Improving Health and Wellbeing

Humber NHS
NHS Foundation Trust

Humber NHS Foundation Trust Annual Report and Accounts 2014/15

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

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Contents

Introduction

Introducing our annual report is an opportunity to reflect on what has been a year of great change for our Trust.

The past 12 months have seen us build a new senior team and begin the process of transforming our organisation to enable us to better deliver more responsive services that have our patients and their families and carers at the heart.

The following pages are a snapshot of the huge amount of hard work and innovation that has taken place across the Trust in the previous year by the dedicated team we are extremely proud to call our colleagues. It is a summary of the most important things we have achieved in terms of quality, patient experience and safety. It tells you something about our new senior team and sets out how we have performed financially.

This has been a busy year with some fond farewells and welcoming new arrivals who have brought a wealth of experience to the Trust. Both of us took on our new roles during 2014 following the retirement of our predecessors David Snowdon and Jane Fenwick who led the Trust through many of the achievements and challenges a modern NHS provider faces, culminating in the Care Quality Commission (CQC) inspecting us last April with a team of 55 inspectors visiting 15 service areas over 71 sites.

The reports were published last October and as the new chairman and chief executive, we had the very great pleasure of hearing the CQC praise our team of caring, compassionate, committed professionals and the way the overwhelming majority of our services are effective and have a very positive impact on the lives of the people using them.

As you maybe aware, we also responded to some difficult questions from our partners, stakeholders and the media about areas for improvement flagged up by the CQC who also highlighted that unfortunately people still sometimes have to wait too long for our services. More people than ever before are in the need of the support we offer, whether this is from our adult or young people's mental health services or from our community and neighbourhood care teams who care for an ageing population with often complex and long term physical and emotional health needs.

We continue to work very closely with our partners and commissioners to understand how our services can respond flexibly to the changing needs of our population and make sure local people of all ages always get the most appropriate care and support.

The Trust exists to support the people of Hull and the East Riding of Yorkshire to live healthier lives, manage periods of ill health, live as independently as possible and take control of their

own wellbeing. However, we are aware that both populations have areas of inequality where some parts of the community do not enjoy the same health outcomes as other parts of the region and the country as a whole.

Our Trust is an integral part of Hull 2020, a programme of work led by NHS Hull Clinical Commissioning Group which is creating a better future for the city. The aim is that all public organisations function together as a single system, delivering services that make sense without the waste and inefficiency that often leaves people frustrated.

In addition, we are working on numerous projects with NHS East Riding of Yorkshire under the Better Care Fund which will see local health and social care services working more closely together, as we deliver caring and high quality services in a joined-up way that is fair and consistent.

Once again those who use our services and the people close to them tell us how much they value the quality of care and support they get from us. Our patient survey ratings remain amongst the best in the country, supported by Friends and Family Test results, feedback from the Meridian Patient and Carer Survey Feedback System and the Community Mental Health survey.

The Trust continues to perform well against most of our national and local targets. However, the challenging backdrop we operate against and the way income continues to decrease for all NHS providers means for the first time as Foundation Trust, we have not met all of our underlying financial targets in spite of keeping tight control on our spending. Rest assured, we are addressing this urgently by looking at ways to reduce our operating costs and make savings without compromising on the levels of care we deliver. You can read more about this in our financial statements which are towards the end of this report.

An organisation cannot strive to become the best it can be by standing still. In spite of financial restraints, we continue to add to our excellent team of clinical and therapeutic staff and invest in improving and modernising our buildings, particularly our inpatient units which are, at least for a short while, home to many of the people who use our services.

2014/15 saw us wind down activity on Buckrose Ward at Bridlington hospital. You may recall a lengthy review and consultation process concluded that patient care could be improved by offering alternatives to hospital admission through crisis assessment and home intensive treatment in the Bridlington area and providing acute inpatient services, when necessary, in our other modern, fit-for-purpose adult mental health environments which Buckrose was not able to provide. The ward closed in December 2014 and this was undoubtedly an emotional moment for staff who had worked there for some time.

Our commitment to supporting people to take positive steps to improve their own health and wellbeing continues. With the backing of our commissioners in the East Riding of Yorkshire, we now have Health Trainers clinics operating in towns and villages across this vast, largely

rural area so most of our population are within easy reach of this fantastic, free resource that really does support people to turn their own lives around.

We want better outcomes for the people in our care and their wider families but we know we cannot change this alone. Our Trust works in partnership with many other organisations and as we move into 2015/16, working together will help create a more joined up health and social care system. For example, our Trust works with the Alcohol and Drugs Service and East Riding of Yorkshire Council to support people in the East Riding with drug and alcohol problems. The joint service was recently praised highly by the CQC who found a high standard of person-centred care delivered by a team of staff who are passionate about what they do.

You can read about some of our most important achievements further on in this report but quite simply, every single day many members of staff from all of our service areas continue to care, innovate and inspire each other to excel. Thanking people enough for doing what they continue to do is impossible but we would like to take this opportunity to at least try. We know words really can't do justice to what you all continue to achieve but, all the same, thank you, to everyone working, or supporting that work, across the Trust.

It is often difficult to look after ourselves and look after each other when faced with the demands and challenges of working in an increasingly squeezed NHS. We both spend a lot of time with our different services and staff at all levels tell us it is getting harder to find ways of keeping up their resilience and staying mentally and physically healthy as pressures from outside become more intense. As a Trust this is something we want to address as a priority and we closed 2014/15 with a listening and learning event for our staff to let us know how they believe we can support them better.

Finally, thank you very much for your interest in our Trust and for taking the time to read this report. While there are elements of the content which we are asked to include by both the Department of Health and Monitor (the independent regulator for NHS Foundation Trusts), we hope you find it interesting and we always welcome any suggestions you may have as to how we can make our Annual Report more informative and useful to you.

David Hill
Chief Executive

Sharon Mays
Chairman

Delivering high quality and effective services

East Riding Addictions Services Praised by Health Watchdog

Our joint service that supports people in the East Riding with drug and alcohol addictions was praised by health watchdog, the Care Quality Commission.

CQC inspectors visited the services earlier this year and found a high standard of person-centred care delivered by a team of staff who are passionate about what they do.

Addictions Services in the East Riding have been provided since 2006 by a partnership between ourselves, the Alcohol and Drugs Service and East Riding of Yorkshire Council.

Feedback from people who have used the service was very positive with one patient telling the CQC that the team had, “Made me feel better, thanks to everyone who helped me on the road to recovery”.

The team is working closely with GP practices to make the services even more accessible, particularly to young people, throughout the East Riding.

David Hill, our Chief Executive, said he was delighted the CQC had highlighted the high quality of care.

“We are very pleased to see the CQC has noted the high standard of care which is assessed, planned and delivered around the individual, taking into account their needs and the needs of their families,” said David. “This was also something that really came out in the feedback from people who have used the service.”

Inspectors found that addictions services were safe and effective with clear reporting procedures and systems in place to ensure staff could learn from any incidents that occurred.

The report highlights staff morale is very high and that teams work well together with staff,

feeling supported by their colleagues and management. CQC inspectors also praised the facilities which were well-maintained, safe and secure.

Dr Tim Allison, Director of Public health for the East Riding, said: “This is well deserved recognition of a high quality service for both drug and alcohol users. The East Riding has been a top performing area for five years now and part of this success has been the good working relationship between Humber, ADS and our commissioning team.”

Tim Young, Chief Executive of the Alcohol and Drugs Service (ADS) said: “I am pleased the CQC has recognised the high standard of service and the staff involved are rightly proud of their achievements. Most importantly though, our service users, their families and the communities in the East Riding have benefitted from a high quality service which brings together the best of the NHS and third sector by working in partnership.”

Health Champions show age is no barrier to encouraging others to be healthier

Two Bridlington Practice Health Champions are helping older people in Bridlington to be more physically active after completing the Active in Age training programme. Judith Burke and Heather Downs are now fully trained to deliver this gentle chair-based exercise programme that aims to improve mobility, flexibility, balance and co-ordination while encouraging people who might otherwise be stuck at home to get out and about. They both signed up to be Active in Age mentors after they became Practice Health Champions at their GP surgery.

Before becoming an Active in Age mentor, Judith had taken part in the exercise programme at Bridlington Hospital after the 73 year old noticed that climbing the stairs or walking small distances left her struggling for breath.

“I am feeling a lot better and more mobile since joining the exercise class” said Judith. “Taking part in regular activity can really improve your overall health and wellbeing. My husband now joins in with me when I am practicing and is now able to move around more and has become more stable.”

Judith enjoyed the Active in Age class so much that she wanted to help improve the wellbeing of others. She wanted to show people of her own age that regular exercise can help you feel confident, happier and healthier. “I am so proud of what I have achieved and look forward to supporting others in the future,” said Judith.

Heather Downs, who also completed the Active in Age training found it a fun way to exercise and meet new people. “I thoroughly enjoyed my Active in age training with new friends,” said

Heather. “I’d love to open countryside classes where people of all abilities can experience relaxed movement to music, can work at their own pace, improve flexibility, stamina and co-ordination.”

Natalie Belt, our Health Trainer Service Manager and Active in Age Coordinator for Hull and East Riding said: “From all the mentors I have trained in the last five years, Judith stands out as someone who has taken on the role with a passion She is a great role model for older people and has shown that you can learn new skills no matter what age you are. Judith encompasses everything that the Health Trainer Service stands for.”

“Active in Age training is open to professionals, social care staff, activity co-ordinators, day care workers and volunteers. The aim is to get as many mentors out in the community offering sessions to encourage those that are isolated, lonely, may have suffered a health problem or lack confidence to socialise and have fun in their community.”

For more information about Active in Age sessions run across the East Riding of Yorkshire please contact 0800 9177752 or email healthtrainers@humber.nhs.uk.

Humber NHS Foundation Trust Celebrates UNICEF Baby Friendly Initiative Stage 2 Success

The Trust was delighted to achieve Stage 2 Accreditation of the UNICEF Baby Friendly Initiative (BFI).

The Baby Friendly Initiative is designed to support breast feeding and parent infant relationships.

By adopting the Baby Friendly practices, the Health Visitors and Nursery Nurses working in the community ensure a high level of care for all pregnant women, mothers, babies and their families around all aspects of infant feeding but in particular the promotion of breast feeding.

Achieving this award means that mothers, babies and families in the East Riding will receive consistent information to support and promote safe infant feeding. Research clearly shows that breastfeeding is the best way to feed a baby and it provides health benefits to mums too with a long term positive impact on maternal and child health.

Pauline Dumble, breast feeding lead, said: “This accreditation gives us the opportunity to evidence the excellent work that goes on in the Health Visiting services to support breast feeding.’

Jacqui Dawson the Service Manager for Children and Young People at the Trust, said: “Achieving Stage 2 Accreditation is a great achievement for our services.”

Nia Abbott Head of the Trust’s Children and Young Peoples service, added “I’d like to thank all our staff who have been involved for their continued commitment, to improving outcomes and patient experience for our clients in this area.”

Making an Active Difference in Kids’ Lives

We all know taking part in sports is good for young people’s health but a new study by academics at the Trust has shown its benefits go beyond making kids fitter.

The study looked at the impact attending the Tiger’s Trust Able and Active programme had on the lives of a group of local 9 to 13 year olds with learning disabilities.

Able and Active is a fun, multi-sport club for children, young people and adults with disabilities where they get to take part in activities such as football, basketball, handball, volleyball and short tennis.

Dr Chris Garrod, our Clinical Psychologist, said the children and their families took part in structured interviews about going to the sports club and were encouraged to talk about whether it had made a difference it to their lives. The youngsters were asked to look at and draw pictures to help the researchers understand what playing sports with other kids in the group meant to them.

“The responses from the children and their families showed that going to the sports group really helped the kids to make friends, feel happier and find fun stuff that they were good at doing,” explained Dr Garrod. “It demonstrates groups like this serve an important purpose in improving the health, wellbeing and resilience of kids with learning disabilities and their families, as well as helping them to become physically fitter. “

Rob Johnson, Able and Active Project Coordinator, explained that by working with people with a disability in a sporting context for the last 10 years, he has seen what a positive impact this can have.

“I have witnessed the difference it makes on the lives of everyone involved,” said Rob. “Participants, their families, staff and volunteers all benefit in some way. The Tigers Trust are determined to sustain and develop projects like Able and Active.”

Able and Active are using the results from Dr Garrod’s study to support a bid for more funding to enable the project to continue.

A Lifeline to reduce falls in hospital

East Riding of Yorkshire Council's Lifeline scheme supported our East Riding Community Hospital to meet the surge in demand for care.

State of the art technology used by the council's lifeline telecare service has improved patient safety at the community ward in Beverley where the number of beds available to patients has increased from 26 to 36.

As these additional beds are in rooms not usually used for this purpose, and are therefore further away from the nurses station, the lifeline team were called in to install extra equipment including bed sensors, chair sensors and falls detectors that are linked to monitors carried by nurses on the ward.

In the event of a patient getting out of bed, for example, the sensors send a signal to the monitor, informing the nurse of what has happened and at which bed so they can respond appropriately and quickly.

Jo Mcneil, our Community Ward Matron, said: "This is another example of how we are using advances in technology to reduce risks and improve patient safety. The equipment enables our team to have a greater awareness of patient movement – something that it is vital in a busy ward. By reducing the risk of patients mobilising un-aided, we can reduce the risks of falls. "Patients feel safe, confident and reassured as a result of the equipment."

The support offered by lifeline does not necessarily end when a patient is discharged from hospital.

Lifeline offers people who have been recently discharged from hospital, and are in need of additional support and assistance at home, a free disablement service for up to six weeks.

The service consists of a range of sensors being placed in a person's home and linked to the monitoring centre which is manned by trained operators who are ready to take the most appropriate action should a sensor be triggered.

This action could be contacting a family member, neighbour, doctor, lifeline responder or the emergency services.

Councillor Harrap, East Riding of Yorkshire Council's portfolio holder for adult and carer services said: "As we all know hospitals are currently under an unprecedented level of pressure to care for increasing numbers of patients.

"The way in which East Riding Community Hospital has been using our lifeline service is a prime example of the way in which this technology can be used to help alleviate the pressures that this particular ward has been experiencing at this time.

"It is also a good example of the way in which lifeline can offer help, support and reassurance to those people who need it the most, whether they are in hospital, have recently been discharged from hospital, or want to live as independently as possible in their own homes."

Patients using Trust services in Withernsea and Bridlington are also using the equipment.

Valuing people

Staff from across the organisation received recognition for their hard work and dedication at our Annual Staff Awards.

Taking place as part of the Annual Members Meeting (formerly our Annual General Meeting) around 400 staff and members of the public attended the event at The Country Park Inn in Hessle to hear about our achievements over the year and to applaud the winners in nine categories.

These included our chairman's 'Who Cares, Wins' award, which recognises someone who has really gone the extra mile in a caring role. This year's award was won by Community Stroke Support Worker Tracy Webb who goes above and beyond the call of duty in her mission to help people recover from the sudden and life-changing effects of a stroke.

A stroke can change the lives of people of all ages, often leaving patients and the people who care for them feeling isolated and helpless. As well as her "day job" supporting people who have had a stroke, Tracy has put in hours of her own free time to organise a series of celebration dinners which boost the confidence of stroke survivors and help them to get their sparkle back.

"So many people have been in touch to tell us what a huge difference Tracy has made to them or someone they care about," explained Sharon. "This is all done in Tracy's own free time and she puts so much of herself into making these events to remember and cherish for people who have been through a very tough time."

We are fortunate to have a workforce that is committed to providing the very best mental health, learning disability, children's services and community care services for people living in Hull and the East Riding of Yorkshire. While many of our staff view going the extra mile as just a part of their job, we recognise the achievements of teams and individuals with a series of awards and also give staff the chance to nominate colleagues as Unsung Heroes.

Highlights include the Inspirational Leader of Year award which this year went to Trish Bailey who leads our Learning Disability services and the Chief Executive's Making a Difference award which had a very popular recipient in the form of Matron of Withernsea and Bridlington Community Hospitals, Karen Gordon-Russell.

Our Chief Executive David Hill said he was overwhelmed by the quality of the entries and moved by many of the stories that accompanied them.

"Winning our awards is not easy," explained David. "Each entry has to meet a set of tough criteria including evidence of significant improvement through innovative ways of working, offering real benefits for our patients and their carers and other members of staff as well as contributing to the value for money and on-going affordability of the services we provide. Reading out the names of the nominees, runners up and winners, telling their stories and watching the delighted reaction of the many staff members who had gathered to celebrate these incredible achievements was humbling."

The winners in each category were:

Service Delivery

Hull Memory Clinic; for reducing waiting times and increasing dementia detection rates for older adults who required a memory assessment and diagnosis.

Innovation and Progress

Recovery and Psychological Interventions Team (Hull); for developing a recovery skills course to equip clients with skills to promote recovery within a supportive environment.

Improving Patient Dignity and Respect

Inpatient Intermediate Care Service HMP Wakefield; this service has gone from strength to strength in the 16 months it's been operating. Providing nursing care and interventions for 750 inmates within a high security prison, it aims to facilitate early hospital discharge from acute hospitals and preventing admission.

Improving Patient Safety

Safer Staffing Team; This multi-disciplinary group have worked together to produce and publish our safer staffing levels in a way that supports our quality agenda, providing a greater level of detail than the statutory requirement.

Promoting Equality in Service Provision

Andrea Court – Community Learning Disability Nurse; for helping a profoundly disabled lady who was afraid of ophthalmologists, due to previous treatment, to access these services as she was in danger of losing her eyesight.

Most Inspirational Leader

Trish Bailey, Head of Service - Older People Mental Health and Learning Disability Services; Trish has been an Inspirational Leader to the staff she has worked with for many years. Everyone who had the privilege of working with Trish has greeted the news that she was put forward for this award with enthusiasm.

Trish has always been an advocate for people with a learning disability. Her commitment and passion is infectious and her staff have modelled themselves on her values. Over the years, Trish has influenced and empowered both her staff and the people who use our services in equal measure.

She is well known throughout the organisation and her reputation precedes her as someone who expects high standards of care and commitment from her staff. Trish demonstrates the ability to think outside of the box, is always up to date with current drivers and has the ability influence across the Trust.

Trish knows her teams well and is aware of individual skills and ambitions. Trish is always keen to promote her services and will utilise all resources to take projects forward and be a voice for service users and their families. If there is the opportunity to create a new service or facilitate links with another service, which will have a positive effect on people's lives, Trish will endeavour to support that opportunity by either securing funding, preparing business cases or sitting with clinicians to support their planning.

Trish has faced pressures in her job that may have overwhelmed other managers but her courage and commitment has enabled her to endure all adversities with the poise and determination that is evident when you see her.

Trish has the ability to adapt her leadership style to compliment any situation, whether that's comforting an anxious staff member, meeting with commissioners or supporting a grieving relative. Although this could reflect a typical day for Trish, she always makes time for her staff and service users despite her busy schedule.

Team of the Year

This year has seen some incredible work by our teams as we all strive to deliver excellent, safe and compassionate care to the people who use our services and their carers and families.

It was incredibly difficult to select one winner from the many submissions and so two teams shared the honor.

These were:

•East Riding Community Ward, and

•our Psychiatric Intensive Care Unit

East Riding Community Ward (based at the East Riding Community Hospital)
2013 saw a difficult time for staff working on the community ward at East Riding Community Hospital when we took the decision to temporarily reduce bed numbers following issues raised by a visit from the independent health service regulator the Care Quality Commission.

This was the beginning of a transformational process which saw:

- the development of a listening, open, challenging, learning and sharing culture;
- meaningful engagement of patients and their carers;
- the development of effective real time systems and processes;
- leadership, commitment and passion of ALL the staff working in the ward environment e.g. nurses, managers, health care assistant, allied health professionals, medics, ward clerks, cooks etc to make it happen.

This is an ongoing journey that continues with a rejuvenated team whose ownership of areas that once created difficulties enables us to constantly drive up quality and deliver a safe, effective and caring service.

Psychiatric Intensive Care Unit
The Psychiatric Intensive Care Unit based at Miranda House in Hull is a 14 bedded, purpose built unit for men and women who are in absolute crisis. These are some of our most vulnerable service users who have been compulsorily detained for their own or for other people's safety.

Providing compassionate and excellent care for people who are experiencing an acutely disturbed phase of serious mental disorder requires a dedicated team of staff. Our visits to the unit have highlighted the often challenging situations the team face and the professionalism and compassion with which the multi-disciplinary team manages risk and provides care and patient-centered solutions.

Chairman's Award 'Who Cares, Wins'

Tracy Webb, Community Stroke Support Worker; Tracy has truly gone above and beyond the call of duty to improve the lives of many service users and their loved ones.
She has used countless hours of her own free time over the past three years to plan and deliver two major celebrations that have delighted people recovering from the traumatic and life-changing effects of a stroke and already has plans well underway for another Stroke Survivor's Dinner in 2015.

Tracey has motivated patients and carers to get involved with the event. The last one in 2013 was a huge success and many people have contacted the Trust to say what it meant to them and their recovery or the recovery of a loved one.

Chief Executive's Award for 'Making a Difference'

Karen Gordon-Russell, Matron for the Community Hospitals at Withernsea and Bridlington; Karen is a valued colleague to everyone she works with, regardless of grade or position within the organisation. She leads by example and is an excellent role model for all her clinical colleagues.
She is a compassionate nurse who puts the patient, their carers and loved ones at the heart of everything she does. She is always willing to go the extra mile to support the staff and patients.

Strategic Report

About our Trust

We provide a very broad range of community services (including therapies), community and inpatient mental health services, learning disability services, healthy lifestyle support and addictions services to people living in Hull and the East Riding of Yorkshire, a large geographical area with a population of approximately 600,000. We also provide specialist services for children including physiotherapy, speech and language therapy and support for children and young people and their families who are experiencing emotional or mental health difficulties.

Our specialist services, such as forensic support and offender health, support patients from the wider Yorkshire and Humber area and from further afield.

We employ approximately 3000 staff across more than 70 sites at locations throughout the East Riding and Hull and the Trust strives to promote activities that make a positive impact on the work-life balance of the people who work for us.

We have now been a Foundation Trust for five full years. We acquired Community Health Services from NHS East Riding of Yorkshire in April 2011. Prior to this, Humber Mental Health Teaching NHS Trust had been providing Mental Health, Learning Disabilities and Addictions services to people in Hull and the East Riding since October 1994.

Our income in 2014/15 was 131.8 million with the majority of this coming from our two main commissioners, NHS Hull and NHS East Riding of Yorkshire Clinical Commissioning Groups (CCGs).

Our services include:

- A&E liaison for working age adults and older people
- addictions, including inpatient alcohol detox in the East Riding
- bladder and bowel specialist care
- child and adolescent mental health services (CAMHS)
- children's services
- chronic fatigue
- counselling
- diabetes services
- community nursing
- East Riding Community hospitals situated in Beverley, Withernsea and Bridlington provide inpatient medical beds with Hornsea and Driffield providing a wide range of outpatient services and clinics
- a multi-disciplinary falls prevention team
- forensic services for mental health, learning disability patients and personality disorder patients, including some from outside our area
- health services in prisons including mental health in-reach
- healthy lifestyle support through our award winning Health Trainers

• health visiting
• Huntington's disease team
• inpatient and community mental health for working age adults and older people
• intermediate care
• learning disability community and inpatient services
• long-term conditions
• Macmillan nurses
• nutrition and dietetics
• out-of-hours and unscheduled care
• pain
• palliative care
• perinatal mental health
• physiotherapy
• podiatry
• psychiatric liaison
• psychological interventions
• psychotherapy
• school nursing
• self-harm
• stroke services
• therapy services (physiotherapy, speech and language)
• tissue viability
• traumatic stress
• unscheduled care

The list above is not exhaustive and services can change. For more information and information about referral pathways, go to www.humber.nhs.uk/services.

In addition to health and care services, we have service level agreements to provide medical teaching to undergraduates of the Hull York Medical School.

People who use our mental health services receive a wide range of care and therapeutic treatments in a variety of settings including their own homes, health centres, outpatient clinics, local authority premises and our inpatient units. More specialised care is provided by the psychiatric intensive care unit and forensic services, including in-reach in to the local prisons.

