rate %				Annual Sickness Rate %
	Q1 2025-2026	Q2 2025-2026	Q3 2025-2026	Q4 2025-2026	
Children's and Young Peoples Public Health	7.16 %	7.79 %	8.93 %	8.41 %	**8.07%**
Corporate Services	2.74 %	3.00 %	4.15 %	3.02 %	**3.23%**
Long Term, Urgent, Cancer and Community	4.39 %	4.52 %	5.38 %	4.30 %	**4.65%**
Planned, Surgical and Children's Care	3.45 %	4.48 %	4.73 %	4.29 %	**4.24%**
TOTAL	**4.67 %**	**5.21 %**	**5.99 %**	**5.23 %**	**5.28%**

Key
Q1 2024-2025 – April 2025 to June 2025
Q2 2024-2025 – July 2025 to September 2025
Q3 2024-2025 – October 2025 to December 2025
Q4 2024-2025 – January 2026 to March 2026

Directorate	Sickness Rate %				Annual Sickness Rate %
	Q1 2024-2025	Q2 2024-2025	Q3 2024-2025	Q4 2024-2025	
Children's and Young Peoples Public Health	6.61%	6.45%	7.56%	7.74%	**7.09%**
Corporate Services	3.28%	3.51%	3.68%	2.95%	**3.36%**
Long Term, Urgent, Cancer and Community	4.21%	4.37%	4.58%	4.49%	**4.42%**
Planned, Surgical and Children's	4.35%	4.31%	5.09%	4.27%	**4.51%**
TOTAL	**4.79%**	**4.80%**	**5.42%**	**5.09%**	**5.03%**

Key
Q1 2024-2025 – April 2024 to June 2024
Q2 2024-2025 – July 2024 to September 2024
Q3 2024-2025 – October 2024 to December 2024
Q4 2024-2025 – January 2025 to March 2025

5.5 Analysis of Disability Profile of the Workforce as at 31 March 2026

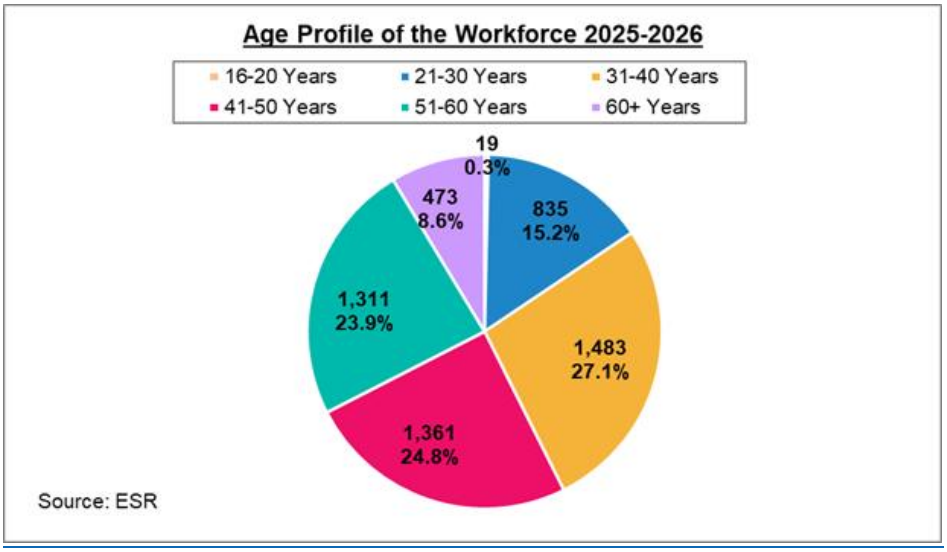


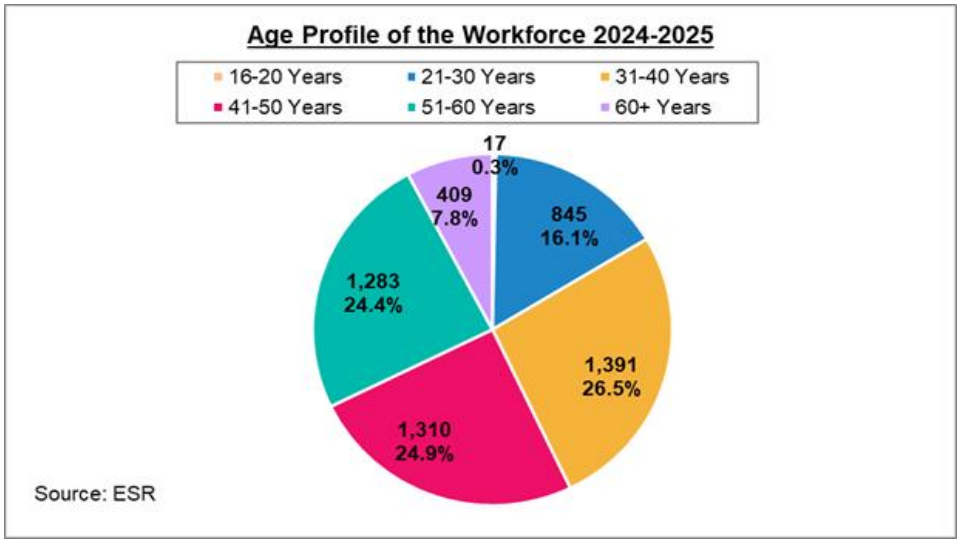
The graph and table below give a breakdown of the number of employees registered as having a disability as at 31 March 2026

Disabled	2024-2025	2025-2026
	Headcount	Headcount
No	4,392	4,521
Yes	377	435
Not Declared	475	511
Prefer Not To Answer	11	15
TOTAL	**5,255**	**5,482**

5.6 Analysis of the Age Profile of the Workforce as at 31 March 2026

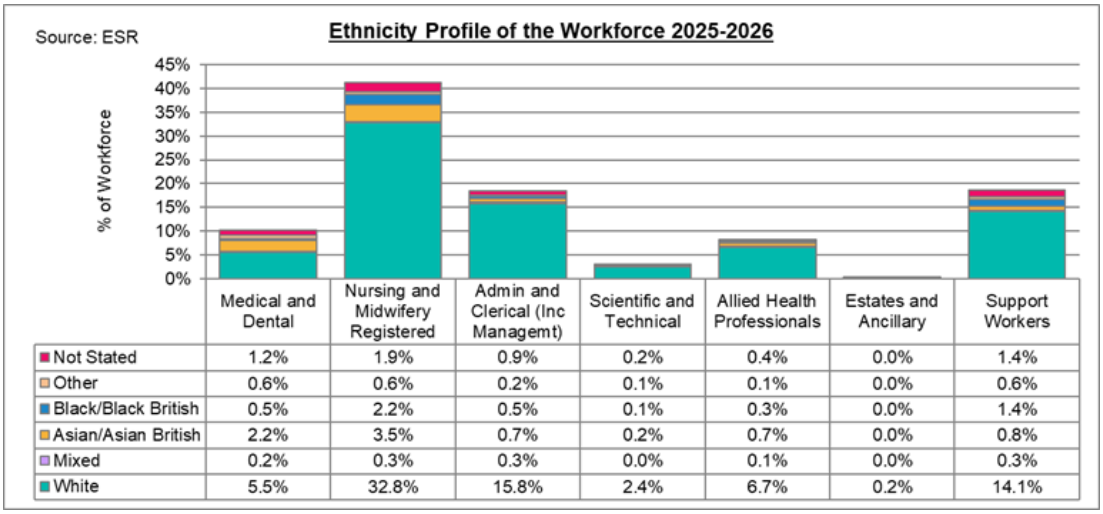
	2024-2025		2025-2026	
Age Band	Headcount	% of Workforce	Headcount	% of Workforce
16-20 Years	17	0.3%	19	0.3%
21-30 Years	845	16.1%	835	15.2%
31-40 Years	1,391	26.5%	1,483	27.1%
41-50 Years	1,310	24.9%	1,361	24.8%
51-60 Years	1,283	24.4%	1,311	23.9%
60+ Years	409	7.8%	473	8.6%
TOTAL	**5,255**		**5,482**	


Age Profile of the Workforce 2025-2026
16-20 Years
21-30 Years
31-40 Years
41-50 Years
51-60 Years
60+ Years
19
0.3%
835
15.2%
1,483
27.1%
1,361
24.8%
1,311
23.9%
473
8.6%
Source: ESR

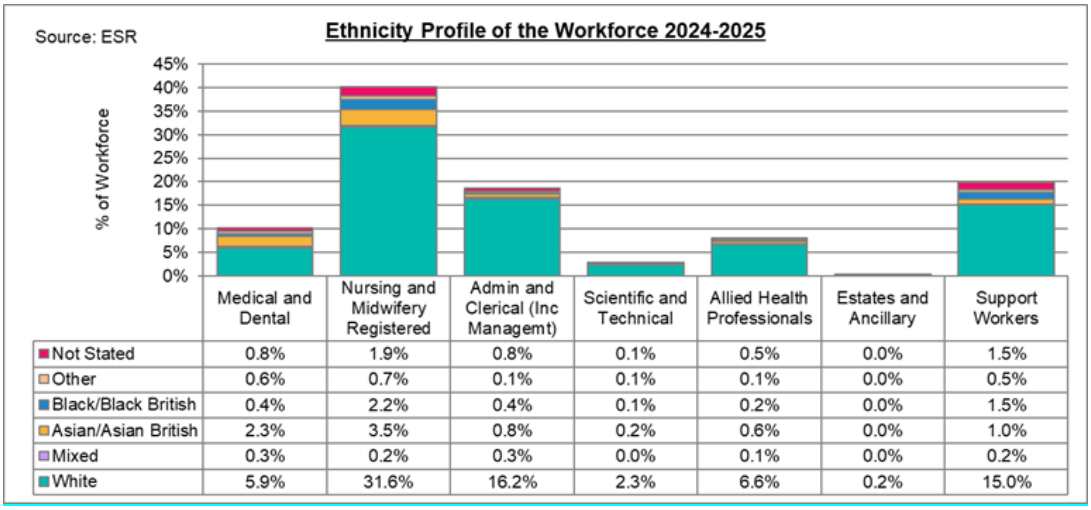

Age Profile of the Workforce 2024-2025
16-20 Years
21-30 Years
31-40 Years
41-50 Years
51-60 Years
60+ Years
17
0.3%
845
16.1%
1,391
26.5%
1,310
24.9%
1,283
24.4%
409
7.8%
Source: ESR

5.7 Analysis of the Ethnicity Profile of the Workforce as at 31 March 2026

16.4% of the Trust workforce identify as BME. This remains at the same position as March 2025.



	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	1.2%	1.9%	0.9%	0.2%	0.4%	0.0%	1.4%
Other	0.6%	0.6%	0.2%	0.1%	0.1%	0.0%	0.6%
Black/Black British	0.5%	2.2%	0.5%	0.1%	0.3%	0.0%	1.4%
Asian/Asian British	2.2%	3.5%	0.7%	0.2%	0.7%	0.0%	0.8%
Mixed	0.2%	0.3%	0.3%	0.0%	0.1%	0.0%	0.3%
White	5.5%	32.8%	15.8%	2.4%	6.7%	0.2%	14.1%



	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	0.8%	1.9%	0.8%	0.1%	0.5%	0.0%	1.5%
Other	0.6%	0.7%	0.1%	0.1%	0.1%	0.0%	0.5%
Black/Black British	0.4%	2.2%	0.4%	0.1%	0.2%	0.0%	1.5%
Asian/Asian British	2.3%	3.5%	0.8%	0.2%	0.6%	0.0%	1.0%
Mixed	0.3%	0.2%	0.3%	0.0%	0.1%	0.0%	0.2%
White	5.9%	31.6%	16.2%	2.3%	6.6%	0.2%	15.0%

Headcount 2025-2026	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	303	1796	866	133	366	9	775	**4,248**
Mixed	13	17	17	1	4	0	14	**66**
Asian/Asian British	123	192	40	11	37	0	46	**449**
Black/Black British	25	118	26	6	15	0	76	**266**
Other	33	34	11	3	5	0	31	**117**
Not Stated	66	106	52	10	24	1	77	**336**
TOTAL	**563**	**2,263**	**1,012**	**164**	**451**	**10**	**1,019**	**5,482**

Headcount 2024-2025	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	311	1663	853	121	347	8	790	**4,093**
Mixed	14	12	18	2	5	0	12	**63**
Asian/Asian British	119	185	40	12	29	0	53	**438**
Black/Black British	22	114	20	3	12	0	80	**251**
Other	33	36	6	3	6	0	28	**112**
Not Stated	41	102	40	7	27	1	80	**298**
TOTAL	**540**	**2,112**	**977**	**148**	**426**	**9**	**1,043**	**5,255**

5.8 Starters and Leavers 2025-2026

	Headcount	FTE
Starters	439	382.64
Leavers	471	363.28

Exclusions applied:

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

5.9 National Staff Survey

Staff experience, engagement and involvement

The Trust gauges staff experience, engagement and involvement mostly regularly (three times per annum) through the National Quarterly Pulse Surveys (NQPS) using the Inpulse Survey platform. The platform gives team and departmental managers the ability to view the results from their team providing ten or more people within a team complete the survey generating a sense of ownership of the surveys and their results within Directorates, departments and teams.

Such accessibility of the quarterly Inpulse survey results plays a large part in engaging staff to complete the survey. In the financial year 2025-2026, HDFT has been a top performer amongst its benchmark group of Acute, and Acute and Community Trusts for both response rate and engagement score.

Senior leaders within Directorates are well-versed in sharing a summary of their national and quarterly survey results, and actions they have taken to improve staff experience, at an extended Senior Management Team meeting. This takes place once a year.

National Staff Survey

The NHS staff survey is conducted annually. From 2021-2022 the survey questions align to the seven elements of the NHS 'People Promises' and retains the two previous 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 response rate to the 2025 NHS Staff Survey among Trust staff was 62%, a 13% increase compared with the 2024 survey.

Scores for each indicator together with that of the survey benchmarking group (Acute and Acute & Community Trusts) are presented below.

Indicators (People Promises and Themes)	2025		2024		2023	
	Trust score	Benchmark average	Trust score	Benchmark average	Trust score	Benchmark average
People Promise:						
We are compassionate and inclusive	7.68	7.28	7.60	7.29	7.64	7.31
We are recognised and rewarded	6.34	5.87	6.26	5.92	6.34	5.94
We each have a voice that counts	6.96	6.60	6.86	6.67	6.93	6.70
We are safe and healthy	6.39	6.07	6.31	6.13	6.27	6.11
We are always learning	5.86	5.57	5.70	5.64	5.75	5.62
We work flexibly	6.65	6.22	6.51	6.24	6.46	6.20
We are a team	7.13	6.75	7.04	6.75	7.11	6.75
Staff engagement	7.07	6.74	7.00	6.84	7.05	6.91
Morale	6.19	5.84	6.07	5.93	6.07	5.90

The Trust has scored higher than the average scores in its benchmarked group in each of the People Promises and Themes.

Areas to Celebrate

- Scores on all three sub-themes of Staff Engagement have improved, with the most notable increase in the sub-theme of Advocacy (including staff recommending the Trust as a place to work and to receive treatment).
- The Trust achieved the best score in its benchmark group for People Promise 2: “We are recognised and rewarded”.
- Feedback about teamworking and line management remain well above the benchmark average with the Trust achieving the best scores in its benchmark group on a number of indicators.

Key Areas for Improvement

- Systemic workforce resilience: staff feedback highlights concerns about the pressure of work and the risk of burnout. Work is underway to widen the roll-out of workplace stress risk assessments to identify improvements that can be made at a local level to mitigate these risks around service demands.
- Safe working environment: compared with benchmark Trusts, Harrogate and District NHS Foundation Trust scores favourably on staff reporting experiencing violence and aggression in the workplace although 7.96% of respondents reported experiencing physical violence from patients / service-users / relative / public. This sits alongside a rise in the number of incidents being reported around violence and aggression. Work will continue to equip staff to manage such incidents and to develop additional SOPs to handle specific types of incidents.
- Inclusive workplace: again, the Trust compares favourably with benchmark Trusts for staff saying they experienced bullying or harassment. However, a greater proportion of those saying they had experienced bullying or harassment selected “...on grounds of...” disability / long-term condition or age compared with benchmarked Trusts. Work will continue to improve the experience of staff with protected characteristics.

5.10 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 2025-2026 or 2024-2025.

5.11 Consultancy Expenditure

The Trust is required to report on Consultancy expenditure, which in 2025-2026 equated to £363k and in 2024-2025 equated to £197k.

5.12 Exit Package, Subject to audit

	Foundation Trust & Group		Foundation Trust & Group	
Exit cost band	2025-2026 Number of compulsory redundancies	2025-2026 Number of other departures agreed	2024-2025 Number of compulsory redundancies	2024-2025 Number of other departures agreed
<£10,000	-	-	-	2
£10,001 - £25,000	1	-	-	2
£25,001 - £50,000	-	-	-	-
£50,001 - £100,000	-	-	-	1
£100,001 - £150,000	-	-	-	-
£150,001 - £200,000	-	-	-	-
>£200,000	-	-	-	-
Total number of exits by type	**-**	**-**	**-**	**5**
Total resource cost	**£12,000**	**£0**	**£0**	**£89,000**

Section Six
NHS Foundation Code of Governance

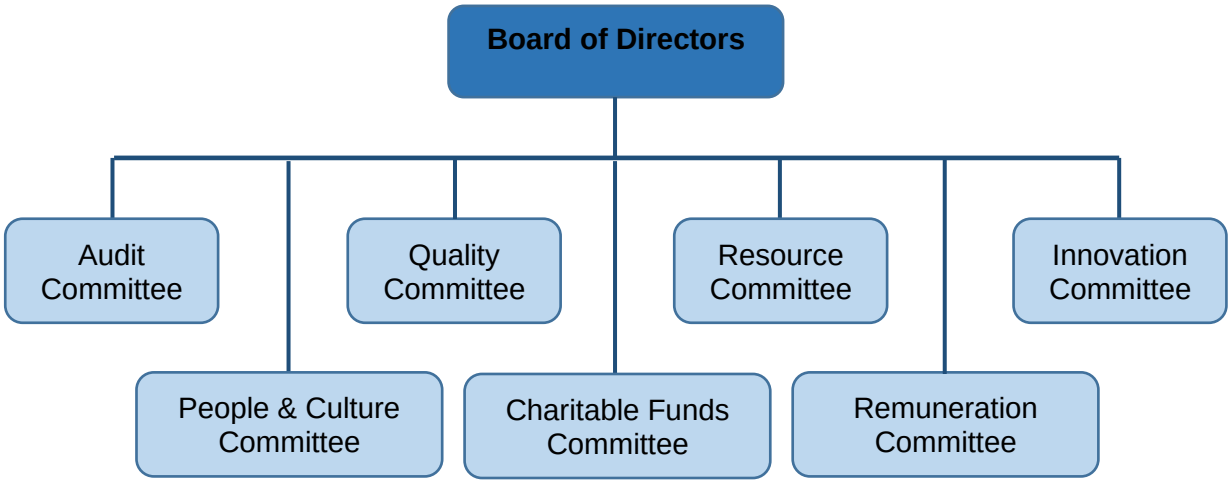
6. NHS Foundation Trust Code of Governance

6.1 Overview

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

The Executive, and Non-executive Directors and Associate 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.

The Board can delegate and manage arrangements to exercise any of its functions through a committee, sub-committee or other group, such as a task and finish group. During 2025-2026 there were seven Committees of the Board



The Board approves the terms of reference which detail the remit and delegated authority of each committee. Committees routinely provide verbal updates to the Board showing how they are fulfilling their duties as required by the Board and highlighting any key issues and achievements.

6.2 Attendance at Board Sub-Committees 2025-2026

The table below summarises Committee Members' attendance at their respective Committees for 2025-2026.

Committee Members		Audit Committee	Quality Committee	Resource Committee	Innovation Committee	People & Culture Committee	Charitable Funds Committee	Remuneration Committee
Sarah Armstrong	Chair	1/7	1/6	7/8	6/6		4/4	2/2
Denise Chong	Interim Non-executive Director		5/6	2/8	1/6	5/6	2/4	2/2
Jeremy Cross	Non-executive Director	7/7		6/8				1/2
Chiara De Biase	Non-executive Director	7/7		5/8	4/6		1/4	1/2
Colin Melville	Non-executive Director		3/6[2]	1/8[2]	3/6[2]			1/2[2]
Andrew Papworth	Non-executive Director and Vice Chair			7/8		6/6		2/2
Laura Robson	Non-executive Director and Senior Independent Director	6/7	6/6	1/8		6/6		2/2
Wallace Sampson OBE	Non-executive Director			1/8	5/6		1/4	2/2
Julia Weldon	Non-executive Director		4/6			3/6		1/2
Azlina Bulmer	Associate Non-executive Director			1/8[4]		1/6[4]		
Jonathan Coulter	Chief Executive Officer	3/7[1]		6/8[1]				2/2[1]
Jacqueline Andrews	Executive Medical Director		5/6	1/8	5/6			
Breeda Columb	Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs)		6/6			6/6		
Matthew Graham	Director of Strategy & Transformation			8/8	6/6		4/4	
Jordan McKie	Director of Finance	7/7		8/8			3/4	
Russell Nightingale	Chief Operating Officer (and Deputy Chief Executive)			8/8			3/4	
Alison Smith	Interim Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs)		1/6[3]			1/6[3]		
Angela Wilkinson	Director of People and Culture			7/8		5/6		2/2

[1] Not a formal member of the Committee but attend to observe / participate as required.
[2] In post from September 2025.
[3] Interim post until May 2025.
[4] In post until 31st August 2025.

6.3 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 2025-2026 financial year.

Work Performance

The Audit Committee has a membership of three Non-executive Directors and during 2025-2026 this comprised of:

- Chiara De Biase — Non-executive Director (Chair)
- Jeremy Cross — Non-executive Director / Chair of Resources Committee
- Laura Robson — Non-executive Director / Senior Independent Director / Chair of Quality Committee

The Committee is supported by:

- Jordan McKie — Director of Finance
- Kate Southgate — Associate Director of Quality and Corporate Affairs

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 also support the meetings as and when required.

The Audit Committee met formally on seven occasions during 2025-2026. Committee members' attendance is set out in the table below:

Committee Member	Number of business meetings attended	2025						2026
		23 April	7 May	19 June	3 September	17 October	2 December	4 March
Chiara De Biase	7/7	✓	✓	✓	✓	✓	✓	✓
Jeremy Cross	7/7	✓	✓	✓	✓	✓	✓	✓
Laura Robson	6/7	✓	✓	✓	✓	-	✓	✓

Audit Committee members meet in private prior to the start of each Committee meeting. Additionally, 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. 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.

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 on the 17th June 2026 prior to submission to the Board on 24th June 2026.

The Chief Executive (or another designated Executive Director) attends the Audit Committee annually at the year-end to provide 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 regular attendance of the Associate Director of Quality and Corporate Affairs. As required, the Executive Medical Director and the Executive Director of Nursing, Midwifery and AHPs attend the Committee when in receipt of limited assurance audits within their portfolios and on an ad hoc basis. 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 Director of Finance sits on the Audit Yorkshire Board which oversees Audit Yorkshire at a strategic level. An Internal Audit Charter formally defines the purpose, authority and responsibility of internal audit activity.

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

A system whereby all Internal Audit recommendations and actions are followed up by Executive Directors is overseen by the Audit Committee. In addition, Internal Audit Reports are circulated to the relevant Board Sub-Committee which has responsibility for the area of work, for further assurance and oversight.

External Audit

Following a robust procurement exercise, led by Governors, the Trust appointed a new External Audit partner in 2021-2022, Azets Audit Services. They remained the Trust external auditors in 2022-2023, 2023-2024, 2024-2025 and 2025-2026.

6.4 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 Executive Directors and Board Sub-Committees. The Trust's Scheme of Delegation provides details of the matters for delegation. This was reviewed and updated in year. A copy of the Scheme of Delegation is available through the Trust website and on request through the Company Secretary's Office.

The Board's 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 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 met in public on a bi-monthly basis during 2025-2026 and in closed workshops on the intervening months. Details of Board attendance can be found later in the Annual Report.

Formal meetings with the Council of Governors take place 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 Chair, Chief Executive, Associate Director of Quality and Corporate Affairs, Company Secretary and Corporate Governance Officer 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. Additionally, informal meetings are also held on a regular basis (normally bi-monthly).

6.5 Balance, Completeness and Appropriateness of the Board of Directors ----------

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

Decision making and operational management of the Trust is led by the Executive Directors reporting to the Chief Executive as Accountable Officer. The Standing Orders of the Board detail the decisions reserved for Board and are available through pages on the Trust website and on request from the Company Secretary's Office.

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.

6.6 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.

Breeda Columb, Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs) (Appointed 23 June 2025)

An experienced nurse and clinical leader Breeda completed her RN training in Essex. A Coronary Care nurse by background she has however worked in a variety of specialities in her nursing career, including medical, elderly, surgical and Emergency Medicine. She has worked in several Trusts in England and also has international healthcare experience working for two years in California in a senior nurse management position.

Breeda joined Harrogate and District NHS Foundation Trust in June 2025 from Leeds Teaching Hospitals where she was Deputy Chief Nurse for over two years, working as a Director of Nursing prior to this alongside other senior management roles at Leeds.

She holds a BSc in Specialist Nursing Practice, a Post Graduate Diploma in Management and a Master's Degree. She also holds the Nye Bevan Award in Executive Healthcare Management. She is currently undertaking the national CNO Safer Staffing Fellowship.
Breeda is passionate about nursing, midwifery and allied health professionals, the impact these professions have on the outcomes for patients and the development of people to deliver outstanding services.

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.

Russell Nightingale, Chief Operating Officer (Appointed 5 April 2021) Deputy Chief Executive (Appointed 1 April 2025)

Russell commenced his professional journey within the private sector, subsequently transitioning into the NHS. His initial roles 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 across a range of organisations in London, including Bart's Health, Whittington Health and latterly North Middlesex Trust NHS Trust.

Now Chief Operating Officer and Deputy Chief Executive at HDFT in Yorkshire, where he has also assumed the role of Senior Responsible Officer for elective recovery across the West Yorkshire Association of Acute Trusts. Russell's professional ethos is characterised by an unwavering commitment to continuous improvement and fostering collaborative leadership based on radical candour.

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 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 Director of Finance in February 2022. He began his NHS career as a Graduate Management Trainee in 2006 and gained extensive knowledge of the NHS in both financial and operational roles in York and Leeds. He started in Harrogate as Deputy Director of Finance in 2014 and has worked in various roles in the Trust before being appointed substantively as Director of Finance in July 2023.

Jordan is a member of the Chartered Institute of Management Accountants, having qualified as an Accountant in 2009.

In addition, Jordan is also Chair of Audit Yorkshire who provide internal audit services to numerous organisations across Yorkshire.

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 and delivery of HDFTs People Plan.

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

6.7 Non-executive Directors and Associate Non-executive Directors

Non-executive Directors are appointed initially for a term of three years in office. They can be re-appointed for up to three terms (i.e. 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.

In 2025, the Trust Board was temporarily depleted owing to ill health and personal circumstances. Under the exceptional circumstances, the Council of Governors' Remuneration, Nomination and Conduct Committee approved the appointment of an interim Non-Executive Director for a fixed term 6-month term whilst a replacement Non-executive Director was recruited. This was subsequently extended to a full year's term to ensure Board continuity.

The table below sets out 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	31 March 2028	-
Jeremy Cross**	Non-executive Director	1 January 2020	31 December 2022	31 December 2025	31 December 2028
Chiara De Biase	Non-executive Director	3 October 2022	2 October 2025	2 October 2028	-
Andrew Papworth**	Non-executive Director / Vice Chair	1 March 2020	29 February 2023	28 February 2026	28 February 2029
Laura Robson**	Non-executive Director / Senior Independent Director	1 September 2017	31 August 2020	31 August 2023	31 August 2026
Wallace Sampson OBE**	Non-executive Director	1 March 2020	29 February 2023	28 February 2026	28 February 2029
Julia Weldon	Non-executive Director	7 November 2022	6 November 2025	6 November 2028	-
Colin Melville	Non-executive Director	22 September 2025	21 September 2028	-	-
Denise Chong***	Interim Non-executive Director	23 March 2025	Fixed term for 12 months	-	-
Azlina Bulmer	Associate Non-executive Director	10 October 2022	31 August 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.
** final three year term is approved on a yearly basis

** In line with best practice, appointments in final terms are reviewed annually by the Council of Governors' Remuneration, Nomination and Conduct Committee for confirmation of independence.
*** Fixed term twelve-month contract

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 Health Services, Equity and Improvement 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. Until March 2025, she was also a clinical Trustee for Candlelighters; a Yorkshire based children's cancer charity.

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

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

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

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

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

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

Jeremy Cross is a fellow of the 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 he 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.

Since stepping back from his local authority CEO role, Wallace has developed a portfolio of responsibilities. In addition to being a HDFT Non-executive Director, Wallace is a Commissioner with the Local Government Boundary Commission for England, is a member of the Public Sector Advisory Group for a local authority owned company, is a Lay Member of Council at Leeds University and chaired the Independent Improvement Advisory Board for Middlesbrough Council between September 2023 and March 2025.

Wallace is the Chair of the Innovation Committee.

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 Chief Finance Officer at Insight222 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 Director of Public Health at Hull City Council since moving into local government in November 2013. She has been Deputy Chief Executive for the last four years. She was one of the first Directors of Public Health to become Deputy Chief Executive in England. Julia became a Non-executive Director for HDFT in November 2022.