An element of our strategy is to provide services as close to a patient's home or usual place of residence as possible and to ensure when inpatient care is necessary, it is provided in safe, high quality environments.

Community services in the East Riding are delivered in a variety of settings. This includes in our community hospitals, GP practices and health centres, locality-based clinics and in patients' homes.

Vision and goals

The Trust Board continually reviews the organisation's strategic direction – originally based on the vision and strategic goals originally developed as part of the public consultation for Foundation Trust status - which is particularly important against a backdrop of significant structural change within the wider NHS.

Our vision is to improve the health and wellbeing of the communities we serve, supporting people to live longer and healthier lives.

The people who use our services and their families are at the heart of everything we do and we work closely with partners from organisations with similar goals to our own to ensure people have the best experience possible in our care.

We have nine strategic goals that form the direction and aspirations of our organisation and underpin our vision. The goals are supported by comprehensive strategies for finance, workforce, estates, risk management, clinical governance, strategic investments and performance management.

These goals are to:

- Provide services that are safe, person-centred, delivered in appropriate environments and sensitive to the needs of the individual
- Retain the confidence of patients, carers and commissioners by upholding the principles of the NHS
- Be an excellent employer, maximising the skills and talents of our valued workforce
- Ensure a firm financial foundation underpins the delivery of our vision
- To work in partnership with other organisations and local authorities to develop seamless service provision
- Through the use of evidence-based practice, provide high quality services to establish a reputation for exceptional standards of care
- Use our positive reputation to develop new services and expand existing ones
- Provide and develop services that are efficient, cost-effective and responsive to the needs of the people who use them
- Work with our members to achieve our vision.

Development and Performance

Our performance management framework reports progress against key performance indicators, based on the strategic goals to our Board on a monthly basis. Added to this is a risk register which tracks key risks identified on an ongoing basis and as such ensures any major concerns are dealt with. A larger set of indicators is reviewed by our Board each quarter. To support this, the business units account to the executive team via quarterly performance review meetings and likewise the senior operational managers review their teams on a structured basis.

Any problems with performance are formally reported up through these channels which are designed to ensure involvement of staff at all levels in understanding and influencing performance in their areas of responsibility.

Achievements

Some of our most important achievements during the past 12 months include:

- Care Quality Commission Inspectors found a high standard of person-centred care delivered by a team of staff who are passionate about what they do in our East Riding

Addictions Service, provided in partnership with the Alcohol and Drugs Service and East Riding of Yorkshire Council.

- Families are now able to refer themselves to Child and Adolescent Mental Health Services by calling one of our Contact Point numbers and speaking directly to a clinician.

- We have launched a new mobile APP and an internet portal to make it easier for people to refer themselves for talking therapies in the East Riding of Yorkshire.

- We are embedding Children and Young People Improving Access to Psychological Therapies into our services to give families a greater say in decisions about their care and the way the services that are important to them are developed with a number of our staff currently undergoing training.

- Introduction of a Single Point of Contact (SPOC) for our neighbourhood care services in the East Riding.

- Our dietitians launched the Nutrition Mission – an award-based incentive scheme to ensure people living in care homes benefit from optimal nutrition and hydration.

- Our Occupational Health Service was awarded the Safe Effective Quality Occupational Health Services (SEQOHS) Accreditation that recognises Occupational Health Services that provide safe, appropriate and effective quality care for staff in the NHS and Independent Sector.

- Our East Riding Health Trainers began regular clinics in GP surgeries throughout rural Holderness and other locations in the East Riding.

- Hawthorne Court achieved AIMS (Accreditation for Inpatient Mental Health Services) accreditation with excellence for the second time. This is the Royal College of Psychiatry mark of good practice designed to guarantee a high quality of care in mental health wards.

- We achieved Stage 2 Accreditation of the UNICEF Baby Friendly Initiative (BFI) designed to support breast feeding and parent-infant relationships.

- We began recruiting a team of Patient Voice Volunteers who support people spending time on our units to speak up about the care they are receiving.

- We joined other public sector organisations in Hull to launch Hull 2020, an ambitious transformation programme to enable local people to take control of their health and wellbeing and support them towards achieving their aspirations.

- We launched our Practice Health Champions website, a new programme in partnership with East Riding GP surgeries for people who want to improve health and wellbeing in their local community by establishing groups and projects and advising others.

Finance Director's Report

Summary of the Financial Year

This report covers our financial position for the year from April 2014 to March 2015. We are reporting a deficit of £0.3m on income of £131.8m in the year. After adjustments, this is a £1.9m underlying surplus which is a significant reduction on last year's performance.

Operationally we have worked very hard to achieve this result, however it is partly achieved via a range of non-recurrent means and there was some under delivery on our efficiency programme. As such it cannot mask the size of the financial challenge that we continue to face in the next financial year and beyond.

We incurred a reduction in income of 1.7% in 2014/15 from our commissioners following on from the 1.3% reduction in 2013/14. In addition, we have faced reductions due to the decommissioning of some services, most notably the provision of some mental health services in Hull.

We anticipate the efficiency reductions will continue at a similar level for the foreseeable future. Coupled with the effect of cost inflation, this has placed increasing emphasis on the need to deliver financial efficiencies throughout the organisation. During the year, £4.0m of cost efficiencies were generated, some of which were non recurrent. This has enabled us to meet our underlying financial targets and remain financially healthy.

It is particularly pleasing to note that we continue to deliver cost savings that have not negatively impacted on our key performance indicators which is a huge credit to all staff.

The closing cash balance decreased to £12.3m in the year, which although still healthy is a decline from last year's £15.7m. This balance is likely to continue to reduce whilst we fail to generate year end surpluses. However coupled with careful working capital management and management of capital investment strong balances can be maintained.

Total capital spend in the year was £5.2m. This level of expenditure is high compared with previous years and is due in part to insurance funded reinstatement work to the Sunshine House Children's centre (£0.8m). Other major schemes included the works to extend the bed base at Newbridges (£0.7m) and redevelopment work at townend court to accommodate additional services including the wheelchair service (£0.8). The net current assets position reduced in the year to £8.5m, the reduction is due mainly to the purchase of capital and expenditure made against income received in 2013/14. Our total net assets increased to £70.4m compared to £68m a year ago.

We have a risk rating of 3 at the end of quarter 3. The scale is from 1 to 4, with 4 being the lowest risk. This is primarily based on our strong liquidity position (cash balance). We are not in a position to report on our governance rating for Q4 or annual position as this has not been confirmed by Monitor.

Financial results 2014/15

Headlines

- Income of £131.8m
- Deficit of £0.3m after impairment adjustment
- A surplus of £1.9m after adjustment for asset revaluations
- The cash balance was £12.3m compared to £15.7m at March 2014
- Net current assets of £8.5m compared to £12.2m at March 2014
- Total net assets of £70.4m compared to £68m at March 2014

Income and expenditure

Income in the period was £131.8m compared to £132.6m in the prior year. We incurred a reduction in income from commissioners of 1.7%, as well as a reduction from Hull CCG for low level anxiety and depression services (cluster 1-4) during the year. This decrease was partially compensated for in the year by both a range of non recurrent income received to establish a number of pilot schemes as well as additional investment in some services.

The underlying surplus delivered was again good and is reflective of the quality of financial management across the Trust and the amount of financial planning that takes place. Despite it being a difficult year in terms of receiving a further 1.3% reduction in income, incurring cost inflation as well as other financial pressures; our deficit of £0.3m was lower than anticipated.

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 its income from the provision of goods and services for any other purposes. The Trust met this requirement during 2014/15.

Capital Expenditure

Capital expenditure totalled £5.2m during the year. The most notable schemes in the year related to the refurbishment of Newbridges £0.7m, a re-development of Townend Court of £0.8m, and the refurbishment following the flooding of the Children's Centre £0.8m.

The other most notable expenditure covered a range of projects and facilities including addressing backlog maintenance issues and the continuation of investment following on from the Care Quality Commission assessments.

£1.5m was invested in additional IT equipment and systems.

Management costs

Management costs for the year amounted to £7.4m which equates to 5.7% of income. This shows an increase in both value and percentage of total costs when compared to the previous year. Details of directors' remuneration are provided on page 54 - 55.

Better payments practice code

In accordance with the Confederation of British Industry's (CBI) Better Payment Practice Code, our payment policy is to pay non-NHS trade creditors within 30 days of receipt of goods or services, or a valid invoice (whichever is the later) unless other payment forms have been agreed with the supplier. The figures for non NHS creditors improved from 90% to 96% in terms of the value paid within 30 days. The number of invoices paid within this time frame also improved from 92% to 95%. We will continue to focus on this important performance measure.

	2014/15		2013/14	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	29,385	27,682	28,184	25,089
Total non-NHS trade invoices paid within target	27,978	26,648	26,034	22,654
Percentage of non-NHS trade invoices paid within target	95%	96%	92%	90%
Total NHS trade invoices paid in the year	332	2,376	507	2,694
Total NHS trade invoices paid within target	318	2,284	445	2,323
Percentage of NHS trade invoices paid within target	96%	96%	88%	86%

Financial Outlook

We have responded well to the financial challenges we have faced over the last three years in particular. Over £11.7m of cost-efficiency savings have been generated over the course of the past three years. For 2015/16 a further income deflator of 1.6% is being applied and as well as pay inflation pressures we face other inflationary pressures. To offset these issues, further cost efficiency improvements of approximately £6.5m are required. Medium term plans demonstrate the need to continue to deliver this level of efficiency improvement over the next five years. Given the amount already saved it is naturally more difficult to identify further savings. We continue to operate a very robust process for identifying and implementing cost savings projects. All projects must be approved by both the Medical Director and Director of Nursing to ensure there is no negative impact on patient safety or quality of care. The programme of work for identifying savings initiatives for 2015/16 is largely complete and will continue to be reviewed on an ongoing basis.

We remain committed to delivering the best possible care and service within the financial resources we have at our disposal. The focus of the cost saving projects has therefore been very much on maintaining service provision and re-structuring the organisation to meet that service provision.

As reported last year there is no doubt the difficult economic environment will remain for some time. We have maintained a solid financial base but will need to continue to improve financial

management to remain in a healthy financial position. All staff are encouraged to identify where any waste occurs and a staff suggestion scheme was introduced to this effect.

Following on from a good performance in 2013/14 against our Commissioning for Quality and Innovation (CQUIN) framework, we accomplished a high level of payment for achievement of these indicators in 2014/15. We continue to focus on these indicators in 2015/16 to ensure this level of income remains in place.

The Payment by Results (PbR) system for generating income within a number of mental health services continues to develop both locally and nationally. A vast amount of work has taken place within the organisation to prepare for this. We continue to work with our commissioners to ensure our income levels are appropriate for the services we provide.

Conclusion

We delivered a good underlying financial performance last year, particularly in the face of a further income deflator being applied and the loss of some commissioned services. This was very pleasing bearing in mind it was the fourth year of receiving a reduction in income and that it is becoming increasingly difficult to identify cost efficiency improvements. As ever, it was very much a team effort across the whole organisation to deliver this financial performance. Even more importantly, the delivery of the financial results did not compromise patient care. We achieved the vast majority of our performance targets for the year and received positive results from the patient survey.

In conclusion, it is appropriate to re-affirm the comments made last year. We will continue to face financial challenges both this coming year and beyond. We remain positive that these challenges will be met, although we should not be under any illusions that it will require a great deal of effort and it will involve making difficult decisions on occasions.

The Financial Statements included in this report (and also available on our website) are merely a summary of the information in the full accounts which are available on demand, simply contact: Alison Maxwell, Communications Manager, Humber NHS Foundation Trust, Trust Headquarters, Willerby Hill, Beverley Road, Willerby, HU10 6ED.

The directors consider the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

Charitable Donations

As an NHS Foundation Trust, we make no political or charitable donations. We do however continue to benefit from the receipt of charitable donations which are monitored and allocated separately through a charitable funds committee. We are extremely grateful to fundraisers and members of the public for their continued support in providing these donations.

Going Concern

After making enquiries, the directors have a reasonable expectation that the NHS Foundation

Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Directors' Statement

As far as each Director is aware there is no relevant audit information that the NHS Foundation Trust's auditor is unaware of. Each Director has taken all the required steps in order to make themselves and the NHS Foundation Trust's auditor aware of any relevant audit information.

Review of tax arrangements

We have complied with implementing the recommendations of Her Majesty's Treasury (HMT) review of tax arrangements. The following tables show all off-payroll engagements at a cost of over £58,200 per annum and more than £250 per day for more than six months.

Table 1: For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months

No. of existing engagements as of 31 March 2015	4
Of which…	
No. that have existed for less than one year at time of reporting	4
No. that have existed for between one and two years at the time of reporting	0
No. that have existed for between two and three years at the time of reporting	0
No. that have existed for between three and four years at the time of reporting	0
No. that have existed for four or more years at the time of reporting	0

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015, for more than £220 per day and that last longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015	20
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	20
No. for whom assurance has been requested	5
Of which	0
No. for whom assurance has been received	0
No. for whom assurance has not been received	5
No. that have been terminated as a result of assurance not being received	0

Table 3: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2014 and 31 March 2015

Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year	1
Number of individuals that have been deemed 'board members, and/or senior officials with significant financial responsibility' during the financial year. This figure should include both off-payroll and on-payroll engagements	13

Lessons Learnt

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England.

Its purpose is to make sure health and social care services (such as hospitals and care homes) provide people with safe, effective, compassionate, high-quality care and encourages them to improve. Its role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and publish what it finds, including performance ratings to help people choose care.

We are fully compliant with the registration requirements of the CQC. Our current registration status is ‘registered without conditions’. The CQC has not taken enforcement action against the Trust in 2014/15.

In the year 2014/15, our services were inspected by the CQC on two separate occasions. In March 2014, we were informed by the CQC that we were to be involved in a second wave pilot of the new style CQC inspections. The new style looks at five areas:

- Are we caring
- Are we safe
- Are we responsive
- Are we effective
- Are we well led

Our first inspection took place in May 2014, with around 50 inspectors spending three days visiting a variety of the services we provide. Following this inspection, we received five ‘must do’ actions and a list of ‘should do’ recommendations.

We immediately produced an improvement plan for the CQC with assurance that we would address the ‘must do’ actions. Four of the five actions highlighted were completed on notification whilst the CQC were still on site. One action will take longer to complete as the work is part of a wider refurbishment programme of three wards within our forensic services.

We are also acting on the recommendations categorised as ‘should do’ by the CQC and assure our Board with monthly progress reports.

The second inspection was an unannounced inspection. This took place at HMP Wakefield in July 2014 where we provide nursing care and interventions within HMP Wakefield along with two other providers. The CQC report highlighted improvements that could be made in joint working practices. All three providers worked together to improve this and following a re-inspection in March, 2015, verbal feedback from the CQC was very positive.

The Trust Board takes a proactive approach to improving quality (e.g. it actively seeks to apply lessons learnt in other trusts and external organisations)

Lessons from quality performance issues are well-documented and shared across the trust on a regular, timely basis, allowing us to implement good-practice effectively.

A full copy of our registration certificate and inspection reports can be viewed at www.humber.nhs.uk or by request, a copy can be made available from the Trust Secretary by emailing jenny.jones26@nhs.net

Principal Risks and Uncertainties

National Policy and Drivers

The environment against which we operate is extremely fluid. Current key influences include:

- a change in provider landscape including increased competition by the introduction of "Any Qualified Provider" (AQP) and an increasing range or eProcurement's;
- pressure on existing funding levels with an income deflator of 1.8% in 2014/15;
- cost inflation;
- ageing of our local population and increased life expectancy with more people living with long term health conditions.

These influences are reflected in national health policies and initiatives which include:

- deferral of the Mental Health Tariff (a transparent rules based system for paying trusts based on activity) until April 2016;
- identification of efficiency savings including service re-design;
- improvements in performance monitoring with an increased focus on patient outcomes;
- excepted improvements in patient access to our full range of services
- development of patient choice;
- improving patient and carer involvement;
- tackling social exclusion and discrimination.

Resources and Risks

High level business risks have been identified as part of the development of the assurance framework and risk register. Those risks which reflect the operating environment are summarised below:

- failure to recruit, retain, deploy and develop a workforce that is sufficient in number, capable, skilled and fit for purpose to deliver business plans;
- adverse use of care cluster currencies for contracts;
- that income declines through loss of contracts, implementation of tariff, national and local commissioner targets;
- the impact of world economic situation on NHS and wider public sector funding;
- potential financial and quality implications of not delivering national and local CQUIN indicators;
- lack of development of new strategic partnerships with existing and emerging stakeholders;
- risk of contract losses resulting from failure to compete effectively for provision of services;
- failure to engage with patients and carers resulting in services that do not meet the patients' needs;
- adverse impact of inadequate IT systems failing to effectively support management decisions, performance management or contract compliance;
- potential loss of reputation resulting from any future very serious untoward incident;
- lack of engagement of partner organisations;
- failure to deliver financial plans, Monitor compliance targets;
- non-compliance with NICE and other national guidance due to a lack of provision of relevant funding, lack of process and recording of data;
- non-compliance with statutory and regulatory requirements resulting in disruption to business, claims etc;
- failure to ensure all patient environments are safe and provide privacy and dignity;
- staff do not own the culture required to ensure Trust values and goals and NHS principles are at the heart of service delivery;

- failure of Integrated Governance processes which could lead to poor performance ratings, registration failures and/or damage to the Trust in relation to commissioners, regulators and the public.

Mitigation plans are in place for the above risks which are updated regularly and with progress monitored by our Board.

We have contractual arrangements with a wide variety of organisations. The main contracts are for patient care services provided to local Clinical Commissioning Groups and NHS England, largely under "block" contracts. We also provide social care services under section 75 agreements with the two local authorities and have various shared service arrangements with local health organisations.

It should be noted that the introduction of the new Mental Health Tariff System has been deferred until April 2016.

Regulatory Ratings

The table below summarises the performance ratings we have received from Monitor throughout the year and compared to the previous year. The Risk Assessment Framework scale is 1 to 4 with 4 being the lowest risk.

We have a risk rating of 3 at the end of quarter 3. We are not in a position to report on our governance rating for Q4 or annual position as this has not been confirmed by Monitor.

Monitor performance ratings 2014/15

	Annual Plan 2014/15	Q1	Q2	Q3	Q4
Continuity of service rating	4	4	3	3	4
Governance rating	Score not received from Monitor	Green	Green	Green	Score not received from Monitor

Monitor performance ratings 2013/14

	Annual Plan 2013/14	Q1	Q2	Q3	Q4
Under the Compliance Framework					
Financial risk rating	4	3	4		
Governance risk rating	Amber/ Green	Amber/ Red	Green		
Under the Risk Assessment Framework					
Continuity of service rating				4	4

Governance rating				Green	Green

Counter Fraud

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy our financial position at any time, to enable them to ensure that the accounts comply with requirements outlined in Secretary of State Directions. They are also responsible for safeguarding our assets and taking reasonable steps for the prevention and detection of fraud and other irregularities.

Compliments, queries and complaints

We aim to provide the best possible care for the people who use our services, their families and carers. We recognise, however, that there may be times when an individual is not satisfied with the service they have received and may wish to raise a concern or complaint and we offer them a choice of how to do this. They may wish to speak to the staff supporting them or to the local manager of the service. If they feel unable to do this or they have done this and remain dissatisfied they can contact the Patient Advice Liaison Service (PALS) to receive an informal response to their concern. Alternatively, they may wish to raise their concerns as a formal complaint through the NHS Complaints Procedure.

PALS also record compliments that we receive and comments made on any of the services we provide which are passed to the appropriate manager. PALS also answer general questions about the services we provide or will signpost the caller to the correct person/agency to answer their query.

Each formal complaint is allocated an investigating manager who carries out a thorough investigation. The process includes speaking to the complainant, where possible, to discuss their concerns and to establish their desired outcome if this is not already known. Following this, the relevant staff are interviewed, medical records are reviewed and any recommendations and actions are agreed. At the end of the investigation a response letter outlining the findings from the investigation is sent to the complainant from an Executive Director. The response letter includes an apology (if appropriate); an explanation of what happened and why; any recommendations and actions identified to try to ensure that mistakes are not repeated whether this is to improve an individual's care or involves changes to our internal systems and/or procedures. The agreed actions are then monitored to ensure they have been completed.

In the event that the complainant remains dissatisfied on conclusion of local resolution, they have the right to ask the Parliamentary and Health Service Ombudsman to review their case.

Health and Safety

We take the subject of health and safety very seriously. We have adopted a health and safety strategy and have a range of relevant policies and procedures. We employ a health and safety lead (non-clinical) and a specialist fire safety advisor, legislation is complied with and best practice followed. Health and safety assessments are regularly carried out at each of our premises and recommendations identified from these assessments are implemented. Clinical

safety is overseen by the Clinical Management Team, Clinical Governance Team and a Clinical Safety Officer.

Information Governance incidents reported during 2013-14

Summary of serious incidents requiring investigations involving personal data as reported to the information commissioner's office 2014-15

Date of incident (month)	Nature of incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
June 2014	Accidental disclosure of personal information to third party	Extract of patient's medical record	2	Individuals notified by telephone and followed up in writing
Further action on information risk	The investigation made a number of recommendations: • Reminder to staff to confirm that all information relates to the correct patients when disclosing information to a third party. • Staff also reminded that it is essential that patient information is filed in the correct record. IG training has been updated to specifically include filing accurately and the steps that need to be taken to ensure that this is done .			
October 2014	Accidental disclosure of personal information to a third party	Extract of patient's medical record	2	Individuals notified by post
Further action on information risk	A reminder was issued to all staff about the importance of correct filing of information in patient records. The Access to Records Policy has been updated and specifies that all requests will include a signed memorandum prior to the release of records confirming that all documents relate to the correct patient.			

Summary of other personal data related incidents in 2014-15

Category	Breach Type	Total
A	Corruption or inability to recover electronic data	0
B	Disclosed in Error	15
C	Lost in transit	0
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	9
F	Non-secure Disposal – hardware	0
G	Non-secure Disposal – paperwork	0
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	0
K	Other	1

Equality and Diversity

Our director of human resources and diversity oversees our strategy to ensure we meet our equality and diversity responsibilities. Our performance in this key area is monitored through the Integrated Audit and Governance Committee, a sub-committee of the Board. Patient Experience and Equality oversee the patient care elements of equality and diversity, with the HR directorate overseeing the staff elements. We aim to embed equality and diversity in everything we do which is evident in the delivery of our training.

Progress against objectives for 2014-15

Progress against staff objectives

Objectives for 2014/15 were:

1. **To repeat the review of our NHS job applications and the HR case work by protected characteristics. The period covered in this report is 1 April 2014 to 31 March 2015.**

    - Our Trust profile shows a **Gender** split of approximately 79% female and 21% male. NHS Job applications are broadly proportionate in that 75% females were shortlisted and 25% males.

- **Age** profile of the Trust remains an ageing one with the highest headcount in the age ranges 41-60 (59%). NHS job applications show the highest range of applications come from age ranges 20-29 (44%) which is an encouraging sign for future workforce needs.

- The majority of applicants choose not to specify if they do or do not have a **Disability** (94%). However the Trust currently reports 5% of staff employed have declared to have a disability which is proportionately more than the 0.13% of applicants that do declare a disability.

- **Ethnicity** of the Trust is reported as 90% white British/white other which is in line with the Yorkshire and Humber ethnicity data detailed as 91% white British/white other.

- Christianity is the highest **religion** recorded in the Trust (44%) however 37% of staff have not disclosed their religion or it remains unspecified. NHS job applications show 49% shortlisted declared themselves as Christians, 18% declared themselves atheists, 14% were undisclosed. So the Trust profile remains broadly proportionate with regard to applicants and Trust profile.

- **Sexuality** disclosure in the Trust remains predominantly heterosexual (70%) or undisclosed or unspecified (28%). NHS jobs applications report 90% heterosexual although there is a slight increase in declaration on applications regarding gay/lesbian/bisexual. These figures are very similar to last year and it is encouraging to see an increase of those gay/lesbian/bisexual applicants disclosing their sexuality during the recruitment process.

- **Marital** status in the Trust is reported as 55% married and 29% single whilst NHS job applications report single as the most recorded status at 55% followed by married at 30%.

Please note we are unable to report on appointments into posts due to the change from NHS Jobs – the national vacancies site for NHS jobs - to NHS Jobs 2 as no data was migrated to the new system. Therefore, only three appointments are showing on NHS Jobs 2 for the period 1 April 2014 to 31 March 2015.

- **HR casework** during this period reports that there have been 15 bullying and harassment cases, 10 capabilities, 52 disciplinary cases, 14 formal flexible working requests and 19 grievances, of which involved a third (33%) male and two third (67%) female staff, which indicates a slightly higher proportion of male staff are involved in formal HR cases when compared to the Trust figure of 78% female and 21% male staff employed by the Trust.

- Of the 14 formal flexible working requests six were male, and eight were female, demonstrating a higher proportion of requests from men as opposed to women when compared to Trust workforce data.

Overall the review of the NHS jobs and HR activity data is broadly in line with Trust and local demographics. There has been a slight increase in the number of male staff employed in the

Trust (3%) and there is an increase in the amount of younger applicants applying to the Trust, both of which are positive drivers for the future workforce needs.

2. **To review the Equality Impact Assessments undertaken within the Trust e.g. consultation documents, policies, service developments to ensure that actions have been taken where required.**

   Eight papers have been submitted to Trust Consultation and Negotiation Committee during the period, six of which involved consultation with staff regarding extending hours of service provision or changes of work location in order to improve access to patients or re – distribution of existing staff resources for effective service provision. Six consultations had a positive effect on service access and provision and limited impact on staff.

3. **To review the needs of the ageing workforce and identify positive actions that can be implemented.**

   We are committed to being an employer of choice, and therefore we need to understand the national and legal context (people are living longer and have choice to work longer, which combined with a lower birth rate has led to an ageing workforce) driving the need to support and retain key skills, knowledge and experience of our ageing workforce. Human Resources has undertaken a research based report as part of Chartered Institute of Personnel and Development (CIPD) management qualification and has identified the following key areas for us to assess and respond to which are:

   - legislation, in particular equality in relation to ageism and prejudice;
   - recruitment of older workers;
   - occupational health and health and wellbeing;
   - education, training and development;
   - flexible working.

   Positive actions identified from the research report are as follows:

   - review of our policies regarding ageism particularly: retirement, Performance Appraisal and Development Review (PADR) and flexible working using the Advisory, Conciliation and Arbitration Service (ACAS) practical assessment for age bias in policies guide;
   - to conduct a review of recruitment data of starters and leavers to establish any potential age discrimination or trends. Consider best practice guides ACAS age monitoring framework and CIPD talent management checklist;
   - review PADR and performance management to include specific questions regarding future work plans and identify any associated training and/or flexible workforce needs of staff. Consider CIPD guidance on behaviours and support needed to enable staff return to work;
   - to review access to training and type of training undertaken by staff by age criteria to establish any potential age discrimination/gaps or trends;
   - to review the retire and return procedure, establish guidelines for managers and staff and consider all retire and return requests are returned using the flexible working model in order to establish a consistent, fair approach to retire and return or step down to retirement requests.

Proposed objectives for 2015/16 are to:

- implement the requirements within the Race Equality Standard;
- repeat the review of NHS job applications and HR case work activity;
- review the findings from the positive actions regarding supporting the needs of an ageing workforce.

Analysis of Trust Staff Roles

Staff Role	March 2013	March 2014	March 2015
Consultants	36	36	35
Junior Medical	33	32	27
Nursing, midwifery and health visitors	944	900	927
Scientific, therapeutic and technical	398	388	313
Other clinical staff	801	518	546
Non-clinical staff	412	585	592
Total	2624	2489	2440

In March 2013 admin staff working in clinical settings were recoded from the other clinical settings to non clinical categories. In March 2013 we had also included an estimate for bank staff in all categories, but have not repeated this since.

The key points are as follows:

The Trust profile is 90% British/white other which is broadly comparable with the Yorkshire and Humber ethnicity data at 91%.
In 2014/15, there was a slight reduction in the number of females employed dropping from 82% to 79% and an increase in male employees rising from 18% to 21%.
Directors (on Director pay, does not include Chair or non executive directors)

Female 3
Male 7

Other senior managers (Agenda for Change Band 8a to very senior manager; clinical and non-clinical)

Female 119
Male 43

The Trust has an ageing workforce with the highest headcount in the age range 41-60 (59%) in line with national social statistics. The most common reason for leaving the Trust as at December 2014:

Reason for leaving	Number
Voluntary resignation	27
Retirement	21
Dismissals	5
Redundancies	2

The Trust currently reports 5% of staff employed have declared to have a disability.

Sickness Absence

Our annual average sickness absence rate for the year 2014/15 is shown below in comparison with previous years.

Year	2011/12	2012/13	2013/14	2014/15
Annual average sickness %	5.19	4.88	4.98	5.01%

The 12 month rolling average staff sickness absence figures have decreased for the previous three years, with a very slight increase in both 2013 and then again in 2014. However, this increase is not statistically significant as it is only 0.04% of the total and within the original stretch target of 4.5% to 5.5%.

There has been a significant amount of change in the external environment in which the NHS functions and internally with the new appointment of a number of key Board posts and some increase may be attributable to the unprecedented levels of change which staff have faced. This is expected to reduce now that there is a substantive Board in place with a clear vision and direction moving forward.

A case management approach is used where managers, occupational health and staff work together to support staff in the fair management of their absence with adjustments to roles where possible to reduce sickness absence rates in order to achieve our absence rate target of 4.5%.

Staff Engagement

The relationship between managers and staff representatives continues to be a positive one. The Joint Consultation and Negotiating Committee continue to meet on a bi-monthly basis. The chairmanship of the committee rotates between the Chief Executive and the staff side Chairman. Secretariat support to the committee is provided by the Director of Human

Resources and Diversity. There is also a separate negotiating forum for medical staff. We employ a variety of communication methods to ensure that we involve our staff in all Trust activity. Methods include:

• monthly team briefing;
• regular electronic newsletters;
• interactive intranet;
• team meetings;
• staff newsletters;
• staff roadshows;
• regular visits by Board members to wards and teams;
• workshops held with the Board and members of staff;
• meetings with staff governors;
• internal electronic surveys.

Consultation

We conduct our formal consultations through our two major negotiating committees. Our "Management of Change" policy includes guidance on how staff and their representatives are to be consulted during periods of organisational change and covers both formal and informal consultation.

Policy in relation to disabled employees

The main Trust policies which support the employment of disabled employees are recruitment and selection, managing attendance and equality and diversity. The harassment and bullying policy makes specific reference to disabled employees. All human resources policies have been equality impact assessed to ensure that they are non-discriminatory. Disabled employees are also supported to undertake training and development opportunities in a way in which their particular requirements can be met. The recruitment and selection policy is specific about our duty to treat all applicants equally. If a person with a disability meets the essential criteria of the person specification for a post then they are guaranteed an interview. Our Positive Assets team also works to support mental health service users in seeking and applying for jobs internally and with other organisations.

Occupational Health

We provide a consultant-led occupational health service for managers and staff. Services provided include screening, immunisation programmes, health and stress assessments, counselling, advice and guidance on infection control and back care and ergonomic advice. Staff can refer themselves to the service. Managers are also assisted in managing staff attendance with expert guidance on adjustments and back to work programmes. Our occupational health consultant chairs our Trust-wide Staff Health and Wellbeing Group.

NHS Staff Survey Results 2014

As in previous years, we had positive responses to the national staff opinion survey. Some of our responses were lower than last year and we believe that this may be due to significant changes in the organisation which were happening around the time of the annual staff survey.

Last year we triangulated the results from the three staff surveys (an internal stress audit, the annual staff survey and the first Staff Family and Friends Test) which identified that there are three key areas which need to be addressed:

- effective leadership, including vision and values;
- meaningful communication with and involvement in decisions for staff at all levels;
- improved information systems (IT and paper-based).

Improvement in all of these areas will ultimately have a positive impact on staff engagement and the health and wellbeing of our staff. It is evidenced that improved staff engagement results in improved quality of care to patients.

In relation to the national annual staff survey, below are tables that illustrate:

- response rate for 2014/2015 compared with previous years;
- top four ranked scores in comparison with other trusts;
- bottom four ranked scores in comparison with other trusts.

Response Rates

	2011/2012		**2012/2013**		**2013/14**		**2014/15**		**Trust Improvement or Deterioration**
	Trust	National Average	Trust	National Average	Trust	National Average	Trust	National Average	
Response Rate	57%	54%	57%	51%	56%	-	44%	44%	12% deterioration

Top Four Ranking Scores
Where the Trust did better than the national average

	2012/13		**2013/14**		**2014/15**		**Trust Improvement or Deterioration**
Category	Trust	National Average	Trust	National Average	Trust	National Average	
Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	95%	90%	92%	89%	92%	86%	Same
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	26%	30%	27%	30%	26%	29%	1% deterioration
Percentage of staff appraised in last 12 months	-	-	90%	87%	93%	88%	3% improvement
Percentage of staff witnessing potentially harmful error, near misses or incidents in last	-	-	25%	26%	18%	26%	7% improvement

month							

Bottom Four Ranking Scores

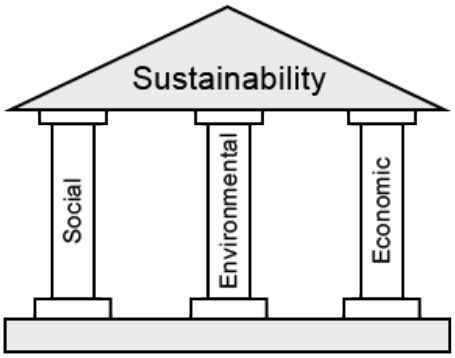
Where the Trust Score was lower than the national average

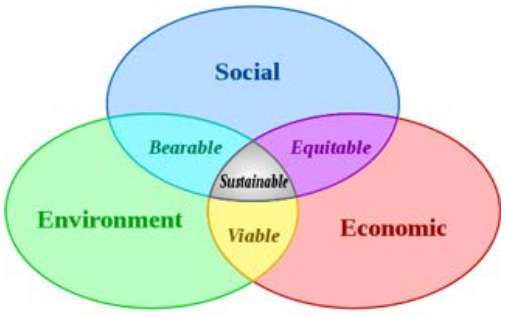
	2013/14				Trust Improvement or Deterioration
Category	Trust	National Average	Trust	National Average	
Percentage of staff reporting good communication between senior management and staff	28%	31%	23%	30%	5% deterioration
Percentage of staff agreeing that feedback from patients/service users is used to make informed decisions in their directorate/department	-	-	42%	53%	-
Percentage of staff able to contribute towards improvements at work	69%	72%	66%	72%	3% deterioration
percentage of staff having equality and diversity training in last 12 months	51%	67%	43%	67%	8% deterioration

Sustainability

The Trust continues to demonstrate its commitment to Sustainability, reducing its carbon emissions and minimising its impact on the environment and climate change.

Our fundamental commitment to sustainable development across our Trust is paramount. To create a sustainable Trust we need to strike the right balance between economic, social and environmental sustainability. This is highlighted in the diagrams below.

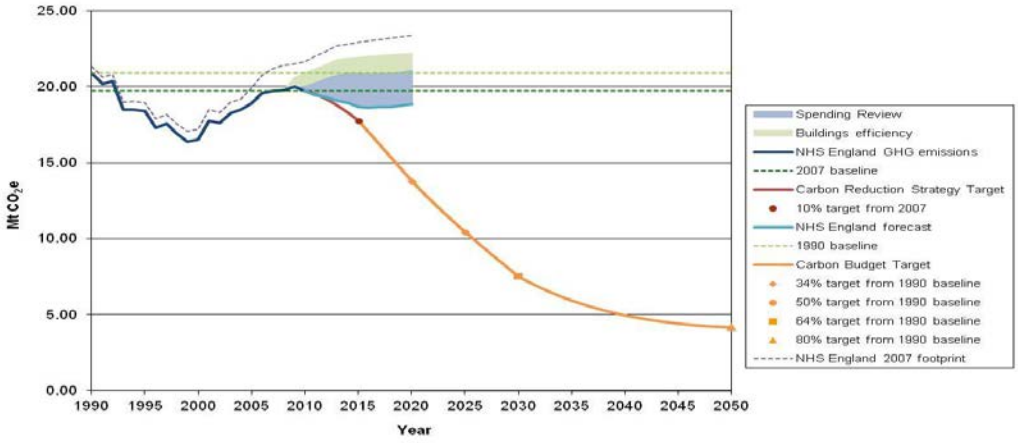




The driving force behind the reduction of all trust's energy consumption are the guidelines set by government (Sustainability Development Unit (SDU) Sustainability Strategy 2015) that says all trusts must reduce their carbon foot print by 10% by 2015 and 34% by 2020, based on 2007

level. The NHS has been set a target of 80% reduction of its emissions by 2050. We are committed to helping to get to this target by looking at innovative ways of reducing our own emissions. This will include introducing new technologies and behaviour change across our organisation.

The below graph shows the progress the NHS is making as a whole. This is the 2015 forecast supplied by the SDU.



The NHS Good Corporate Citizenship (GCC) assessment model is used by all NHS organisations including our own. This will continue to be used to measure and assess our environmental performance and to help produce our annual Sustainability Action Plan. Following this year's GCC report, we will use the Good Corporate Citizen model for guidance to highlight were we can make improvements in the future.

It's a very exciting time for us as we look at more innovative ways to make the Trust a front runner in the fight against climate change, through pushing sustainable thinking throughout the organisation and becoming a leader for sustainability across our region.

We are continually looking at ways to improve our energy performance making our organisation more sustainable for the future. The Sustainable Development Strategy written by the SDU for the NHS has given us a great deal to look at and work with, highlighting set goals for us to achieve over the coming years.

As 2015/16 is the final year we have to reduce our carbon footprint set by the Government using the 2007 benchmark, we have started implementing changes.

Our aim is to reduce our carbon foot print by introducing new technologies and changing our behaviour. We have been working closely over the past 12 months with the Carbon Energy Fund (CEF) and also SALIX Finance looking at what we could do to become more sustainable, not only for the benefit of our estate but for the benefit of our clients and staff. Our Estates department has been looking at technology to reduce our carbon emissions and our energy costs. These include CHP (combined heat and power) boilers, LED lighting, BMS (building management systems) and also general updating of the heating systems and problem areas within the organisation. By doing this, we will not only create a more sustainable organisation for our staff and our clients but meet the targets set by the SDU and NHS England.

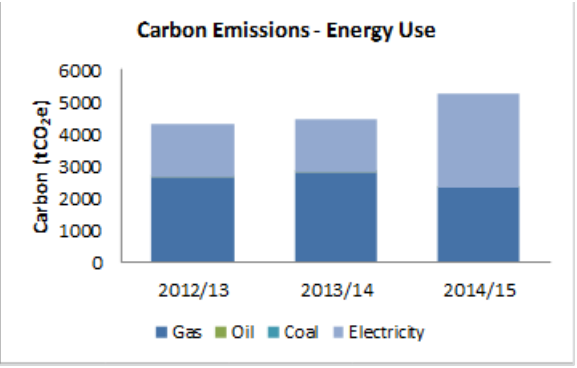
Utilities and energy

The 2014/15 performance figures highlighting the trusts CO2 and Carbon Emissions show that whilst overall energy usage has increased, electricity and water consumption appears to have increased on previous years; this is due to new/refurbished properties being put into action over the year and a higher use in general across the inpatient areas. The cost of electricity is rising at a rate of around 5% per year which we are combating by bringing in new and innovative technology and changing staff behaviour towards energy conservation.

Our water consumption is due to be assessed and we have a project to reduce water usage. We are also using the Aquamark project to benchmark all of our properties and reduce our consumption and cost by a third.

Gas has been at an all-time low this year due to low prices on the barrel worldwide and has benefitted the Trust greatly and reducing our costs considerably, resulting in an 8.4% decrease on energy spend from last year. Although our electricity consumption has increased, the cost of gas has been greatly reduced and resulted in a reduction in the overall cost of our energy usage. See chart below.

Resource		2012/13	2013/14	2014/15
Gas	Use (kWh)	12863231	13249127	11051928
	tCO_2e	2628.60125	2810.6698	2318.72768
Oil	Use (kWh)	24276	25004.28	5000
	tCO_2e	7.7404026	7.98511682	1.60009702
Coal	Use (kWh)	0	0	0
	tCO_2e	0	0	0
Electricity	Use (kWh)	4392769	4377776.5	6287128
	tCO_2e	1675.6196	1610.7501	2899.96751
Total Energy CO_2e		4311.96126	4429.40501	5220.29529
Total Energy Spend		£ 1,044,235	£ 1,096,447	£ 1,003,940



This year we have moved the procurement of our gas supply to CCS (Crown Commercial Services). We will look to do the same with the electricity from April 2016 as this gives us better control of our utilities and the best prices available to the organisation, resulting in cost savings for the organisation.

British Independent Utilities (BIU) carried out a forensic audit of our utilities which proved a worldwide process. Although the revenue is still to be finalised we predict this will be in the region of £141,000 revenue recovered and savings in the region of £30,000 in the first year.

We have also been working alongside ASDM; a government funded organisation funded by HM Treasury, and has joined the Aquamark project. This is a very exciting project as it will give the Trust the chance to benchmark its properties against other organisations and reduce our consumption by a third.

Our business travel emissions calculated from the miles staff claimed show a reduction in the usage claimed and the CO2 emissions produced on the previous year.

The CO2 emissions of our lease car fleet vehicles continues to reduce.

The total waste we produce has reduced and our recycling volumes have improved. The new general waste contract is for Dry Mixed Recycling (DMR) and general waste. The DMR all goes for recycling and the general waste is sorted with around 90% being recycled and the remainder being disposed of sustainably and used to recover as much energy in the form of landfill gas combustion as is practical while minimising their environmental impact.

Directors' Report

Board of Directors

The Board of Directors sets our strategic goals and objectives and monitors our performance, ensuring appropriate action is taken where necessary. It is responsible for managing the business of the Trust and legally responsible for delivering high quality, effective services and financial control and performance of the Trust.

During the year there were some further changes at board level. The Chairman, Jane Fenwick, retired in September 2014 and Sharon Mays was appointed as her replacement. The appointment process was led by the Council of Governors and a recommendation made to the Council by the Appointments, Terms and Conditions Committee. The Chief Executive, David Snowdon also retired in June 2014 and an external recruitment process was used to appoint his replacement, David Hill who joined the Trust on 1 July 2014. To facilitate this recruitment the services of Odgers Berndtson were engaged. Non executives David Crick and John Whitton have both had their term office extended to 31 August 2016.

Dr Dasari Michael was appointed as Medical Director in May 2014 after jointly sharing the role with Dr Kwame Fofie whilst the appointment process took place. Angie Mason, the Director of Nursing, Integrated Governance and Quality retired in July 2014 and an interim Director of Nursing covered the post until the end of March 2015 whilst the permanent post was being recruited to.

In March 2015, the Council of Governors reappointed two non executive directors whose term of office was coming to an end. John Whitton and David Crick were reappointed until 31 August 2016 following a recommendation made to the Council of Governors by the Governor Appointment, Terms and Conditions Committee.

The chairman of the Board of Directors is Sharon Mays and the Board comprises of six non executive directors (NEDs) including the chairman and five executive directors (including the chief executive). On appointment as chairman, Sharon Mays relinquished the role of senior independent director and Andrew Milner, Non Executive Director was appointed to that role.

Elizabeth Thomas, Director of Human Resources and Diversity is a non-voting member of the Board of Directors. The two service directors, Alison Flack and Peter Flanagan also attended the board meetings as non-voting members during the year.

The Board of Directors reviews and evaluates its performance on at least a bi-annual basis, led by the senior independent director or a nominated non executive director. This review covers areas such as constructive challenge, appropriateness of the agenda, quality of papers, quality and inclusiveness of debate, and effectiveness of the chairman. A review of the strategic priorities is reported on a quarterly basis.

Sub-committees of the board each produce an annual report on their activities, achievements and plans for the year ahead. The report is presented to the Board of Directors by the committee chair.

The arrangements for evaluation of the chairman and non executive directors were agreed by the Council of Governors Appointments, Terms and Conditions Committee**.** The senior independent director led the appraisal of the chairman, with appropriate consultation with non executive directors, governors and other relevant parties. The chairman and chair of the Council of Governors Appointments, Terms and Conditions Committee led the evaluation of the non executive directors.

The chief executive and executive directors are subject to formal appraisal by the chairman and chief executive respectively. This is based on the agreement of objectives linked to the key components of the Trust's annual plans. Progress is monitored through the year. The chairman is consulted concerning the corporate, as opposed to professional, performance of the executive directors. The chairman holds regular meetings with the non executive directors without the executive directors being present. The board's composition is in accordance with the Trust's constitution and details of attendance at meetings is provided in the attendance table.

Composition of the Board of Directors

Name	Position	Appointed to Humber NHS Foundation Trust	Term of Office
Sharon Mays	Trust Chairman and Chairman of Council of Governors and Remuneration and Nomination Committee	16 September 2014	15 September 2017
David Hill	Chief Executive	1 July 2014	N/A
John Whitton	Independent Non Executive Director	1 February 2010	31 August 2016
Sharon Mays (Deputy Chairman)	Independent Non Executive Director, Senior Independent Director and Chair of Mental Health Legislation Committee	1 July 2011	30 June 2014 reappointed up to 15 September 2014 appointed as Chairman 16 September 2014
David Crick	Independent Non Executive Director, Chair of Mental Health legislation Committee from September 2014	1 June 2012	31 August 2016
Andrew Milner	Independent Non Executive Director and Chair of Strategic Investment Committee. Senior Independent Director (from 1 September 2014)	1 April 2013	31 March 2016
Peter Baren	Independent Non Executive Director and Chair of Audit	1 December 2013	31 January 2017

Name	Position	Appointed to Humber NHS Foundation Trust	Term of Office
	Committee (up to 30 November 2014) which merged to become the Integrated Audit and Governance Committee (from 1 December 2014) and Charitable Funds Committee		
Vanessa Walker	Independent Non Executive Director	1 March 2014	28 February 2017
Jane Fenwick	Trust Chairman and Chairman of Council of Governors and Remuneration and Nomination Committee	1 February 2010	16 September 2014
David Snowdon	Chief Executive	1 February 2010	Retired 30 June 2014
Angie Mason	Director of Nursing, Integrated Governance and Quality	1 February 2010	Retired 31 July 2014
Philip King	Interim Director of Nursing	21 July 2014	31 March 2015
Dasari Michael	Medical Director	Appointed 1 May 2014	N/A
Simon Hunter	Director of Strategy and Performance	1 August 2011	N/A
Adrian Snarr	Director of Finance, Informatics and Infrastructure	9 December 2013	N/A
Kwame Fofie	Acting Medical Director	1 December 2013	30 April 2014
Elizabeth Thomas (non voting)	Director of H R & Diversity	1 February 2014	N/A
Alison Flack (non voting)	Service Director	Board attendee from April 2013	1 April 2015
Peter Flanagan (non voting)	Service Director	Board attendee from April 2013	1 April 2015

The composition of the board allows it to fulfil its statutory and constitutional functions and to comply with Monitor's terms of authorisation. The balance of the Board of Directors meets the provisions of the NHS foundation trust Code of Governance requirements for at least half of the directors (excluding the chairman), being independent non executive directors. The non executive board members possess a wide range of skills and experience essential for an effective Board of Directors. These skills enable them to provide independent judgement and advice on issues of strategy, vision, performance, resources and standards of conduct and constructively challenge, influence and help the executive team develop proposals on such strategies.

The chairman also chairs the Council of Governors meetings and is responsible for providing leadership to both the Board of Directors and the Council of Governors. The chairman ensures there is effective communication between the Board of Directors and the Council of Governors, gaining the views of the governors as necessary for consideration by the Board of Directors.

Executive and non executive directors have an open invitation to attend the Council of Governors meetings, the governor groups and governor development days that are held. They also receive copies of the Council of Governors meeting papers including the minutes. The chairman, supported by the senior independent director, promotes an engaging relationship between the Board of Directors and Council of Governors. Sessions with board members and governors take place within the development day meetings which give an opportunity for governors to engage with executive and non executive directors. There has also been regular attendance by governors at the Board of Directors public meetings.