Julia's background is in the NHS, starting her career in nursing in 1984. She worked in acute hospitals, primary care and later as a specialist respiratory nurse and senior NHS manager where she gained support to do the further study in public health that led to her to a successful career in public health.

Julia is passionate about social justice, is experienced in personal and organisational development and enjoys being a coach, mentor and United Kingdom Public Health Register (UKPHR) assessor.

Julia has held several regional roles including chair of the Yorkshire and Humber Association of Directors of Public Health (YHADPH) during the pandemic response, an assessor for the UKPHR, and regional advisor for the Faculty of Public Health.

Julia was elected by her national peers to be a member of the UK Association of Directors of Public Health (ADPH) Board in 2023.

Professor Colin Melville, Non-executive Director (Appointed September 2025)

Professor Colin Melville is a strategic healthcare leader, educator, and former senior clinician with 20+ years' experience shaping policy, governance, medical education and medical regulation for the NHS and internationally.
Colin has held senior clinical leadership roles including Clinical Director, Medical Director, Director of Medical Education and Foundation School Director. He went on to senior academic leadership positions at HYMS, Warwick and Lancaster medical schools before joining the GMC as Medical Director and Director of Education and Standards in 2017.

In the eight years of this executive role, he led significant regulatory developments including the education and ethics response to the COVID pandemic, the development and implementation of the Medical Licensing Assessment (UK MLA), and the revision and updating of the key professional and education standards.

He has non executive experience with GMCSI (GMC services international) and as a Trustee for the Faculty of Medical Leadership and Management.
He was involved in the establishment of the NHS Clinical Entrepreneurs Programme and remains an active part of the programme. He also provides mentoring and coaching to early career doctors and other professionals to support and encourage the next generation of potential medical leaders. He continues to maintain a portfolio of educational research, co-authoring papers and chairing steering committees for NIHR funded research programmes.

Denise Chong, Interim Non-executive Director (Appointed 23 March 2025, fixed term for 12 months)

Denise is a seasoned executive with over 25 years of Human Resources experience in international, highly regulated organisations within the pharmaceutical, chemical, technology, and public sectors. Denise has lived and worked in five countries and is culturally astute. She is passionate about the importance of employee engagement and leadership development.

Denise also works as a consultant, facilitator, and coach and is a Fellow of the Chartered Institute of Personnel and Development (CIPD).

Having held previous positions as a Trustee in both the academic and charitable sectors, Denise is also currently a Trustee at the Community Learning Partnerships (CLP) and is a member at the Kaleidoscope Learning Trust (KLT) a multi-academy Trust.

Most recently Denise successfully completed the Insight Programme developed by Gatenby Sanderson for prospective Non-executive Directors which entailed working as a Non-executive Director on the Board of Harrogate and District NHS Foundation Trust to develop a deeper understanding of the NHS.

In her spare time, Denise enjoys living in North Yorkshire and spending time with family and friends, as well as travelling and walking.

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

Azlina Bulmer is currently the Managing Director at the Institute of the Motor Industry. Previously she held the position of Executive Director of Membership & Engagement at the Chartered Insurance Institute (CII) where she had oversight of CII's membership activities and engagement programmes, including responsibility for the day to day international operations.

Prior to the CII, she was 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.

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, and a Board member of the Personal Finance Society. Azlina served as an Associate non-Executive Director until she stepped down from the role in August 2025.

6.8 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 2025-2026. When the Board of Directors met in public there was also a private meeting.

6.9 Board of Directors (Trust Board) Attendance 2025-2026

	Number of business meetings attended	28 May 2025	Extra Ordinary Board 25 June 2025	30 July 2025	Extra Ordinary Board 27 August 2025	24 September 2025	Extra Ordinary Board 22 October 2025	26 November 2025	Extra Ordinary Board 17 December 2025	Extra Ordinary Board 14 January 2026	28 January 2026	Extra Ordinary Board 11 February 2026	25 March 2026
Sarah Armstrong	**12/12**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jeremy Cross	**8/12**	-	-	✓	-	-	✓	✓	✓	✓	✓	✓	✓
Denise Chong	**11/12**	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓
Chiara De Biase	**7/12**	-	✓	✓	✓	-	-	✓	✓	✓	-	✓	-
Andrew Papworth	**12/12**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Laura Robson	**12/12**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Wallace Sampson OBE	**8/12**	✓	-	✓	✓	✓	-	✓	-	✓	✓	✓	-
Julia Weldon	**8/12**	-	-	✓	✓	✓	✓	✓	-	✓	-	✓	✓
Colin Melville	**6/8**	-	-	-	-	✓	✓	-	✓	-	✓	✓	✓
Azlina Bulmer	**1/4**	-	-	-	✓	-	-	-	-	-	-	-	-
Jonathan Coulter	**11/12**	✓	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓

Jacqueline Andrews	**11/12**	✓	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓
Matthew Graham	**11/12**	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓
Jordan McKie	**12/12**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Russell Nightingale	**11/12**	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓
Alison Smith	**1/1**	✓	-	-	-	-	-	-	-	-	-	-	-
Breeda Columb	**11/12 (in attendance May)**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Angela Wilkinson	**10/12**	-	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	✓

6.10 Council of Governors Overview

An integral part of the Trust is the Council of Governors who bring the views and interests of the public, patients, staff colleagues and other stakeholders into the heart of governance framework.

This group of committed individuals supports opportunities for public views to be taken into account in service development and redesign to help improve the quality of services and care.

The Council of Governors is chaired by the Chair of the Trust, who ensures a link between the Council and the Board of Directors.

Governors do not undertake operational management of the Trust – they seek assurance from the Board. The overriding responsibility of the Council is to hold the Non-executive Directors individually and collectively to account for the performance of the Board of Directors, and to represent the interests of the members of the Trust and the wider public

The statutory responsibilities of the Council include:

- Holding the Non-executive directors individually and collectively to account for the performance of the Board of Directors.
- Appointment or removal of the Chair and other Non-executive Directors.
- Approving the appointment (by Non-executive Directors) of the Chief Executive.
- Deciding the remuneration, allowances and other terms and conditions of office of Non-executive Directors.
- Appointment or removal of the Foundation Trust's external financial auditor.
- Reviewing and developing the Trust's membership strategy.
- Approving significant transactions, mergers, acquisitions, separation or dissolution.
- Considering if the Trust's non-NHS work would significantly interfere with its principal purpose.
- Approving amendments to the Trust's constitution.
- Receiving the Trust's Annual Report and Accounts, and the report of the auditor on them.
- Representing the interests of the members of the Trust as a whole and the interests of the wider public.
- To be consulted on and provide views on the Trust's annual plan and determining strategic direction.
- Consideration of their duties in the context of the Trust working effectively with the wider ICB system.

Should a dispute arise between the Board and the Council of Governors, there is a formal procedure in place. During 2025-2026, no issues of dispute arose and governors did not exercise their power under paragraph 10(c) of schedule 7, NHS Act 2006

The Governors represent different categories of members:

- Public Governors are elected by members of the Trust living within specific constituencies.
- Staff Governors are elected by members of staff who work within the same staff class.
- Stakeholder Governors represent the views of the organisations with whom the Trust works closely.

During 2025-2026 there were no changes to the composition of seats within the Council of Governors, as detailed in the Trust's constitution. The following table shows the composition of seats within the Council of Governors.

Type of Governor	Constituency / Class	Number of Governors
Public (elected)	Harrogate & Surrounding Villages	5
	Ripon & West District	2
	Knaresborough & East District	2
	Wetherby, Harewood, Alwoodley, Adel, Wharfedale, Otley and Yeadon	2
	Rest of North Yorkshire & York	1
	Rest of England	1
Staff (elected)	Medical Practitioners	1
	Nursing, Midwifery & Allied Health Professionals	1
	0-19 Services	1
	Community Services	1
	Other Clinical Staff	1
	Non-Clinical Staff	1
Stakeholder (appointed)	Patient Experience	1
	Local Authority	2
	Further Education	1
	Voluntary Sector	1
	Harrogate Healthcare Facilities Management Ltd	1

Both elected and appointed (stakeholder) governors normally hold office for a term of three years and are eligible for re-election or reappointment at the end of that period. Elected governors can stand to be elected for a maximum of three terms of office, holding a seat for up to nine years. The governors holding office as at 31 March 2026 are:

Last name	First name	Constituency/ Organisation	Date of initial appointment
Elected Public Governors			
Carter	Rachel	Ripon & West District	July 2023
Farrar	Richard	Harrogate & Surrounding Villages	July 2025
Fisher	Mike	Harrogate & Surrounding Villages	January 2025
Hindle	John	Ripon & West District	September 2024 *
Hopps	Nigel	Wetherby, Harewood, Alwoodley, Adel, Wharfedale, Otley and Yeadon	July 2025
Lincoln	Jackie	Knaresborough & East District	July 2022
Owen-Hughes	Richard	Knaresborough & East District	January 2022
Parry	Kevin	Harrogate & Surrounding Villages	July 2023
Raspin	Dawn	Harrogate & Surrounding Villages	January 2025
Sweeney	Richard	Harrogate & Surrounding Villages	July 2022

Elected Staff Governors			
Allen	Jonathan	Community Services	July 2024
Hutchinson	Mark	0-19 Services	July 2024
Legge	Emily	Other Clinical	July 2024
Mehar	Binish	Medical Practitioners	October 2023
Williams	Steve	Nursing, Midwifery & AHPs	October 2023
Stakeholder (appointed) Governors			
Brown	Nick	North Yorkshire Council	May 2023
Haynes	David	Harrogate Healthcare Facilities Management Ltd	November 2024
Cunningham	Alan	Healthwatch North Yorkshire	September 2025

*Reduced term of 2 years 10 months in order to bring all election dates in line

6.11 Council of Governors' Elections 2025-2026

There was one member election campaign for the Council of Governors held during 2025-2026. The election was required due to there being several vacant seats on the Council caused by:

- Governors stepping down early
- Governors reaching their end of term of office
- Seats that had not been successfully filled in previous elections

The "Summer 2025" elections had terms of office commencing on 1 July 2025. The results were:

Constituency / Seat	Candidate	Election Outcome
Public Elections		
Harrogate & Surrounding Villages	Richard Sweeney	Elected (re-elected)
Harrogate & Surrounding Villages	Richard Farrar	Elected
Wetherby, Harewood, Alwoodley, Adel, Wharfedale, Otley and Yeadon	Nigel Hopps	Elected
Rest of England	Vacancy remains	No nominations received
Knaresborough & East District	Jackie Lincoln	Elected unopposed
Staff Elections		
Non-Clinical Staff	Ian Hardcastle	Elected unopposed*

* Candidate withdrew upon election

The Trust would like to thank all outgoing Governors for their hard work and commitment to the Trust and welcome the new Governors that have been elected or nominated during 2025-2026.

The role of Deputy Lead Governor became vacant in Summer 2025 following the election. The Council of Governors determined the process for electing a new Deputy Lead Governor from

existing members of the Council. In January 2026 a process commenced where Expressions of Interest were requested, however none were received and the position of Deputy Lead Governor remained unelected.

6.12 Council of Governors' Attendance 2025-2026

The Council of Governors meets approximately quarterly and held four meetings in 2025-2026 as well as the Annual Members' Meeting. Executive and Non-executive Directors of the Trust Board are invited to attend to enable further interaction and assurance.

	Governor Category	Number of business meetings attended	17 June 2025	02 September 2025	10 December 2025	4 March 2026	Annual Members' Meeting 22 September 2025
Sarah Armstrong	Chair	4/5	✓	✓	✓	-	✓
Andy Papworth	Vice-Chair	5/5	✓	✓	✓	✓	✓
Elected Public Governors							
Rachel Carter	Public	5/5	✓	✓	✓	✓	✓
Andrew Clark***	Public	1/2	-	✓	-	-	-
Mike Dunn *	Public	1/1	✓	-	-	-	-
Mike Fisher	Public	5/5	✓	✓	✓	✓	✓
John Hindle	Public	3/5	-	-	✓	✓	✓
Jackie Lincoln **	Public	5/5	✓	✓	✓	✓	✓
Richard Owen-Hughes	Public	5/5	✓	✓	✓	✓	✓
Kevin Parry	Public	5/5	✓	✓	✓	✓	✓
Dawn Raspin	Public	4/5	-	✓	✓	✓	✓
Rick Sweeney	Public	4/5	-	✓	✓	✓	✓
Nigel Hopps	Public	1/4	-	-	✓	-	-
Richard Farrar	Public	2/4	-	-	✓	✓	-
Elected Staff Governors							
Jonathan Allen	Staff	0/5	-	-	-	-	-
Mark Hutchinson	Staff	0/5	-	-	-	-	-
Emily Legge	Staff	0/5	-	-	-	-	-
Binish Mehar	Staff	0/5	-	-	-	-	-
Stephen Williams	Staff	0/5	-	-	-	-	-
Stakeholder Governors							
Cllr Nick Brown	Stakeholder	5/5	✓	✓	✓	✓	✓
Alan Cunningham	Stakeholder	3/4	✓	✓	✓	-	-
David Haynes	Stakeholder	0/5	-	-	-	-	-

* Deputy Lead Governor
** Deputy Lead Governor (until September 2024), then Lead Governor
*** Resigned September 2025

In addition, regular Informal Governor Briefing sessions provide further opportunities for Governors to engage with the Chair, Non-executive Directors and the Chief Executive. These meetings are held online to give flexibility for those who are unable to attend additional in-person meetings. Governors are able to ask questions, seek assurance and receive briefings on topical subjects. Non-executive directors are able to ensure they understand Governors' views and those of Trust members.

Governors are provided with in-depth briefings and development sessions on topics of strategic or operational interest to enable them to develop their knowledge around the range of information presented to them for assurance purposes and to seek their views on how we can improve aspects of our business. During 2025-2026, these included:

- Briefing on the NHS 10 Year Plan
- Bid process for the 0-19 Services
- Business Development
- Waste Reduction and Productivity initiatives
- Model Hospital
- Strategic Planning

Governors play an active role in assuring the quality of services provided by the Trust through regular walk-around visits to clinical and non-clinical areas. During these visits, Governors meet staff, patients and carers to gain first-hand insight into the care being delivered, the experiences of those who use our services, and the working environment for our teams. These visits provide an important opportunity for Governors to observe practice, seek assurance on patient safety and quality, and listen to feedback from frontline staff.

Governors also have an open invitation to observe the Trust's Board meetings held in public which enables them to observe the Non-executive and the papers are circulated to them as well as being available on the Trust's website: https://www.hdft.nhs.uk/about/board-meeting

Council of Governors' Remuneration, Nomination and Conduct Committee

A separate Remuneration, Nomination and Conduct Committee exists for the nomination, appointment and remuneration of the chair, vice-chair and non-executive directors. This is a committee of the Council of Governors and its membership comprises the Chair, the Lead Governor and five elected (public and staff) governors.