The Board of Directors delegate the day to day management of the Trust's operational services to the executive directors with the non executive directors sharing corporate responsibility for ensuring the Trust is run in an economically, effective and efficient way. The Executive Management Group (EMG) meet on a monthly basis to ensure delegated duties were discharged.

Executive and non executive directors had a visibility programme to sites and teams within the organisation during the year including shadowing staff to gain a better understanding of the services being provided and any issues that staff may be faced with. In April 2015, a new process for visits will be introduced to give better assurance and to reduce the number of individual group visits to services which in turn will reduce any inconvenience or disruption to services. The new look visits will be undertaken following the Fifteen Steps and Patient Safety First guidance.

The chairman and chief executive continually review the balance, appropriateness and effectiveness of the Board of Directors, ensuring there is continuity when new directors are appointed.

Trust performance was closely monitored during the year by the Board of Directors through the presentation of reports and discussion of key performance information at each of its meetings.

The Board of Directors acknowledge its responsibility for preparing the annual report and accounts and considers that, taken as a whole, they are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy. As far as the Board of Directors is aware there is no relevant audit information which the auditors are unaware of and the Directors have taken all the necessary steps as Directors to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

The Board of Directors annually reviews the risk management strategy. The Board Assurance Framework and Risk Register are reviewed on a quarterly basis. This ensures the Trust has an effective programme for managing all types of risk and that it is making appropriate risk management decisions to enable the organisation to deliver its objectives. It does this by receiving regular updates from the executive management team of the Trust and from the Governance Committee and by receiving assurance from the Audit Committee and the Mental

Health Legislation Committee. The Governance Committee and Audit Committee merged in December 2014 to form the Integrated Audit and Governance Committee.

The Board of Directors has access to independent professional advice, where it is judged that it is necessary to discharge their responsibilities as directors.

Board of Directors, Sub-committee and Council of Governors Meeting Attendance

There were a number of Board of Directors and sub-committee meetings held during the period of this report, the table below shows the attendance by members of the Board of Directors. Some members of the Board of Directors are not members of some of the committees, but will attend by request if there is a specific item to be discussed.

On some occasions, non executive directors may have observed a committee meeting that they are not normally a member of. If there have been times when the allocated non executive director is unable to attend a meeting, another non executive director colleague may have attended in their place.

Code of Governance

Monitor, the sector regulator for health services in England, published a revised Code of Governance in July 2014 to ensure that trusts demonstrate compliance and best practice for corporate governance and maintain high standards.

The 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**.**

Code provision A 1.1 states there should be a clear statement defining the roles and responsibilities of the Council of Governors. This is included in the Schedule of Matters Reserved to the Board of Directors and is part of the Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions document. It also explains the process to be taken in the event of a disagreement between the Board of Directors and Council of Governors.

During the financial year 2014/15, the principles of the code were applied and requirements met. Schedule A of the Code of Governance sets out the requirements in six areas and the response and declaration from the Trust for each area are included in the table below.
As per section 1 of Schedule A of the Code of Governance, all statutory requirements have been complied with, if appropriate.

Schedule A, section 2 of the Code of Governance requires a declaration and supporting explanation for the provisions set out below and an explanation is included or a reference is made to the relevant section in the Annual Report.

Code of Governance Reference	Requirement
A.1.1	The schedule of matters reserved for the Board of Directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the Board of Directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the Board of Directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the Board of Directors. Comply – Board of Directors – page 41
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors. Comply – Board of Directors – pages 41 and 52
A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. Comply – Council of Governors – page 68
B.1.1	The Board of Directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary. Comply - Board of Directors – page 41
B.1.4	The Board of Directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust. Comply - Board of Directors – pages 41 and 59
B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.

Code of Governance Reference	Requirement
	Comply – Board of Directors – page 41
B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report. Comply – register of interest is publicly available for the chairman and all those on the Board of Directors. It is presented at meetings of the Board of Directors.
B.5.6	Governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied. Comply – Council of Governors – page 68
B.6.1	The Board of Directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted. Comply – Board of Directors – page 41
B.6.2	Where there has been external evaluation of the board ***and/or governance of the Trust***, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the Trust. Comply – Board of Directors – page 41
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). Comply – Board of Directors – page 41 External Auditors responsibilities – page 50

Code of Governance Reference	Requirement
	Annual Governance Statement – page 78
C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls. Comply – Annual Governance Statement – page 78
C.2.2	A Trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes. Comply – Integrated Audit and Governance Committee – page 50
C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the Board of Directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position. Comply - not applicable
C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded. Comply – Integrated Audit and Governance Committee – page 50
D.1.3	Where an NHS foundation trust releases an executive director, for

Code of Governance Reference	Requirement
	example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings. Comply –not applicable
E.1.5	The Board of Directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations. Comply – Board of Directors – pages 41 and Council of Governors – page 68
E.1.6	The Board of Directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report. Comply- foundation trust membership – page 74

The information listed in Schedule A, section 3 is publicly available via the Annual Report, the Trust's website or via the Trust secretary.

To comply with section 4, re-appointment of the non executive directors, the Chairman will confirm to governors, that following formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and demonstrates commitment to the role.

In respect of section 5, the names of governors submitted for election or re-election are accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This includes prior performance information. This requirement is met through the individual's election statement.

The Trust complies with all provisions of section 6.

External Reviews

External reviews of Governance and the Quality Governance Framework have been conducted during the year which involved Board of Directors performance being observed as part of this. The Quality Governance Framework review was undertaken by Deloitte, the

Trust's external auditor. The independent governance review was done by PKP Consulting which has no connection with the Trust.

Board of Directors Sub-committees

The Board of Directors has five sub-committees, details of each are provided below:

- **Integrated Audit and Governance Committee formerly Audit Committee**

  The Audit Committee merged with the Governance Committee to create the Integrated Audit and Governance Committee. The Committee provides a means of independent and objective review and seeks assurance about the adequate and effective operation of the Trust's internal control systems. It also seeks assurance on the controls in place within the organisation that support the Trust's compliance with the Care Quality Commission and appropriate legislative guidance on clinical, patient safety and quality issues.

  The committee comprises of four non executives directors and is chaired by Peter Baren, Non Executive Director. In accordance with Monitor's guidance, Peter Baren has relevant and recent financial experience.

  The committees met five times last year (Governance Committee met three times and Integrated Audit and Governance Committee met twice) and were attended by the director of finance, infrastructure and informatics, the director of nursing, the external and internal auditors, the counter fraud manager and other identified attendees. The committee approved the annual audit and counter fraud plans and reviews all internal and external audit reports. It received the minutes of the Charitable Funds and Mental Health Legislation Committees as a means of enacting its role in the overall governance of the Trust. The chair of the committee reports on its proceedings to the Board of Directors, in particular raising any significant issues of concern.

  The Audit committee considered the significant risks to the truth & fairness of the financial statements and considered the following to be the key risks:

  - valuations of land and buildings;
  - revenue recognition;
  - management override of controls.

- **External Audit**

  For 2014/15, the Trust's external auditors were Deloitte. During the year a total of £58,000 was paid to Deloitte for audit services of which £2,000 was for charitable funds.

  At its May 2014 meeting the Audit Committee received the Report of the External Auditors (ISA 260). The report provided the unqualified opinion on the accounts.

- **Internal Audit**

  In public sector organisations, internal audit work is regulated by the Public Sector Internal Audit Standards, which became effective on 1 April 2013 and govern the way in which all internal audit services operating within the public sector (including the NHS)

should undertake their functions with regard to assurance audits and consultancy activity. The standards also support the professional practice of internal audit across the NHS.

The East Coast Audit Consortium (ECAC) provides the internal audit service for the Trust. The Director of the ECAC takes a strategic role for overseeing the effective delivery of the audit service at the Trust and the operational element of the service is undertaken by a team led by an Audit Manager, who maintains regular contact with Trust staff. Executive responsibility for the internal audit function lies with the director of finance, infrastructure and informatics.

The role of internal audit, as defined by the Institute of Internal Auditors, is to provide an independent assurance function that the Trust's risk management, governance and internal control processes are operating effectively. Internal audit oversight forms part of the core remit of the Integrated Audit and Governance Committee within the Trust – the committee's terms of reference require it to regularly review the effectiveness of internal audit and to oversee the overall delivery of the internal audit service to the Trust.

Audit work is planned in advance as part of a three-year strategic approach, which ensures that fundamentally important and high risk areas are audited more frequently and less critical (but nonetheless significant) systems are reviewed cyclically (perhaps only once every three years).

Attendance of directors at all committees meetings is presented in the Board of Directors attendance table. The Terms of Reference of the Integrated Audit and Governance Committee are published on the Trust website.

- **Charitable Funds Committee**

The Charitable Funds Committee oversees the administration of the charitable funds, on behalf of the Trust (charity number 1052727). The committee meets quarterly and provides advice to the Board of Directors. The Committee is chaired by Peter Baren, Non Executive Director, and comprises of another Non Executive Director, the director of finance, infrastructure and informatics, acting as financial trustee, the charitable funds manager and the financial services manager. The method of appointment of trustees is governed by the Trust's Standing Orders with the Charitable Funds Committee structure being established within its terms of reference.

Attendance of directors at the committee meetings is presented in the Board of Directors attendance table.

- **Mental Health Legislation Committee**

The Mental Health Legislation Committee is established as a sub-committee of the Board of Directors accountable to the Board of Directors. The principal aims of the committee are to:

- provide strategic leadership pertaining to the Mental Health Act, the Mental Capacity Act and their respective Codes of Practice;

- monitor, provide challenge and seek assurance of compliance with external standards relating to Mental Health Legislation;

- approve and review Mental Health Legislation polices and protocols.

The committee is chaired by Dave Crick, Non Executive Director and has a core membership of one other non executive director (who is also a designated hospital manager), the medical director, director of nursing, integrated governance and quality and the mental health legislation manager (who is also the chair of the Mental Health Legislation Steering Group). One independent consultant psychiatrist who has recognised particular experience in mental health and related legislation is also part of the membership together with a representative of each local authority and a general manager with nursing experience.

Attendance of Directors at the Mental Health Legislation Committee meetings is presented in the Board of Directors attendance table.

- **Strategic Investment Committee (StIC)**

The Strategic Investment Committee ensures that processes that govern strategic investments are being followed, and makes recommendations to the Board of Directors on major capital or revenue expenditure, joint ventures, acquisitions and mergers, purchase, sale or alteration of property (above an agreed threshold) and service expansion or major service change.

The committee chair is Andrew Milner, Non Executive Director, and has a core membership of two other non executive directors, the director of finance, infrastructure and informatics, director of strategy and performance and the director of nursing, integrated governance and quality.

Attendance of directors at the Strategic Investment Committee meetings is presented in the Board of Directors attendance table.

Name	Position	Board	Audit	Rem	MHLC	CF	Gov	IAGC	StIC	CoG
Sharon Mays	Chairman (from 16 September 2014)	5/5		1/1			1/1			2/2
David Hill	Chief Executive (from 1 July 2014)	6/6		1/1	1/1				1/1	3/3
David Crick,	Non Executive Director	9/9		2/2	3/3	3/3	4/4	2/2		3/3
Sharon Mays	Non Executive Director / Senior Independent Director (up to 15 September 2014)	3/4		1/1	2/2					1/1
Andrew Milner	Non Executive Director (Senior Independent Director from 1 September 2014)	9/9	3/4	2/2	2/2	1/1			7/7	2/3
John Whitton	Non Executive Director	8/9	3/4	2/2			4/4	1/2	7/7	1/3
Peter Baren	Non Executive Director	9/9	4/4	2/2	2/2	4/4	2/2	2/2	7/7	3/3

Name	Position	Board	Audit	Rem	MHLC	CF	Gov	IAGC	StIC	CoG
Vanessa Walker	Non Executive Director	8/9		2/2	3/4		3/4	2/2		1/3
Simon Hunter	Director of Strategy and Performance	8/9							7/7	3/3
Angie Mason	Deputy Chief Executive/ Director of Nursing, Integrated Governance & Quality (up to 31 July 2014)	3/4			2/2		3/3		3/3	0/1
Adrian Snarr	Director of Finance, Infrastructure and Informatics	8/9	4/4			3/4		2/2	6/7	3/3
Kwame Fofie	Acting Medical Director (joint) (up to 30 April 2014)	0/1			0/1					0/1
Dasari Michael	Acting Medical Director (joint) (up to 30 April 14) and Medical Director (from 1 May 2014)	9/9			3/4		4/4	1/2		0/3
Philip King	Interim Director of Nursing (from 21 July 2014 – 31 March 2015)	4/6			2/2		1/1	2/2	0/2	1/3
Elizabeth Thomas (non voting)	Director of Human Resources & Diversity	9/9					3/4	2/2		
Alison Flack (non voting)	Service Director	8/9						1/2		
Peter Flanagan (non voting)	Service Director	5/9						0/2		
Jane Fenwick	Chairman (up to 30 September 2014)	4/4	2/2	1/1			1/1			1/1
David Snowdon	Chief Executive (up to 30 June 2014)	2/3	1/1	1/1			2/2			0/1

Audit (up to 30.11.14) Rem = Remuneration Committee MHLC = Mental Health Legislation Committee CF = Charitable Funds Gov = Governance Committee (up to 30.11.14) IAGC = Integrated Audit and Governance Committee (from 1.12.14) StIC = Strategic Investment Committee CoG = Council of Governors

- **Remuneration and Nominations Committee**

The Trust has a Remuneration and Nominations Committee which is a key sub-committee of the Board of Directors. This committee makes recommendations to the Board of Directors about appointments, remuneration and terms of service of the chief executive and the executive directors and gives consideration to succession planning for directors and reviews the structure, size and composition of the Board of Directors. The Committee is chaired by the Trust Chairman, Sharon Mays and membership includes all the non executive directors and where appropriate, the chief executive.

The role of the committee is to keep under review the size, structure and composition of the Board of Directors and to make recommendations for any changes. It is responsible for the recruitment and selection process for the chief executive and executive directors and for the determination of salary, terms and conditions and appraisal arrangements. Any proposed suspension or termination of an executive director would also come under its remit, in conjunction with the Trust's disciplinary procedures. The committee also works with the Appointment, Terms and Conditions Committee of the Council of Governors in terms of the equivalent processes in relation to the chairman and non executive directors. As previously referred to in the Board of Directors section, there have been many changes at board level, however the appropriate process was followed in each case.

Policy on Board Remuneration

The Chairman and non-executive directors of the Trust are appointed by the Council of Governors and are remunerated in accordance with terms and conditions approved by the Council of Governors.

Details of salaries and allowances paid to the Chairman and non executive directors during 2013/14 and 2014/15 are provided in Table 1. The information included in this table is subject to audit. These allowances are not pensionable remuneration.

The Chief Executive and executive directors hold permanent Trust contracts with six-month notice periods and standard NHS terms and conditions. The Remuneration and Nomination Committee aims to ensure the executive board members are fairly rewarded having proper regard to the Trust's circumstances and linked to national advice such as uplift for directors.

Directors do not receive any bonus-related payments. Details of the salaries and allowances of the Chief Executive and other executive directors during 2013/14 and 2014/15 are shown in Table 1. Details of the pension benefits of the Chief Executive and other executive directors are shown in Table 2. The information in these tables is subject to audit.

The Remuneration and Nomination Committee is not involved in setting the remuneration and terms of service of these or any other senior managers currently employed within the Trust. All current senior managers are on permanent contracts with three-month notice periods and standard NHS terms and conditions. The remuneration of these senior managers is based on the NHS-wide job evaluation scheme (known as Agenda for Change), which is uplifted annually by the Executive Management Group in line with the national uplift advised by the Department of Health.

The Trust has no outstanding equal pay claims to date and generic job descriptions have now been developed, ensuring current and future compliance with equal pay requirements. Past and present employees are covered by the provisions of the NHS Pension Scheme. A description of the scheme and its accountancy treatment is described in Note 10 to the Annual Accounts.

Table 1 Salaries and allowances of Trust Board and other senior managers (1 April 2014 – 31 March 2015)

Chair and non-executive directors

Name & Title	2014/15						2013/14					
	Salary (Bands of £5000)	Taxable Benefits (Nearest £100)	Annual Performance Related Bonus (Bands of £5000)	Long Term Performance Related Bonus (Bands of £5000)	Pension Related Benefits (Bands of £2,500)	Total (Bands of £5000)	Salary (Bands of £5000)	Taxable Benefits (Nearest £100)	Annual Performance Related Bonus (Bands of £5000)	Long Term Performance Related Bonus (Bands of £5000)	Pension Related Benefits (Bands of £2,500)	Total (Bands of £5000)
J Fenwick Chairman (to 30 Sept 2014)	15-20					15-20	40-45					40-45
S Mays Non-Executive Director (to 30 Sept 2014) & Chairman (from 1 Oct 2014)	25-30					25-30	10-15					10-15
V Walker Non Executive Director (from 1 April 2014)	10-15					10-15						
J Whitton Non Executive Director	10-15					10-15	10-15					10-15
P Baren Non Executive Director	10-15					10-15	5-10					5-10
A Milner Non Executive Director	10-15					10-15	10-15					10-15
D Crick Non Executive Director	10-15					10-15	10-15					10-15

Executive directors

Name & Title	2014/15						2013/14					
	Salary (Bands of £5000)	Taxable Benefits (Nearest £100)	Annual Performance Related Bonus (Bands of £5000)	Long Term Performance Related Bonus (Bands of £5000)	Pension Related Benefits (Bands of £2,500)	Total (Bands of £5000)	Salary (Bands of £5000)	Taxable Benefits (Nearest £100)	Annual Performance Related Bonus (Bands of £5000)	Long Term Performance Related Bonus (Bands of £5000)	Pension Related Benefits (Bands of £2,500)	Total (Bands of £5000)
D Snowdon Chief Executive (to 30 June 2014)	40-45	0.8			45-47.5	90-95	145-150	3.1			220-222.5	370-375
D Hill Chief Executive (from 1 July 2014)	110-115	3.3			0	110-115						
A Mason Director of Nursing, Integrated Governance and Quality (to 3 August 2014)	40-45	3.1			185-187.5	230-235	105-110	8.7			50-52.5	165-170
A Snarr Director of Finance	105-110	3.8			0	110-115	30-35	1.2			12.5-15	45-50
E Thomas Director of Human Resources & Diversity	85-90	3.5			2.5-5	95-100	15-20	0.3			5-7.5	20-25
D Michael Medical Director	165-170			10-15	0	180-185	55-60	0		0-5	32.5-35	90-95
K Fofie Acting Medical Director (to 30 April 2014)	10-15			0-5	0-2.5	10-15	35-40	0		0-5	35-37.5	70-75
S Hunter Director of Strategy and Performance	95-100	3.1			0	95-100	95-100	1.7			17.5-20	115-120
P King Acting Director of Nursing, Intergrated Governance and Quality (from 21 July 2014 to 31 March 2015)	220-225					220-225						
P Flanagan Service Director (from 1 April 2014)	85-90	0.7			10-15	100-105						
A Flack Service Director (from 1 April 2014)	85-90	6.7			0	95-100						

The Benefits in Kind covers the monetary value of the provision of a car and travel costs.

The 2014-15 Pension Related Benefits figures have been adjusted for employee pension contributions, as per amended guidance in the Monitor Annual Reporting Manual. The 2013-14 comparison figures have not been adjusted. Within this column, zero entries relate to a reduction in pension benefits.

Reporting bodies are required to disclose relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in Humber NHS Foundation Trust in the financial year 2014/15 was £145,000. This was 6.8 times the median remuneration of the workforce, which was £21,748.

Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Table 2 below illustrates this calculation.

Table 2

	2014/15
Band of Highest Paid Director's Total Remuneration (£'000)	145-150
Median Total	21,748
Remuneration Ratio	6.8

Table 3 Pension benefits of Trust Board and other senior managers (1 April 2014 – 31 March 2015)

Executive directors

Name and Title	Real increase in pension at age 60 (bands of £2500) £000	Lump sum at age 60 related to real increase in pension (bands of £2500) £000	Total Accrued pension at 60 at 31 March 2015 (bands of £5000) £000	Lump sum at 60 related to accrued pension at 31 March 2015 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension £000
D Snowdon Chief Executive	0	0	70-75	215-220	0	1,591	0	
D Hill Chief Executive	0-2.5	0	0-5	0	21	0	16	
A Mason Director of Nursing, Integrated Governance and Quality	0-2.5	0-2.5	45-50	145-150	0	1,025	0	
A Snarr Director of Finance	0	0	35-40	115-120	654	631	7	
E Thomas Director of Human Resources and Diversity	0-2.5	2.5-5	25-30	75-80	557	494	50	
D Michael Medical Director	0-2.5	2.5-5	35-40	105-110	658	596	46	

K Fofie	Acting Medical Director	0-2.5	0-2.5	25-30	80-85	472	429	3	
S Hunter	Director of Strategy and Performance	0-2.5	0-2.5	30-35	100-105	643	603	23	
A Flack	Service Director	0	0	30-35	95-100	509	501	0	
P Flanagan	Service Director	0.2.5	5-7.5	40-45	120-125	768	694	55	

Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the members' accrued benefits and any contingent spouse or civil partner's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves the scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures include the value of any pension benefits in another scheme or arrangement, which the individual has transferred to the NHS pension scheme and any additional benefits accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period

Current CPI applied to Pensions is 2.7%

Signature: 

Date: 26 May 2015

Board of Directors experience and expertise

Sharon Mays

Chairman (term of office expires 15 September 2017. Up to 15 September 2014 served as non executive director, deputy chairman and senior independent director)

Sharon is chairman of the Trust, having previously been a non executive director of the Trust and, before that, a governor.

Sharon joined the board of the Trust in July 2011 when she became the senior independent non-executive director and, subsequently, she became deputy chairman. Following the governors re-appointment of her as non-executive director in June 2014, Sharon was appointed as chairman of the Trust with effect from September 2014.

Before joining the board of the Trust, Sharon was a non executive director of East Riding of Yorkshire Primary Care Trust.

Sharon is a qualified lawyer and, prior to her involvement with the NHS, she was a partner at a locally based commercial law firm where she specialised in property regeneration and other commercial property transactions.

Sharon is a member of the joint independent audit committee of the Police and Crime Commissioner for Humberside and Humberside Police Force and, until recently, she was also the principal independent person for standards investigations undertaken by the East Riding of Yorkshire Council in connection with alleged breaches of the Council's Code of Conduct.

John Whitton

Non executive director (term of office expires 31 August 2016)

John is a retired engineer and businessman who brings a wealth of experience from the manufacturing, construction, defence, retail and service industries and from his work in more than 20 countries across Europe, North America, Asia and Australia.

He was initially appointed on 1 February 2010 for three years and was reappointed by the Council of Governors during 2013. Due to a series of changes at board level during 2015, the Council of Governors decided to appoint John for a further year to ensure continuity and stability of the trust.

John also holds another non executive director position with St Martins of Tours Housing Association based in London.

Andrew Milner

Non executive director and senior independent director (term of office ends 31 March 2016)

Andrew brings almost three decades of experience in the private sector and another 13 years of senior leadership in the public sector to the Trust, including assistant chief executive and chief officer roles with East Riding of Yorkshire Council and North East Lincolnshire Council.

He has been a board member of other local NHS organisations as well as lay chair of NHS complaints panels and has chaired a number of partnership boards. Andrew has also been extensively involved in local education as a governor.

He is currently a director of Sun Organics Ltd, a trustee of local charities HEY Smile Foundation and Help for Health, a governor at Archbishop Sentamu Academy and chairman of Brantingham village hall trustees.

David Crick

Non executive director (term of office expires 31 August 2016)

David was a family doctor in Hull for more than 30 years with training in psychiatry and counselling.

During his many years as a GP, David took on various roles with local health authorities including servicing as executive committee vice chair and lead for Mental Health and Musculo-skeletal services with the then West Hull Primary Care Trust for several years.

He was an Honorary Senior Clinical Tutor with Hull York Medical School from September 2006 to July 2014 and teaches Whole Person Medicine (with an emphasis on Mental Health) in Eastern Europe.

Vanessa Walker

Non executive director (term of office expires 28 February 2017)

Vanessa, who is currently Chairman of Hull and East Yorkshire MIND, was previously an elected Stakeholder Governor for the Trust. She has an extensive background in leadership within both the public and voluntary sectors and has acted as an advisor to local Health and Wellbeing Boards on the causes and consequences of loneliness, especially for older people.

With a background in district nursing, Vanessa's qualifications include an MBA specialising in organisational development and training. These skills have been used in various director and leadership positions where Vanessa focussed on governance, partnership working, organisational improvement, community cohesion and development in local government, the NHS and voluntary sector.

She has previously been a trustee of the women's refuge on the Isle of Mann, an Independent Member on East Riding of Yorkshire Council's Standards Committee and governor at a local primary school.

Peter Baren

Non executive director (term of office expires 31 January 2017)

A chartered accountant with a degree in Business Finance, Peter has many years' experience working in organisational finance at the most senior level.

Peter has held group finance controller positions in engineering and manufacturing companies for almost 30 years with his most recent post being group finance director of Cheshire-based national house builder and commercial property developer the Emerson Group from 2001 to 2012.

He has served as non executive director with social landlord Coast and Country Housing Ltd and has been a member of the Finance and Capital Development Committee at York St John University.

David Hill

Chief Executive (appointed 1 July 2014)

With a background in senior management in local government this is David's first direct role within the NHS, although his past roles mean he has worked in partnerships with many NHS organisations.

David served as Chief Executive of Guildford council for six years, leading a comprehensive transformation programme delivering financial sustainability and performance improvement.

David holds an MBA and is a Fellow of the Chartered Management Institute. He held senior strategic roles with three other local authorities and served as a trustee of University of Surrey Students Union and chaired the trustees of two charities associated with poverty alleviation.

Adrian Snarr

Director of finance, infrastructure and informatics and deputy chief executive

Adrian joined the Trust in December 2013 from his role as Chief Financial Officer for the Vale of York and Scarborough Ryedale Clinical Commissioning Groups from the transition from NHS North Yorkshire and York Primary Care Trust.

A Fellow of the Chartered Institute of Management Accountants, Adrian has held a number of senior finance roles with both commissioners and healthcare providers in Yorkshire.

Simon Hunter

Director of Strategy and Performance Appointed 1 August 2011

Originally from the North East of England, Simon has more than 25 years' experience within the NHS. He joined the Trust in 2011 after holding various senior roles at NHS Hull.

Simon has a background in Public Health and Health Economics. He has an MSc in Population Health and an MBA in Health Services Management and has served as Assistant Director of Public Health in Hull and was Hull and East Riding Health Action Zone Director for seven years.

Dr Dasari Michael

Joint Acting Medical Director from 1 December 2013 until 30 April 2014. Appointed Medical Director 1 June 2014

A Consultant Psychiatrist in Learning Disability, Dr Dasari Michael is a Fellow of the Royal College of Psychiatrists and an Executive Committee Member in the Faculty of Learning Disability. He is also a CASC Examiner for the Royal College of Psychiatrists.

Dr Michael joined what became Humber NHS Foundation Trust in 2006 after working as a Consultant psychiatrist in Learning Disability since 2003. He became Clinical Director of the Trust's Learning Disability Service in 2006.

Jane Fenwick

Chairman from October 2007, Retired 30 September 2014

With a background in education and health, Jane joined the Trust as Chairman in 2007 and chaired the Board of Directors and Council of Governors.

Previously Jane had served as chief executive for eight years with two training, education and guidance companies and had also been the HR regional director for Safeway.

A management consultant, Jane has also been a non executive director for both the former South Yorkshire Strategic Health Authority and the Humber Strategic Health Authority. She has also served as a lay reviewer for the Healthcare Commission and an Ofsted inspector.

David Snowdon

Chief Executive, Appointed 1 December 2007 retired 30 June 2014

David joined the Trust as Chief Executive in December 2007 after being a Deputy Chief Executive/Chief Nurse at Derbyshire Mental Health Services NHS Trust for six years.

A registered Mental Health and Learning Disability Nurse, David has been Director of Mental Health Services and Adult Mental Health Services at Leicester and Rutland Health Care NHS Trust and Leicestershire Partnership NHS Trust.

He also has a MBA from Sheffield Hallam University and a Diploma in Health and Social Services Management.

Angie Mason

Deputy Chief Executive/Director of Nursing, Integrated Governance and Quality, appointed 3 February 2006 retired 31 July 2014

Angie has had a long career with the Trust and its predecessor organisations which started in 1979 when she joined as a Mental Health Nurse and progressed over the next 14 years with staff nurse, activing sister, sister and community psychiatric nurse roles.

She became a Clinical Team Manager in 1993, Service Development Manager in 1996, Head of Service in 2000 and Senior Operational Manager in 2003. Prior to her Deputy Chief Executive Role she was Director of Service Delivery from 2005 until 2006.

In addition to her professional qualifications, she has NVQ Level 5 in Management and an MBA from the Open University.

Dr Kwame Fofie

Acting Medical Director from 1 December 2013 to 30 April 2014

Dr Fofie has been a consultant psychiatrist with the Trust since 2006 and clinical director since September 2011.

He is also a senior clinical tutor with Hull York Medical School (HYMS).

Dr Fofie is a member of the General Medical Council, the British Medical Association and the Royal College of Psychiatrists.

Philip King

Interim Executive Director of Nursing and Operations, July 2014 to March 2015

Philip has 27 years' senior clinical, policy, advocacy and leadership experience in the fields of law, health and social care.

An experienced national regulator and Barrister, he has held several board level, executive director and national leadership posts in public service. Philip has specialist skills in policy, clinical leadership, regulation and regulatory methods, equalities, diversity, involvement, engagement and human rights.

With a background in mental health and learning disabilities, Philip has also held honorary academic posts in law and health and social care.

Elizabeth Thomas

Director of Human Resources and Diversity, January 2014 to present

Elizabeth took on the role of HR Director following the retirement of Kate Truscott in 2014. She had been Deputy Director since 2010.

A Fellow of the Institute of Personnel and Development, Elizabeth has a Masters degree in Human Resource Management and has many years' experience in NHS workforce planning and management.

Elizabeth has held senior roles in the local NHS since 1994 including Associate Director of Human Resources at NHS East Riding of Yorkshire Primary Care Trust from 2004 to 2010 and Head of Human Resources at the former East Riding of Yorkshire and Yorkshire Wolds and Coast Primary Care Trusts from 2001 to 2004.

The Register of Directors' Interests is held by the Trust Secretary. It is a public document which can be accessed by contacting the Trust Secretary on (01482) 389194. It is also available on the website**.** Directors' interests have been fully considered and it has been concluded that there are no such interests which may conflict with their management responsibilities as per the requirements of Monitor's Code of Governance.

It is reported that the chairman had no other significant commitments that affected her ability to carry out her duties to the full and was able to allow sufficient time to undertake those duties.

The Board of Directors work as a unitary board and members have been selected to ensure the success of the organisation as a foundation trust, with an appropriate balance of clinical, financial, business and management backgrounds and skills. Should it be necessary to remove either the chairman or any non executive director, this shall be undertaken by the Council of Governors in accordance with the Trust's constitution.

The chairman and non executive directors of the Trust are appointed by the Council of Governors and are remunerated in accordance with terms and conditions approved by the Council of Governors.

Council of Governors – Lead Governor's Report

Governors engage with members of their constituencies and work with staff in service areas. During the year elections were held to fill vacant seats and those seats where existing Governors coming to the end of their term of office had decided not to re-stand for election. Elections took place for the East Riding, Hull and staff constituencies with a total of seven seats available. All of the seats were filled and those elected took up their seats from 1 February 2015. The newly elected governors are learning about their role and starting to engage with their constituencies. The Council of Governors is comprised of people who have various skills and experience which they bring to the role together with enthusiasm and commitment to really make a difference.

To fulfil their role governors are members of sub groups of the Council of Governors and have also forged links with staff and service areas. Governors also attend the Annual Members' Meeting which forms part of the Trust's annual review. The event also showcased the staff awards which recognised the work and extra effort that our staff have gone to so that patient care is of a high quality and standard.

The visiting programme for governors was modified and extended to include Clinical Commissioning Group colleagues. This gave governors the opportunity to talk to both patients and staff to find out what they think about our services. Future visits will be conducted using the new process following the Fifteen Steps and Patient Safety First guidance.

During the year governors were involved with the Patient Led Assessment of the Controlled Environment (PLACE) inspections and were part of the inspection panels. The visits involved talking to patients about the environment they are in and asking what they think of the food and service they receive.

The overall aim of governors is to help the Trust to continue to provide excellent quality of care and standards for patients and carers and to support staff in achieving this.

Julie Hastings, Lead Governor

The Council of Governors comprises of 28 Governors and one observer, who are members of the public and staff constituencies and representatives from partner organisations.

The table below sets out the composition of the Council of Governors.

Composition of the Council of Governors	
Public 16 Governors	9 East Riding of Yorkshire
	6 Hull
	1 Wider Yorkshire and Humber
Staff Five Governors	From various service areas in the Trust
Partner Organisations Eight Governors	East Riding of Yorkshire Council
	Hull and East Yorkshire MIND
	Kingston Upon Hull City Council

	Humberside Police
	HEY Smile Foundation
	NHS Hull Clinical Commissioning Group
	University of Hull Faculty of Health and Social Care
	Hull and East Yorkshire Hospitals NHS Trust
Observer	NHS East Riding of Yorkshire Clinical Commissioning Group

The Council of Governors met four times during 2014/15 including an Annual Members' Meeting (AMM). Governor attendance at these meetings is provided in the table later in this section. Governors are involved in setting the agenda for the Council meetings. Each meeting begins with a patient story which is a presentation by a service area team and, where possible, service users who give their view of the service. Council of Governors public meetings are open for members of the public to attend. The meeting dates and papers are published on our website.

The Council of Governors did not use its powers to require one of more of the directors to attend a Council of Governors meeting for the purpose of obtaining information about the Trust's performance of its functions or the directors' performance of their duties. Directors chose to attend the Council of Governors meetings and a summary of their attendance is included in the table detailing attendance at board and sub-committee meetings.

The Council of Governors is made up of individuals who have been elected by the local people and staff who represent our constituencies. The Council also includes representatives who are nominated from a range of partner organisations. The Council of Governors is chaired by the Trust chairman. Monitor, the sector regulator for health services in England, requires foundation trusts to appoint a Lead Governor. Following the resignation of Robert Awty, Julie Hastings was elected by the Council of Governors to fulfil this role from 4 December 2014.

The specific statutory powers and duties of the Council of Governors are:

- appoint and, if appropriate, remove the chairman;
- appoint and, if appropriate, remove the other non executive directors;
- decide the remuneration and allowances and the other terms and conditions of office of the chairman and the other non executive directors;
- approve (or not) any new appointment of a chief executive;
- appoint and, if appropriate, remove the Trust's auditor;
- receive the Trust's annual accounts, any report of the auditor on them and the annual report;
- hold the non executive directors, individually and collectively, to account for the performance of the Board of Directors;
- represent the interests of the members of the Trust as a whole and the interests of the public;
- approve "significant transactions";
- approve an application by the Trust to enter into a merger, acquisition, separation or dissolution;
- decide whether the Trust's non NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions;

- approve amendments to the Trust's constitution.

The Council of Governors holds the non executive directors on the Board of Directors to account for the performance of the Trust, including ensuring the Board of Directors acts so that the Trust does not breach the terms of its Licence.

Governors are invited to attend the Trust's public board meetings and sub-committee meetings so they can see how the Board of Directors works and learn more about the services and business the Trust provides. The Board of Directors meet on a monthly basis (with the exception of January and August) with every meeting held in public. The agendas and supporting papers for the public meetings are published on our website. Details of attendance at this meeting for the period of this report is detailed in another section of this report.

Confidential and commercially sensitive matters are discussed in a Part II (private) meeting and matters which were not confidential or commercially sensitive were discussed at meetings held in public. Governors are sent the agenda for the part II meeting and have access to the minutes.

The Council of Governors may not delegate its responsibilities, but can choose to carry out its duties through groups, committees or individuals. The Council has a sub-committee and three governor groups which are detailed below:

- Appointments, Terms and Conditions Committee;
- Finance and Audit Governor Group;
- Communications and Membership Governor Group;
- Strategy and Business Development Governor Group.

During 2014/15 the Appointments, Terms and Conditions Committee, chaired by a governor, met three times and made recommendations to the Council for the re-appointment of two non executive directors and a new chairman. In considering these appointments the committee took into account the view of the Board of Directors and the skills, experience and qualifications required for the position. Committee membership is primarily governors and it is chaired by a governor, supported by the senior independent director and director of human resources and diversity.

Governors have built working relationships within our service areas with our staff and patients and have learnt more about the service areas and the quality of care delivered.

Patient Led Assessment of the Controlled Environment (PLACE) inspections were held during the year which governors took part in. These inspections looked at the environment, facilities, cleanliness and the food that is provided on our in-patient wards for our patients.

Governors were involved in developing the Trust's Five Year Strategy and Operational Plan in 2014. The Council of Governors receives regular updates on implementation on specific aspects of the plan delivery and in November 2014 considered a full report on progress. They have also been involved in developing the annual plan for 2015/16 through the Strategy and

Business Development Governor Group, the outcome of which was reported to the Council of Governors.

Governors have taken part in the Recovery College Board and are invited to attend meetings of sub committees of the board to observe how they are run.

Governors have been involved in the development of the Quality Report and representatives attended events to decide what the priorities would be for the coming year. Governors were asked to make comments on the report and those received were published in the Quality Report.

Staff governors have been promoting their role by attending team meetings and the Staff Induction Market Place events.

Bi-monthly governor development days were held with various topics being discussed including the patient pathway, a presentation from external auditors on their findings of the Trust's audit and presentations from various services areas. In addition there are sessions with the Board of Directors built into the governor development day to discuss issues and improve communication between the Board of Directors and Council of Governors. Governors are involved in setting the agenda for the development days. Governors have also developed a governor forum, where only governors are present. The agenda for these meetings is set by the governors themselves and the actions from these meetings are shared with the chairman so they can be addressed.

There is a procedure for dealing with disputes between the Council of Governors and the Board of Directors and this is set out in Annex 8 of the Trust's constitution, but it was not necessary to use this during the year.

The detailed breakdown of current governors is as below. Public and staff governors were publicly elected.

Council of Governors Members and their Attendance in 2014/15

Name	Constituency	No of Council Meetings attended / possible total	Term of Office ended/s
Current Governors			
Rodney Evans	Hull Public	3/4	Jan 2016
Robert Hunt	Hull Public	4/4	Jan 2017
Gwen Lunn	Hull Public	1/4	Jan 2017
Eric Bennett	Hull Public	1/1	Jan 2018

Name	Constituency	No of Council Meetings attended / possible total	Term of Office ended/s
Ron Morgan	East Riding Public	4/4	Jan 2016
John Nicholls	East Riding Public	2/4	Jan 2016
David Gibson	East Riding Public	2/4	Jan 2016
Pat Collard	East Riding Public	4/4	Jan 2016
Julie Hastings	East Riding Public	4/4	Jan 2016
Ros Jump	East Riding Public	1/1	Jan 2018
Marie Nicoll	East Riding Public	1/1	Jan 2018
Mike Oxtoby	East Riding Public	1/1	Jan 2018
Peter Lacey	Wider Yorkshire and Humber Public	2/4	Jan 2016
Vanessa Colman	Staff	1/1	Jan 2018
Jezz Farmer	Staff	2/4	Jan 2016
Kevin Blyth	Staff	3/4	Jan 2016
Sarah Tyreman	Staff	1/1	Jan 2016
Natalie Belt	Staff	4/4	Jan 2017
Greg Aitken	Hull and East Yorkshire Mind	2/4	Aug 2017
Kay Durrant	Humberside Police	1/4	Jan 2016
Elaine Aird	East Riding of Yorkshire Council	2/4	Jan 2016
Helena Spencer	Kingston upon Hull City Council	2/4	Jun 2016
Jonathan Beckerlegge	NHS East Riding of Yorkshire Clinical Commissioning Group	0/4	Aug 2016
Kirsty Fishburn	University of Hull Faculty of Health and Social Care	0/1	Feb 2018
Andy Barber	HEY Smile Foundation	0/1	Feb 2018

Name	Constituency	No of Council Meetings attended / possible total	Term of Office ended/s
Governors who left during 2014/15			
Robert Awty	Hull Public	1/1	Jan 2015
Michael Lamb	East Riding Public	1/3	Jan 2015
Marie Wood	North Bank Forum	0/1	Jan 2017
Judith Dyson	University of Hull Faculty of Health and Social Care	0/1	Jan 2017
Jason Stamp	NHS Hull Clinical Commissioning Group	0/1	Jan 2016
Sue Cooper	Staff	1/3	Jan 2016
Julie Jones	Staff	3/4	Jan 2015
Eddie Brooks	Hull Public	0/3	Jan 2016
Stephen Howard	Hull Public	0/3	Jan 2016

Expenses

Governors receive no remuneration for their role. However, the Trust provides appropriate reimbursement, for example to cover travel expenses for governors who participate in events or activities arranged by the Trust. During the period 1 April 2014 to 31 March 2015, a total of 11 governors claimed reimbursement for expenses. This included those governors who are no longer in post or who have left during the year. The total cost reimbursed to governors for this period was £1,504.10.

Register of Interests

Governors are required to declare any interests as per the Constitution. The register of interests for the Council of Governors is available from the Membership Office, telephone 01482 389132 or email HNF-TR.governors.nhs.net.

Governor Elections

Elections were held in November for governor seats covering three constituencies. The details are below:

- Public – Hull – There was one seat available and one candidate was elected
- Public – East Riding of Yorkshire – There were four candidates to elect. All four seats were filled.

- Staff – There were two candidates to elect; two candidates were elected.

Members of the Board of Directors are engaging with governors enabling them to gain an understanding of governor and member views:

- Attendance at Council of Governors meetings
- Joint board and governor meetings for budgets, cost improvement programme and quality accounts
- Membership of governor groups
- Attendance at development days
- Involvement in visits by governors to patient areas
- Attending Patient Led Assessment of the Controlled Environment (PLACE) inspections
- Involvement in member events

The Board of Directors is responsible for the day to day running of the Trust although the Board of Directors takes account of the views of governors when developing its strategy and forward plans.

Members and Governors

591 new members joined our Trust during 2014/15 taking our membership total (excluding staff members) to 13,298. This was in line with our Membership Strategy to recruit at least the number of members that were lost due to bereavement, moved out of area or other reasons.

As of 31 March 2015, the Trust had 6,549 members in the East Riding, 5,971 in Hull, 673 in the wider Yorkshire and Humber area, 3,056 staff members and 105 members live outside our catchment area. Our Trust membership continues to grow and we continue to try to make it as representative as possible of the communities we serve. Our staff are broadly representative of the Trust's public membership in numerical terms.

Various membership recruitment events were held across Hull and East Riding in different locations for example in health centres, colleges and at local events including World Mental Health Day which was also attended by various local organisations. We also work closely with other local NHS organisations to promote membership in the local area and undertake joint membership recruitment.

The charts below show how membership is made up and the ethnicity profile.

Membership Size and Movement		
Public Constituency	2014/15	2015/16 (est)
At year start 1 April	13,426	13,298
New Members	591	1000
Members Leaving	719	750
At year end 31 March	13,298	13,548

Staff Constituency	2014/15	2015/16 (est)
At year start 1 April	3,025	3,056
New Members	293	200
Members Leaving	262	300
At year end 31 March	3,056	2,956

Analysis of Current Membership		
Public Constituency	Number of Members	Eligible Membership
Age (years)		
0 – 16	13	1,071,840
17 – 21	651	366,685
22+	11,663	3,930,394
Ethnicity		
White	12,647	4,692,156
Mixed	52	84,561
Asian or Asian British	136	385,964
Black or Black British	121	80,346
Other	30	40,910
Gender Analysis		
Male	4,905	2,649,813
Female	8,379	2,719,105

Trust members must be over 14 years old. Our membership constituencies are Hull, East Riding of Yorkshire, the wider Yorkshire and Humber area and staff. We also have a public out of area catchment constituency, but these members only receive information on the services we provide and are not eligible to vote in governor elections.

The Trust's members play an important part in our future development and can become involved in services by working with our governors if they so wish.

One of the greatest benefits of being a foundation trust is having a membership that can influence the services we provide. We produce a membership magazine – Humber People three times a year which gives information on what is happening within the Trust, patient activities and competitions.

Membership is about community engagement and developing our organisation in partnership with the community. As a foundation trust we have moved away from the control of the department of health to local people determining the future of services. It also gives us new opportunities to tackle stigma and discrimination.

Through our membership we want our members to be truly interested in making a difference and getting involved.

Our Membership Strategy identifies how we continue to:

- develop our membership to reflect the diversity of the services provided and ensure it is representative of the local population;
- develop relationships with other organisation and explore opportunities of joint working with other organisations;

- encourage members to increase awareness of mental health, learning disability and other health related issues to reduce associated with these conditions.

Contact Details

The Membership Office is the initial contact point for new and existing members. Details are below for contacting the Membership Office and our governors:

By Phone: 01482 389132 or 01482 389194

By Post:

Membership Office
Freepost RLZB-RKZB-AJSJ
Trust Headquarters
Willerby Hill
Beverley Road
Willerby
HU10 6ED

By email - HNF-TR.governors.nhs.net

To contact members of the Board of Directors, please telephone our Trust Headquarters Reception on 01482 301700 or write to us using the freepost address above.

Statement of the chief executive's responsibilities as the accounting officer of Humber 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 Monitor.

Under the NHS Act 2006, Monitor has directed Humber NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Humber NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, 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 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; and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her 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 NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Signed 

Chief Executive Date: 26 May 2015

Annual Governance Statement 2014/15

Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of Humber 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 Humber 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*.

During the course of the year, it was agreed that the Audit and Governance Committees be merged to form the Integrated Audit and Governance Committee (IAGC). This newly formed Committee came into force on 1 December 2014.

The Trust Board through its Audit Committee (now known as the IAGC agreed the Trust's 2014/15 Internal Audit Plan with its Internal Auditors. The results of these audits culminated in the Head of Internal Audit's opinion on the system of internal control.

Contracts were in place with a range of commissioners including Clinical Commissioning Groups (CCGs) and NHS England for 2014/15 setting out the contractual arrangements for services provided by the Trust, which have been agreed. Partnership agreements with Hull City Council and East Riding of Yorkshire Council for the provision of social care are also in place. I regularly meet with all Chief Executives in the Yorkshire and the Humber area and the Trust has a range of mechanisms in place to facilitate effective working with key partners. These include monthly meetings of the local patch Chief Executives and appropriate Directors from the Local Authority; various monthly meetings of Executive Directors from the Trust and the (CCG; meetings of two Partnership Boards which involves the Directors of Social Services or their representatives, local councilors and CCG representatives.

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 Humber 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 Humber NHS Foundation Trust for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

The Trust has a comprehensive, integrated framework in place to ensure a structured control environment where risks are identified, assessed and properly managed, where high standards are safeguarded and excellence can flourish.

The Assurance Framework forms a key document of the Trust Board in ensuring all principal risks are controlled, that the effectiveness of key risks has been assured and there is sufficient evidence to support the Annual Governance Statement.

The Risk Management Strategy covers all types of corporate risk confronting the organisation providing definition, analysis, rating, control and mitigation, actions to date and residual risk. It includes clinical, financial, operational, human resources and information management and technology risks. The Trust operates five major systems that come together through the risk assessment process to facilitate the management of all risks throughout the organisation. These systems comprise of those dealing with adverse incidents, complaints, claims, risk assessment, and health and safety. A range of policies are in place to describe these systems and structures. Copies of all key documents are available to all staff through the Trust Intranet. The Trust, through its training needs analysis, provides a comprehensive training programme that includes risk management training to staff, managers and directors to ensure they are equipped to manage risks appropriate to their authority and duties, and are competent to fulfil their roles. They are recognised and integral parts of each person's Training and Development Plan.