During 2025, RNCC was not quorate. Laura Robson's appointment as a Non-executive Director was reviewed at Council and it was considered that she remained independent. It was agreed by the Council of Governors that her appointment should be extended for a final third year in her three-year term. It was also approved for Non-Executive Directors Jeremy Cross, Andy Papworth and Wallace Sampson to be extended for the first year of their final three-year terms.

6.13 Council of Governors' Conduct and Interests

All Governors are required to sign a Code of Conduct both on appointment and annually thereafter which includes acceptance of the standards of behaviours in public life, particularly the Nolan Principles of:

- Selflessness
- Integrity
- Objectivity
- Accountability

- Openness
- Honesty
- Leadership

In addition, they are asked to declare any interests and conflicts of interest that are relevant to their role both on appointment and as they subsequently arise during their term of office. Finally, Governors are asked to confirm they meet the fit and proper person conditions as set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The register of Governors' interests is received at each Council of Governors' meeting and is available through public papers, pages on the Trust website (https://www.hdft.nhs.uk/) or by contacting:

The Company Secretary
Corporate Affairs Office
Harrogate & District NHS Foundation Trust
Trust Headquarters
Harrogate District Hospital
Lancaster Park Road
Harrogate HG2 7SX
hdft.nhsfoundationTrust@nhs.net

Governors may also be contacted by using the same contact information.

6.14 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 by 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 which was reviewed and ratified by the Board of Directors in 2026.

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

6.15 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;
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern;
- 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;

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
DATE 25th June 2026

Section Seven
Annual Governance Statement

7. Annual Governance Statement

Annual Governance Statement 2025-26

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 2026 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

Risk Leadership

The Board of Directors has the overall responsibility for risk management within the Trust and 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, Quality, Resources, People and Culture, Innovation and Remuneration 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 Executive Director of Nursing, Midwifery and AHPs for the implementation of quality governance and risk management.

The Board has a number of overarching principles and procedures related to governance that are 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 patient safety events is aligned to the values and behaviours set out in our Strategy and through our KITE (Kindness, Integrity, Teamwork, Equality) 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.

Employees, contractors and agency staff are required to report all safety events 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 including the revised Fit and Proper Person's test. Assurance on these areas is through the Trust's corporate governance framework.

The Datix system supports our safety event reporting process. Guidance on reporting events on Datix, grading of events, risk assessment, risk registers, undertaking investigations and statement writing, is available for all staff on the Trust intranet.

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

The Trust's Guardian of Safe Working meets with the Clinical Directors on a regular basis. They report to the People and Culture Committee on a quarterly basis and by exception Board. This report allows the Trust the opportunity to review any emerging themes and to implement mitigating actions where required.

Equality & Quality impact assessments (EQIA) 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.

Risk Training

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

The specific responsibilities of The Board of Directors, Directorates, Care Groups and departmental managers who oversee staff (including those promoted or acting up, contractors, locum, agency and bank staff) are set out in our Risk Management Policy.

An ongoing training programme has been developed based on a training needs analysis. 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 through the Patient Safety Incident Response Framework (PSIRF) and risk assessment for health and safety.

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 outcomes, standards, effectiveness and audit
    - Performance governance

To achieve this, the Trust has an accountability framework which consists of:

- Individual Director's portfolios of responsibility,
- The Constitution, Scheme of Delegation, Standing Orders and Standing Financial Instructions;
- A Corporate Framework which includes details of Terms of Reference and Workplans for Board Committees, and reporting lines between the Board, Sub-Committees of the Board and operational committees / groups, and
- Risk processes and the Trust Risk Appetite as described in the Risk Management Policy and supporting documents.

The Audit Committee and Board of Directors have reviewed assurance on the effective operation of controls to manage potential significant risk via the Corporate Risk Register and the Board Assurance Framework. The 2025-2026 Internal Audit review of risk management provided High Assurance and the review of the Board Assurance Framework also provided High Assurance.

As at 31 March 2026, 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. The corporate risks are reviewed each month by the Executive Risk Review Group and are linked to the Trust Ambitions as well as to the five CQC Domains and the NHSE Use of Resources Framework.

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. Compliance is overseen by:

- Self-assessments against the Key Lines of Enquiry defined within the criteria of the Well-Led Review and preparing the Trust for an external review;
- Liaising with the Care Quality Commission and Clinical Directorates to address specific concerns where required;
- Engaging with the Care Quality Commission on the inspection process, coordinating the Trust's response to inspections and recommendations and actions arising from this;
- Analysing trends from event 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 through meetings of the Quality Governance Management Committee, Patient Safety Event Committee, Quality Committee and the Audit Committee.

During 2025-2026 the Care Quality Commission inspected the core service of Maternity. The Service received a rating of "Good" in all five domains (Safe, Effective, Caring, Responsive and Well-Led) and a rating of "Good" overall. As with all inspections, there were areas noted for improvement and a robust action plan was developed as a result. The improvements continue to be monitored internally and directly to the CQC in our engagement meetings.

During 2025-2026 the Care Quality Commission inspected the Harrogate District Hospital site though the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) programme. One improvement notice was issued which the Trust responded to.

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".

External Review

In year, NHS England launched the new National Oversight Framework (NOF). This is a system designed to assess how NHS Organisations perform in areas such as finance, quality operations and leadership. Each Trust receives an organisational delivery score, based on key performance indicators linked to operations, quality and workforce. A financial review is performed alongside this. Where a Trust is in deficit or in receipt of deficit support, a financial override will apply and the Trust will be limited to a score no greater than 3. The Trust will then be placed in one of five segments. Segment 1 (high performing) to Segment 4 (low performing) With Segment 5 reserved for the most challenged organisations. The Segmentation results were first published in September 2025.

In year the Trust received a delivery score which would have placed us in Segment 2. However, due to the Trust being in deficit, a financial override was applied and the Trust remained in Segment 3 for the duration of 2025-2026.

In addition, in year the Trust completed a Provider Capability Assessment which focused on the six areas of the Insightful Provider Board:

- Strategy, leadership and planning
- Quality of Care
- People and Culture
- Access and delivery of services
- Productivity and Value for Money
- Financial performance and oversight.

Following review by NHS England, the Trust were allocated a capability rating of Amber-Green for 2025-2026. The main driver for this was the financial position.

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. Significant development has occurred with the IBR in 2023-2024 with the development of PowerBI. During 2025-2026 these improvements have been embedded further within the working practices of the Trust, linked directly to our continuous improvement programme HDFT Impact.

The Trust Strategy, identified key metrics (Driver Metrics and Watch Metrics) broken down by our Strategic Ambitions. These are presented to each Board meeting and relevant meeting of Sub Committees through our Board Assurance Framework.

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.

In order to mitigate any risks to compliance with the NHS Provider Licence Condition 4, the Trust has in place a Corporate Governance Framework. This has clear lines of accountability and reporting to: ensure integrated governance, delivery of the Trust's objectives and to provide assurance to the Board of Directors.

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 2025-2026 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 Innovation Committee.

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. We have robust arrangements in place that:

- Set, review and implement strategic and operational objectives on an annual basis;
- 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.

Performance against objectives are monitored and actions identified by:

- Approval of an annual Operation Plan by the Board of Directors and subsequently by the ICB and NHS England.
- Bi-monthly reporting to the Resource Committee and the Board on key performance indicators covering finance, activity and workforce. *NB the Resource Committee increased meetings to monthly from November 2025.*
- Monthly Performance Review Meetings for Directors and the Subsidiary on each areas KPIs.
- The Corporate Framework for monitoring, assurance and delivery through Board and Sub-Committees.
- External reporting to the ICB and NHS England.

The Trust participates in initiatives to deliver Value for Money, for example:

- Fragile service reviews across ICB footprints.
- Collaborative service reviews of corporate services across the ICB footprints.
- Review of Model Hospital data on a regular basis to consider efficiency and effectiveness.
- Internal and External Audit programme.

The Trust has a standard process for the development, review and approval of business cases to ensure oversight of value for money, productivity and benefits realisation.

The Trust follows best practice processes with regards to Counter Fraud and regular updates are provided through the Audit Committee.

Information governance

Information Governance

The UK General Data Protection Regulation (UK GDPR) and the Data Protection Act (DPA) 2018 together provide the legal framework for data protection.

In September 2024 the Data Security and Protection Toolkit (DPST) for a number of organisations was changed to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and information governance assurance.

The CAF-aligned DSPT is an online self-assessment tool for organisations to measure their information governance and cyber security performance against its five *objectives*:

1. Managing risk
2. Protecting against cyber-attack and data breaches
3. Detecting cyber security events
4. Minimising the impact of incidents
5. Using and sharing information appropriately

Each *objective* is broken down into a number of *outcomes* where organisations can assess their compliance with the stated *indicators of good practice.* The results of each outcome determines the organisation's overall level of assurance from the following options:

- Standards Not Met
- Standards Met
- Standards Exceeded

For the 01/07/2024-30/06/2025 submission HDFT achieved: *Standards Met*

An independent audit was undertaken of a sample of 12 outcomes across the five objectives. The possible outcomes were:

Risk rating:

- Very High
- High
- Moderate
- Low
- Very Low

Confidence level:

- Low
- Medium
- High

The overall risk rating given by the independent audit was: *Very Low - All minimum achievement levels have been met and achievement levels have been exceeded for at least one outcome*.

The overall confidence level given by the independent audit was: *High - Low level or no deviation, the organisation's self-assessment against the Toolkit does not differ / deviates only minimally from the Independent Assessment.*

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.

Staffing processes (Nursing, Midwifery and AHPs)

Our staffing governance processes have been developed in line with the National Quality Board (NQB) guidance and recommendations within Developing Workforce Safeguards, (NHSI, 2018). This is to ensure that the Trust deploys sufficient suitably qualified, competent, skilled and experienced staff, that there is a systematic approach to determine staffing levels and that this reflects current legislation and guidance.

Optimal staffing on our wards and departments is critical to providing safe, high quality care to our patients. We keep staffing levels and skill mix under constant review to ensure that each ward area is staffed according to real-time need and with reference to best practice staffing models. The Trust's Nursing and Midwifery Staffing Escalation Policy clearly defines the dynamic systems and processes that function daily to ensure that any shortfalls in staffing are mitigated. These are further supported by senior oversight provided by once daily nurse staffing meetings to consider plans for staffing over the next 24 hours.

The actual and planned staffing levels on all our wards on a shift-by-shift basis are calculated and published on the Trust's website, in line with national guidance. Those wards where staffing capacity and capability fall short of the plan, the reasons for the gap and the impact and actions being taken are documented on SafeCare.

Twice a year each inpatient clinical area assesses the care needs of patients, using an evidence-based tool to help determine the nurse / midwifery staffing required to provide safe, compassionate and effective care. In nursing, the tool used is the Safer Nursing Care Tool (SNCT) and in midwifery it is Birthrate+. Informed further by professional judgement and evaluation of outcome measures, these establishment reviews are reported through the governance process to the Board of Directors.

In 2025-2026 a process to triangulate quality data with staffing compliance was introduced and is reviewed via the Quality Committee to enhance assurance methods. Since its introduction, there have been no significant quality impacts that have resulted from staffing variations.

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 and Senior Management Team 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 annually 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. A formal Corporate Framework is in place throughout the year.

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 oversaw a wide range of audits in year and those completed in the 2025-2026 plan included:

High Assurance
Board Assurance Framework
Risk Management Framework and Strategy
Patient Safety Incident Response Framework

Significant Assurance
NICE Guidance – Transition from Child to Adult Services
Controlled Documentation
National Cost Collection
Outpatient Clinic Utilisation
Cost Improvement Plans / Waste Reduction
Backlog Maintenance

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 2026 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 remain with the NHS , and the Trust has an internal control environment in place to manage these 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
DATE 25th June 2026

Section Eight
Independent Auditors Report

8. Independent Auditors Statement

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

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of Harrogate and District NHS Foundation Trust (the 'Trust') and its subsidiaries (the 'Group') for the year ended 31 March 2026, which comprise the Consolidated Statement of Comprehensive Income, the Consolidated Statement of Financial Position, the Consolidated Statement of Changes in Taxpayers Equity, the Consolidated Statement of Cash Flows, the Foundation Trust Statement of Comprehensive Income, the Foundation Trust Statement of Financial Position, the Foundation Trust Statement of Changes in Taxpayers' Equity, the Foundation Trust Statement of Cash Flows and notes to the financial statements, including accounting policies and other information. 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 2025 to 2026.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Group and of the Trust as at 31 March 2026 and of the Group's and Trust's 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 2025 to 2026; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), applicable law and Practice Note 10 'Audit of Financial Statements and Regularity of Public Sector Bodies in the United Kingdom', as required by the Code of Audit Practice ("the Code of Audit Practice") approved by the Comptroller and Auditor General. 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 Group and 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 Group's and the Trust's ability to continue as a going concern for a period of at least twelve months from the date 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.

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 2025/26; 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 2025/26 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 (set out on page 104), 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, 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 and Group'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 and the Group 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 2025 to 2026.

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 it is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

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

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. 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 the ISA's (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 and Group, their activities, control environment, and likely future developments, including in relation to the legal and regulatory framework applicable and how the Group and Trust are complying with that framework. We determined that the most significant legal and regulatory frameworks that are applicable to the Trust and Group, 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 2025 to

2026.

Based on this understanding, we identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. This includes consideration of the risk of acts by the Group or 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 Group and 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 Group and Trust's financial statements and the operations of the Group and 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, including evaluating the rationale of any significant transactions outside the normal course of business and reviewing key accounting estimates including property plant and equipment valuations for indicators of potential bias;
- Other audit procedures responsive to the risk of fraud, non-compliance with laws and regulation or irregularity include testing the accuracy and occurrence of non block contract income, the existence of receivables, assessing the completeness of non-pay expenditure; review of accounting for the in year asset transfer; and
- 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 and engaged audit specialists to support our work on IT general controls.

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 2026.

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 Schedule 10(1)(d) 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 November 2024. 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 which will be included 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.

Delayed certificate

We cannot formally conclude the audit and issue an audit certificate for Harrogate and District NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of the National Health Service Act 2006 and the Code of Audit Practice (the "Code") until we have completed all our responsibilities mandated by the Code.

We have completed our Consolidated NHS Provider Accounts (CPA) group audit work for the year ended 31 March 2026, as mandated under the Part 1 of the National Audit Office's group instructions, but confirmation had not been received from the NAO that the Department of Health and Social Care (DHSC) Group Accounts audit for 2025-26 has been certified by the Comptroller and Auditor General.

We are satisfied that this work does not have a material effect on the financial statements, or on our conclusion on the Trust's arrangements for securing economy, efficiency, and effectiveness in its use of resources for the year ended 31 March 2026.

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.