Training provided by the Trust to support staff in managing risk includes:

- corporate induction for all new starters
- health and safety
- fire training
- infection control
- information governance
- safeguarding
- Mental Health Act
- Mental Capacity Act
- incident reporting and investigation
- medicines management
- managing violence and aggression.
- Prevent training

The Trust has systems in place to ensure that we learn from good practice and adverse incidents through a range of mechanisms including benchmarking, clinical supervision, performance management, continuing professional development, clinical audit and research and systems to ensure that we implement national safety alerts and national guidance.

The strategy clearly states that I have overall accountability and responsibility for risk management within the Trust. The Director of Nursing is the Director lead with day to day responsibility for risk management, and each Director is responsible for managing risks within their own areas of work. The individual responsibilities of directors, managers and staff are identified in the Risk Management Strategy.

The Risk Management Strategy is endorsed by the Trust Board and reviewed annually and is available to all staff on the intranet.

Training covers mandatory requirements and elements that are dependent on the job role.

The Risk and Control Framework

The continued delivery of responsive, high quality services requires the Trust to identify, manage and reduce the effect of events or activities which could result in a risk to our service users, visitors, staff and those who work with us to deliver services. All our staff are expected to identify, manage and reduce risk as one of their fundamental duties in an environment of honesty and openness, where mistakes and untoward incidents are identified quickly and dealt with in a positive and responsive way.

The Trust Risk Management Strategy describes the arrangements for embedding risk management in the activities of the organisation. This is achieved through the use of a risk rating tool developed in accordance with national guidance to ensure that a consistent approach is taken to prioritising risks and incidents. Current risks confronting the operation of the organisation are identified as part of a 'top down' assessment process and a 'bottom up' risk identification process involving analysis of incidents, claims, complaints and other tools and by directorate and business unit risk assessments. Any risks identified by stakeholders either on an individual basis or as a group are taken account of in the risk assessment process. The profile of current risks is recorded in the Risk Register together with the associated treatment plans. Regular reports are made to the IAGC (and previously the Governance Committee) of progress in implementing the risk treatment plans and thus reducing the risks and on two occasions per year a report on all current risks is made to the Trust Board.

The requirement to sign an Annual Governance Statement as part of the statutory accounts and annual report requires the Trust Board to demonstrate that they are managing potential risks which would prevent the achievement of the Trust's principal corporate objectives. The Assurance Framework fulfils this purpose. The Assurance Framework does not exclude risks that are well-controlled but describes the existing controls and assesses independent assurance. The Assurance Framework also identifies gaps in control and gaps in assurance. The Assurance Framework is reported to and updated by the IAGC (previously the Governance Committee) and the Trust Board on a quarterly basis, following a review of evidence which includes current risks identified in the risk register. During 2014/15 the Assurance Framework identified a number of gaps in control or assurance. None of these gaps is deemed to be significant. The Trust has identified the actions required to address all these gaps and the action plans, were monitored in year on monthly basis by the Organisational Risk Management Group and by the Trust Board on a quarterly basis.

The Trust maintains a strict management and accountability framework for information governance and data security. Information Governance is assured by the annual information governance self-assessment using the NHS Information Governance (IG) toolkit. The self-assessed scores have been independently audited and an action plan developed to ensure further improvement. The Trust has scored highly with respect to the IG toolkit assessment. Additionally the Trust has encrypted laptops, encrypted data devices and desktop computers and reviewed the security of all bulk data in transit and personal identifiable data flows and mitigated against any risks identified. All data classified incidents were reviewed and none was deemed to be significant. The Trust has a qualified Chief Information officer who is up to date with the training required by the Information Authority. The Trust has also migrated to NYHS Mail for additional security for data transfers.

Public stakeholders are involved in the Trust through the implementation of the patient experience strategy. Governors are actively involved with service areas and their activity with patients and carers. There is clear focus on improving information, involvement in training, culture issues related to service delivery and involvement in development and review of services. Skills support packages are offered to members of the groups as required. Active development of working relationships with Health Watch and Overview and Scrutiny Committees is being pursued. The Patient Advice and Liaison Service (PALS) is well established and there is effective reporting quarterly to the Trust's IAGC and Board meetings. The Trust Board holds a meeting in public on a monthly basis.

The Trust self-assesses its performance against the requirements of the Care Quality Commission (CQC) on a regular basis throughout the year and ensures that controls are in place and effective in order to provide evidence of continuing compliance with these standards. Assured by this process the Trust Board has declared that the Trust is fully compliant with the requirements of the Care Quality Commission for the year. This self-assessment also assures that control measures are in place to ensure that all the Trust's obligations under equality, diversity and human rights legislation are complied with.

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

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

Humber NHS Foundation Trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Humber NHS Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC) as at the 31 March 2015.

Some of our most important achievements during the past 12 months include:

- Care Quality Commission (CQC) Inspectors found a high standard of person-centred care delivered by a team of staff who are passionate about what they do in our East Riding Addictions Service, provided in partnership with the Alcohol and Drugs Service and East Riding of Yorkshire Council.

- Families are now able to refer themselves to Child and Adolescent Mental Health Services by calling one of our Contact Point numbers and speaking directly to a clinician.

- We have launched a new mobile APP and an internet portal to make it easier for people to refer themselves for talking therapies in the East Riding.

- We are embedding Children and Young People Improving Access to Psychological Therapies (IAPT) into our services to give families a greater say in decisions about their care and the way the services that are important to them are developed with a number of our staff currently undergoing training.

- Introduction of a Single Point of Contact (SPoC) for our neighbourhood care services in the East Riding.

- Our Occupational Health Service was awarded the Safe Effective Quality Occupational Health Services (SEQOHS) Accreditation that recognises Occupational Health Services that provide safe, appropriate and effective quality care for staff in the NHS and Independent Sector.

- Our East Riding Health Trainers began regular clinics in GP surgeries throughout rural Holderness and other locations in the East Riding. Health trainers also attend major events such as Driffield Show.

- Hawthorne Court achieved AIMS (Accreditation for Inpatient Mental Health Services) accreditation with excellence for the second time. This is the Royal College of Psychiatry mark of good practice designed to guarantee a high quality of care in mental health wards.

- We achieved Stage 2 Accreditation of the UNICEF Baby Friendly Initiative (BFI) designed to support breastfeeding and parent infant relationships.

- We began recruiting a team of Patient Voice Volunteers who support people spending time on our units to speak up about the care they are receiving.

- We joined other public sector organisations in Hull to launch Hull 2020, an ambitious transformation programme to enable local people to take control of their health and wellbeing and support them towards achieving their aspirations.

- We launched our Practice Health Champions website, a new programme in partnership with East Riding GP surgeries for people who want to improve health and wellbeing in their local community by establishing groups and projects and advising others.

Humber staff continue to excel not only in their professional commitment to quality, improvement and the patient experience but in the way they so often go the extra mile to motivate and inspire each other and provide care that is exemplary.

Our remarkable team of compassionate, responsive professionals were acknowledged when a team of 55 inspectors from the Care Quality Commission (CQC) visited 15 different service areas over 71 sites in April and May last year.

Feedback from the CQC, alongside comments from patients and carers through our Friends and Family Test feedback and Community Mental Health survey, also showed the overwhelming majority of our services were effective and had a positive impact on the lives of the people using them.

Seven essential improvements were flagged by the CQC at the time of the inspection and we either put them right or immediately started to make improvements. Other feedback from the inspectors has been used throughout the year as we work with our commissioners and partners to create even more responsive, patient-centred services.

The CQC reports highlighted issues around the length of time people sometimes have to wait for our services, particularly Child and Adolescent Mental Health Services (CAMHS).

Sadly, more young people are in need of this kind of support than ever before. This is not just the case here in Hull and the East Riding, across the country more families are asking for help to deal with some serious mental health issues including anxiety, self-harm, behavioural problems and eating disorders.

For example, there are three times more teenagers self-harming in England than there were ten years ago. We are working with our partners to try and understand why this is the case and how our services can respond flexibly to deal with this rise and make sure local children and young people get the most appropriate care and support.

The current demand means we cannot avoid that some young people will have to wait to be assessed and treated although young people who are very unwell are prioritised and we work closely with their GP to make sure their condition is monitored. While we are working very hard to reduce waiting lists for these important services, we recognise some families still have to wait for too long and we are very sorry about this.

Innovation continues to be important to us with many exciting new initiatives coming directly from our own teams. Just two examples;

- Trust dietitians have launched an exciting new scheme to empower care home staff in Hull and the East Riding with the most up-to-date knowledge about food and diet. The project – called the Nutrition Mission – is an award-based incentive scheme which will award bronze, silver, gold and platinum standards to care homes.
- Trust-wide professional lead for Arts Therapies Karl Tamminen has designed and is leading on a seclusion and restraint reduction in our Psychiatric Intensive Care Unit (PICU) that has had input from all of the different professions working in our low and medium secure services. Karl will be speaking at a national conference on reducing restrictive practices.

There is a greater acknowledgement than ever before that we are all in this together and this year has seen some fantastic examples of joint working with our partners and commissioners.

The Integrated Care pilot, which is being hosted by Pocklington Group Practice, focuses on delivering the right care by the most appropriate person at the best time and place for patients that have a health and social care need. Delivered by a joint team of doctors, nurses, social workers, care assistants and therapists, the service will run between 8am - 6pm, along with the

current Out of Hours services that support patients who require care or treatment in the evening and throughout the night.

The Trust is working with East Riding of Yorkshire Council's Lifeline scheme to use advances in technology to improve patient safety on the ward at East Riding Community hospital. The equipment enables our team to have a greater awareness of patient movement – something that it is vital in a busy ward. By reducing the risk of patients mobilising un-aided, we can reduce the risks of falls.

We recognise that a highly skilled, confident and caring workforce is fundamental to delivering compassionate services in settings that are the very best we are able to provide. The Trust continues to see improvements in compliance with mandatory training and individual personal appraisal and development reviews. We are continuing to develop our Apprentice Training Scheme to create our dedicated workforce of the future. All future bands 1-3 vacancies will be recruited to as an Apprenticeship role. This is a mechanism by which to "grow our own" and to address recruitment and retention difficulties.

Our Trust has continued to operate against the background of challenge that the public sector is facing, in continuing to improve the quality and effectiveness of services at a time when resources are increasingly scarce and where innovation and improvement are absolutely vital in supporting service transformation and quality improvement. Trust staff continue to excel both in their professional commitment to quality and the patient experience but in the way they so often go that extra mile to motivate and inspire their colleagues and provide exemplary care.

Review of Economy, Efficiency and Effectiveness of the Use of Resources

The Trust Board is leading a number of processes applied to ensure that resources are used economically, efficiently and effectively. A major operational transformation project was launched in 2014/15 designed to ensure the best alignment and efficiency between the management of services and ensure that our senior clinical leaders are at the heart of our operational structure.

This is being achieved by the reorganisation of the Trust into Care Group structures. With each Care Group having a triumvirate of a senior manager, senior nurse/allied professional and a senior medic as their leadership team.

To support this work, the trust has commissioned a piece of work from KPMG to build stronger foundations to ensure long term sustainability. This includes key objectives for 2015/16 including:

- Further enhance the programme management office and gateway process
- Review robustness of Cost improvement and transformations schemes
- Review of trust liquidity position
- Review of trust financial control mechanisms

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

Developing the Accounts

In developing the Quality Accounts for 2014/15 the Trust worked with key stakeholders, for example Governors, the local LINKs (ahead of their curtailment), local authority members, members of the Overview and Scrutiny Committees, patients and carers and their representative and commissioners to ensure that the priorities selected for review and publication represented the quality of our service delivery. Where these partners have commented on the quality accounts these are printed verbatim within the document.

The clinical improvement initiatives were prioritised by the Trust and stakeholders using the following criteria:

1. **impact** on improving quality through considering the likely improvement in safety, clinical outcomes and experience
2. **Feasibility**, in terms of the ease of implementation, resources required and likely time to completion or delivery.

This has resulted in our commitment to set key priorities as laid out in the table below:

Humber Foundation Trust Priorities 2015-16
Improve access to and support from Child and Adolescent Mental Health Service
Improve communications with patients, relatives, carers and our staff
Ensure systems are in place to support organisational learning across the Trust and release staff time for patient care and professional development through increased use of technology
Increase awareness of the needs of dementia patients and carers across Trust services
Review our Neighbourhood Care Teams to ensure they are able to be responsive to future service needs

Each of these has a set of clear key performance indicators to ensure delivery.

A public consultation on the priorities for 2014/15 took place during quarters 3 and 4, a number of events were held with stakeholders including commissioners, Governors, staff, Hull and East Riding Local Involvement Network (LINk) and Hull and East Riding Overview and Scrutiny Committee members, patients and carers and their representatives. During these events, presentations were given of the progress with the priorities and attendees were given the opportunity to share their views on Trust services with the Medical Director, Non-Executive Directors and Deputy Directors in group discussions.

The Trust also ran a very successful newspaper and internet campaign to encourage people to share their views on our services.

Data Quality

The Trust has taken a number of steps to ensure itself of the robustness of data quality. Over the past 12 months the Data Quality policy has continued to be implemented. The Trust has met the data quality requirements of all our contracts. However our work in this area is not yet complete and we will continue to address the issues during 2015/16.

Governance Arrangements

The keys to effective governance within the Trust are robust integrated committee structures and management processes, which give the Board of Directors confidence that all risks are being effectively controlled and managed and that attention is focused on the core business of the organisation to care for and treat patients.

The Trust Board and its sub-committee structure have a clear role in providing assurance and governance leadership within the Trust. The IAGC is the senior sub-committee with a remit including independently scrutinising other Board committees. It also reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities. This committee also gains assurance that confirms effective systems of internal control are in place.

The IAGC also evidences clinical and information governance and risk management within the Trust and provides strategic leadership for the development of continuous quality improvement taking account of the user experience and feedback from stakeholders. It also approves and monitors the implementation of clinical governance delivery plan and provides assurance on the systems and processes in place for the delivery of clinical governance and assurance on clinical quality throughout the Trust.

The Mental Health Legislation Committee oversees the operation of Mental Health and associated relevant legislation relating to patient care within the Trust and provides assurance on compliance with the Mental Health Act.

The Strategic Investment Committee ensures that processes governing strategic investments are being followed and makes recommendations to the Board on major capital expenditure, joint ventures, acquisitions and mergers, purchase, sale or alteration of property (above and agreed threshold) and service expansion or major service change.

The Remuneration and Nomination Committee make recommendations regarding the remuneration allowances and terms of service for Executive Board members.

The Charitable Funds Committee oversees the use of charitable funds on behalf of the Trust.

Review of Effectiveness

As Accountable 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 managers and clinical leads within Humber NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to 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 Trust Board and the IAGC and a plan to address weaknesses and ensure continuous improvement of the systems is in place.

Our internal auditors provide me with an opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The assurance framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by assurances from other sources which include the Care Quality Commission, patient and staff surveys, Patient Led Assessment of the Controlled Environment (PLACE) inspections , the National Health Service Litigation Authority, a number of Foundation Trust driven external reviews and the registration requirements of the Care Quality Commission and Information Governance Toolkit self-assessments.

The Trust Board annually reviews the Risk Management Strategy and reviews the Assurance Framework on a quarterly basis and ensures the Trust has an effective programme for managing all types of risk and is making appropriate risk management decisions so that the organisation can deliver its objectives. It does this by receiving regular reports from the executive management of the Trust and from the IAGC and the Mental Health Legislation Committee.

The IAGC has provided the Trust Board with an independent and objective review of controls in place within the organisation based on assurance it has received from Internal Audit and External Audit, from the IAGC and from management. Internal and external audit have reviewed and reported on control, governance and risk management processes, based on audit plans approved by the IAGC. Where scope for improvement was found, recommendations were made and appropriate action plans agreed with management. The Trust has a mechanism in place to track progress in implementing agreed recommendations and the results of re-audit are fed back to the IAGC.

The IAGC seeks assurance on the controls in place within the organisation that support the Trust's compliance with the requirements of the Care Quality Commission and Information Governance Toolkit, and the Mental Health Legislation Committee seeks assurance that the operation of the Mental Health Act is legally compliant.

The Trust continues to be committed to delivering safe, quality and compassionate care.

Conclusion

The Head of Internal Audit opinion statement has been received on the effectiveness of the system of internal control. The overall opinion is that significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives and that controls are generally being applied consistently.

My review confirms that Humber NHS Foundation Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Signed  Date: 26 May 2015

Chief Executive

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF HUMBER NHS FOUNDATION TRUST

Opinion on the financial statements of Humber NHS Foundation Trust

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2015 and of the Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cashflows and the related notes 1 to 35. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts.

Going concern

We have reviewed the Accounting Officer's statement that the Trust is a going concern. We confirm that:

- 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; and
- we have not identified any material uncertainties that may cast significant doubt on the Trust's ability to continue as a going concern.

However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Trust's ability to continue as a going concern.

Our assessment of risks of material misstatement	The assessed risks of material misstatement described below are those that had the greatest effect on our audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team:

Risk	How the scope of our audit responded to the risk
Recognition of NHS revenue This risk is focussed upon incremental adjustments to the Trust's revenue contracts arising during the year. The risk particularly arises where there are elements of judgement as to whether, and the extent to which, revenue should be allocated to the current or future accounting periods depending, for example, upon the performance obligations included in the contract for services. NHS revenue totalled £114.6m for 2014/15. Incremental adjustments resulted in changes to the income budget for 2014/15 of £2.5m. Income for the year is disclosed in note 3 to the financial statements. Accounting policies in relation to revenue are disclosed in note 1.1 to the financial statements.	• We evaluated the design and implementation of management's controls governing the acceptance of incremental adjustments. • We examined a sample of incremental adjustments to determine whether valid contract documentation existed. • We challenged the allocation of revenue to accounting periods by looking at a sample of revenue recognised at either side of the year end and assessing the appropriateness of the period in which the revenue has been recognised.
Property valuations As at 31 March 2015, The Trust holds property assets of £60m within Property, Plant and Equipment at a modern equivalent asset valuation. Impairments and upward revaluations are disclosed in note 15.1 to the financial statements. The valuations are by nature significant estimates which are based on specialist and management assumptions and which can be subject to material changes	• We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Trust to the valuer. • We used internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the Trust's properties, including the comparison of

in value. Accounting policies in relation to property valuations are disclosed in note 1.4 to the financial statements.	the approach and methodology adopted for the asset valuation to professional guidance. • We assessed whether the valuation and the accounting treatment of the impairment were compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Statement of Comprehensive Income or in Other Comprehensive Income. • We reviewed the accounting policies that are employed by the Trust in this area for appropriateness.

The description of risks above should be read in conjunction with the significant issues considered by the Audit Committee discussed on page 50 of the Annual Report.

Our audit procedures relating to these matters were designed in the context of our audit of the financial statements as a whole, and not to express an opinion on individual accounts or disclosures. Our opinion on the financial statements is not modified with respect to any of the risks described above, and we do not express an opinion on these individual matters.

Our application of materiality	We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work. We determined materiality for the Trust to be £1.455m. This is below 1.2% of Operating income and below 2.1% of Taxpayers' Equity. We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £73,000, as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit	Our audit was scoped by obtaining an understanding of the entity and its environment, including internal controls. Audit work was performed at the Trust's offices in Willerby, directly by the audit engagement team, led by the audit partner. The Trust's Charitable Fund was deemed not material by management and as such is not consolidated. The Trust's charity will be subject to independent examination later in the year. The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations.

Opinion on other matters prescribed by the National Health Service Act 2006	In our opinion: • the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006, and • the information given in the Strategic Report and the Directors' 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	
Annual Governance Statement, use of resources, and compilation of financial statements	Under the Audit Code for NHS Foundation Trusts, we are required to report to you if, in our opinion: • the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; • the NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or • proper practices have not been observed in the compilation of the financial statements.

	We have nothing to report in respect of these matters. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

Our duty to read other information in the Annual Report	Under International Standards on Auditing (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is: • materially inconsistent with the information in the audited financial statements; or • apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or • otherwise misleading. In particular, we have considered whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable and whether the annual report appropriately discloses those matters that we communicated to the Audit Committee which we consider should have been disclosed. We confirm that we have not identified any such inconsistencies or misleading statements.

Respective responsibilities of the accounting officer and auditor	As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors. We also comply with International Standard on Quality Control 1 (UK and Ireland). Our audit methodology and tools aim to ensure that our quality control procedures are effective, understood and applied. Our quality controls and systems include our dedicated professional standards review team. This report is made solely to the Council of Governors and Board of Directors ("the Boards") of Humber NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards 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 Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Scope of the audit of the financial statements	An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Paul Thomson, ACA (Senior statutory auditor)

for and on behalf of Deloitte LLP

Chartered Accountants and Statutory Auditor

Leeds, UK

27 May 2015

Humber NHS Foundation Trust
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Beverley Road
Willerby
East Riding of Yorkshire
HU10 6ED

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www.humber.nhs.uk

Improving Health and Wellbeing

Humber NHS
NHS Foundation Trust

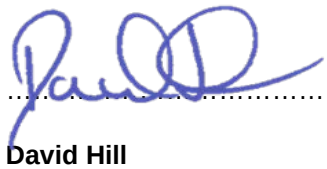
Humber NHS Foundation Trust
Financial Statements
2014/15

Foreword to the accounts

Humber NHS Foundation Trust

These accounts for the year ended 31 March 2015 are set out on the following pages and comprise of the statement of comprehensive income, the statement of financial position, the statement of changes in taxpayers equity, the statement of cashflow and the notes to the accounts

These accounts, for the year ended 31 March 2015, have been prepared by Humber NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Name **David Hill**
Job title **Chief Executive**
Date **22 May 2015**

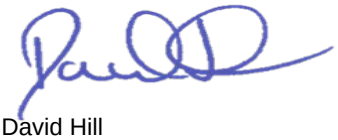
Statement of Comprehensive Income for the Year Ended 31st March 2015

	Note	2014/15 £000	2013/14 £000
Operating income from patient care activities	3	122,491	124,612
Other operating income	4	9,317	7,974
Total operating income from continuing operations		**131,808**	**132,586**
Operating expenses	5.1	(129,996)	(129,370)
Operating surplus/(deficit) from continuing operations		**1,812**	**3,216**
Finance income	10	39	41
Finance expenses	11.1	(220)	(250)
PDC dividends payable		(1,943)	(1,254)
Net finance costs		**(2,124)**	**(1,463)**
Share of profit of associates/joint arrangements		-	-
Gains/(losses) arising from transfers by absorption	32	-	-
Movement in the fair value of investment property and other investments		-	-
Corporation tax expense	12	-	-
Surplus/(deficit) for the year from continuing operations		**(312)**	**1,753**
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations	13	**-**	**-**
Surplus/(deficit) for the year		**(312)**	**1,753**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Gains/(losses) arising from transfer by absorption from demising bodies		-	16,930
Impairments	6	(103)	(852)
Revaluations		2,292	1,465
Share of comprehensive income from associates and joint arrangements		-	-
Other recognised gains and losses		-	-
Other reserve movements		-	-
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains/(losses) on available-for-sale financial investments	10	-	-
Recycling gains/(losses) on available-for-sale financial investments	10	-	-
Total comprehensive income/(expense) for the year		**1,877**	**19,296**

Statement of Financial Position as at 31 March 2015

	Note	31 March 2015 £000	31 March 2014 £000
Non-current assets			
Intangible assets	14	536	382
Property, plant and equipment	15	66,985	61,576
Trade and other receivables	21	-	-
Total non-current assets		**67,521**	**61,958**
Current assets			
Inventories	20	109	97
Trade and other receivables	21	8,900	4,906
Non-current assets for sale and assets in disposal groups	22	-	3,191
Cash and cash equivalents	22	12,348	15,709
Total current assets		**21,357**	**23,903**
Current liabilities			
Trade and other payables	23	(10,746)	(9,058)
Other liabilities	24	(1,045)	(1,225)
Borrowings	25	(255)	(265)
Provisions	27	(768)	(1,165)
Total current liabilities		**(12,814)**	**(11,713)**
Total assets less current liabilities		**76,064**	**74,148**
Non-current liabilities			
Trade and other payables	23	-	-
Other liabilities	24	-	-
Borrowings	25	(4,723)	(4,977)
Provisions	27	(974)	(1,175)
Total non-current liabilities		**(5,697)**	**(6,152)**
Total assets employed		**70,367**	**67,996**
Financed by			
Public dividend capital		44,293	43,800
Revaluation reserve		5,933	3,841
Available for sale investments reserve		-	-
Other reserves		-	-
Merger reserve		-	-
Income and expenditure reserve		20,140	20,355
Total taxpayers' equity		**70,366**	**67,996**

The notes on pages 8 to 44 form part of these accounts.
The financial statements on pages 1 to 44 were approved by the Board on the 22 May 2015 and signed on its behalf by:



Name David Hill
Position Chief Executive
Date **22 May 2015**

Statement of Changes in Equity for the year ended 31 March 2015

	Public dividend capital	Revaluation reserve	Available for sale investment reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2014 - brought forward	**43,800**	**3,841**	**-**	**-**	**-**	**20,355**	**67,996**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Surplus/(deficit) for the year	-	-	-	-	-	(312)	**(312)**
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	-	-	**-**
Other transfers between reserves	-	(97)	-	-	-	97	**-**
Impairments	-	(103)	-	-	-	-	**(103)**
Revaluations	-	2,292	-	-	-	-	**2,292**
Transfer to retained earnings on disposal of assets	-	-	-	-	-	-	**-**
Share of comprehensive income from associates and joint arrangements	-	-	-	-	-	-	**-**
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-	**-**
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	-	-	**-**
Public dividend capital received	493	-	-	-	-	-	**493**
Public dividend capital repaid	-	-	-	-	-	-	**-**
Public dividend capital written off	-	-	-	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	-	-	-	**-**
Other reserve movements	-	-	-	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2015	**44,293**	**5,933**	**-**	**-**	**-**	**20,140**	**70,366**

Statement of Changes in Equity for the year ended 31 March 2014

	Public dividend capital	Revaluation reserve	Available for sale investment reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2013 - brought forward	**42,519**	**2,038**	**-**	**-**	**-**	**2,861**	**47,418**
Prior period adjustment	-	-	-	-	-	-	**-**
Taxpayers' and others' equity at 1 April 2013 - restated	**42,519**	**2,038**	**-**	**-**	**-**	**2,861**	**47,418**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Surplus/(deficit) for the year	-	-	-	-	-	1,754	**1,754**
Transfers by absorption:gains/(losses) on 1 April transfers	-	-	-	-	-	16,930	**16,930**
Transfers by absorption: transfers between reserves	-	1,365	-	-	-	(1,365)	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	-	-	**-**
Other transfers between reserves	-	(175)	-	-	-	175	**-**
Impairments	-	(852)	-	-	-	-	**(852)**
Revaluations	-	1,465	-	-	-	-	**1,465**
Transfer to retained earnings on disposal of assets	-	-	-	-	-	-	**-**
Share of comprehensive income from associates and joint arrangements	-	-	-	-	-	-	**-**
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-	**-**
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	-	-	**-**
Public dividend capital received	-	-	-	-	-	-	**-**
Public dividend capital repaid	-	-	-	-	-	-	**-**
Public dividend capital written off	-	-	-	-	-	-	**-**
Other movements in public dividend capital in year	1,281	-	-	-	-	-	**1,281**
Other reserve movements	-	-	-	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2014	**43,800**	**3,841**	**-**	**-**	**-**	**20,355**	**67,996**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. Additional PDC may also be issued to NHS Foundation Trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS Foundation Trust.

Statement of Cash Flows for the year ended 31 March 2015

	Note	2014/15 £000	2013/14 £000
Cash flows from operating activities			
Operating surplus/(deficit)		1,812	3,217
Non-cash income and expense:			
Depreciation and amortisation	5.1	2,453	3,227
Impairments and reversals of impairments	6	(194)	1,432
(Gain)/loss on disposal of non-current assets	5.1 & 4	2	(55)
Non-cash donations/grants credited to income	4	(98)	-
Amortisation of PFI deferred credit	4	-	-
Non-cash movements in on-SoFP pension liability		-	-
(Increase)/decrease in receivables and other assets		(1,901)	(2,067)
(Increase)/decrease in inventories		(12)	(5)
Increase/(decrease) in payables and other liabilities		521	8
Increase/(decrease) in provisions		(620)	(1,358)
Tax (paid)/received		-	-
Operating cash flows movement of discontinued operations		-	-
Other movements in operating cash flows		2	(3)
Net cash generated from/(used in) operating activities		**1,965**	**4,396**
Cash flows from investing activities			
Interest received		39	41
Purchase and sale of financial assets		-	-
Purchase of intangible assets		(306)	(50)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(4,200)	(2,395)
Sales of property, plant, equipment and investment property		1,000	220
PFI lifecycle prepayments		-	-
Investing cash flows of discontinued operations		-	-
Net cash generated from/(used in) investing activities		**(3,467)**	**(2,184)**
Cash flows from financing activities			
Public dividend capital received		493	1,281
Public dividend capital repaid		-	-
Movement on loans from the Independent Trust Financing Facility		(109)	(109)
Movement on loans from the Department of Health		(146)	(146)
Movement on other loans		(10)	(20)
Capital element of finance lease rental payments		-	-
Capital element of PFI, LIFT and other service concession payments		-	-
Interest paid on finance lease liabilities		-	-
Interest paid on PFI, LIFT and other service concession obligations		-	-
Other capital receipts		-	-
Other interest paid		(198)	(209)
PDC dividend paid		(1,889)	(1,152)
Financing cash flows of discontinued operations		-	-
Cash flows from (used in) other financing activities		-	(1,281)
Net cash generated from/(used in) financing activities		**(1,859)**	**(1,636)**
Increase/(decrease) in cash and cash equivalents		**(3,361)**	**576**
Cash and cash equivalents at 1 April		**15,709**	**15,133**
Cash and cash equivalents at start of year for new FTs		**-**	**-**
Cash and cash equivalents transferred under absorption accounting	32	-	-
Cash and cash equivalents at 31 March	22.2	**12,348**	**15,709**

Notes to the Accounts for the year ended 31 March 2015

Note 1 Accounting policies and other information

Basis of preparation

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15 issued by Monitor. The accounting policies contained in that manual follow International FInancial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

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.

Going concern

These accounts have been prepared on a going concern basis. After making enquiries, the directors have a reasonable expectation that Humber NHS Foundation Trust has adequate resources to continue in operational existence in the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Note 1.1 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for Humber NHS Foundation Trust is contracts with commissioners in respect of health care services. Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract. Humber NHS Foundation Trust does not receive income under the NHS Injury Cost Recovery Scheme.

Note 1.2 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the Humber NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme : the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

Employers pension cost contributions are charged to operating expenses as and when they become due.

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

Note 1.3 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.

Note 1.4 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes;
• it is probable that future economic benefits will flow to, or service potential be provided to, Humber NHS Foundation Trust;
• it is expected to be used for more than one financial year; and
• the cost of the item can be measured reliably, and
the item has a cost of at least £5,000; or

• Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependant, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

• Items form part of the initial equipping and setting-up cost of a new buliding, 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, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

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. All assets are measured subsequently at fair value.

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

- Land and non-specialised buildings – market value for existing use;
- Specialised buildings – depreciated replacement cost.

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. Humber NHS Foundation Trust undertook a revaluation of the Estate by an independent valuer on 31 March 2015. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors (RICS) appraisal and valuation manual.

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

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 the national equipment indicies issued by the Department of Health are no longer available. The carrying value of existing assets at that date is written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

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

Depreciation, amortisation and impairments

Freehold land and properties under construction are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which Humber NHS Foundation Trust expects to obtain economic benefits or service potential from the asset. This is specific to Humber NHS Foundation Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting year end, Humber NHS Foundation Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Impairments arising from consumption of economic benefits or service potential are in accordance with the requirements of the Financial Reporting Manual (FReM). In this manual it adopts the following divergence from IAS 36, where an impairment loss arises from a clear consumption of economic benefits or service potential, the loss is recognised in operating expenses. However, to ensure that the Foundation Trust's reserves are in the same position as if IAS 36 applied, an amount should be transferred from the revaluation reserve to the income and expenditure reserve. This transfer is the lower of:

(i) the amount of the impairment loss charged to expenses; or
(ii) the balance on the revaluation reserve in respect of the asset.

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Donated, government grant and other grant funded assets

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

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

Useful Economic lives of property, plant and equipment

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

	Min life Years	**Max life Years**
Buildings, excluding dwellings	0	89
Plant & machinery	0	11
Transport equipment	0	3
Information technology	0	5
Furniture & fittings	0	8

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the FT expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.5 Intangible assets

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

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

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

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

Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

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

	Min life Years	Max life Years
Intangible assets - purchased		
Software	0	5

Note 1.6 Revenue government and other grants

Government grants are grants from Government bodies other than income from commissioners or NHS 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.

Capital grants are credited to deferred income initially and released immediately to operating revenue once all conditions have been met. Assets purchased from government grants are valued, depreciated and impaired as described above for purchased assets.

Note 1.7 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.8 Financial instruments and financial liabilities

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

Financial assets are recognised when Humber NHS Foundation Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred.

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

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

Classification and measurement
Financial assets are classified into the following categories: financial assets at fair value through statement of comprehensive income; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets and financial liabilities at "fair value through income and expenditure"
Humber NHS Foundation Trust does not have any embedded derivatives that have different risks and characteristics to their host contract.

Held to maturity investments
Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

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

Humber NHS Foundation Trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS receivables, accrued income and "other receivables".

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

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets
Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

Financial liabilities
Financial liabilities are recognised on the statement of financial position when Humber NHS Foundation Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

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

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

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial liabilities at fair value through profit and loss
Humber NHS Foundation Trust does not have any embedded derivatives that have different risks and characteristics to their host contract.

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from the Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Note 1.9 Leases

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Humber NHS Foundation Trust does not have any property, plant and equipment held under finance lease.

Note 1.10 Provisions

Provisions are recognised when Humber NHS Foundation Trust has a present legal or constructive obligation as a result of a past event, it is probable that Humber NHS Foundation Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms. The exception being early retirement provisions and injury benefit provisions which both use the HM Treasury's pensions discount rate of 1.9% in the short-term and 0.65% in the medium-term.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where Humber NHS Foundation Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when Humber NHS Foundation Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arsing from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 27, but is not recognised in the NHS Foundation Trust's accounts.

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 Humber NHS Foundation Trust pays an annual contribution to the NHS Litigation Authority 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 when the liability arises.

Note 1.11 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 28 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 28, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.12 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.13 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.

Note 1.14 Corporation tax

Under current regulations Humber NHS Foundation Trust is not liable to Corporation Tax.

Note 1.15 Foreign exchange

The functional and presentational currencies of Humber NHS Foundation Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where Humber NHS Foundation Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items (other than financial instruments measured at “fair value through income and expenditure”) are translated at the spot exchange rate on 31 March;
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.16 Third party assets

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

Note 1.17 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, including losses which would have been made good through insurance cover had NHS Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the 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.

Note 1.18 Pooled budgets

Humber NHS Foundation Trust has not entered into a pooled budget (section 75, NHS Act 2006) with any Local Authority.

Note 1.19 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2014/15.

Note 1.20 Standards, amendments and interpretations in issue but not yet effective or adopted

No accounting standards, amendments or interpretations are in issue and not yet effective or adopted in 2014/15.

Note 1.21 Critical accounting estimates and judgements

In the application of Humber NHS Foundation Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Note 1.22 Critical accounting estimates and judgements

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Humber NHS Foundation Trust applies estimates for the pension provision and injury provision based on average life expectancy. The holiday pay accrual is based on an actual data collection at 31 March 2015. The compulsory redundancy provision is based on actual salary of the expected redundant posts.

Note 1.23 Consolidation of Charitable Funds

Humber NHS Foundation Trust is the Corporate Trustee of the Humber NHS Foundation Trust Charitable Funds - Registered charity number 1052727. The Charitable Funds have not been consolidated into the accounts of Humber NHS Foundation Trust on the basis of immateriality. The balance of the funds at 31 March 2015 is £475k.

Note 2 Operating Segments

Humber NHS Foundation Trust activities are purely healthcare related, therefore no segmental analysis required.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2014/15	2013/14
	£000	£000
Mental health services		
Cost and volume contract income	281	249
Block contract income	67,681	70,728
Clinical partnerships providing mandatory services (including S75 agreements)	4,559	3,799
Clinical income for the secondary commissioning of mandatory services	-	-
Other clinical income from mandatory services	5,524	5,940
Community services		
Community services income from CCGs and NHS England	42,475	42,858
Community services income from other commissioners	1,023	301
All services		
Private patient income	-	-
Other clinical income	948	737
Total income from activities	**122,491**	**124,612**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2014/15	2013/14
	£000	£000
CCGs and NHS England	112,263	111,736
Local authorities	7,833	8,676
Department of Health	56	-
Other NHS Foundation Trusts	351	89
NHS Trusts	1,967	1,787
NHS other	-	-
Non-NHS: private patients	-	-
Non-NHS: overseas patients (chargeable to patient)	-	-
NHS injury scheme (was RTA)	21	26
Non NHS: other	-	2,298
Total income from activities	**122,491**	**124,612**
Of which:		
Related to continuing operations	122,491	124,612
Related to discontinued operations	-	-

The prior year Non NHS Other includes income relating to education,and clinical services from Non NHS providers. In the current year this has been split and reclassified into the relevant catagories

Note 3.3 Overseas visitors (relating to patients charged directly by the NHS Foundation Trust)

	2014/15	2013/14
	£000	£000
Income recognised this year	-	-
Cash payments received in-year	-	-
Amounts added to provision for impairment of receivables	-	-
Amounts written off in-year	-	-

Note 4 Other operating income

	2014/15	2013/14
	£000	£000
Research and development	644	1,038
Education and training	3,571	4,006
Receipt of capital grants and donations	98	-
Charitable and other contributions to expenditure	-	-
Non-patient care services to other bodies	2,153	1,995
Profit on disposal of non-current assets	-	55
Reversal of impairments	1,708	645
Rental revenue from operating leases	-	-
Rental revenue from finance leases	-	-
Amortisation of PFI deferred credits	-	-
Income in respect of staff costs where accounted on gross basis	808	-
Other income	335	235
Total other operating income	**9,317**	**7,974**
Of which:		
Related to continuing operations	9,317	7,974
Related to discontinued operations	-	-

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its Provider License, Humber NHS Foundation 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 license 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:

	2014/15	2013/14
	£000	£000
Income from services designated (or grandfathered) as commissioner requested services	128,215	129,887
Income from services not designated as commissioner requested services	3,593	2,699
Total	**131,808**	**132,586**

Note 5.1 Operating expenses

	2014/15	2013/14
	£000	£000
Services from NHS Foundation Trusts	25	53
Services from NHS Trusts	177	136
Services from CCGs and NHS England	-	-
Services from other NHS bodies	-	-
Purchase of healthcare from non NHS bodies	815	1,099
Purchase of social care	-	-
Employee expenses - executive directors	1,065	907
Employee expenses - non-executive directors	123	123
Employee expenses - staff	102,841	99,934
Supplies and services - clinical	4,547	4,058
Supplies and services - general	1,492	1,224
Establishment	3,201	2,658
Research and development	554	976
Transport	2,767	2,620
Premises	3,221	5,976
Increase/(decrease) in provision for impairment of receivables	27	10
Increase/(decrease) in other provisions	-	353
Change in provisions discount rate(s)	-	-
Inventories written down	-	-
Drug costs	637	620
Inventories consumed	-	-
• Rentals under operating leases	2,316	639
Depreciation on property, plant and equipment	2,301	3,063
Amortisation on intangible assets	152	164
Impairments	1,514	2,077
Audit fees payable to the external auditor		
audit services- statutory audit	56	68
audit services- regulatory reporting (external auditor only)	-	-
other auditor remuneration (external auditor only)	-	35
Clinical negligence	384	354
Loss on disposal of non-current assets	2	-
Legal fees	314	311
Consultancy costs	307	227
Training, courses and conferences	733	630
Patient travel	36	111
Car parking & security	-	-
Redundancy	382	942
Early retirements	-	-
Hospitality	-	-
Publishing	-	-
Insurance	-	-
Other services, eg external payroll	-	-
Grossing up consortium arrangements	-	-
Losses, ex gratia & special payments	7	2
Other	-	-
Total	**129,996**	**129,370**
Of which:		
Related to continuing operations	129,996	129,370
Related to discontinued operations	-	-

- Rental under operating leases includes rent paid to NHS Property Services which in 2013-14 was included in premises. Details of the operating leases can be found in Note 9.2.

The increase in other provisions of £417k is included within relevant the expenses codes. £88k Legal fees, £223k Establishment and £106k redundancy costs.

Note 5.2 Other auditor remuneration

	2014/15	2013/14
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of Humber NHS Foundation Trust	-	-
2. Audit-related assurance services	-	35
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**-**	**35**

Note 5.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2014/15 or 2013/14.

Note 6 Impairment of assets

	2014/15	2013/14
	£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	(194)	1,432
Other	-	-
Total net impairments charged to operating surplus/deficit	**(194)**	**1,432**
Impairments charged to the revaluation reserve	103	852
Total net impairments	**(91)**	**2,284**

Humber NHS Foundation Trust revalued its Land and Buildings during the period, resulting in an impairment charge to revaluation reserve of £103k (2013-14 £852k), £2,292k as an operating expense (2013-14 £2,077k) and £1,708k reversal of impairments credited to operating income in the statement of comprehensive income (2013-14 £645k).

Note 7 Employee benefits

	Permanent	Other	2014/15 Total	2013/14 Total
	£000	£000	£000	£000
Salaries and wages	77,607	5,601	**83,208**	82,910
Social security costs	5,461	582	**6,043**	6,087
Employer's contributions to NHS pensions	9,293	475	**9,768**	9,810
Pension cost - other	-	-	**-**	82
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	382	-	**382**	942
Agency/contract staff	-	5,379	**5,379**	2,713
Total gross staff costs	**92,743**	**12,037**	**104,780**	**102,544**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**92,743**	**12,037**	**104,780**	**102,544**
Included within:				
Costs capitalised as part of assets	-	-	**-**	-

Note 7.1 Average number of employees (WTE basis)

	Permanent	Other	2014/15 Total	2013/14 Total
	Number	Number	Number	Number
Medical and dental	63	-	**63**	69
Ambulance staff	-	-	**-**	-
Administration and estates	458	34	**492**	499
Healthcare assistants and other support staff	607	101	**708**	659
Nursing, midwifery and health visiting staff	932	32	**964**	930
Nursing, midwifery and health visiting learners	20	-	**20**	28
Scientific, therapeutic and technical staff	347	5	**352**	388
Social care staff	9	-	**9**	9
Agency and contract staff	-	111	**111**	40
Bank staff	-	-	**-**	-
Other	-	-	**-**	-
Total average numbers	**2,436**	**283**	**2,719**	**2,622**
Of which:				
Number of employees (WTE) engaged on capital projects	3	-	**3**	3

Note 7.2 Retirements due to ill-health

During 2014/15 there were 10 early retirements from Humber NHS Foundation Trust agreed on the grounds of ill-health (6 in the year ended 31 March 2014). The estimated additional pension liabilities of these ill-health retirements is £419k (£299k in 2013/14).
This information has been supplied by NHS Pensions.

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7.3 Staff Sickness Absence	2014/15 Number	2013/14 Number
Total FTE Days Lost	27,671	43,781
Total FTE Days Available (Years)	1,487	2,415
Average Sick Days per FTE	19	18

Staff Sickness Absence figures are calculated on a calendar year basis.

Note 7.4 Reporting of compensation schemes - exit packages 2014/15

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	4	2	**6**
£10,001 - £25,000	-	1	**1**
£25,001 - 50,000	2	-	**2**
£50,001 - £100,000	1	-	**1**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	1	-	**1**
>£200,000	-	-	**-**
Total number of exit packages by type	**8**	**3**	**11**
Total resource cost (£)	£353,000	£30,000	**£383,000**

Note 7.5 Reporting of compensation schemes - exit packages 2013/14

The table below summarises the costs of all staff exiting Humber NHS Foundation Trust in 2013-14 including any exit packages in respect of senior managers (of which there were none for Humber NHS Foundation Trust in 2013-14).

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	8	5	**13**
£10,001 - £25,000	9	3	**12**
£25,001 - 50,000	6	4	**10**
£50,001 - £100,000	1	-	**1**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	1	-	**1**
Total number of exit packages by type	**25**	**12**	**37**
Total resource cost (£)	£730,000	£213,000	**£943,000**

Note 7.6 Exit packages: other (non-compulsory) departure payments

	2014/15		2013/14	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	2	22	12	213
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	1	8	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**3**	**30**	**12**	**213**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Note 7.7 Management Costs

	2014/15	2013/14
	£000	£000
Management Costs	7,426	6,656
Income	129,168	132,586

Note 8 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the 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 the scheme liability is carried out annually by the scheme actuary 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 are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March
2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding)

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.
The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.
The Scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below.
This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:
The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.
With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) been used and replaced the Retail Prices Index (RPI).
Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.
Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Note 9 Operating leases

Note 9.1 Humber NHS Foundation Trust as a lessor

Humber NHS Foundation Trust does not act as a lessor, but does allow occupancy of the estate by licence.

Note 9.2 Humber NHS Foundation Trust as a lessee

The majority of leases are based on annual contracts. Humber NHS Foundation Trust has no contingent rents and lease arrangements do not contain purchase options or escalation clauses.

Following the NHS reforms as part of the Health and Social Care Act 2012 (Commencement No.4. Transitional, Savings and Transitory Provisions) Order 2013, the lease for properties that the Humber NHS Foundation Trust occupied during 2014/15 are held by NHS Property Services. Although the Humber NHS Foundation Trust does not have a formal lease agreement in place with NHS Property Services, substance over form dictates that this is disclosed in the accounts as an operating lease. The minimum lease payment represents the recharge by NHS Property Services to the Humber NHS Foundation Trust in year.

	2014/15	2013/14
	£000	£000
Operating lease expense		
Minimum lease payments	2,316	639
Contingent rents	-	-
Less sublease payments received	-	-
Total	**2,316**	**639**

	31 March 2015	31 March 2014
	£000	£000
Future minimum lease payments due:		
- not later than one year;	2,286	1,169
- later than one year and not later than five years;	1,461	2,035
- later than five years.	3,343	4,384
Total	**7,090**	**7,588**
Future minimum sublease payments to be received	-	-

Note 10 Finance income

	2014/15	2013/14
	£000	£000
Interest on bank accounts	39	41
Interest on loans and receivables	-	-
Interest on impaired financial assets	-	-
Interest on available for sale financial assets	-	-
Interest on held-to-maturity financial assets	-	-
Fair value gains/(losses) on other financial assets held at fair value through the income and expenditure	-	-
Recycling of gains/(losses) on available for sale financial instruments	-	-
Other	-	-
Total	**39**	**41**

Note 11.1 Finance expenditure

	2014/15	2013/14
	£000	£000
Interest expense:		
Loans from the Independent Trust Financing Facility	82	87
Loans from the Department of Health	116	122
Commercial loans	-	-
Overdrafts	-	-
Finance leases	-	-
Interest on late payment of commercial debt	-	-
Other - Unwinding of discount	22	41
Main finance costs on PFI and LIFT schemes obligations	-	-
Contingent finance costs on PFI and LIFT scheme obligations	-	-
Total interest expense	**220**	**250**
Other finance costs	-	-
Total	**220**	**250**

Note 11.2 The late payment of commercial debts (interest) Act 1998

	2014/15	2013/14
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation.	-	-

Note 12 Corporation tax

Humber NHS Foundation Trust is not subject to Corporation Tax during 2014/15.