Andrew Reid

Andrew Reid, Key Audit Partner
for and on behalf of Azets Audit Services, Local Auditor Birmingham

25 June 2026

Section Nine
Annual Accounts
2025-26

9. Harrogate and District NHS Foundation Trust – Annual Accounts 2025-2026

Foreword to the Accounts

These accounts are prepared in accordance with paragraphs 25 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
DATE 25th June 2026

Contents **Page**

CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2026

	Note	Group 2025/26 Total £000	Group 2024/25 Total £000
Operating income from patient care activities	3.1	**384,817**	372,712
Other operating income	3.2	**33,638**	29,161
Operating expenses	4.1	**(445,713)**	(399,823)
OPERATING SURPLUS/(DEFICIT) FROM CONTINUING OPERATIONS		**(27,258)**	2,050
FINANCE COSTS			
Finance income	6.1	**2,652**	2,253
Finance expense - financial liabilities	7	**(498)**	(339)
Finance expense - unwinding of discount on provisions	17.2	**(2)**	(3)
Public Dividend Capital - dividends payable		**(5,477)**	(4,545)
NET FINANCE COSTS		**(3,325)**	(2,634)
Losses on disposal of assets	9.1	**-**	12
Movement in fair value of investments	11	**112**	61
Share of profit of joint venture		**160**	-
SURPLUS/(DEFICIT) FOR THE YEAR		**(30,311)**	(511)
Other comprehensive income			
Impairments	9.1	**-**	(4,765)
Revaluations	9.3	**3,853**	-
Other reserve movements		**(1,330)**	(558)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**(27,788)**	(5,834)

The notes on pages 135 to 172 form part of these financial statements.

CONSOLIDATED STATEMENT OF FINANCIAL POSITION
31 March 2026

		Group	
		31 March 2026	31 March 2025
	Note	**£000**	£000
Non-current assets			
Intangible assets	8	**18,941**	12,856
Property, plant and equipment	9.1 & 9.3	**194,430**	163,703
Right of use assets	10.1	**6,267**	7,473
Investments in joint ventures and associates		**160**	
Other Investments	11	**1,938**	1,860
Trade and other receivables	14.1	**927**	837
Total non-current assets		**222,663**	186,729
Current assets			
Inventories	13.1	**3,766**	4,528
Trade and other receivables	14.1	**37,648**	32,086
Cash and cash equivalents	15	**7,489**	8,811
Total current assets		**48,903**	45,425
Current liabilities			
Trade and other payables	16	**(51,133)**	(37,013)
Borrowings	19	**(2,476)**	(3,266)
Provisions	17.1	**(96)**	(96)
Other liabilities	18	**(209)**	(1,934)
Total current liabilities		**(53,914)**	(42,309)
Total assets less current liabilities		**217,652**	189,845
Non-current liabilities			
Borrowings	19	**(10,638)**	(11,847)
Provisions	17.1	**(459)**	(552)
Total non-current liabilities		**(11,097)**	(12,399)
Total assets employed		**206,554**	177,446
Financed by taxpayers' equity:			
Public Dividend Capital		**213,636**	156,740
Revaluation reserve		**13,020**	6,512
Income and expenditure reserve		**(23,048)**	11,792
HDFT charitable fund reserves	26	**2,946**	2,402
Total taxpayers' equity (see page 8)		**206,554**	177,446

The notes on pages 135 to 172 form part of these financial statements.

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

Date: 25 June 2026

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2026

	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 2025	2,402	156,740	6,512	11,792	177,446
Surplus for the financial year (Page 6)	532	-	-	(30,843)	(30,311)
Net impairments (Note 9.1)	-	-	-	-	-
Revaluations	-	-	3,853	-	3,853
Public Dividend Capital received	-	56,896	-	-	56,896
Public dividend capital repaid	-	-	-	-	-
Other reserve movements	37	-	2,655	(4,022)	(1,330)
Other reserve movements - charitable funds consolidation adjustment	(25)	-	-	25	-
Balance at 31 March 2026	2,946	213,636	13,020	(23,048)	206,554

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2025

	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 2024	2,219	130,515	11,278	13,043	157,055
Surplus for the financial year (Page 6)	220	-	-	(731)	(511)
Net impairments (Note 9.1)	-	-	(4,765)	-	(4,765)
Public Dividend Capital received	-	26,225	-	-	26,225
Public dividend capital repaid	-	-	-	-	-
Other reserve movements	-	-	(1)	(557)	(558)
Other reserve movements - charitable funds consolidation adjustment	(37)	-	-	37	-
Balance at 31 March 2025	2,402	156,740	6,512	11,792	177,446

The notes on pages 135 to 172 form part of these financial statements.

CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2026

	Note	Group 2025/26 £000	2024/25 £000
Cash flows from operating activities			
Operating (deficit)/surplus from continuing operations		**(27,258)**	2,050
		(27,258)	2,050
Non-cash income and expense			
Depreciation and amortisation	4.1	**11,893**	11,837
Net impairments	8.0 & 9.1	**6,766**	20
Income recognised in respect of capital donations		**(390)**	-
Increase in trade and other receivables		**(8,584)**	(3,357)
Increase in inventories	13.1	**762**	(1,132)
Increase/(Decrease) in trade and other payables		**20,807**	(703)
Decrease in other liabilities	18	**(1,725)**	(110)
Increase/(Decrease) in provisions		**(95)**	82
Other movements in operating cash flows		**(1,366)**	(558)
HDFT Charitable Funds - net adjustments for working capital		**30**	(96)
NET CASH GENERATED/(USED) FROM OPERATIONS		**840**	8,033
Cash flows from investing activities			
Interest received		**2,665**	2,197
Purchase of Intangible assets	8	**(6,541)**	(5,403)
Purchase of Property, Plant and Equipment		**(47,978)**	(27,402)
Proceeds from sales of property, plant and equipment and investment property		**-**	137
Receipt of cash donations to purchase capital assets		**390**	-
HDFT Charitable funds - net cash flows from investing activities		**118**	49
Net cash used in investing activities		**(51,346)**	(30,422)
Cash flows from financing activities			
Public dividend capital received (please see page 8)		**56,896**	26,225
Movement in loans from the DHSC	19	**(1,181)**	(1,181)
Capital element of lease liability repayments		**(1,858)**	(2,114)
Interest paid		**(127)**	(133)
Interest element of lease liability repayments		**(371)**	(212)
PDC dividend paid		**(4,175)**	(5,214)
Net cash generated in financing activities		**49,184**	17,371
Net decrease in cash and cash equivalents	15	**(1,322)**	(5,018)
Cash and cash equivalents at 1 April 2025	15	**8,811**	13,829
Cash and cash equivalents at 31 March 2026	15	**7,489**	8,811

The notes on pages 135 to 172 form part of these financial statements.

FOUNDATION TRUST STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2026

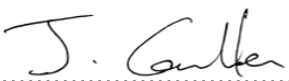
	Note	Foundation Trust 2025/26 Total £000	Foundation Trust 2024/25 Total £000
Operating income from patient care activities	3.2	**384,150**	372,116
Other operating income	3.2	**31,736**	27,627
Operating expenses	4.2	**(454,294)**	(398,078)
OPERATING SURPLUS/(DEFICIT) FROM CONTINUING OPERATIONS		**(38,408)**	1,665
FINANCE COSTS			
Finance income	6.2	**3,806**	2,840
Finance expense - financial liabilities	7	**(307)**	(340)
Finance expense - unwinding of discount on provisions	17.2	**(2)**	(3)
Public Dividend Capital - dividends payable		**(5,477)**	(4,545)
NET FINANCE COSTS		**(1,980)**	(2,048)
Gains/(Losses) on disposal of assets	9.2	**-**	12
SURPLUS FOR THE YEAR		**(40,388)**	(371)
Other comprehensive income			
Impairments charged to Revaluation Reserve	9.2	**-**	(4,688)
Revaluations	9.4	**2,835**	-
Other reserve movements		**-**	(787)
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		**(37,553)**	(5,846)

The notes on pages 135 to 172 form part of these financial statements.

FOUNDATION TRUST STATEMENT OF FINANCIAL POSITION
as at 31 March 2026

		Foundation Trust	
		31 March 2026	31 March 2025
	Note	**£000**	£000
Non-current assets			
Intangible assets	8	**18,941**	12,856
Property, plant and equipment	9.2 & 9.4	**194,948**	112,687
Right of Use Asset	10.1	**6,267**	7,731
Investment in Subsidiary	12	**1,000**	1,000
Loan to Subsidiary	12	**-**	53,138
Trade and other receivables	14.1	**927**	1,177
Total non-current assets		**222,082**	188,589
Current assets			
Inventories	13.1	**3,530**	4,314
Loan to Subsidiary	12	**-**	3,369
Trade and other receivables	14.1	**32,799**	25,172
Cash and cash equivalents	15	**6,098**	7,124
Total current assets		**42,427**	39,979
Current liabilities			
Trade and other payables	16	**(48,899)**	(26,204)
Borrowings	19	**(2,476)**	(2,974)
Provisions	17.1	**(96)**	(96)
Other liabilities	18	**(209)**	(1,934)
Total current liabilities		**(51,680)**	(31,208)
Total assets less current liabilities		**212,829**	197,360
Non-current liabilities			
Borrowings	19	**(9,273)**	(11,431)
Provisions	17.1	**(459)**	(552)
Total non-current liabilities		**(9,732)**	(11,983)
Total assets employed		**203,097**	185,377
Financed by taxpayers' equity:			
Public Dividend Capital		**213,638**	156,742
Revaluation reserve		**13,515**	12,306
Income and expenditure reserve		**(24,056)**	16,329
Total taxpayers' equity (see page 12)		**203,097**	185,377

The notes on pages 135 to 172 form part of these financial statements.

Signed:  Mr. Jonathan Coulter - Chief Executive

Date: 25 June 2026

FOUNDATION TRUST STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2026

	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Foundation Trust Total
	£000	£000	£000	£000
Balance as at 1 April 2025	**156,740**	**12,305**	**16,332**	**185,377**
Surplus for the financial year (see page 10)	**-**	**-**	**(40,388)**	**(40,388)**
Impairments (Note 9.2)	**-**	**-**	**-**	**-**
Revaluation	**-**	**2,835**	**-**	**2,835**
Impairments	-	-	**-**	**-**
Public Dividend Capital received	**56,896**	**-**	**-**	**56,896**
Public Dividend Capital repaid	**-**	**-**	**-**	**-**
Other reserve movements	**2**	**(1,625)**	**-**	**(1,623)**
Balance at 31 March 2026	**213,638**	**13,515**	**(24,056)**	**203,097**

FOUNDATION TRUST STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2025

	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Foundation Trust Total
	£000	£000	£000	£000
Balance as at 1 April 2024	130,515	17,350	16,703	164,568
Surplus for the financial year (see page 10)	-	-	(371)	(371)
Impairments (Note 9.2)	-	(4,688)	-	(4,688)
Public Dividend Capital received	26,225	-	-	26,225
Public Dividend Capital repaid	-	-	-	-
Other reserve movements	-	(357)		(357)
Balance at 31 March 2025	156,740	12,305	16,332	185,377

The notes on pages 135 to 172 form part of these financial statements.

FOUNDATION TRUST STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2026

	Note	Foundation Trust 2025/26 £000	2024/25 £000
Cash flows from operating activities			
Operating (deficit)/surplus from continuing operations		**(38,408)**	1,665
		(38,408)	1,665
Non-cash income and expense			
Depreciation and amortisation	4.2	**11,800**	9,309
Net impairments	8.0 & 9.2	**15,951**	20
Income recognised in respect of capital donations	3.1	**(390)**	-
(Increase)/Decrease in trade and other receivables		**(8,493)**	(1,098)
(Increase)/Decrease in inventories	13	**784**	(1,141)
Increase/(Decrease) in trade and other payables		**23,668**	(4,650)
Increase/(Decrease) in other liabilities	18	**(1,725)**	(110)
Increase / (Decrease) in provisions		**(95)**	82
Other movements in operating cash flows		**(1,576)**	-
NET CASH GENERATED FROM OPERATIONS		**1,516**	4,077
Cash flows from investing activities			
Interest received		**3,806**	2,912
Purchase of Intangible assets	8	**(6,232)**	(3,601)
Purchase of Property, Plant and Equipment		**(49,690)**	(6,859)
Receipt of cash donations to purchase capital assets		**390**	-
Net cash used in investing activities		**(51,726)**	(7,548)
Cash flows from financing activities			
Public dividend capital received (please see page 12)		**56,896**	26,225
Movement in loans from the DHSC		**(1,181)**	(1,181)
Movement in loans to subsidiary		**-**	(19,724)
Capital and Interest element of lease liability repayments		**(2,229)**	(2,172)
Interest paid		**(127)**	(352)
PDC dividend paid		**(4,175)**	(5,214)
Net cash generated/(used) in financing activities		**49,184**	(2,418)
Net increase/(decrease) in cash and cash equivalents	15	**(1,026)**	(5,889)
Cash and cash equivalents at 1 April 2025	15	**7,124**	13,013
Cash and cash equivalents at 31 March 2026	15	**6,098**	7,124

The notes on pages 135 to 172 form part of these financial statements.

1 GROUP ACCOUNTING POLICIES AND OTHER INFORMATION

1.1 Basis of preparation

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 2025-26, 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.

1.2 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 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 NHS Foundation Trust's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

1.4 Consolidation

NHS Charitable Fund
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.

Other subsidiaries
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 materially not aligned with NHS Foundation Trust.

The amounts consolidated are the actual amounts for each month of the NHS Foundation Trust's financial year are obtained from the subsidiary and consolidated. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

Joint ventures
Joint ventures are arrangements in which the NHS Foundation Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method. The NHS Foundation Trust has equity investment in the following joint ventures:

- Integrated Laboratory Solutions LLP
- Integrated Pathology Solutions LLP

1.5 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the NHS Foundation Trust accrues income relating to performance obligations satisfied in that year. Where the NHS Foundation Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The main source of revenue from contracts for the NHS Foundation Trust are contracts with local authority commissioners in respect of children's service areas. 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.

1.6 Revenue from NHS Contracts

The main source of income for the NHS Foundation Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the NHS Foundation Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to NHS Foundation Trusts for NHS funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

The NHS Foundation Trust also receives income from commissioners the Best Practice Tariff (BPT) scheme. Delivery under this scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BTP on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £1.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

1.7 NHS Injury Cost Recovery Scheme

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 performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements or measuring expected credit losses over the lifetime of the asset.

1.8 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income (formerly called Apprenticeship Levy)

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.9 Expenditure on employee benefits

Short term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs - NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employer, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the NHS Foundation Trust commits itself to the retirement, regardless of the method of payment.

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.

1.9 Expenditure on employee benefits (continued)

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.

1.10 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.11 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where;

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential 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 similar 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, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. 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.

Measurement (valuation)

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

1.11 Property, plant and equipment (continued)

Measurement (valuation)

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are defined as market value except where a building is so specialised in nature that no active market exists from which to draw a satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.□

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which have been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses

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 expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

1.11 Property, plant and equipment (continued)

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of 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.

An impairment that arises from a clear consumption of economic benefit or of 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.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

This includes assets donated to the NHS Foundation Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the NHS Foundation Trust applies the principle of donated asset accounting to assets that the NHS Foundation Trust controls and is obtaining economic benefits from at the year end.

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

1.12 Intangible Assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the NHS Foundation Trust. They are capable of being sold separately from the rest of the NHS Foundation Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the NHS Foundation Trust and where the cost of the asset can be measured reliably.

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset where it meets recognition criteria.□

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.□

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	Max life Years
Information technology	2	10
Development expenditure	2	10
Websites	2	10
Software licences	2	10
Licences & trademarks	2	10
Patents	2	10
Other (purchased)	2	10
Goodwill	2	10

1.13 Inventories

Inventories are valued at the lower of cost and net realisable value, using the first-in first out (FIFO) method.

1.14 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.

1.15 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the NHS Foundation Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes 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 and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Financial assets and financial liabilities at amortised cost (continued)

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets and financial liabilities at fair value through income and expenditure.

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The NHS Foundation Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

There are no expected credit losses for NHS receivables. The NHS Foundation Trust split other debtors into categories e.g. overseas visitors, private patients etc. These classes are assessed for expected credit losses based on the last 12 months' data, and the percentages are then applied to the current debts.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset’s gross carrying amount and the present value of estimated future cash flows discounted at the financial asset’s original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition

Financial assets are de-recognised when the contractual 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.

1.16 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 NHS Foundation Trust does not apply lease accounting to new contracts for the use of intangible assets.

The NHS Foundation 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 NHS Foundation Trust is reasonably certain to exercise.

1.16 Leases (continued)

The NHS Foundation Trust as a lessee

Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the NHS Foundation 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 NHS Foundation Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The NHS Foundation 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 NHS Foundation 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 NHS Foundation 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 NHS Foundation Trust as a lessor

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

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS Foundation 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 NHS Foundation 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.

1.17 Provisions

The NHS Foundation 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 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
	Exceeding 40 years	5.07%	4.55%

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 2026:

	Inflation rate	Prior year rate
Year 1	2.50%	2.60%
Year 2	2.00%	2.30%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

1.18 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 17 but is not recognised in the Trust's accounts

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 the liability arises.

1.20 Contingent liabilities and contingent assets

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in notes to the Accounts where an inflow of economic benefits is probable.

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.

Contingent liabilities are not recognised, but are disclosed in notes to the Accounts, unless the probability of a transfer of economic benefits is remote.

1.21 Public Dividend Capital

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 contract, PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the NHS Foundation Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), 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 calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.22 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.

1.23 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 NHS Foundation 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.

1.24 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.

1.25 Foreign exchange

The functional and presentational currency of the NHS Foundation Trust is sterling.

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange rate gains and losses are taken to the Statement of Comprehensive Income.

1.26 Third party assets

Assets belonging to third parties in which the NHS Foundation 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.

1.27 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.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.28 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.

1.29 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025-26.

1.30 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2025-26. These Standards are still subject to HM Treasury FReM adoption.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £111m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for all of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £111m at 31 March 2026. This will have a material impact on our property value but at present we are unable to quantify this value.

1.31 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the NHS Foundation Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Valuation of land and buildings

HM Treasury requires NHS Foundation Trusts to value their land and buildings on a Modern Equivalent Asset (MEA) basis i.e. the "replacement cost", based on the cost of a modern replacement asset that has the same productive capacity as the property being valued. IAS 16 requires NHS Foundation Trusts to ensure that fixed assets are shown in their accounts at a fair value. To ensure compliance a full review of land and buildings values was undertaken. The NHS Foundation Trust commissioned the Valuation Office to conduct this piece of work with the remit that the MEA valuation should be based on an alternative site basis. The NHS Foundation Trust relies on the professional services of the Valuation Office for the accuracy of such valuations.

The HDFT site is treated as a single asset for the purposes of assessing and accounting for revaluation and impairment movements.

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.

Leases

All leases, with limited exceptions, are now treated as Finance leases under IFRS16. Management judgement has been excercised in the absence of the legal form of a contract where lease-like arrangements are in place, to include them as Finance leases. Management have used historical knowledge and understanding of the commercial terms normally in place for such arrangements, to make informed assumptions regarding the lease terms, which have been used in the initial measurement of the Right of Use asset and the corresponding liability.

1.32 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

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.

The site is treated as a single asset for valuation purposes. The closing asset valuation is £103m.

2 Operating segments

2.1 Group operating segments

The NHS foundation trust's Board as "Chief Operating Decision Maker" has determined that the Trust operates in one material segment, which is the Provision of Healthcare Services. The segmental reporting format reflects the Trust's management and internal reporting structure.

The Provision of Healthcare Services (including Medical Treatment, Research and Education) is within one main geographical segment, the United Kingdom, and materially from Departments of HM Government in England.

Income from Patient Activities (medical treatment of patients) is analysed by nature and source in Note 3.1 to the Financial Statements. Other Operating Income is analysed in Note 3.2 to the Financial Statements and materially consists of revenues from Education and Training, Staff Recharges (secondments) and Non-patient care services to other bodies.

The Trust's 100% wholly owned subsidiary Harrogate Healthcare Facilities Management Ltd (HHFM) commenced trading on 1 March 2018 to deliver services under a 25 year Operated Healthcare Facility contract back to the Trust. However this has not resulted in a change to the operating segment which is the Provision of Healthcare Services.

3 Operating Income from continuing operations

3.1 Analysis of patient care operating income

	Foundation Trust & Group	
	2025/26	2024/25
	£000	£000
Income from activities by nature:		
Acute services		
Aligned payment & incentive (API) income - Variable (based on activity)	**70,166**	70,995
Aligned payment & incentive (API) income - Fixed (not variable based on activity)	**130,397**	89,193
High cost drugs income from commissioners	**10,458**	10,003
Other NHS clinical income	**57,844**	50,174
Community services		
Aligned payment & incentive (API) income	**28,805**	69,519
Income from other sources (e.g. local authorities)	**67,001**	64,061
All trusts		
Private patient income	**574**	477
Pay award central funding	**-**	559
Additional pension contribution central funding (see below*)	**18,472**	16,626
Other clinical income	**1,100**	1,105
Total income from activities	**384,817**	372,712

	Foundation Trust & Group	
	2025/26	2024/25
	£000	£000
Income from activities by source:		
NHS England (including central funding for AfC pay award in 2022/23)	**35,902**	39,373
Integrated care boards	**279,357**	265,411
NHS foundation trusts and NHS Trusts	**463**	455
Local Authorities	**67,001**	64,061
Department of Health and Social Care	**12**	13
NHS Other	**16**	20
Non NHS: Private Patients	**574**	477
Non NHS: Overseas Patients (non-reciprocal, chargeable to patient)	**98**	119
Injury cost recovery scheme (see below**)	**392**	386
Non NHS: Other	**1,002**	2,397
Total income from activities	**384,817**	372,712

3.2 Analysis of other operating income

	Group	
	2025/26	2024/25
	£000	£000
Group other operating income:		
Research and development	**948**	1,335
Education and training (excluding notional income from apprenticeship fund)	**12,610**	12,138
Non-patient care services to other bodies	**6,315**	3,535
Staff recharges (secondments)	**5,051**	5,279
Education and training - notional income from apprenticeship fund	**1,056**	880
Cash grants for the purchase of capital assets - received from other bodies	**390**	-
Contributions to expenditure - consumables (inventory) donated from DHSC	**-**	-
HDFT Charitable Funds: Incoming Resources excluding investment income	**1,029**	529
Other	**6,239**	5,465
Group total other operating income	**33,638**	29,161
Group total operating income	**418,455**	401,873

*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 lower 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.

** Injury cost scheme income is subject to a provision for doubtful debts of 24.62% (2025: 24.45%) to reflect expected rates of collection.

3.2 Analysis of operating income (continued)

	Foundation Trust	
	2025/26	2024/25
	£000	£000
Total income from activities	**384,817**	372,712
Less additional pension contribution central funding (belonging to Subsidiary Company)	**(667)**	(596)
	384,150	372,116
Foundation Trust other operating income:		
Research and development	**948**	1,334
Education and training (excluding notional income from apprenticeship fund)	**12,610**	12,137
Non-patient care services to other bodies	**7,053**	4,282
Staff recharges (secondments)	**5,055**	5,301
Education and training - notional income from apprenticeship fund	**1,056**	880
Cash grants for the purchase of capital assets - received from other bodies	**390**	-
Other	**4,624**	3,693
Foundation Trust total other operating income	**31,736**	27,627
Foundation Trust total operating income	**415,886**	399,743

3.3 Overseas visitors (relating to patients charged directly by the foundation trust)

Income recognised in year relating to overseas visitors was £98k (2025 £119k), payments received in year (relating to invoices raised in current and previous years) was £31k (2025 £28k) and amounts written off in year (relating to invoices raised in current and previous years) was £1k (2025 £0k).

3.4 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	
	2025/26	2024/25
	£000	£000
Commissioner Requested Services	**231,532**	224,249
Non-Commissioner Requested Services	**153,285**	148,463
Total	**384,817**	372,712

4. Operating Expenses from continuing operations

4.1 Group operating expenses comprise:

	Group	
	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC group bodies	**40**	34
Purchase of healthcare from non-NHS and non-DHSC group bodies	**407**	87
Staff and executive directors costs	**323,385**	292,877
Non-executive directors	**206**	198
Supplies and services - clinical (excluding drugs costs)	**35,101**	32,672
Supplies and services - general	**2,111**	2,792
Drug costs (see note 13.2)	**26,266**	24,480
Consultancy costs	**363**	197
Establishment	**1,932**	2,493
Premises - business rates payable to local authorities	**1,402**	1,364
Premises - other	**15,235**	15,011
Transport (including Patients' travel)	**1,964**	2,009
Depreciation on property, plant and equipment	**10,020**	10,374
Amortisation on intangible assets (see note 8)	**1,873**	1,463
Net Impairments/(Reversals) of property, plant and equipment	**6,766**	20
Change in provisions discount rate	**-**	1
Decrease in provision for irrecoverable debts	**129**	(836)
Audit services- statutory audit	**242**	249
Charitable fund audit	**11**	8
Internal audit costs	**240**	220
NHS Resolution contribution - Clinical Negligence	**8,086**	6,964
Legal fees	**200**	204
Insurance	**478**	420
Research and development	**-**	12
Education and training	**1,442**	715
Education and training - notional expenditure funded from apprenticeship fund	**1,056**	880
Lease Expenditure	**643**	305
Early retirements	**3**	110
Redundancy	**12**	-
Hospitality	**4**	33
Losses, ex gratia and special payments (see note 20)	**33**	20
HDFT Charitable funds: Other resources expended	**645**	430
Other	**5,418**	4,017
Group total operating expenses	**445,713**	399,823

4. Operating Expenses from continuing operations (Continued)

4.2 Foundation Trust operating expenses comprise:

	Foundation Trust	
	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	**40**	34
Purchase of healthcare from non-NHS and non-DHSC bodies	**958**	87
Staff and executive directors costs	**309,553**	280,373
Non-executive directors	**186**	170
Drug costs (see note 13.2)	**26,266**	24,480
Supplies and services - clinical (excluding drugs costs)	**31,195**	29,619
Supplies and services - general	**25,692**	26,120
Establishment	**1,501**	2,117
Research and development	**-**	12
Transport (including Patients' travel)	**1,875**	1,824
Premises - business rates payable to local authorities	**1,402**	1,364
Premises - other	**10,272**	9,557
Increase/(Decrease) in provision for irrecoverable debts	**136**	(836)
Depreciation on property, plant and equipment	**9,927**	7,846
Amortisation on intangible assets (see note 8)	**1,873**	1,463
Net Impairments/(Reversals) of property, plant and equipment	**15,951**	20
Audit services- statutory audit	**180**	202
NHS Resolution contribution - Clinical Negligence	**8,086**	6,964
Legal fees	**166**	176
Consultancy costs	**165**	178
Internal audit costs	**217**	199
Education and training	**1,344**	205
Education and training - notional expenditure funded from apprenticeship fund	**1,056**	880
Redundancy	**12**	-
Early retirements	**3**	110
Hospitality	**4**	51
Insurance	**351**	311
Losses, ex gratia and special payments (see note 20)	**33**	20
Other	**5,850**	4,532
Foundation Trust total operating expenses	**454,294**	398,078

4.3 Limitation on external auditor's liability

	Foundation Trust & Group	
	2025/26	2024/25
	£000	£000
Limitation on external auditor's liability	**1,000**	1,000
	1,000	1,000

There was no other auditor remuneration payable for 2025/26.

5. Employee costs and numbers

5.1 Employee costs

	Total	**Group Permanently**		Total	Group Permanently	
	2025/26	**Employed**	**Other**	2024/25	Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**247,083**	**243,172**	**3,911**	226,521	223,774	2,747
Annual Leave Accrual	**-**	**-**	**-**	297	297	-
Social Security costs (Employers NI costs)	**28,792**	**28,792**	**-**	20,481	20,481	-
Apprenticeship levy	**1,139**	**1,139**	**-**	1,037	1,037	-
Pension cost - employer contributions to NHS pension scheme	**29,224**	**29,224**	**-**	26,081	26,081	-
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	**18,472**	**18,472**	**-**	16,626	16,626	-
Pension cost - other	**124**	**124**	**-**	106	-	106
Termination benefits	**-**	**-**	**-**	-	-	-
External bank	**4**	**-**	**4**	-	-	-
Agency/contract staff	**2,041**	**-**	**2,041**	3,902	-	3,902
Total employee expenses	**326,879**	**320,923**	**5,956**	295,051	288,296	6,755
Less costs capitalised as part of assets	**(3,482)**	**(3,482)**	**-**	(2,174)	(2,174)	-
Total employee costs excluding capitalised costs	**323,397**	**317,441**	**5,956**	292,877	286,122	6,755

5.2 Employee costs

	Foundation Trust			Foundation Trust		
	Total	**Permanently**		Total	Permanently	
	2025/26	**Employed**	**Other**	2024/25	Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**236,457**	**232,546**	**3,911**	216,319	213,573	2,746
Annual Leave Accrual	**-**	**-**	**-**	298	298	-
Social Security costs (Employers NI costs)	**27,539**	**27,539**	**-**	19,632	19,632	-
Apprenticeship levy	**1,086**	**1,086**	**-**	987	987	-
Agency	**28,169**	**28,169**	**-**	25,382	25,382	-
paid by NHSE on provider's behalf (9.4%)	**17,805**	**17,805**	**-**	16,626	16,626	-
Pension cost - other	**53**	**53**	**-**	57	57	-
Termination benefits	**-**	**-**	**-**	-	-	-
External bank	**4**	**-**	**4**	-	-	-
Agency/contract staff	**1,922**	**-**	**1,922**	3,793	-	3,793
Total employee expenses	**313,035**	**307,198**	**5,837**	283,094	276,555	6,539
Less costs capitalised as part of assets	**(3,482)**	**(3,482)**	**-**	(2,174)	(2,174)	-
Total employee costs excluding capitalised costs	**309,553**	**303,716**	**5,837**	280,920	274,381	6,539