Note 13 Discontinued operations

Humber NHS Foundation Trust had no discontinued operations during 2014/15

Note 14.1 Intangible assets - 2014/15

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2014 - brought forward	**869**	**-**	**869**
Valuation/gross cost at start of period for new FTs	**-**	**-**	**-**
Transfers by absorption	-	-	**-**
Additions	87	219	**306**
Impairments	-	-	**-**
Reversals of impairments	-	-	**-**
Reclassifications	-	-	**-**
Revaluations	-	-	**-**
Transfers to/from assets held for sale	-	-	**-**
Disposals/derecognition	-	-	**-**
Gross cost at 31 March 2015	**956**	**219**	**1,175**
Amortisation at 1 April 2014 - brought forward	**487**	**-**	**487**
Amortisation at start of period for new FTs	**-**	**-**	**-**
Transfers by absorption	-	-	**-**
Provided during the year	152	-	**152**
Impairments	-	-	**-**
Reversals of impairments	-	-	**-**
Reclassifications	-	-	**-**
Revaluations	-	-	**-**
Transfers to/from assets held for sale	-	-	**-**
Disposals/derecognition	-	-	**-**
Amortisation at 31 March 2015	**639**	**-**	**639**
Net book value at 31 March 2015	**317**	**219**	**536**
Net book value at 1 April 2014	**382**	**-**	**382**

Note 14.2 Intangible assets - 2013/14

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2013 - as previously stated	**819**	**-**	**819**
Prior period adjustments	-	-	**-**
Gross cost at 1 April 2013 - restated	**819**	**-**	**819**
Gross cost at start of period for new FTs	**-**	**-**	**-**
Transfers by absorption	-	-	**-**
Additions	50	-	**50**
Impairments	-	-	**-**
Reversals of impairments	-	-	**-**
Reclassifications	-	-	**-**
Revaluations	-	-	**-**
Transfers to/from assets held for sale	-	-	**-**
Disposals/derecognition	-	-	**-**
Valuation/gross cost at 31 March 2014	**869**	**-**	**869**
Amortisation at 1 April 2013 - as previously stated	**323**	**-**	**323**
Prior period adjustments	-	-	**-**
Amortisation at 1 April 2013 - restated	**323**	**-**	**323**
Amortisation at start of period for new FTs	**-**	**-**	**-**
Transfers by absorption	-	-	**-**
Provided during the year	164	-	**164**
Impairments	-	-	**-**
Reversals of impairments	-	-	**-**
Reclassifications	-	-	**-**
Revaluations	-	-	**-**
Transfers to/from assets held for sale	-	-	**-**
Disposals/derecognition	-	-	**-**
Amortisation at 31 March 2014	**487**	**-**	**487**
Net book value at 31 March 2014	**382**	**-**	**382**
Net book value at 1 April 2013	**496**	**-**	**496**

Note 14.3 Intangible assets financing 2014/15

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Net book value at 31 March 2015			
Purchased	317	219	**536**
Finance leased	-	-	**-**
Donated and government grant funded	-	-	**-**
NBV total at 31 March 2015	**317**	**219**	**536**

Note 14.4 Intangible assets financing 2013/14

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Net book value 31 March 2014			
Purchased	382	-	**382**
Finance leased	-	-	**-**
Donated and government grant funded	-	-	**-**
NBV total at 31 March 2014	**382**	**-**	**382**

Note 15.1 Property, plant and equipment - 2014/15

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2014 - brought forward	**10,140**	**47,524**	**-**	**1,002**	**1,215**	**121**	**7,917**	**1,128**	**69,047**
Valuation/gross cost at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Additions	-	1,420	-	3,246	80	-	485	-	**5,231**
Impairments	(567)	(1,050)	-	-	-	-	-	-	**(1,617)**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	200	-	(200)	-	-	-	-	**-**
Revaluations	282	2,010	-	-	-	-	-	-	**2,292**
Transfers to/from assets held for sale	60	131	-	(93)	-	-	-	-	**98**
Disposals/derecognition	-	-	-	-	(3)	-	-	-	**(3)**
Valuation/gross cost at 31 March 2015	**9,915**	**50,235**	**-**	**3,955**	**1,292**	**121**	**8,402**	**1,128**	**75,048**
Accumulated depreciation at 1 April 2014 - brought forward	**-**	**62**	**-**	**10**	**245**	**100**	**6,780**	**274**	**7,471**
Depreciation at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	1,536	-	-	185	6	426	148	**2,301**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	(193)	(1,515)	-	-	-	-	-	-	**(1,708)**
Reclassifications	-	10	-	(10)	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals/ derecognition	-	-	-	-	(1)	-	-	-	**(1)**
Accumulated depreciation at 31 March 2015	**(193)**	**93**	**-**	**-**	**429**	**106**	**7,206**	**422**	**8,063**
Net book value at 31 March 2015	**10,108**	**50,142**	**-**	**3,955**	**863**	**15**	**1,196**	**706**	**66,985**
Net book value at 1 April 2014	**10,140**	**47,462**	**-**	**992**	**970**	**21**	**1,137**	**854**	**61,576**

Note 15.2 Property, plant and equipment - 2013/14

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2013 - as previously stated	**8,310**	**39,319**	**-**	**383**	**848**	**329**	**7,250**	**3,744**	**60,183**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation/gross cost at 1 April 2013 - restated	**8,310**	**39,319**	**-**	**383**	**848**	**329**	**7,250**	**3,744**	**60,183**
Valuation/gross cost at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	2,285	14,654	-	-	824	-	102	436	**18,301**
Additions - purchased/leased/grants/donations	-	934	-	784	124	-	509	10	**2,361**
Impairments	(350)	(853)	-	-	-	-	-	-	**(1,203)**
Reclassifications	-	109	-	(165)	-	-	56	-	**-**
Revaluations	-	(6,376)	-	-	-	-	-	-	**(6,376)**
Transfers to/from assets held for sale	(105)	(264)	-	-	-	-	-	-	**(369)**
Disposals/derecognition	-	-	-	-	(581)	(208)	-	(3,062)	**(3,851)**
Valuation/gross cost at 31 March 2014	**10,140**	**47,523**	**-**	**1,002**	**1,215**	**121**	**7,917**	**1,128**	**69,046**
Accumulated depreciation at 1 April 2013 - as previously stated	**-**	**5,530**	**-**	**-**	**668**	**302**	**5,347**	**3,188**	**15,035**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2013 - restated	**-**	**5,530**	**-**	**-**	**668**	**302**	**5,347**	**3,188**	**15,035**
Depreciation at start of period as FT	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	1,318	-	-	158	6	1,433	148	**3,063**
Impairments	-	1,726	-	-	-	-	-	-	**1,726**
Reversals of impairments	-	(645)	-	-	-	-	-	-	**(645)**
Reclassifications	-	(10)	-	10	-	-	-	-	**-**
Revaluations	-	(7,841)	-	-	-	-	-	-	**(7,841)**
Transfers to/from assets held for sale	-	(16)	-	-	-	-	-	-	**(16)**
Disposals/derecognition	-	-	-	-	(581)	(208)	-	(3,062)	**(3,851)**
Accumulated depreciation at 31 March 2014	**-**	**62**	**-**	**10**	**245**	**100**	**6,780**	**274**	**7,471**
Net book value at 31 March 2014	**10,140**	**47,461**	**-**	**992**	**970**	**21**	**1,137**	**854**	**61,575**
Net book value at 1 April 2013	**8,310**	**33,789**	**-**	**383**	**180**	**27**	**1,903**	**556**	**45,148**

Note 15.3 Property, plant and equipment financing - 2014/15

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2015									
Owned	10,028	49,829	-	3,955	795	-	1,196	705	**66,508**
Finance leased	-	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	-	**-**
PFI residual interests	-	-	-	-	-	-	-	-	**-**
Government granted	-	-	-	-	-	-	-	-	**-**
Donated	80	312	-	-	68	15	-	1	**476**
NBV total at 31 March 2015	**10,108**	**50,141**	**-**	**3,955**	**863**	**15**	**1,196**	**706**	**66,984**

Note 15.4 Property, plant and equipment financing - 2013/14

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2014									
Owned	10,060	47,267	-	992	962	-	1,137	854	**61,272**
Finance leased	-	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	-	**-**
PFI residual interests	-	-	-	-	-	-	-	-	**-**
Government granted	-	-	-	-	-	-	-	-	**-**
Donated	80	195	-	-	8	21	-	-	**304**
NBV total at 31 March 2014	**10,140**	**47,462**	**-**	**992**	**970**	**21**	**1,137**	**854**	**61,576**

Note 16 Donations of property, plant and equipment

During 2014/15 Humber NHS Foundation Trust received a cash donation of £30k to improve the facilities at Withernsea Hospital and a further £98k for the purchase of X-Ray equipment.

Note 17 Revaluations of property, plant and equipment

All land and buildings are restated to current value using professional valuations in accordance with IAS 16.

Note 18.1 Investments - 2014/15

Humber NHS Foundation Trust held no investments in 2014/15 (2013/14 £Nil).

Note 18.2 Investment property income and expenses

Humber NHS Foundation Trust held no investment property in 2014/15 (2013/14 £Nil).

Note 19 Disclosure of interests in other entities

Humber NHS Foundation Trust has no interest in any other entity in 2014/15 (2013-14 £Nil).

Note 20 Inventories

	31 March 2015 £000	31 March 2014 £000
Drugs	-	-
Work in progress	-	-
Consumables	109	97
Energy	-	-
Inventories carried at fair value less costs to sell	-	-
Other	-	-
Total inventories	**109**	**97**

Inventories recognised in expenses for the year were £2,016k (2013/14: £1,851k). Write-down of inventories recognised as expenses for the year were £0k (2013/14: £0k).

Note 21.1 Trade and other receivables

	31 March 2015 £000	31 March 2014 £000
Current		
Trade receivables due from NHS bodies	4,173	2,365
Receivables due from NHS charities	-	-
Other receivables due from related parties	1,611	878
• Capital receivables	2,093	-
Provision for impaired receivables	(63)	(39)
Deposits and advances	-	-
Prepayments (non-PFI)	798	-
PFI prepayments:		
Capital contributions	-	-
Lifecycle replacements	-	-
Accrued income	196	615
Interest receivable	-	-
Corporation tax receivable	-	-
Finance lease receivables	-	-
Operating lease receivables	-	-
PDC dividend receivable	-	-
VAT receivable	92	80
Other receivables	-	1,007
Total current trade and other receivables	**8,900**	**4,906**
Non-current		
Trade receivables due from NHS bodies	-	-
Receivables due from NHS charities	-	-
Other receivables due from related parties	-	-
Capital receivables	-	-
Provision for impaired receivables	-	-
Deposits and advances	-	-
Prepayments (non-PFI)	-	-
PFI prepayments:		
Capital contributions	-	-
Lifecycle replacements	-	-
Accrued income	-	-
Interest receivable	-	-
Corporation tax receivable	-	-
Finance lease receivables	-	-
Operating lease receivables	-	-
VAT receivable	-	-
Other receivables	-	-
Total non-current trade and other receivables	**-**	**-**

The great majority of trade is with Clinical Commissioning Groups, as commissioners for NHS Patient care services. As Clinical Commissioning Groups are funded by Government to buy NHS patient care services, no credit scoring of them is necessary.

- Capital Receivables of £2,093k relates to the deferred receipt of funds from the sale of Westwood Hospital.

Note 21.2 Provision for impairment of receivables

	2014/15	2013/14
	£000	£000
At 1 April as previously stated	**39**	**51**
Prior period adjustments	-	-
At 1 April - restated	**39**	**51**
At start of period for new FTs	**-**	**-**
Transfers by absorption	-	-
Increase in provision	37	19
Amounts utilised	(3)	(22)
Unused amounts reversed	(10)	(9)
At 31 March	**63**	**39**

The provision consists of non NHS receivables outstanding for more than 6 months past their due date.

Note 21.3 Analysis of impaired receivables

	31 March 2015		31 March 2014	
	Trade receivables	Other receivables	Trade receivables	Other receivables
Ageing of impaired receivables	£000	£000	£000	£000
0 - 30 days	-	-	-	-
30-60 days	-	-	-	-
60-90 days	-	-	-	-
90- 180 days	-	-	-	-
Over 180 days	63	-	39	-
Total	**63**	**-**	**39**	**-**
Ageing of non-impaired receivables past their due date				
0 - 30 days	504	-	532	-
30-60 days	317	-	161	-
60-90 days	173	-	236	-
90- 180 days	225	-	56	-
Over 180 days	165	-	13	-
Total	**1,384**	**-**	**998**	**-**

Note 22.1 Non-current assets for sale and assets in disposal groups

	2014/15				2013/14
	Intangible assets	Property, plant & equipment	Investment properties	Total	Total
	£000	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	**3,191**	**-**	**3,191**	**3,000**
Prior year adjustment	-	-	-	-	**-**
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	**-**	**3,191**	**-**	**3,191**	**3,000**
At start of year for new FTs	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	**-**	**-**
Plus assets classified as available for sale in the year	-	94	-	**94**	**353**
Less assets sold in year	-	(3,094)	-	**(3,094)**	**(162)**
Less impairment of assets held for sale	-	-	-	**-**	**-**
Plus reversal of impairment of assets held for sale	-	-	-	**-**	**-**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	-	(191)	-	**(191)**	**-**
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**-**	**-**	**-**	**3,191**

The asset classified as held for sale in 2013/14 of Westwood Hospital was sold in November 2014.

Note 22.2 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2014/15	2013/14
	£000	£000
At 1 April	**15,709**	**15,133**
Prior period adjustments	-	-
At 1 April (restated)	**15,709**	**15,133**
At start of period for new FTs	**-**	**-**
Transfers by absorption	-	-
Net change in year	(3,361)	576
At 31 March	**12,348**	**15,709**
Broken down into:		
Cash at commercial banks and in hand	197	662
Cash with the Government Banking Service	12,151	15,046
Deposits with the National Loan Fund	-	-
Other current investments	-	1
Total cash and cash equivalents as in SoFP	**12,348**	**15,709**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**12,348**	**15,709**

Note 22.3 Third party assets held by the NHS Foundation Trust

Humber NHS Foundation Trust held cash and cash equivalents which relate to monies held by the the Foundation Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2015	31 March 2014
	£000	£000
Bank balances	320	268
Monies on deposit	-	-
Total third party assets	**320**	**268**

Note 23.1 Trade and other payables

	31 March 2015 £000	31 March 2014 £000
Current		
Receipts in advance	-	-
NHS trade payables	1,519	536
Amounts due to other related parties	-	-
Other trade payables	367	702
Capital payables	1,470	537
Social security costs	1,316	1,315
VAT payable	-	-
Other taxes payable	1,832	1,883
Other payables	4,165	4,062
Accruals	-	-
PDC dividend payable	77	23
Total current trade and other payables	**10,746**	**9,058**
Non-current		
Receipts in advance	-	-
NHS trade payables	-	-
Amounts due to other related parties	-	-
Other trade payables	-	-
Capital payables	-	-
VAT payable	-	-
Other taxes payable	-	-
Other payables	-	-
Accruals	-	-
Total non-current trade and other payables	**-**	**-**

Note 24 Other liabilities

	31 March 2015 £000	31 March 2014 £000
Current		
Deferred grants income	-	-
Deferred goods and services income	-	-
Deferred rent of land income	-	-
Other deferred income	1,045	1,225
Deferred PFI credits	-	-
Lease incentives	-	-
Total other current liabilities	**1,045**	**1,225**
Non-current		
Deferred grants income	-	-
Deferred goods and services income	-	-
Deferred rent of land income	-	-
Other deferred income	-	-
Deferred PFI credits	-	-
Lease incentives	-	-
Net pension scheme liability	-	-
Total other non-current liabilities	**-**	**-**

Note 25 Borrowings

	31 March 2015 £000	31 March 2014 £000
Current		
Bank overdrafts	-	-
Drawdown in committed facility	-	-
Loans from the Independent Trust Financing Facility	109	109
Loans from the Department of Health	146	146
Other loans	-	10
Obligations under finance leases	-	-
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	-	-
Total current borrowings	**255**	**265**
Non-current		
Loans from the Independent Trust Financing Facility	2,120	2,229
Loans from the Department of Health	2,603	2,748
Other loans	-	-
Obligations under finance leases	-	-
Obligations under PFI, LIFT or other service concession contracts	-	-
Total non-current borrowings	**4,723**	**4,977**

The DoH loan is for 25 years with a repayment date of 15th March 2034 with a fixed interest rate of 4.07%.

The Foundation Trust Financing Facility loan is for 23 years with a repayment date of 17th September 2035 with a fixed interest rate of 3.56%.

The other loan is a Salix loan which is interest free, repayable over 5 years with a repayment date of 1st September 2014.

Note 26 Finance leases

Humber NHS Foundation Trust had no Finance leases in the year 2014/15 (£Nil 2013/14).

Note 27.1 Provisions for liabilities and charges analysis

	Pensions - former directors	Pensions - other staff	Other legal claims	Agenda for change	Re-structurings	Continuing care	Equal pay	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2014	**-**	**506**	**152**	**-**	**-**	**-**	**-**	**690**	**992**	**2,340**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	-	-	-	-	-	**-**
Change in the discount rate	-	-	-	-	-	-	-	-	-	**-**
Arising during the year	-	-	244	-	-	-	-	255	223	**722**
Utilised during the year	-	(83)	(119)	-	-	-	-	(604)	(231)	**(1,037)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	-	-	**-**
Reversed unused	-	-	(156)	-	-	-	-	(149)	-	**(305)**
Unwinding of discount	-	4	2	-	-	-	-	4	12	**22**
At 31 March 2015	**-**	**427**	**123**	**-**	**-**	**-**	**-**	**196**	**996**	**1,742**
Expected timing of cash flows:										
- not later than one year;	-	94	123	-	-	-	-	196	355	**768**
- later than one year and not later than five years;	-	333	-	-	-	-	-	-	254	**587**
- later than five years.	-	-	-	-	-	-	-	-	387	**387**
Total	**-**	**427**	**123**	**-**	**-**	**-**	**-**	**196**	**996**	**1,742**

The other figure of £996k include the following provisions:

	£k
Injury Provision	577
ECAC Merger	83
Quays (Onerous Contract)	159
Sunshine House Insurance	75
PCT Legacy Invoices	90
Unwinding of Discount (Other)	12
Total Other Provisions	**996**

Note 27.2 Clinical negligence liabilities

At 31 March 2015, £1,149k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Humber NHS Foundation Trust (31 March 2014: £1,027k).

Note 28 Contingent assets and liabilities

	31 March 2015 £000	31 March 2014 £000
Value of contingent liabilities		
NHS Litigation Authority legal claims	-	-
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	**-**	**-**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**-**	**-**
Net value of contingent assets	**-**	**-**

At 31 March 2015, Humber NHS Foundation Trust did not hold any contingent assets (2013/14 £Nil).

Note 29 Contractual capital commitments

	31 March 2015 £000	31 March 2014 £000
Property, plant and equipment	1,247	-
Intangible assets	-	-
Total	**1,247**	**-**

Contractual capital commitments relate to capital schemes which are not completed within 2014/15 but which Humber NHS Foundation Trust have contracts to complete.

Note 30 Financial instruments

Note 30.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that Humber NHS Foundation Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, Humber NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. Humber NHS Foundation Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing Humber NHS Foundation Trust in undertaking its activities.

Humber NHS Foundation Trust's treasury management operations are carried out by the finance department, within parameters defined formally within Humber NHS Foundation Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by Humber NHS Foundation Trust's internal auditors.

Currency risk

Humber NHS Foundation Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. Humber NHS Foundation Trust has no overseas operations. Humber NHS Foundation Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

Humber NHS Foundation Trust borrows from government for capital expenditure. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. Humber NHS Foundation Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of Humber NHS Foundation Trust's income comes from contracts with other public sector bodies, Humber NHS Foundation Trust has low exposure to credit risk. The maximum exposures as at 31 March 2015 are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity risk

Humber NHS Foundation Trust's operating costs were incurred under contracts with Clinical Commissioning Groups in 2014/15, these entities are financed from resources voted annually by Parliament. Humber NHS Foundation Trust funds its capital expenditure from internally raised funds or by borrowing and therefore is not exposed to significant liquidity risks.

Note 30.2 Financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2015					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non financial assets	7,814	-	-	-	**7,814**
Other investments	-	-	-	-	**-**
Other financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	12,348	-	-	-	**12,348**
Total at 31 March 2015	**20,162**	**-**	**-**	**-**	**20,162**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2014					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non financial assets	4,211	-	-	-	**4,211**
Other investments	-	-	-	-	**-**
Other financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	15,709	-	-	-	**15,709**
Total at 31 March 2014	**19,920**	**-**	**-**	**-**	**19,920**

Note 30.3 Financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2015			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	4,978	-	**4,978**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	-	-	**-**
Trade and other payables excluding non financial liabilities	3,356	-	**3,356**
Other financial liabilities	-	-	**-**
Provisions under contract	1,742	-	**1,742**
Total at 31 March 2015	**10,076**	**-**	**10,076**

	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2014			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	5,242	-	**5,242**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	-	-	**-**
Trade and other payables excluding non financial liabilities	1,775	-	**1,775**
Other financial liabilities	-	-	**-**
Provisions under contract	2,340	-	**2,340**
Total at 31 March 2014	**9,357**	**-**	**9,357**

Note 30.4 Maturity of financial liabilities

	31 March 2015	31 March 2014
	£000	£000
In one year or less	9,102	8,182
In more than one year but not more than two years	974	1,175
In more than two years but not more than five years	-	-
In more than five years	-	-
Total	**10,076**	**9,357**

Financial assets and financial liabilities do not differ from the carrying amount.

Note 31 Losses and special payments

	2014/15		2013/14	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	-	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	22	6	113	23
Stores losses and damage to property	6	1	1	2
Total losses	**28**	**7**	**114**	**25**
Special payments				
Extra-contractual payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Compensation payments	-	-	-	-
Special severence payments	-	-	-	-
Ex-gratia payments	-	-	-	-
Total special payments	**-**	**-**	**-**	**-**
Total losses and special payments	**28**	**7**	**114**	**25**
Compensation payments received		-		-

During 2014/15 Humber NHS Foundation Trust had 22 bad debts written off totalling £6k (113 totalling £23k in 2013/14) and 6 cases of other totalling £1k (1 in 2013/14 totalling £2k due to a damaged carpet).There have been no special payments made in 2014/15 (2013/14 £Nil)

Note 32 Transfers by absorption

Humber NHS Foundation Trust did not have any transfers by absorption during 2014/15.

Note 33 Prior period adjustments

Humber NHS Foundation Trust has no prior period adjustment in 2014/15.

Note 34 Events after the reporting date

Humber NHS Foundation Trust has no events after the reporting date.

Note 35 Related parties

The Department of Health is regarded as a related party. During the period Humber NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

	2014/15				2013/14			
	Income £'000	Expenditure £'000	Receivables £'000	Payables £'000	Income £'000	Expenditure £'000	Receivables £'000	Payables £'000
Health Education England	3,533	0	425	0	3,535	0	0	0
Hull & East Yorkshire Hospitals NHS Trust	1,771	964	319	307	2,025	987	667	264
Humber NHS Trust Charitable Funds	98	0	0	0	0	0	0	0
NHS East Riding Of Yorkshire CCG	56,443	48	1,538	0	55,120	0	280	4
NHS England	17,876	4	348	0	17,635	0	453	1
NHS Hull CCG	35,115	26	743	0	37,103	0	239	2
NHS Pensions Agency	0	9,293	0	0	0	9,892	0	1,315
NHS Property Services	335	824	64	964	0	1,147	71	0
NHS Vale of York CCG	2,333	0	145	0	2,334	0	0	0
Northern Lincolnshire & Goole Hospitals NHS Foundation Trust	335	0	86	9	146	104	99	8
York Teaching Hospital NHS Foundation Trust	22	761	10	81	0	0	0	0
Yorkshire Ambulance Service NHS Trust	205	335	47	34	199	300	54	5
NHS Business Services Authority	0	0	0	0	0	0	0	79
Local Government Bodies								
Kingston Upon Hull City Council	3,028	258	201	2	3,492	654	385	38
East Riding of Yorkshire Council	5,333	1,318	715	0	5,184	1,443	492	46

In addition, Humber NHS Foundation Trust has had a number of material transactions with other Government Departments and other central Government bodies. Humber NHS Foundation Trust had no transactions with related parties of senior staff of Humber NHS Foundation Trust.

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