5.5 Pensions costs

Past and present employees are covered by the provisions of the 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 the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. 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 2026, is based on valuation data as 31 March 2022, updated to 31 March 2026 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 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming the employer contribution rate will increase to 23.7% of pensionable pay from 1 April 2024 (previously 20.6%). The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

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	
	2025/26	2024/25
	£000	£000
Interest income:		
Interest on bank accounts	**2,605**	2,185
HDFT Charitable funds: investment income	**47**	68
	2,652	2,253

6.2 Foundation Trust finance revenue received during the year is as follows:

Finance revenue received during the year is as follows:	Foundation Trust	
	2025/26	2024/25
	£000	£000
Interest income:		
Interest on bank accounts	**629**	935
Interest on loans to HHFM	**3,177**	1,905
	3,806	2,840

7. Finance expenses

7.1 Group finance expense incurred during the year is as follows:

Finance expenses incurred during the year are as follows:	Group	
	2025/26	2024/25
	£000	£000
Interest expense:		
Capital Loans from the Department of Health (formerly ITFF see note 18)	**127**	127
Interest on lease obligations	**371**	212
	498	339

7.2 Foundation Trust finance expense incurred during the year is as follows:

Finance expenses incurred during the year are as follows:	Foundation Trust	
	2025/26	2024/25
	£000	£000
Interest expense:		
Capital Loans from the Department of Health (formerly ITFF see note 18)	**127**	127
Interest on lease obligations	**180**	213
	307	340

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 2025	3,263	11,429	187	376	2,932	**18,187**
Additions - purchased	5	3,627	-	2,426	174	**6,232**
Impairments charged to operating expenses	-	-	-	-	-	**-**
Reclassifications	404	1,495	-	(376)	203	**1,726**
Disposals	(1,383)	(522)	(34)	-	(740)	**(2,679)**
Gross cost at 31 March 2026	**2,289**	**16,029**	**153**	**2,426**	**2,569**	**23,466**
Amortisation at 1 April 2025	2,486	1,206	126	-	1,513	**5,331**
Provided during the year	263	1,343	21	-	246	**1,873**
Impairments charged to operating expenses	-	-	-	-	-	**-**
Disposals	(1,383)	(522)	(34)	-	(740)	**(2,679)**
Amortisation at 31 March 2026	**1,366**	**2,027**	**113**	**-**	**1,019**	**4,525**
Net book value						
- Purchased at 31 March 2026	923	14,002	40	2,426	1,550	**18,941**
- Total at 31 March 2026	**923**	**14,002**	**40**	**2,426**	**1,550**	**18,941**

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 2024	3,062	7,995	187	410	2,932	**14,586**
Additions - purchased	199	3,402	-	-	-	**3,601**
Impairments charged to operating expenses	-	-	-	-	-	**-**
Reclassifications	2	32	-	(34)	-	**-**
Disposals	-	-	-	-	-	**-**
Gross cost at 31 March 2025	**3,263**	**11,429**	**187**	**376**	**2,932**	**18,187**
Amortisation at 1 April 2024	1,500	1,206	103	-	1,059	**3,868**
Provided during the year	986	-	23	-	454	**1,463**
Impairments charged to operating expenses	-	-	-	-	-	**-**
Disposals	-	-	-	-	-	**-**
Amortisation at 31 March 2025	**2,486**	**1,206**	**126**	**-**	**1,513**	**5,331**
Net book value						
- Purchased at 31 March 2025	777	10,223	61	376	1,419	**12,856**
- Total at 31 March 2025	**777**	**10,223**	**61**	**376**	**1,419**	**12,856**

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 2025	3,920	98,858	1,203	35,389	39,199	170	24,573	926	**204,238**
Additions - purchased	-	5,803	96	33,913	1,875	-	861	202	**42,750**
Additions - donations of physical assets	-	-	-	-	-	-	-	-	**-**
Additions - assets purchased from cash donations/grants	-	88	-	244	58	-	-	-	**390**
Impairments charged to operating expenses	-	-	-	(6,944)	-	-	-	-	**(6,944)**
Impairments transfered to revaluation reserve	-	-	-	-	-	-	-	-	**-**
Reversal of impairments credited to operating expenses	-	100	-	-	-	-	-	-	**100**
Revaluations	-	(253)	206	-	-	-	-	-	**(47)**
Reclassifications	-	922	-	(8,345)	4,367	-	899	431	**(1,726)**
Disposals	-	-	-	-	(7,854)	(97)	(7,074)	(291)	**(15,316)**
Cost or valuation At 31 March 2026	**3,920**	**105,518**	**1,505**	**54,257**	**37,645**	**73**	**19,259**	**1,268**	**223,445**
Depreciation at 1 April 2025	-	1,018	-	-	24,320	142	14,539	516	**40,535**
Provided during the year (see note 4.1)	-	2,863	97	-	2,807	7	1,938	62	**7,774**
Impairments charged to operating expenses	-	-	-	-	-	-	-	-	**-**
Reversal of impairments credited to operating expenses	-	(78)	-	-	-	-	-	-	**(78)**
Revaluations	-	(3,803)	(97)	-	-	-	-	-	**(3,900)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Disposals	-	-	-	-	(7,854)	(97)	(7,074)	(291)	**(15,316)**
Depreciation at 31 March 2026	**-**	**-**	**-**	**-**	**19,273**	**52**	**9,403**	**287**	**29,015**
Net book value									
- Purchased at 31 March 2026	3,920	92,734	1,505	54,257	16,116	21	9,856	972	**179,381**
- Donated at 31 March 2026	-	12,784	-	-	2,256	-	-	9	**15,049**
Net book value at 31 March 2026	**3,920**	**105,518**	**1,505**	**54,257**	**18,372**	**21**	**9,856**	**981**	**194,430**

At 31 March 2025, of the Net Book Value £3,920,000 related to land valued at open market value and £98,858,000 related to buildings valued at open market value and £1,203,000 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 His Majesty's Revenue and Customs (RICS qualified) as at 31 March 2025. 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 £6,962,000.00.

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 2025	3,920	74,571	668	10,495	34,935	25	24,623	794	**150,031**
Additions - purchased	-	39,549	178	59,358	3,902	16	1,011	294	**104,308**
Additions - assets purchased from cash donations/grants	-	88	-	244	58	-	-	-	**390**
Impairments charged to operating expenses	-	(9,460)	453	(6,944)	-	-	-	-	**(15,951)**
Reversal of impairments credited to operating expenses	-	101	-	-	-	-	-	-	**101**
Revaluations	-	(253)	206	-	-	-	-	-	**(47)**
Reclassifications	-	922	-	(8,345)	4,367	-	899	431	**(1,726)**
Disposals	-	-	-	-	(7,854)	(97)	(7,074)	(291)	**(15,316)**
Cost or valuation At 31 March 2026	**3,920**	**105,518**	**1,505**	**54,808**	**35,408**	**(56)**	**19,459**	**1,228**	**221,790**
Depreciation at 1 April 2025	-	-	-	-	22,413	13	14,443	475	**37,344**
Provided during the year (see note 4.2)	-	2,863	97	-	2,807	7	1,938	62	**7,774**
Transfer to revaluation reserve	-	(2,785)	(97)	-	-	-	-	-	**(2,882)**
Impairments charged to operating expenses	-	-	-	-	-	-	-	-	**-**
Reversal of impairments credited to operating expenses		(78)							
Disposals	-	-	-	-	(7,854)	(97)	(7,074)	(291)	**(15,316)**
Depreciation at 31 March 2026	**-**	**-**	**-**	**-**	**17,366**	**(77)**	**9,307**	**246**	**26,920**
Net book value									
- Purchased at 31 March 2026	3,920	92,734	1,505	54,808	15,786	21	10,152	973	**179,899**
- Donated at 31 March 2026	-	12,784	-	-	2,256	-	-	9	**15,049**
Net book value at 31 March 2026	**3,920**	**105,518**	**1,505**	**54,808**	**18,042**	**21**	**10,152**	**982**	**194,948**

At 31 March 2025, of the Net Book Value £3,920,000 related to land valued at open market value and £98,858,000 related to buildings valued at open market value and £1,203,000 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 His Majesty's Revenue and Customs (RICS qualified) as at 31 March 2025. 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 £6,962,000.00. The NHS Foundation trust purchased all the assets from the subsidiary organisation within the financial year - these assets were impaired to the group value.

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 2024	3,500	100,107	1,278	13,748	38,427	170	22,727	881	180,838
Additions - purchased	-	2,090	-	26,774	253	-	1,097	45	30,259
Additions - donations of physical assets	-	-	-	-	-	-	-	-	-
Additions - assets purchased from cash donations/grants	-	-	-	-	-	-	-	-	-
Impairments charged to operating expenses	-	-	-	-	-	-	-	-	-
Transfer to revaluation reserve	**420**	(7,204)	(75)	**-**	**-**	**-**	**-**	**-**	(6,859)
Reversal of impairments credited to operating expenses	-	-	-	-	-	-	-	-	-
Reclassifications	-	3,865	-	(5,133)	519	-	749	-	-
Disposals	-	-	-	-	-	-	-	-	-
Cost or valuation At 31 March 2025	**3,920**	**98,858**	**1,203**	**35,389**	**39,199**	**170**	**24,573**	**926**	**204,238**
Depreciation at 1 April 2024	-	368	30	-	21,369	135	12,030	475	34,407
Provided during the year (see note 4.1)	-	2,686	8	-	2,951	7	2,509	41	8,202
Impairments charged to operating expenses	-	20	-	-	-	-	-	-	20
Impairments charged to the revaluation reserve	-	(2,056)	(38)	-	-	-	-	-	(2,094)
Reclassifications	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	-	-	-	-	-
Depreciation at 31 March 2025	**-**	**1,018**	**-**	**-**	**24,320**	**142**	**14,539**	**516**	**40,535**
Net book value									
- Purchased at 31 March 2025	3,920	83,377	1,203	35,389	12,334	28	10,025	399	146,675
- Donated at 31 March 2025	-	14,463	-	-	2,545	-	9	11	17,028
Net book value at 31 March 2025	**3,920**	**97,840**	**1,203**	**35,389**	**14,879**	**28**	**10,034**	**410**	**163,703**

At 31 March 2024, of the Net Book Value £3,500,000 related to land valued at open market value and £100,107,000 related to buildings valued at open market value and £1,278,000 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 His Majesty's Revenue and Customs (RICS qualified) as at 31 March 2025. 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 decrease in value of £4,222,000.00. Land and Buildings has increased in value due to the purchase of a new property.

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 2024	3,500	79,382	743	6,061	34,706	25	22,777	749	**147,943**
Additions - purchased	-	1,301	-	4,207	229	-	1,836	45	**7,618**
Reversal of impairments credited to operating expe	-	(20)	-	-	-	-	-	-	**(20)**
Reclassifications	-	84	-	(129)	-	-	10	-	**(35)**
Transfer to revaluation reserve	420	(6,176)	(75)	-	-	-	-	-	**(5,831)**
Revaluation correction				**356**					**356**
Disposals	-	-	-	-	-	-	-	-	**-**
Cost or valuation At 31 March 2025	**3,920**	**74,571**	**668**	**10,495**	**34,935**	**25**	**24,623**	**794**	**150,031**
Depreciation at 1 April 2024	-	-	-	-	19,676	11	11,975	445	**32,107**
Provided during the year (see note 4.2)	0	1,113	30	0	2,737	2	2,468	30	**6,380**
Transfer to revaluation reserve	-	(1,113)	(30)	-	-	-	-	-	**(1,143)**
Impairments charged to operating expenses	-	-	-	-	-	-	-	-	**-**
Disposals	-	-	-	-	-	-	-	-	**-**
Depreciation at 31 March 2025	**-**	**-**	**-**	**-**	**22,413**	**13**	**14,443**	**475**	**37,344**
Net book value									
- Purchased at 31 March 2025	4,340	55,297	593	14,929	7,469	10	9,549	323	**92,510**
- Donated at 31 March 2025	-	14,463	-	-	2,545	-	9	11	**17,028**
Net book value at 31 March 2025	**4,340**	**69,760**	**593**	**14,929**	**10,014**	**10**	**9,558**	**334**	**109,538**

At 31 March 2024, of the Net Book Value £3,500,000 related to land valued at open market value and £79,382,000 related to buildings valued at open market value and £743,000 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 His Majesty's Revenue and Customs (RICS qualified) as at 31 March 2025. 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 decrease in value of £4,202,000.00. Land and Buildings has increased in value due to the purchase of a new property.

9.5 Impairment of assets

	Foundation Trust & Group	
	2025/26	2024/25
	£000	**£000**
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	(178)	20
Impairments of charitable fund assets	-	-
Other	6,944	-
Total net impairments charged to operating surplus / deficit	**6,766**	**20**
Impairments charged to the revaluation reserve	-	4,765
Total net impairments	**6,766**	**4,785**

The impairment has been recognised in relation to the redevelopment of Therapies Unit. Associated with two capital schemes eradication of RAAC and Targeted Investment Funding, this unit was demolished and is being rebuilt.

10. Right of use assets (leases) - Harrogate and District NHS Foundation Trust as a lessee

10.1 Current year information about leases for which the Trust is a lessee.

Group	**Property (land and buildings) £000**	**Plant & machinery £000**	**Transport equipment £000**	**Total £000**	**Of which: leased from DHSC group bodies £000**
Valuation / gross cost at 1 April 2025 - brought forward	13,003	96	439	13,538	7,591
Additions - lease liability	564	-	476	1,040	-
Remeasurements of the lease liability	-	-	-	-	-
Valuation/gross cost at 31 March 2026	**13,567**	**96**	**915**	**14,578**	**7,591**
Accumulated depreciation at 1 April 2025 - brought forward	5,650	89	326	**6,065**	2,338
Provided during the year - right of use asset	2,053	6	187	2,246	894
Accumulated depreciation at 31 March 2026	**7,703**	**95**	**513**	**8,311**	**3,232**
Net book value at 31 March 2026	**5,864**	**1**	**402**	**6,267**	**4,359**

10.2 Prior year information about leases for which the Trust is a lessee.

Group	**Property (land and buildings) £000**	**Plant & machinery £000**	**Transport equipment £000**	**Total £000**	**Of which: leased from DHSC group bodies £000**
Valuation / gross cost at 1 April 2024 - brought forward	12,370	96	285	12,751	7,591
Additions - lease liability	-	-	121	121	-
Remeasurements of the lease liability	633	-	33	666	-
Valuation/gross cost at 31 March 2025	**13,003**	**96**	**439**	**13,538**	**7,591**
Accumulated depreciation at 1 April 2024 - brought forward	3,610	71	212	3,893	1,456
Provided during the year - right of use asset	2,040	18	114	2,172	882
Accumulated depreciation at 31 March 2025	**5,650**	**89**	**326**	**6,065**	**2,338**
Net book value at 31 March 2025	**7,353**	**7**	**113**	**7,473**	**5,253**

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	
	2025/26	2024/25
	£000	£000
Carrying value at 1 April	**8,388**	9,715
Lease additions	**1,040**	121
Interest charge arising in year	**371**	212
Lease liability remeasurements	**-**	666
Financing cash flows - principal	**(1,858)**	(2,114)
Financing cash flows - interest	**(371)**	(212)
Carrying value at 31 March	**7,570**	8,388

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

	Foundation Trust & Group	
	Total	Of which leased from DHSC group bodies:
	31 March 2026	**31 March 2026**
	£000	**£000**
Undiscounted future lease payments payable in:		
- not later than one year;	**1,414**	883
- later than one year and not later than five years;	**4,107**	2,930
- later than five years.	**2,049**	1,252
Net lease liabilities at 31 March 2026	**7,570**	**5,065**
Net lease liabilities at 31 March 2026		
Of which:		
Current	**1,414**	883
Non-Current	**6,156**	4,182
	7,570	**5,065**

Note 10.4 Prior year maturity analysis of future le

	Foundation Trust & Group	
	Total	Of which leased from DHSC group bodies:
	31 March 2025	**31 March 2025**
	£000	**£000**
Undiscounted future lease payments payable in:		
- not later than one year;	**2,053**	858
- later than one year and not later than five years;	**4,057**	3,155
- later than five years.	**2,278**	1,911
Net lease liabilities at 31 March 2025	**8,388**	**5,924**
Net lease liabilities at 31 March 2025		
Of which:		
Current	**2,053**	858
Non-Current	**6,335**	5,066
	8,388	**5,924**

11. Investments

	Group	
	2025/26	2024/25
	£000	£000
Carrying value at 1 April	**1,860**	1,821
Acquisitions in year - other	**275**	756
Movement in fair value of investments	**112**	61
Disposals	**(309)**	(778)
Carrying value at 31 March	**1,938**	1,860

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	
	2025/26	2024/25
	£000	£000
Non-current assets		
Shares in Subsidiary	**1,000**	1,000
Loans to Subsidiary	**-**	53,138
	1,000	54,138
Current assets		
Loans to Subsidiary	**-**	3,369
	1,000	57,507

The shares in the subsidiary company Harrogate Healthcare Facilities Management Ltd comprises a 100% holding of the share capital.

The principal activity of Harrogate Healthcare Facilities Management Ltd is to provide estate management and facilities services.

13. Inventories

13.1 Analysis of inventories	**Group**		**Foundation Trust**	
	2025/26	2024/25	**2025/26**	2024/25
	£000	£000	**£000**	£000
Drugs	**1,011**	1,358	**1,011**	1,358
Consumables	**2,755**	3,170	**2,519**	2,956
Total	**3,766**	4,528	**3,530**	4,314

13.2 Inventories recognised in expenses

	Foundation Trust & Group	
	2025/26	2024/25
	£000	£000
Drug Inventories recognised as an expense in the year	**20,366**	19,933
Total	**20,366**	19,933

14. Trade and other receivables

14.1 Trade and other receivables are made up of:

	Group	
	2025/26	2024/25
Current	**£000**	£000
Contract receivables (IFRS 15): invoiced	**6,509**	7,636
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	**17,885**	9,196
Capital receivables (including accrued capital related income)	**-**	-
PDC Dividend receivable (Department of Health)	**-**	789
Deposits and advances	**(104)**	(67)
Provision for the impairment of contract receivables (see note 14.2)	**(380)**	(601)
Prepayments (revenue and capital)	**5,950**	7,727
Interest receivable (excludes finance lease interest)	**-**	60
VAT receivables	**5,986**	5,536
Clinican pension tax	**11**	4
Other receivables	**1,791**	1,806
Total	**37,648**	32,086

	Foundation Trust	
	2025/26	2024/25
Current	**£000**	£000
Contract receivables (IFRS 15): invoiced	**6,579**	9,279
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	**18,263**	8,093
Capital receivables (including accrued capital related income)	**-**	-
PDC Dividend receivable (Department of Health)	**-**	776
Deposits and advances	**(82)**	(47)
Provision for the impairment of contract receivables (see note 14.2)	**(380)**	(601)
Prepayments	**5,253**	4,789
Interest receivable (excludes finance lease interest)	**-**	-
VAT receivables	**1,456**	1,052
Other receivables	**1,710**	1,831
Total	**32,799**	25,172

	Foundation Trust & Group	
	2025/26	2024/25
Non-Current	**£000**	£000
Other receivables	**664**	510
VAT receivables	**-**	-
Provision for the impairment of receivables (see note 14.2)	**(98)**	(97)
Clinician pension tax provision reimbursement funding from NHSE	**361**	424
Total	**927**	837

Of which receivable from NHS and DHSC group bodies:	Group	
	2025/26	2024/25
	£000	£000
Current	**12,155**	6,096
Non-Current	**361**	424

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 2025/26 £000	2024/25 £000
Allowance for credit losses at 1 April	**698**	796
New allowances arising	**129**	-
Changes in calculation of existing allowances	**-**	(836)
Utilisation of allowances (where receivable is written off)	**(349)**	738
Balance at 31 March	**478**	698

NHS Injury Benefit Scheme income is subject to a provision for impairment of 24.45% (2024: 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 2025/26 £000	2024/25 £000	Foundation Trust 2025/26 £000	2024/25 £000
Balance at 1 April	**8,811**	13,829	**7,124**	13,013
Net change in year	**(1,322)**	(5,018)	**(1,026)**	(5,889)
Balance at 31 March	**7,489**	8,811	**6,098**	7,124
Made up of:				
Cash with Government Banking Service	**7,203**	7,648	**6,098**	7,014
Cash at commercial banks and in hand	**262**	1,141	**-**	110
Other current investments	**24**	22	**-**	-
Cash and cash equivalents	**7,489**	8,811	**6,098**	7,124

16. Trade and other payables

	Group 2025/26 £000	2024/25 £000	Foundation Trust 2025/26 £000	2024/25 £000
Current				
Receipts in advance	**76**	75	**76**	75
Trade payables	**25,047**	14,274	**33,742**	10,461
Other trade payables - capital	**840**	8,098	**840**	2,339
Social Security costs	**3,365**	2,593	**3,218**	2,452
Other tax payable	**3,566**	2,911	**2,978**	2,610
Pension contributions payable	**4,141**	3,673	**3,989**	3,540
PDC dividend payable	**526**	-	**526**	-
Other payables	**200**	129	**28**	64
Accruals	**13,385**	5,260	**3,502**	4,663
Total	**51,146**	37,013	**48,899**	26,204

17. Provisions

17.1 Provisions current and non current

	Foundation Trust & Group Current		Foundation Trust & Group Non current	
	2025/26	2024/25	**2025/26**	2024/25
	£000	£000	**£000**	£000
Pensions relating to the early retirement of staff pre 1995	**24**	26	**30**	58
Legal claims	**40**	46	**20**	-
Pensions - Injury benefits	**21**	20	**49**	70
2019/20 Clinicians' pension reimbursement	**11**	4	**361**	424
	96	96	**459**	552

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 2025/26**
	£000	£000	£000	£000	**£000**
At 1 April 2025	84	46	90	428	**648**
Change in discount rate	-	-	-	(29)	**(29)**
Arising during the year	2	24	2	-	**27**
Utilised during the year	(34)	(10)	(22)	(51)	**(117)**
No longer required	-	-	-	-	**-**
Unwinding of discount	2	-	-	24	**26**
At 31 March 2026	**54**	**60**	**70**	**372**	**555**

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 2024/25**
	£000	£000	£000	£000	**£000**
Within one year	24	40	21	11	**96**
Between one and five years	30	20	49	45	**144**
After five years	-	-	-	316	**316**
	54	**60**	**70**	**372**	**556**

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.

£110,855k is included in the provisions of NHS Resolution (formerly the NHS Litigation Authority) at 31 March 2026 in respect of clinical negligence liabilities of the NHS foundation trust (31 March 2025 - £95,182k). Please see note 1.15.

18. Other liabilities

	Foundation Trust & Group	
	2025/26	2024/25
Current	**£000**	£000
Deferred income	**209**	1,934
Total	**209**	1,934

19. Borrowings

	Group	
	2025/26	2024/25
Current	**£000**	£000
Capital loans from DHSC (formerly ITFF)*	**1,062**	1,213
Lease liabilities	**1,414**	2,053
Total	**2,476**	3,266
Non-Current		
Capital loans from DHSC (formerly ITFF)*	**4,482**	5,512
Lease liabilities	**6,156**	6,335
Total	**10,638**	11,847

	Foundation Trust	
	2025/26	2024/25
Current	**£000**	£000
Capital loans from DHSC (formerly ITFF)*	**1,062**	1,213
Lease liabilities	**1,414**	2,053
Total	**2,476**	3,266
Non-Current		
Capital loans from DHSC (formerly ITFF)*	**4,482**	5,512
Lease liabilities	**4,791**	5,927
Total	**9,273**	11,439

19. Borrowings (Continued)

*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. 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.

The NHS Foundation Trust has not undertaken any additional borrowing after the 2017/18 financial year.

During the 2025/26 financial year the NHS Foundation trust repaid in full the outstanding loan for the Mobile MRI Scanner .

The interest rates on the NHS foundation trust's loans are:-
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).

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			
	2025/26 Total number of cases	**2025/26 Total value of cases**	2024/25 Total number of cases	2024/25 Total value of cases
		£000		£000
Losses:				
Losses overpayment of salaries	**-**	**-**	1	1
Bad debts overseas visitors	**-**	**-**	-	-
Stores losses	**-**	**-**	-	-
Bad debts other	**-**	**-**	342	4
Total losses	**-**	**-**	343	5
Special payments:				
Ex gratia payment loss of personal effects	**9**	**5**	16	14
Other negligence	**2**	**14**	1	**-**
Ex gratia payment personal injury with advice	**-**	**-**	-	-
Ex gratia payment other employment payments	**-**	**-**	-	-
Overtime corrective payments	**-**	**-**	-	-
Maladministration, no financial loss	**8**	**3**	-	-
Special severance payments	**1**	**12**	-	-
Ex gratia payment other	**-**	**-**	-	-
Total special payments	**20**	**34**	17	14
Total losses and special payments	**20**	**34**	360	19

21. Third Party Assets

The NHS foundation trust held £0 cash at bank and in hand at 31 March 2026 which related to monies held by the NHS foundation trust on behalf of patients (31 March 2025: £0).

22. Contractual Capital Commitments

Commitments under capital expenditure contracts at 31 March 2026 were £11,000,000 (31 March 2025: £26,341,000).

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
Middlesbrough Council
Northumberland Unitary Authority
Stockton-on-Tees Borough Council
Sunderland City Metropolitan Borough Council
Cumberland Council
Westmoreland Council
North Yorkshire County Council
Wakefield Council
Health Education England
HM Revenue & Customs
Leeds Teaching Hospitals NHS Trust
NHS Humber and North Yorkshire ICB
NHS West Yorkshire ICB
NHS England
NHS Pension Scheme
NHS Property Services
NHS Resolution (formerly NHS Litigation Authority)
York and Scarborough Teaching Hospitals NHS Foundation Trust

23.3 Transactions with Subsidiary

The Trust engaged in transactions with its wholly owned subsidiary, Harrogate Healthcare Facilities Management Ltd, in relation to managed healthcare facilities during the year. The value of these transactions totalled £25.8m (2024–25: £26.9m). All transactions were undertaken on normal commercial terms and in accordance with the Trust’s related party requirements.

24. Financial instruments.

Disclosure is required under International Accounting Standards of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The Harrogate and District NHS Foundation Trust actively seeks to minimise its financial risks. In line with this policy, the Trust neither buys nor sells financial instruments. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Interest Rate Risk

All of the Trust's financial liabilities carry nil or fixed rates of interest. In addition, the only element of the Trust's assets that are subject to a variable rate are short term cash investments. The Trust is not, therefore, exposed to significant interest-rate risk.

Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

Credit Risk

The Trust operates primarily within the NHS market and receives the majority of its income from other NHS organisations. There is therefore little risk that one party will fail to discharge its obligation with the other. Disputes can arise, however, around how the amounts owed are calculated, particularly due to the complex nature of the Payment by Results regime. For this reason the Trust makes a provision for irrecoverable amounts based on historic patterns and the best information available at the time the accounts are prepared. The Trust does not hold any collateral as security.

Liquidity Risk

The Trust's net operating costs are incurred under three year agency purchase contracts with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust receives such contract income in accordance with Payment by Results (PBR), which is intended to match the income received in year to the activity delivered in that year by reference to the National Tariff procedure cost. The Trust received cash each month based on an annually agreed level of contract activity and there are quarterly payments made to adjust for the actual income due under PBR. This means that in periods of significant variance against contracts there can be a significant cash-flow impact. The Trust has adequate liquidity to deal with these variances.

The Trust finances it's capital expenditure from internally generated funds or funds made available from Government, in the form of additional Public Dividend Capital, under an agreed limit. In addition, the Trust has borrowed from the Department of Health Financing Facility and may also borrow commercially in order to finance capital schemes. Financing is drawn down to match the capital spend profile of the scheme concerned and the Trust is not, therefore exposed to significant liquidity risks in this area.

24. Financial instruments (continued).

	Group		Foundation Trust	
	2025/26	2024/25	**2025/26**	2024/25
	£000	£000	**£000**	£000
Financial assets at amortised cost				
Loans and receivables (including cash and cash equivalents)	**30,575**	26,693	**31,264**	24,336
Investments	**-**	-	**1,000**	1,000
Loans to subsidiary	**-**	-	**-**	56,507
Consolidated NHS Charitable fund financial assets	**3,108**	2,506	**-**	-
	33,683	29,199	**32,264**	81,843
Financial liabilities at amortised cost				
Loans and payables	**44,954**	42,468	**48,919**	31,934
Consolidated NHS Charitable fund financial liabiilities	**162**	-	**-**	-
	45,116	42,468	**48,919**	31,934

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		Trust	
	31 March 2026	**31 March 2025**	**31 March 2026**	**31 March 2025**
	£000	**£000**	**£000**	**£000**
In one year or less	34,593	31,689	39,711	20,509
In more than one year but not more than five years	6,428	9,570	6,224	9,570
In more than five years	4,934	2,278	2,984	1,870
Total	**45,955**	**43,537**	**48,919**	**31,949**

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	
	2025/26	2024/25
	£000	£000
Unrestricted income funds	**914**	410
Restricted funds	**170**	175
Endowment fund	**1,862**	1,817
	2,946	2,402

26. Events after Reporting Period.

There are no known events following the Statement of Financial Position date, either requiring disclosure, or resulting in a change to the financial statements of the Trust or the Group.

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.

THIS PAGE HAS BEEN INTENTIONALLY LEFT BLANK

www.hdft.nhs.uk

www.harrogateintegratedfacilities.co.uk